WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST

ANNUAL REPORT & ACCOUNTS 2015 / 16

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1. Foreword from the Chief Executive

Welcome to Warrington & Halton Hospitals NHS Foundation Trust's Annual Report for the period 1st April 2015 to 31st March 2016.

2015-16 was perhaps one of the most challenging the Trust has faced in some time. We faced a number of major issues that were reflected nationally as the NHS continued to suffer the impact of austerity while at the same time struggling to ensure high quality care and maintain safe staffing levels.

At Warrington and Halton Hospitals NHS Foundation our year of multiple challenges started early following an unplanned deficit of £6.5m in 2014-15. This meant that our 2015-16 financial year commenced with a forecasted deficit of £15m, increasing for a number of reasons which included a large increase in our insurance premium, a reduction in the tariff that we are paid for our services and pay and price inflation.

On submission of a declining budget our regulator Monitor deemed the Trust to be in breach of our operating license, set robust savings and recovery targets and assigned a support team to work with us during this year. Simultaneously we applied to Monitor for a working capital loan of £15m to ensure our cash position as well as a separate capital loan of £13.5m to support the planned £20m modernisation of our hospital estate.

In July the Care Quality Commission published its report following inspection of our hospitals in January 2015. The CQC rated Halton Hospital as good, Bath Street Health and Wellbeing Centre (in Warrington where several clinic services are provided) as good and Warrington Hospital disappointingly as requires improvement. They rated caring and effectiveness across all services as good and applauded the exceptional compassion and dedication of our staff in providing care to our patients every day.

The CQC highlighted several areas for improvement including our continued difficulty in achieving the four-hour standard, long term staffing vacancies (particularly medics) and the variation in mandatory training compliance. While a disappointing outcome, significant progress had been made in all of the areas of concern between inspection and publication and a robust action plan continues to be pursued to ensure that all areas are supported to meet the expected targets.

Like other Trusts we struggled to recruit key healthcare professionals with doctor and nursing shortages across the country. This forced us into a position of having to rely heavily on temporary staff which subsequently had an adverse effect on our financial position. The introduction of the Monitor Agency Cap on payments for temporary staff commenced in November with a sliding scale reduction for locum doctors to 1st April 2016, when all temporary staff were fixed under the same cap. While this is a positive move to eliminate competition in the market place the Trust continued to rely on a significant proportion of temporary nurses and doctors to ensure safe staffing levels.

The continued national shortage of emergency care medics was one of a number of contributing factors hampering our efforts to achieve the 95% target of patients being seen, treated, admitted or discharged within four hours. NHS Warrington Clinical Commissioning Group made temporary funding available for a 24-bed intermediate care ward at the Warrington site in April 2015 for six months, designed to allow patients who had completed their acute care to be moved to appropriate care and free up beds in the main wards and departments. The Short Term Assessment and Rehabilitation ward was exceptionally well received and rated by the many patients and their friends and families who visited.

With a number of similarly struggling Trusts we were offered a range of support measures by the newly created NHS Improvement around the 4-hour target and are confident that, working closely with partners across the whole health economy, we can improve and sustain our performance in 2016-17. One of these measures was the opportunity to hold a Multi Agency Discharge Event (MADE) event in March, bringing all of our partners together over three days on the wards to look at barriers to discharge for some of our longer staying patients. The MADE identified considerable learning and with the whole system approaching the issue in a holistic and collaborative way we know we can improve the length of stay for community fit patients.

Supporting the delivery of urgent care we saw the opening of the Urgent Care Centre funded by Halton Clinical Commissioning Group at Halton General and a further UCC opening at the Widnes Healthcare Resource Centre. Operating seven days a week between 7am to 10pm, the UCCs have proven exceptionally popular with both Halton and Warrington patients handling around 60% of the conditions that normally present at the Emergency Department.

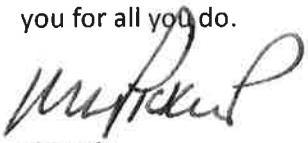
As part of our Five Year Strategy 'Creating Tomorrow's Healthcare Today – using technology to improve health' November also saw the deployment of our new electronic patient record system, Lorenzo, following months of planning. One of the biggest changes to happen at the hospitals in recent years, it was an enormous task to prepare our front line and support staff people to use the new software which required a completely different way of working. We also deployed a new Ormis theatre system at the same time. The new technology is designed to improve patient care and free up time to allow our staff to focus on patients but, like any major IT deployment, it has not been without its difficulties. By year end we were moving into the sustainability phase but acknowledge the stress and frustrations experienced by our staff in dealing with the pressures of the new system and of our patients and GPs who have struggled with appointment and correspondence issues as the new system was bedded in. As one of thirteen Trusts nationally that have adopted this new technology, Warrington and Halton is recognised as one of the best deployments, particularly given the complexity of the number of elements that we elected to 'go live' with in November.

Moving towards being a clinically led organisation, we began working with our senior teams in the creation of eight new clinical business units, putting a clinical director, lead nurse and operational manager as 'triumvirate leads' of Urgent and Emergency Care, Diagnostics, Airway-Breathing-Circulation and Specialist Medicine in the Acute Care Division and Digestive Diseases, Musculoskeletal Care, Specialist Surgery and Women's and Children's Health in the Surgery and Women's and Children's Division. An intensive round of aspirational and supportive assessment centres saw the CBU leads being appointed in time for the new financial year. We are confident that having this level of autonomy and ownership at a service level will place us in a strong position to further improve patient care, develop our services and ensure our sustainability going forward.

No review of the year would be complete without recognising the outstanding achievements of our marvelous staff who, in the face of what must have seemed like relentless performance pressures and a new IT system, continued to strive to give the best possible care and experience to our patients and visitors and to look after each other. There are too many to list but some of the highlights include: We became one of the highest achievers, and most improved Trusts, in the national 'Flu Fighters' campaign with 81.4% of our clinical staff having their flu jabs this year. Our Orthopaedics team was named the best performing trust in the North West for providing hip and knee replacement surgery by the Advancing Quality Alliance (AQuA), the health care quality improvement body which monitors the quality of services; Our trauma unit was

ranked one of the leading units in the country with the highest marks in the Cheshire and Merseyside Network and some of the highest in the country in an NHS England national peer review of trauma networks. The 'Forget Me Not' project was a finalist in the Best Dementia Friendly Organisational initiative in the prestigious Alzheimer's Society Awards and I was once again humbled to present countless Employee and Team of the Month Awards throughout the year culminating in the Thank You Awards at Warrington's Parr Hall in February, which were hugely supported by our patients.

A final word of recognition and thanks for those who give their time freely to support us in helping improve time in hospital for our patients, provide guidance to our visitors and support our staff through their smiles, dedication and moral support on a daily basis. These include our many hospital volunteers, our fundraisers for WHH Charity, our partner organisations and charities who raise awareness or indeed funds for us and our dedicated team of governors who work alongside us to keep us well governed and accountable. We thank you for all you do.



Signed:

Chief Executive

Date: 25th May 2016

2i. Performance Report – Overview of Performance

We are WHH: Three hospitals, two sites, one great team.

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. Many new departments and facilities have opened at the hospital over the last few years and it provides a full range of expert inpatient and outpatient services. Warrington Hospital is home to our accident and emergency department and maternity services as well as specialist critical care, stroke, cardiac and surgical units.

Halton General Hospital

A range of care for medical and surgical conditions is provided at Halton General Hospital delivering both inpatient and outpatient services. Without the pressured environment of its emergency care sister; Halton General 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 provide some chemotherapy services on site and the site is home to the Delamere Macmillan Unit.

Cheshire & Merseyside Treatment Centre

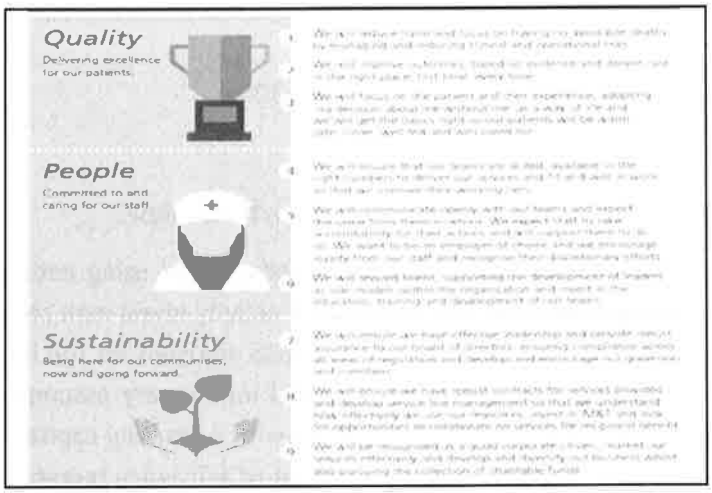
The Cheshire and Merseyside Treatment Centre is the home of orthopaedic surgery and treatment services on the Halton General campus. We perform a wide range of surgeries including hand, foot operations, joint replacements and spinal back surgery. We treat complex sports injuries (sports medicine) and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

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

Our mission is:
'To provide high quality, safe integrated healthcare to all our patients'

Our Vision is:
'To be the most clinically and financially successful healthcare provider in the mid-Mersey region'

To achieve our vision we believe we need to focus on the **QUALITY** of our services, on the **PEOPLE** who deliver them and on ensuring our organisation's **SUSTAINABILITY**, within the wider health economies in which we operate. The **QPS** Aims and Objectives are:



Everything we do is guided by our Values:

Fast Facts: WHH at a Glance

- There are around 600 beds across our hospitals
- More than 4,200 staff work across our wards and departments
- The trust has an annual turnover of £219 million
- We serve a local population of around 330,000 people (126K in Halton and 205K in Warrington)
- We provide almost 500,000 individual appointments, procedures and stays in hospital each year

- Inside our hospitals we've invested in new facilities - from maternity, dementia and critical care units to chemotherapy, endoscopy and ophthalmology facilities
- We have cut hospital infection rates by over 90% in five years and seen positive reductions in our other safety measures like falls and pressure ulcers
- We have been named as one of the 100 Best Places to Work in the NHS by the Health Service Journal
- Patients rate Halton General Hospital and the Cheshire and Merseyside Treatment Centre at the highest satisfaction rating of five stars on the NHS Choices website. Warrington Hospital received 3.5 stars
- We became an NHS Foundation Trust in December 2008

Going Concern Disclosure

The Board approved the 2016/17 Annual Plan for submission to Monitor.

The 2016/17 income and expenditure plans have been constructed using national guidance on tariff and inflationary factors. Income plans are based on anticipated activity levels with commissioners including tariff inflation and expenditure plans are based on current budgets adjusted for the impact of changes in activity levels, activity and quality related cost pressures, national inflationary assumptions and the cost savings requirement. The 2016/17 planned deficit is £18.6million, with a working capital borrowing requirement of £18.6 million. The Trust has been realistic in its assessment of efficiency targets that result in a cost saving target of £8.0 million. The Trust believes that this forward plan provides a realistic assessment of the Trust's position.

The capital plan is based on an in year spend of £6.7m that is funded by internally generated depreciation and the carry forward of the 2015/16 capital underspend so there is no requirement for a capital loan. The capital plan does not include the impact of the Estates Strategy programme that may be undertaken in year.

The Trust believes that this plan is a realistic assessment of the Trust's 2016/17 financial position.

Income and expenditure budgets have been set on robust and agreed principles, which mean that divisions should be able to provide high quality healthcare within the resources available, provided the cost saving targets are achieved.

The Trust has a robust governance structure that means the Finance & Sustainability Committee monitors financial performance and oversees the necessary corrective action, supplemented by the Innovation and Cost Improvement Committee that monitor progress towards the cost savings target. These committees are supplemented by additional scrutiny of the finances through Executive led review initiatives.

The Trust recognises there is an urgent need to develop a wider programme for the delivery of the continued cost savings and to derive benefits from local and economy transformational change. Therefore the Trust is an integral part of an economy wide alliance to contribute to the development of further cost reduction opportunities that may be available this year and beyond.

The preparation of the income and expenditure budgets and cash flow statements is predicated on many national and local factors and assumptions regarding both income and expenditure and profiled accordingly.

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

- 15/16 forecast outturn
- Changes in activity resulting from changes in demographic and demand
- National Payment by Results rules and regulations
- Commissioning intentions
- National tariff prices

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

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

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

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

Notwithstanding the deficits referred to above, the Trust does not have any evidence indicating that the going concern basis is not appropriate as the Trust has not been informed by Monitor that there is any prospect of intervention or dissolution within the next 12 months.

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

However, there is no certainty that further cost savings will be identified as part of the economy wide alliance and this indicates the existence of a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern.

Taking the above into account, the Directors believe that it is appropriate to prepare the financial statements on a going concern basis.

- National Payment by Results rules and regulations
- Commissioning intentions
- National tariff prices

2ii Performance Report – Performance Analysis

The Trust's annual plan for 2015/16 was the delivery vehicle for *Creating Tomorrow's Healthcare Today* - our five year strategic plan. As part of our continued evolution of our planning processes, we decided that our four strategic objectives should represent our core activities, and that the Trust Board and Hospital Management Board will focus on monitoring these.

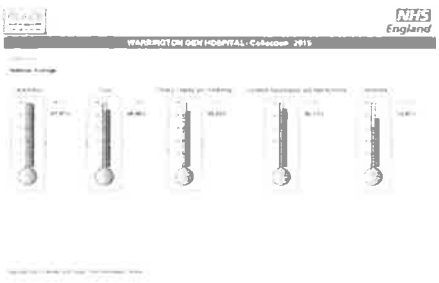
Our strategic objectives were as follows:

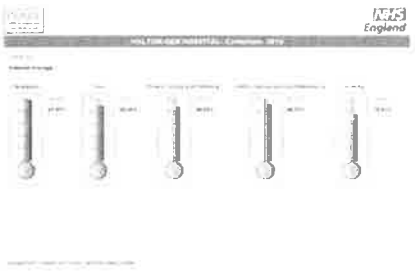
1. To ensure that all care is rated amongst the top quartile in the North West of England for patient safety clinical outcomes and patient experience. *This will ensure we maintain a focus on continuously improving the quality of services, work to decrease variations in care and improve health outcomes.*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

Patient Care Environment

This is the third year of Patient Led Assessment of the Care Environment (PLACE) which replaced Patient Environment Action Team (PEAT) in 2013.

PLACE assessments put patient views at the heart of the process and use information gleaned from patient assessors to report how well a hospital is performing in the areas assessed. Most significantly and importantly patients and their representatives will make up at least fifty percent of the assessment team. Our assessments took place on 29th April 2015 and 6th May 2015 at Warrington and Halton respectively.





We were pleased to see that cleanliness had improved on the Halton site from the previous year and that we better than the national average for cleanliness on both hospital sites and for food/condition, appearance, maintenance for the Halton site.

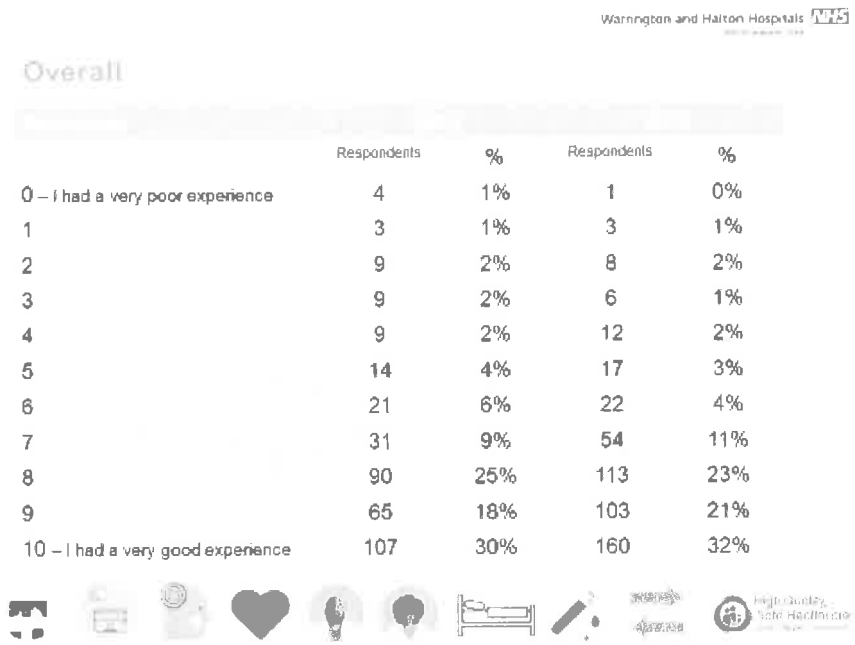
All actions arising from the PLACE assessments are monitored for progress on a monthly basis with 61% having already been completed.

National NHS Inpatient Survey 2015

National NHS Inpatient surveys are undertaken annually and Quality Health conducts the survey on behalf of Warrington and Halton Hospitals NHS Foundation Trust. Patients are randomly selected and for the 2015 survey 1198 patients were eligible to respond to the survey questionnaire, of which 529 (44%) responded. The Trust will receive further information about how our results compare with Trusts from all over the country in May 2016 but the following are the main headlines:

Compared to the 2014 survey, the findings of the 2015 survey tell us that the majority of the results show no significant change and that the Trust was rated:

- Significantly better on 7 questions
- Significantly worse on 1 question – waiting for hospital bed
- 32% of patients rated the Trust 10/10 - an increase of 2% from previous year.



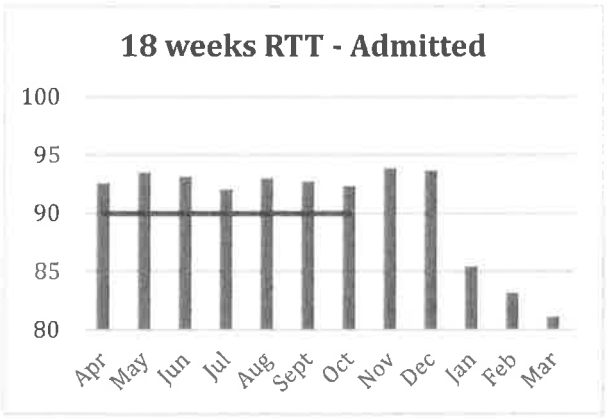
During 2015/16 A&E Attendances increased by 2.8% but non elective admissions reduce by 5.9%. The age and morbidity of the patients we are seeing and treating is increasing reflecting the demographics of the population we serve. This has put significant pressure on our resources and specifically beds and the local health economy's ability to discharge patients. We continue to work very closely with our health and social care partners to redesign patient pathways minimising hospital attendances and admissions.

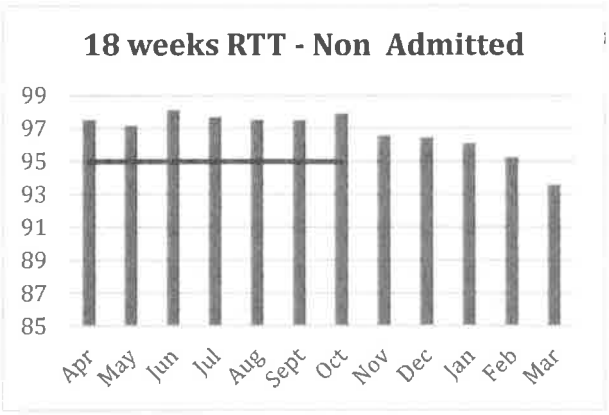
Activity	2014/15	2015/16*	% change
Elective Inpatients Spells	5,249	5,205	(0.8%)
Elective Day Cases Spells	34,553	33,335	(3.5%)
Non – Elective Spells	35,842	33,723	(5.9%)
New Outpatients	81,454	76,505	(6.1%)
A&E Attendances	102,571	105,411	2.8%

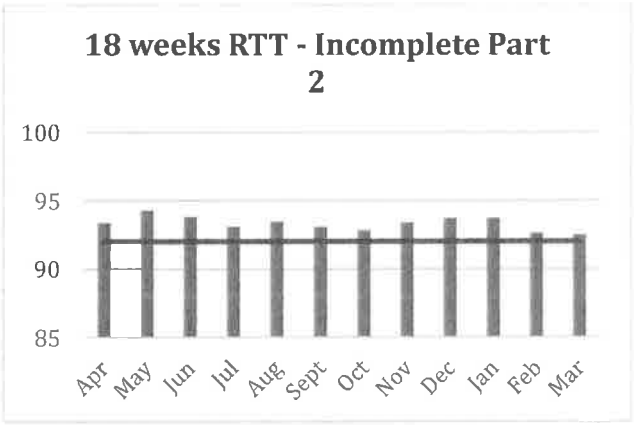
Source: Board of Directors finance report for year ending 31st March 2015 and 31st March 2016

Waiting Times

The Referral to Treatment (RTT) operational standards for England were met throughout 2015/16. In October 2015, the thresholds for RTT Admitted and Non Admitted were removed.







Performance against national target and regulatory requirements 2015/16

National Targets and Minimum Standards	Target	Target 2015/16	2015/16*	2014/15	2013/14
Infection Control	Number of clostridium difficile cases	<= 27	10	31	31
	Number of MRSA blood stream infection cases	0	2	3	3
Access to Cancer Services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	99.33%	97.92%	99.17%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti cancer drugs)	98%	100%	99.81%	100%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94%	99%	99.14%	100%
	% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment - Open Exeter	85%	85.54%	89.44%	89%
	% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment - Reallocation	85%	85.04%	85.64%	85.08%
	% of cancer patients waiting a maximum of 2 months from the consultant screening service referral to treatment	90%	96.88%	99.42%	100%
	% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	93.91%	93.89%	94.79%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	93.43%	93.25%	95%
Access To Treatment	18 weeks Referral to Treatment – admitted**	90%	90.70%	92.34%	91.57%
	18 weeks Referral to Treatment – non-admitted**	95%	96.42%	97.61%	97.80%
	18 weeks Referral to Treatment – patients on incomplete pathway	92%	93.29%	94.42%	93.07%
Access to A&E	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	88.57%	89.75%	95.56%
Access to 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		
Cancelled operations	% of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	<= 2%	0.91%	1.32%	1.36%
Cancelled operations not treated within 28 days	% of those patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days	<= 5%	6.46%	2.81%	1.58%

** Q1 and Q2 only. These targets were not mandated from October 2015

Stroke

The National Institute for Health and Care Excellence (NICE) stroke quality standard provides a description of what a good and effective quality stroke service should look like. These definitions include the treatment of stroke patients within specialist units and the provision of rapid access to the services for people who have had a minor stroke or transient ischaemic attack (TIA).

For all patients with stroke admitted through the A&E Department, a Stroke Specialist Nurse is available to attend on arrival, having been alerted by forward warning from the ambulance team, or 'fast bleep' from A&E Triage Nurses. The Specialist Nurse starts the process of the stroke admission, organising urgent investigations – CT scan, and assessing suitability for thrombolysis. The Stroke Nurse Specialists are augmented by nursing staff from the Acute Stroke Unit, to facilitate speedy transfer of the patient from A&E. The Trust maintains a specialist consultant rota to ensure all patients are assessed and their diagnosis confirmed.

This service is available 7 days per week from 08.00hrs – 20.00hrs. Between the hours 20.00 – 08.00, patients with suspected acute stroke are treated by St Helens & Knowsley hospitals NHS Trust. This service is a collaboration with St Helens and Knowsley Hospitals NHS Trust (SHKT) to deliver stroke care across the footprint of Warrington, Widnes, Runcorn, St Helens, Halton and Knowsley for a population of almost 700,000 residents.

The pathway aims for patients to be transported to CT scan then directly admitted to the Acute Stroke Unit, based on Ward B14, which aims to have a minimum of 2 assessment beds (1male, 1 female) available, for such eventualities. This has been a significant challenge in ensuring access to such beds. Eligible patients are thrombolysed on the Acute Stroke Unit or in circumstances where a bed is not available in A&E and treatment has not been delayed due to co-operation and support of A&E.

For TIA referrals from GP's or A&E is sent to single point of access, which allows specialist nurses to screen and allocate appointments according to urgency, this service is available daily with specialist consultant review, with 6 day access to carotid dopplers. For eligible patients, rapid referral via the specialist consultant to vascular surgeons occurs to ensure timely access for carotid endarterectom

	Target	2013/14	2014/15	2015/16
% of stroke patients spending >90% of their stay on a stroke unit	80%	77.4%	82.55%	79.9%
% of stroke patients admitted to a stroke unit within 4 hours	90%	49.4%	50.3%	45.4%
% of patients with TIA at higher risk of stroke seen and treated within 24 hours	60%	33%	40%	42%

Delayed Transfers of Care

Delayed transfers of care occur when a patient who is medically fit to be sent home from hospital is unable to do so. We continue to work with our partners across the health and social care economy to ensure that patients return to their home when they are fit to do so ensuring beds remain available for those patients being admitted who need our care.

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 has been essential for frail older patients to ensure a timely and appropriate diagnosis is made, and then a plan for discharge can be implemented. Warrington and Halton Hospital is working with our partners to achieve this. A community geriatrician is working closely with GPs and the extended community team to prevent admissions and monitor those patients over 75 who have been identified at high risk of admission /readmission.

A Short Term Assessment and Rehabilitation (STAR) Unit was instigated. An agreement was reached between Commissioners and Providers to operate the Unit. The unit has been one of the key resources used to manage the flow of patients to be discharged safely.

Regular reviews with social services to discuss complex cases continues. Over the last year there have been workshops with Social Services to consider those who are 'community fit' and a 'Single Assessment' approach. Further work has been completed with our partners undertaking a unified whole system approach. This culminated in a Multidisciplinary Accelerated Discharge Event (MADE) at the Hospital in March.

The table below shows our performance across the particularly difficult winter months:

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Number of patients delayed on the last Thursday of each month	22	13	2	23	27	4
Total days lost in month	607	344	408	465	562	592
Number of occupied bed days (patients aged 18+)	14547	15173	15232	14173	15385	16956
% of occupied bed days	4.17%	2.27%	2.68%	3.28%	3.65%	3.49%
Average daily bed days lost	20	11	13	15	19	19
Average general and acute occupied beds (excluding Neonatal, Paediatrics and Daycase beds)	518	506	471	526	544	530

Financial Performance 2015-16

During 2015/16 and moving into the 2016/17 financial year the Trust has strengthened financial governance with an increase in the level of scrutiny of the Trust's finances. For the year ending 31st March 2016 the Trust delivered a financial deficit of £17.3m excluding impairment expenses of £1.0m (£18.3m deficit including impairments) and a FSRR rating of 1.

Strategic Objectives 2016-17

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

Principle Risks faced by the Trust

The risks facing the Trust are both operational and strategic and follow extensive consultation regarding our future challenges. Mitigation strategies are in place in relation to all risk areas and all risks are mapped to the Assurance Framework and Corporate Risk Register. All risks have been assessed for likelihood and consequence.

During the course of the year the Framework has been reviewed on a quarterly basis by Board for each of the key risks. The Assurance Framework is presented on a quarterly basis to the Board with the risks to the achievement of the strategic objectives identified, assessed and mitigated on a continual basis.
We have reviewed our future objectives and strategy and have identified the following key strategic risks for 2016/17:

BAF risk ref:	
Objective 1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience	
1.1	CQC compliance for quality
1.2	Health and safety
1.3	National and local mandatory, operational targets
1.4	Business continuity
Objective 2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients	
2.1	Engage staff; adopt new working, new systems.
2.2	Nurse staffing
2.3	Medical staffing
2.4	Engaging and involving workforce
2.5	Right people, right skills in workforce
Objective 3: To deliver well-managed, value for money, sustainable services	
3.1	Developing Estates OBC to FBC
3.2	Monitor undertakings: corporate governance and financial management
3.3	Clinical and business information systems
Objective 4: To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.	
4.1	Length of stay; delayed transfers; bed shortages.

Developments in Information Technology

A major technology-enabled change event for the organisation in 2015/16 was the completion of the replacement of Meditech, our Patient Administration System (PAS) with a comprehensive new Electronic Patient Record (EPR) service, with Lorenzo at its core. The new service was delivered on time and within budget for 2015/16, achieving a successful go-live as planned on 23 November 2015.

The Medicorr system, used mainly for generating clinical documentation, and the Symphony system used in the Emergency Department, were also replaced as part of this transformation.

In addition to the core EPR Lorenzo system, the ORMIS theatre management system was introduced to support the Trusts operating theatres, e-WhiteBoards were brought in to bring ward-based care into the digital age and electronic kiosks to enable patients to register themselves were deployed into the Emergency Department.

This was an organisational achievement supported by the Information Management & Technology Team and in order to accomplish this, a complex set of plans and activities had to be co-ordinated and executed:

- Over 35 new Standard Operating Procedures were designed with clinical and operational staff to support the new ways of working
- Over 17 million lines of data were migrated using the supplier toolset to move the data needed from the Meditech system to Lorenzo. In addition to this, over 55,000 outpatient appointments were migrated into the Lorenzo application itself using automated "robots"
- 11 new data interfaces to other Trust systems were developed and tested ready for the introduction of the new EPR
- 2,300 users were trained in preparation for go-live and every user issued with a "smartcard" to enable them to access the new systems, which in turn are connected to the national systems such as the Personal Demographics Service and Summary Care Record
- A new data warehouse was implemented to support the information gathering and reporting capability within the Trust, to support almost 600 statutory and operational reports required in order to manage the day-to-day operation of Trust services as well as meeting the reporting requirements of external stakeholders
- Over 1,000 new end-user devices (tablets, laptops, etc.) were rolled out across the estate, and the network infrastructure, notably Wi-Fi connectivity, was upgraded
- Connectivity to the NHS 'N3' network was significantly improved with bandwidth being quadrupled as well as additional points of connectivity installed on Trust premises to improve network resilience

The next phase of the EPR development plan is due to start in July 2016 when work commences to introduce additional Lorenzo capability including Electronic Prescribing and Medications Administration.

Environmental Matters

The Trust has continued its investment in energy management and sustainability, and will be reducing its carbon footprint for the 2015/2016 period as a consequence. The Trust has also produced a Travel Plan, and carried out a Staff Travel Survey in this period, to help formulate its approach to minimising the use of single passenger car journeys, and better utilisation of car sharing, public transport, bike purchasing schemes, and in conjunction with Warrington Council is producing a Travel to Work leaflet for staff. The Trust has an active Sustainability Group, and completes both the Good Corporate Citizen self-assessment tool (current score 77%), as well as the Premises Assurance Model assessment.

Sustainability

The 2015-2016 financial year has seen the Trust continue to develop and introduce measures and initiatives that will enable the organisation to continue to make steady progress on the sustainability and carbon management agenda into the future. It saw the combined heat and power units on both the Halton and Warrington sites put into full operation in July 2015, the removal and replacement of local gas fired plant with plate heat exchangers, and the installation of new low energy dual-fuel boilers on the Halton site. A range of smaller energy initiatives were also completed in this financial year. An analysis of the full impact of these changes is being prepared in line with the standard reporting template.

Modern Slavery Act 2015

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, has a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

The Trust's Statutory Statement in relation to this Act can be found on the Trust's website www.whh.nhs.uk

3i Accountability Report – Directors' Report

The Board of Directors

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

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

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

Melany Pickup - Chief Executive

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

Executive Directors

Prof Simon Constable - Medical Director & Deputy Chief Executive

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

Tim Barlow - Director of Finance & Commercial Development

Tim joined the Trust in September 2013 and resigned with effect from 30th November 2015. Tim was previously chief operating officer and chief financial officer at Trafford Clinical Commissioning Group. He is a graduate certified accountant with an MBA from Manchester

Business School. Tim's background before joining NHS Trafford consisted of 26 years' experience, in a variety of senior finance roles within large Private sector organisations including UK finance director for both Thomas Cook and MyTravel PLC and subsequently the finance director for the merged Thomas Cook Airlines. Tim lives in South Manchester, is married and has one daughter.

Andrea Chadwick - Director of Finance & Commercial Development

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

Karen Dawber - Director of Nursing & Governance

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

Simon Wright – Chief Operating Officer & Deputy Chief Executive

Simon was appointed as director at the trust in June 2007 and resigned with effect from 27th September 2015. Simon started his management career with nine years in the independent health sector before joining The Walton Centre for Neurology and Neurosurgery NHS Trust in 1997. He joined Salford Royal Hospitals Trust in 2001 and oversaw the integration of Greater Manchester Neurosciences, followed by extending the surgical specialties brief as general manager. The general manager post was changed to associate director with an operating budget of £70m and 1,800 staff. Simon has a MSc from Lancaster University. He is married with a son and enjoys music, sport and reading. He took on the role of deputy chief executive in July 2013.

Sharon Gilligan – Chief Operating Officer

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

Non-Executive Directors

Lynne Lobley

Lynne joined the Trust Board as a non-executive director in December 2009 and is Chair of the Quality Committee. Lynne is also Deputy Chair of the Trust. She previously held non-executive director appointments on the Boards of the Walton Centre NHS Foundation Trust and Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust in Shropshire. She is also the lay member of the Senior Management Team of Mersey Deanery which is responsible for commissioning and quality managing post-graduate medical education and training in the region. In addition, she has considerable executive level experience within the Further and Higher Education sector, in both academic and management roles. Lynne is married and has a son at University and a daughter at 6th Form College in Warrington.

Ian Jones

Ian Jones joined the Trust Board as a non-executive director in July 2014 and is Chair of the Audit Committee. Ian is also the Senior Independent Director. After a career of over 35 years in the banking sector as regional corporate director for RBS, Ian changed direction in 2003 to take on wider interests and put something back. He is a non-executive director of several charities in the education sector. Ian is currently vice chair with The Liverpool School of Tropical Medicine - a position held since 2012 following an association with the school since 2004 - and chair of The Liverpool Institute for Performing Arts. Ian has lived in Warrington for over 20 years.

Terry Atherton

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

Dr Mike Lynch

Dr Mike Lynch joined the Trust as non-executive director in July 2013. Mike trained extensively in the United Kingdom and the United States and was a consultant at St Helen's and Knowsley Hospitals from 1982 in general medicine and rheumatology, becoming medical director at the trust. Mike worked with Warrington and Halton Hospitals as interim clinical director of unscheduled care in 2012 and 2013 before becoming a non-executive director with the Trust. Mike stepped down from the Trust in November 2016.

Anita Wainwright

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

Central Manchester NHS Foundation Trust. Anita has lived in Warrington for over 25 years and both her sons were born at Warrington Hospital.

During the reporting period there were interim arrangements in place for the role of Director of Finance was from 1st December 2015 until 31st January 2016 and the role of Chief Operating Officer from 28th September 2015 until 30th November 2015.

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

- Pat McLaren, Director of Community Engagement
- Roger Wilson, Director of Human Resources & Organisational Development
- Jason DaCosta, Director of Information Management & Technology
- Lucy Gardner, Director of Transformation

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

How the Board Operates

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

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

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

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

The Trust is committed to having a diverse Board in terms of gender and diversity of experience, skill, knowledge and background. The biographical details of all voting directors together with details of the deputy chair and senior independent director can be found at the beginning of this section. Of the eleven voting serving members on the Board as at 31 March 2016, six are female and five are male. During the year the structure and composition of the executive directors changed.

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

All directors have full and timely access to relevant information to enable them to discharge their responsibilities. The Board meets on a monthly basis during the year and at each meeting reviews the trust's key performance information, including reports on quality and safety, patient experience and care, operational activity, financial analyses and strategic matters.

The proceedings at all Board and committee meetings are fully recorded and allow for any director to discuss any concerns. The Board meetings are held in public and minutes of these meetings and papers are published on the trust's public website.

Directors are able to seek individual professional advice or training at the Trust's expense to further support them in the delivery of their duties. All directors have access to the professional advice of the company secretary who is responsible for advising the board on all governance matters, including ensuring that the organisation complies with the relevant legislation and regulations and for ensuring compliance with board probity and procedures. The appointment or removal of the company secretary is a matter for the Board as a whole.

Balance, completeness and appropriateness

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

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

In line with Monitor's guidance, the terms of office of directors appointed to the antecedent NHS Trust are not considered material in the calculation of the length of office served in the Trust. The directors' biographical details (pages 23-25) set out in this report demonstrate the wide range of skills and experience that they bring to the Board. The Trust's non-executive directors have each signed a letter of appointment to formalise their terms of appointment.

Following the strengthening of the executive team undertaken during the year, the Board believes it has a good balance of skills, experience and length of service, however it recognises the value of succession planning for Board members. The Trust has a programme of Board appraisal, individual appraisal and appointment or re-appointment to ensure the stability, succession, effectiveness and improve performance of the Board.

Evaluation of Board and committees

During the year the Board undertook a review of its corporate governance statements and in doing so addressed any matters highlighted regarding its effectiveness and that of its committees.

Each committee of the Board assesses on an on-going basis its performance in order to address any areas of weakness. Any changes made to the committee terms of reference were reported to the Board for ratification.

In addition to the Board and committees, all directors were subject to appraisal in 2015-16. In the case of the chief executive the appraisal was led by the chair; for the executive directors by the chief executive; for the non-executive directors by the chair and for the chair by the senior independent director.

Understanding the views of the governors, members and the public

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

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

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

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

The chair provides informal and formal updates and ad hoc briefings to governors and attends with the chief executive a bi-monthly informal question and answer session for governors to raise matters outside of the formal council meeting.

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

The Trust has also held a number of Board to governor workshops to discuss issues with the governors. The workshops considered the priorities of the Trusts strategic/annual plan and consider the priorities of the Quality Accounts 2016-17. For further details on the workshops and other aspects of the governors' work please see pages 41-47.

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

Board meetings and attendance

The Board of Directors met twelve times during the reporting period. All meetings were held in public and the Board reserves the right to go into private session where items are considered to be commercially sensitive.

Committees of the Board of Directors

The Board has three statutory committees; the Charitable Funds Committee and the Audit Committee, and the Nominations and Remuneration Committee. There are three additional committees; the Quality Committee; the Strategic People Committee; and the Finance and Sustainability Committee. Each works closely with the Audit Committee but report directly to the Board by way of exception reporting. Urgent matters are escalated by the committee chair to the Board as deemed appropriate. Each committee is chaired by an independent non-executive director.

For further details on the work of the Audit Committee see pages 32-35 and the Nominations and Remuneration Committee see the Remuneration Report.

Audit Committee

The role of the Audit Committee is to ensure that there is an effective system of integrated governance, risk management and internal control, across the whole of the Organisation's activities (both clinical and non-clinical), that supports the achievement of the Organisation's objectives.

The Committee comprises all Non-Executive Directors with the Trust's Chairman specifically excluded from membership. Membership of the Committee and attendance at meetings is reported on page 30.

The Director of Finance and Commercial Development; Company Secretary; External and Internal Auditors and Local Counter Fraud are invited to attend each meeting, as per the Committee Terms of Reference. The Chief Executive attends at least once a year to deliver the Annual Governance Statement.

Nominations & Remuneration Committee (for Executive Directors)

The remuneration and conditions of Service for the Chief Executive and Executive Directors are set by the Board's Nominations & Remuneration Committee whose membership comprises the Chairman and all Non-Executive Directors.

This Committee is accountable to the Trust Board and operates under agreed Terms of Reference. Further details concerning this committee can be found in the Remuneration Report.

Quality Committee

The role of the Quality and Risk Committee is to deliver assurance to the Board that high standards of care are provided by the Trust and in particular that adequate and appropriate clinical governance structures; processes and controls are in place through the Trust.

The Committee comprises 2 Non-Executive Directors and their attendance is reported on page 30.

Finance & Sustainability Committee

The role of the Finance & Sustainability Committee is to deliver assurance to the Board that high standards of performance are provided by the Trust and in particular that adequate and appropriate financial governance structures; processes and controls are in place through the Trust.

The Committee comprises 2 Non-Executive Directors and their attendance is reported on page 30.

The Charitable Funds Committee

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

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

In accordance with current reporting requirements the Trust is required to consolidate the results of the charity for the 2015-16. However following consideration of the external audit plan, the Audit Committee recognised that the fund size was immaterial to the Trust and therefore agreed that the charity would not be consolidated in the accounts on the basis of materiality.

Attendance at Board of Director Meetings and Sub-Committees 1 April 2015 – 31 March 2016

Board Member	Term of Appointment	Trust Board	Audit Committee	Quality Committee	Finance & Sustainability Committee	Strategic People Committee
		Attendance (Actual/Max)				
Non-Executive Directors						
Steve McGuirk (Chairman)	01.04.15-31.03.18	10/12	-	3/7	4/12	-
Lynne Lobley	01.12.09-30.11.16	12/12	5/5	7/7	5/12	3/4
Ian Jones	01.07.14-30.06.17	11/12	5/5	-	3/12	1/4
Terry Atherton	01.07.14-30.06.17	12/12	5/5	-	12/12	-
Anita Wainwright	01.01.15-31.12.18	10/12	5/5	-	9/12	4/4
Mike Lynch	Until 30.11.15	6/8	3/3	4/7	-	-
Executive Directors (Voting)						
Mel Pickup	-	11/12	-	4/7	9/12	-
Prof Simon Constable	-	11/12	-	5/7	8/12	-
Karen Dawber	-	12/12	-	6/7	8/12	2/4
Simon Wright	until 25.09.15	5/6	-	4/7	4/6	2/4
Jan Ross (Acting)	28.09.15-30.11.15	3/3	-	-	-	-
Sharon Gilligan	from 01.12.15	4/4	-	1/1	4/4	-
Tim Barlow	until 30.11.15	6/8	6/6	6/6	8/8	-
Mark Brearley (Interim)	01.12.15-31.01.16	2/2	-	-	1/1	-
Andrea Chadwick	from 01.02.16	2/2	1/1	1/1	1/2	-

Directors' Responsibility for Preparing the Financial Statements

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

Statement of Disclosure to Auditors

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

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

For the purposes of this declaration:

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

Annual Report of the Audit Committee

The 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. I am pleased to present my Audit Committee Annual Report which covers the reporting period 1 April 2015 to 31 March 2016.

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.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of at least three Non-Executive Directors with a quorum of two. I have been the Chair of the 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 myself, the Chair of the Committee and the details of my biography can be found on page 25.

Member	Attendance (Actual v Max)
Ian Jones, Non-Executive Director & Chair	5/5
Lynne Lobley, Non-Executive Director	5/5
Mike Lynch, (until November 2015) Non-Executive Director	3/3
Terry Atherton, Non-Executive Director	5/5
Anita Wainwright, Non-Executive Director	5/5

Regular attendees at the Committee Meetings are PricewaterhouseCoopers (External Auditors), Mersey Internal Audit Agency ("MIAA") (Internal Audit & Counter Fraud Services), the Director of Finance & Commercial Development and the Company Secretary.

Terms of Reference

The Committee's Terms of Reference will be reviewed during Q1 of 2016-17 to ensure they continue to remain fit-for-purpose.

Frequency of Meetings & Summary of Activity

The Committee met five times during the year. A summary of the activity covered at these meetings follows:

Governance & Risk Management

During the year the Trust has sought to build on the significant work undertaken in the previous year in this area to embed an integrated Governance & Risk system and approach to comply fully with Monitor's Foundation Trust Code of Governance.

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

Internal Audit Activities

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

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

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

Specific attention has been focused during the year on:

- Financial Systems
- IM&T
- Performance
- Clinical Quality
- Workforce
- Governance, Risk & Legality
- Follow up of previous audits where issues were identified

During the year significant assurance reports were received for the following audits:

- Estates Strategy
- Payroll
- Absence Management
- Recruitment Quality Spot Check – Ward CMTC
- Quality Framework –Phase 2
- NICE Quality Standards
- Safe Staffing Levels
- Quality Spot Check – Ward C22
- Activity Targets (Cancer waiting time)
- Combined Financial Systems
- Information Governance

and the Committee congratulate those involved for their dedicated work. The aim of the Committee is to ensure best practice is shared within the wider Trust where high assurance levels are received.

I am also pleased to report that the Head of Internal Audit overall opinion for 2015-16 is significant assurance.

External Audit

PricewaterhouseCoopers (PWC) has continued its role as Auditors to the Trust and during the year reported on the 2015-16 Financial Statements & Quality Accounts. Technical support has been provided on an on-going basis to the Committee and the Trust and representatives of PWC attend each Audit Committee.

The five year contract for the supply for external audit services by PWC will expire at the end of September 2016. In accordance with Monitor's guidance, the Trust will be required to undertake a full market testing exercise during 2016.

PWC attends a Council of Governors meeting following the production of the Annual Report and Financial Statements to ensure Governors are assured by the process undertaken to audit the accounts. In addition, they also present their opinion on the Quality Account to the Council of Governors and to the Annual Members Meeting.

During 2015-16, the Trust remained red for governance under Monitor's Risk Assessment Framework and consequently the Value For Money (VFM) conclusion will be limited.

Counter Fraud Activity

The Committee and the Trust are supported in carrying out Counter Fraud activity by MIAA's Counter Fraud Service (CFS) working to a programme agreed with the Audit Committee.

The role of CFS is to assist in creating a counter-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 Counter-Fraud, Bribery and Corruption Policy.

The Audit Committee received regular progress reports from the CFS and at the time of writing is awaiting an annual report.

No significant cases or issues of Counter-Fraud took place or were identified during the year.

Issues Carried Forward

The Audit Committee will continue its work to ensure the overall system of internal controls and the assurance processes remain robust.

In the reporting period there were no significant and material issues raised by the Committee to the Board of Directors or the Council of Governors.

During 2016-17, the Committee will formalise clear policy guidelines around the provision of non-audit services by external auditors.

Whilst the outcomes of the Clinical Audit programme falls under the remit of the Quality Committee and are reported and challenged in that forum; this Committee will review its approach purely from an audit perspective and to obtain assurance of methodology and approach as well as its contribution to improving quality.

The Committee has also resolved to ensure that during 2015-16 relevant Directors and senior managers will be expected to attend meetings of the Audit Committee where limited assurance reports are presented and discussed in order to be held to account for governance failings. This will ensure that all corrective actions are agreed with appropriate timelines for completion.

With respect to the Internal Audit plan for 2016-17, a certain number of risk areas will be kept under review to see if they should be made a priority above those proposed in the Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

Alongside the Audit Committee, there are now three main Board assurance committees: (1) Quality; (2) Finance & Sustainability and (3) Strategic People. This structure ensures there is greater visibility and focus at Non-Executive level on the key issues facing the Trust. Arrangements are being made for the Board assurance Committee Chairs to meet formally on an annual basis going forward to ensure appropriateness and effectiveness across the Committees and to address any potential gaps in assurance.

Summary

During the year the Audit Committee has been involved in reviewing the governance arrangements for the Trust and it is pleasing to report that the Trust has established and embedded for the whole of the reporting period an Assurance Framework which is operating to support the Chief Executive's Annual Governance Statement. This provides reasonable assurance that there is an effective system of internal control to manage the principle risks identified by the Trust. This has been confirmed by MIAA in a report to the Audit Committee in April 2016.

The Committee encourages frank, open and regular dialogue with the Trust's internal and external audit teams and regular attendees to the meetings.

Throughout the reporting period, the Chair of the Committee reported in writing on the nature and outcomes of its work to the Board of Directors highlighting any area that should be brought to its attention.

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors during Q2 of 2016-17.

The Committee has arranged for an assessment of its own performance, facilitated by Mersey Internal Audit, to be carried out during Q1 of 2016-17. The Terms of Reference and work programme for 2016-17 will be presented to the Trust Board Meeting in May 2016 for ratification.

The Audit Committee acknowledges the significant amount of work carried out by the other Board sub-committees and the executives and their teams, in continuing to embed the Trust's governance and risk management systems.

I would also like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Ian Jones
Chair of Audit Committee
25th May 2016

Membership

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

Members play a key role in the hospitals providing input into what services they want their hospitals to provide. They do this by electing Public and Staff Governors who represent the membership's views and therefore that of the local community. This section gives more detail of our membership and work to involve our members and sustain our membership this year.

Eligibility, constituencies and boundaries for membership

There are two constituencies of membership for Warrington and Halton Hospitals NHS Foundation Trust – the public constituency and the staff constituency.

The public constituency comprises of those members that live in one of the following sixteen public constituencies:

Halton

- Public 1 – Daresbury, Windmill Hill, Norton North, Castlefield
- Public 2 – Beechwood, Mersey, Heath, Grange
- Public 3 – Norton South, Halton Brook, Halton Lea
- Public 4 – Appleton, Farnworth, Hough Green, Halton View, Birchfield
- Public 5 – Broadheath, Ditton, Hale, Kingsway, Riverside

Warrington

- Public 6 – Lymm, Grappenhall, Thelwall
- Public 7 – Appleton, Stockton Heath, Hatton, Stretton and Walton
- Public 8 – Penketh and Cuerdley, Great Sankey North, Great Sankey South
- Public 9 – Culcheth, Glazebury and Croft, Poulton North
- Public 10 – Latchford East, Latchford West, Poulton South
- Public 11 - Bewsey and Whitecross, Fairfield and Howley
- Public 12 – Poplars and Hulme, Orford
- Public 13 – Birchwood, Rixton and Woolston
- Public 14 – Burtonwood and Winwick, Whittle Hall, Westbrook

Surrounding areas

- Public 15 – North Mersey
- Public 16 – South Mersey

Eligibility for membership is explained in detail on the Foundation Trust section of our website and in the Trust's constitution. Membership is available to any individual aged 16 years and over who lives in the constituency areas above. The constitution states that there is a requirement for a minimum of 65 members in each of our constituencies. The Trust has met this requirement since authorisation as an NHS Foundation Trust.

The North Mersey and South Mersey areas take in the geographic areas around our core catchment areas of Warrington, Runcorn and Widnes and allow for representation of patients who travel to the hospitals from these areas.

We also have out of area members who are able to join the Trust but who fall outside our core areas. The majority of these members are former staff members who have moved away from the area but who wished to become affiliate members of the Trust to keep in touch with developments.

The staff constituency is divided into 5 classes:

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

Staff employed by Warrington and Halton Hospitals NHS Foundation Trust automatically become Staff Members unless they choose to opt-out of the membership. Since becoming an NHS Foundation Trust on 1st December 2008, a total of three staff members have opted out of membership.

Membership Size and Movements 1st April 2015 to 31st March 2016

Membership size and movement Total membership at 31st March 2016 = 16,168		
Public constituency	**Last year (2015/16)**	**Next year (estimated)(2016/17)**
At year start (April 1)	12,034	11,678
New members	242	300
Members leaving	598	500
At year end (March 31)	11,678	11,478
Staff constituency	**Last year (2015/16)**	**Next year (estimated)(2016/17)**
At year start (April 1)	4,177	4,251
New members	511	471
Members leaving	437	471
At year end (March 31)	4,251	4,251
Affiliate members	**Last year (2015/16)**	**Next year (estimated)(2016/17)**
At year start (April 1)	234	239
New members	6	10
Members leaving	1	45
At year end (March 31)	239	204
Analysis of current membership		
Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	16	4,187
17-21	386	19,787
22 +	10,955	240,322
Not stated on form	321	N/A
Ethnicity:		
White	11,404	256,624
Mixed	52	1,888
Asian or Asian British	166	4,492
Black or Black British	21	798
Other	15	494
Not stated on form	20	N/A
Socio-economic groupings:		
AB	1,584	51,451
C1	5,203	64,883
C2	3,897	36,736
DE	828	84,178
Unknown	166	27,048
Gender analysis		
Male	4,058	129,194
Female	7,620	135,102
Affiliate Members	**Number of members**	**Eligible membership**
Age (years):		
0-16	3	N/A
17-21	2	N/A
22 +	229	N/A
Not stated on form	4	N/A

Summary of membership strategy and steps and work in year to recruit and involve members

2015-2016 was the Trust's seventh full year as an NHS Foundation Trust. Our focus was on delivering the three-year strategy called *Making Membership Work* that was developed by the Communications & Membership Committee (CAMC) in 2013. This set out a range of activities to further develop the engagement of the membership at the hospitals and support engagement between members, their governors and the wider public.

Engagement over the year included the further development of the Trusts family open day. This was held at the Cheshire and Merseyside Treatment Centre for the second time which generated a large number of members (approx. 400) and the public from the local area. A series of six of our popular your health events were held over the year, and we built on our patient centric model which enabled us to continue to build on our annual surveys and focus groups around the perceptions of the membership and their priorities for Trust development.

In 2015-2016 recruitment was scaled down to focus on under-represented areas of the membership to move towards ensuring our membership is balanced and representative of the local population. Local events were attended including local colleges to target the under-represented areas of the membership – mainly in terms of geographic representations, but also by gender and age to encourage younger people to get involved.

The Trust's public membership target was 10,573 (4% of the eligible public population) which was achieved in 2012. To reflect the membership we aim to continue to improve engagement with our members a revision of the membership strategy is planned for 2015-2016.

Changes in membership numbers over last twelve months

The numbers of public members leaving the membership was as expected this year. This was mainly due to the removal of 'gone away' members who either moved from the area or who could not be located at their original address and a number of deceased members have been removed from the membership as part of the regular audits that we have carried out to ensure our membership list is up to date and accurate during the year. This also removes any duplicate members. We have a system of double checking our data through both our database providers (Capita) and the mail house we use for mailshots to ensure as far as we possibly can that we do not mail to members who have sadly passed away.

Staff membership is reflective of the general turnover of staff with no staff members wishing to opt out of membership this year. All staff members are informed about Foundation Trust status and membership at induction.

Predicted Changes in membership numbers over the next twelve months

We expect that the public membership figures will reduce slightly over the year in line with the membership strategy due to a focus on more engagement activity.

Key Developments in 2015-2016

Recruitment

- Partnership working links with local colleges to attract more 17-21 year old members to join the Trust. There will be continued focus on this during 2015-2016.

- Attendance at large community events around the Warrington, Widnes and Runcorn areas including Disability Awareness Day to help further the balance of representative membership.
- The Communications and Membership Committee (CAMC) began work on an outreach presentation programme in January 2014 whereby governors are actively contacting and visiting community and voluntary groups to promote the services at the Trust, recruit members and engage in programmes of work. The visits commenced in spring 2014.

Communications

- Continuation of the Your Hospitals magazine that include membership information, articles on key health topics from our clinical staff and general hospital news. The Communications and Membership Committee conducted a review around how we can continue to engage with our members and also the wider public. It was agreed to reformat and distribute the newsletter via local newspapers which provided further circulation to the wider public within the membership catchment area.
- The continuation of our members Your Health Events - where our clinicians present topics of interest to members in the form of lectures, talks, workshops and tours. We staged six events in 2015-2016 ranging from presentations by the stroke awareness team and audiology team through to ophthalmology and cardiology teams.
- Our fifth hospital family Open day was organised for members and their families in July at Halton Hospital to find out about what goes on at the Trust, get some useful advice and attend departmental tours. The open day event will again take place at Warrington in 2016 – with a separate annual members meeting to be held in September.

Involvement

- Our out-patients membership survey was distributed to all members during the first half of 2015 and focused on current issues around patient experience after feedback was generated from a members focus group held the previous year.

Council of Governors

Warrington & Halton Hospitals NHS Foundation Trust is accountable to its members through a Council of Governors (CoG). The CoG is responsible for representing the interests and views of the Trust members and the local population.

Between 1st April 2015 and 31st March 2016 the CoG met formally on five occasions. The Chairman of the Trust Board is also the Chairman of CoG. The Non-Executive Directors have a standing invitation to attend all CoG meetings but there is no mandatory requirement to attend each meeting. Executive Directors attend as appropriate; however the Chief Executive usually attends each meeting.

The CoG 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 engagement strategy.

Governors' Committees and work programme

The council meetings held in public are a small part of the governors' overall work in the Trust. Governors' have been involved in a range of work, using their experience and expertise to represent the views of members and the public and focus on issues of that impact on the quality of care to patients.

Governor committee structure

Communications and Membership Committee - Recommending objectives and strategy for the Trust in the development of communication and engagement with members.

Monitor Quarterly Reporting Compliance Committee - Reviewing quarterly finance and corporate performance reports and receipt of the Board's quarterly submission to monitor.

Quality In Care Committee – Receiving and reviewing monthly quality dashboards, reviewing the annual quality report and accounts and recommending objectives and strategy for the trust in the development and improvement of the patient and workforce experience.

Nominations and Remuneration Committee – The role of this committee is outlined in more detail in the Remuneration Report.

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

Other meetings and involvement

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

Board meeting observation

In accordance with the requirements of the Health and Social Care Act 2012, Board meetings have been held in public since 1st April 2013. Governors, members and the public are able to attend these meetings. A rota of attendance has been established so that governors can attend and observe the Board meetings to enable them to fulfil the statutory duty to hold to the non-executive directors, individually, and collectively, to account for the performance of the Board. Governors attending the Board meeting are able to provide feedback to the council on any matters arising from the Board.

Board/Governor Workshops

During the year Governors were involved in a number of workshops with other stakeholders to consider the priorities of the Quality Report 2015-2016.

Quality Report 2015/16

The Governors were also involved in a workshop during February 2015 with a range of other stakeholders involved including Warrington CCG, Halton CCG, Healthwatch and Warrington and Halton local authorities. The workshop considered the improvement priorities for the Trust for 2015/16. The Quality in Care Committee on behalf of the council considers the Quality Report 2015/16 and provides a statement on its appropriateness that is included in the Quality Report.

Governors' ward observation visit programme

During the year the Quality in Care Committee continued the unannounced ward observation visits to observe wards within the trust. This was implemented in 2011 following the publication of the first report on the findings of the Mid Staffordshire NHS Foundation Trust Inquiry. The observation ward visits enable the Governors to observe first-hand the quality of care provided to patients of the Trust. Feedback from the observation visits are provided to the Quality in Care Committee who report the findings to the Trust management and the Care Quality Committee. Where areas of concern are raised by the observation team, an action plan is developed with and feedback on improvements is reported back to the Quality in Care

Committee. The Trust is fully supportive of the governors unannounced ward observation visits which provides valuable 'real time' information and feedback of the quality of care provided to patients.

Governors' attendance at organised and supported events

The Governors' continue to support the Trust and engage with both the membership and the public across the Trust's catchment areas attending events organised by the Trust and the governors at outpatient clinics and at large events such as the Hospital's Open Day and Warrington Disability Day. Governors have actively sought to engage with patients and contribute to a process of improving services.

Council of Governors' meetings and attendance

The constitution outlines the requirement that the Council would meet at least six times a year excluding the Annual Members Meeting to better facilitate business. Agenda and minutes from the Council meetings are available on the Trust website www.whh.nhs.uk

Composition of the Council of Governors

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

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

Public Governors

Public governors are elected by the Trust's public membership. The public membership has been divided into areas based on the electoral wards for Warrington and Halton and includes two additional areas that cover areas outside the electoral wards; these include North and South Mersey. Public members within the electoral areas are able to vote during an electoral process on the person they wish to represent them as a governor of the Trust. There are certain requirements that a governor is required to comply with before they can become a governor, one of which is that are only eligible to be a governor of the area they reside. This means that when a governor election is undertaken, members of an electoral area can only vote for a governor who also resides in the same electoral area. The Trust has grouped together the electoral wards in Warrington, Widnes and Runcorn and outside the area.

The lead governor is Alf Clemo and is the point of contact between Monitor and the council, in circumstances only where it would be inappropriate for Monitor to contact the chair.

Full biographies and details on the tenure of office for each governor is available on the Trust website www.whh.nhs.uk. During the year the Public Governors of the trust were:

Staff Governors

Staff Governors represent the Trust's staff on the Council and will bring their own knowledge and skills from working in the organisation. There are five Staff governors representing the main five staff groups at the Trust. Staff automatically become a member of the Trust at the commencement of their employment. Staff can, if they wish, choose to opt out of being a member of the Trust.

Partner Governors

The Trust's partner governors are nominated by key local partnership organisations that work closely with the Trust. They bring their knowledge and experience to the Council and help the Trust to work in partnership with the community.

How to contact your Governors

Governors for the Trust can be contacted through our Membership Office. Messages are passed on directly to Governors and general enquiries from members can also be addressed to the Membership Office.

The contact details for the Membership Office are:

Warrington and Halton Hospitals NHS Foundation Trust
Communications/Membership Office
Kendrick Wing
Warrington Hospital
Lovely Lane
Warrington WA5 1QG
Telephone – 01925 664222
E-Mail – foundation@whh.nhs.uk

Membership & Attendance of the Council of Governors and Sub-Committees as at 31st March 2016

Governor	Term Expires	Council of Governors	Quality In Care Sub-Committee	Communications & Membership Sub-Committee	Nominations & Remuneration Committee
CHAIRMAN					
Steve McGuirk		5/5	-	-	2/2
PUBLIC GOVERNORS					
Alison Kinross Daresbury, Windmill Hill, Norton North, Castlefields	30.06.2018	4/4	3/5	5/5	-
Iris Keating Daresbury, Windmill Hill, Norton North, Castlefields	30.06.2015	1/1	1/2	0/1	-
Joe Whyte *(elected 01.07.2015)* Beechwood, Mersey, Heath, Grange (Vacant 01.04.15-30.06.15)	30.06.2018	2/4	2/5	0/5	-
Vacant Norton South, Halton Brook, Halton Lea	-	-	-	-	-
Elaine Tweedle (elected 01.07.2015) Appleton, Farnworth, Hough Green, Halton View, Birchfield (Vacant 01.04.15-30.06.15)	30.06.2018	1/4	1/5	1/5	-
Kenneth Dow *(elected 01.07.2015)* Broadheath, Ditton, Hale, Kingsway, Riverside (Vacant 01.04.15-30.06.15)	30.06.2018	0/4	0/5	2/5	-
Jeanette Scott Lymm, Grappenhall, Thelwall	30.11.2017	5/5	0/7	1/6	-
Susan Kennedy Appleton, Stockton Heath, Hatton, Stretton and Walton	20.11.2017	5/5	3/7	2/6	-
Paul Campbell Culcheth, Glazebury and Croft, Poulton North	30.06.2015	1/4	0/3	0/3	-
Barbara Meager *(elected 1st July 2015)* Culcheth, Glazebury and Croft, Poulton North	30.12.2015 resigned	1/1	1/2	0/1	-
Vacant Culcheth, Glazebury and Croft, Poulton North	-	-	-	-	-
Peter Harvey Penketh and Cuerdley, Great Sankey North, Great Sankey South	30.12.2015	1/4	0/3	0/3	-
Carol Astley Latchford East, Latchford West, Poulton South	30.06.2015	1/1	1/2	0/1	-
Phil Chadwick *(elected 1st July 2015)* Bewsey and Whitecross, Fairfield and Howley (Vacant 01.04.15-30.06.15)	30.11.2017	4/5	6/7	0/6	-
Alfred Clemo (Lead Governor) Poplars and Hulme, Orford	30.06.2018	4/5	3/7	1/6	-
David Ellis Birchwood, Rixton and Woolston	30.11.2016	5/5	7/7	6/6	2/2
Norman Holding *(elected 1st July 2015)* Burtonwood and Winwick, Whittle Hall, Westbrook (Vacant 01.04.15-30.06.15)	30.06.2018	2/4	4/5	3/5	-

James Henderson **North Mersey**	30.11.2017	0/5	3/7	1/5	-
Peter Folwell **South Mersey**	30.11.2016	5/5	7/7	6/6	2/2
STAFF GOVERNORS					
Vacant **Medical Staff**	-	-	-	-	-
Gaynor O'Brien **Nursing and Midwifery**	30.11.2016	0/5	1/7	0/6	-
Sue Bennett **Support Staff**	30.11.2017	1/5	0/7	0/6	-
Louise Cowell **Clinical Scientist or Allied Health Professionals**	30.11.2016	3/5	2/7	0/6	-
Mark Ashton (elected 1st July 2015) **Estates, Administrative & Managerial**	30.11.2017	3/4	0/5	3/5	1/2
PARTNER GOVERNORS					
Warrington Borough Council **Cllr Pat Wright**	n/a	4/5	0/7	0/6	0/2
Halton Borough Council **Cllr Peter Lloyd Jones**	n/a	4/5	3/7	0/6	-
Warrington Wolves Charitable Foundation **Neil Kelly**	n/a	0/5	0/7	0/6	-
University of Chester **Naomi Sharples** ***(Peter Harrop up to 31st July 2015)***	n/a	0/3 1/2	1/4 1/3	0/4 0/3	- -
Warrington Voluntary Action **Alison Cullen**	n/a	1/2	1/3	0/2	-
Halton and St Helens Voluntary & Community Action **Vacant**	n/a	2/5	0/7	0/6	-

Governor elections in year

The Trust public and staff governor elections were carried out by UK Engage and the returning officer was Tony Slater. The close of polls for the elections was 26th June 2015 and the reports from the contested elections by constituency are shown below.

- Three Public Governor seats were contested with more than one candidate standing. These areas were:
    - Public 1: Daresbury, Windmill Hill, Norton North, Castlefields
    - Public 11: Bewsey, Whitecross, Fairfield, Howley
    - Public 14: Burtonwood, Winwick, Whittle Hall, Westbrook
- Five Public Governor seats were uncontested with one candidate standing. These areas were:
    - Public 2: Beechwood, Mersey, Heath, Grange
    - Public 4: Appleton, Farnworth, Hough Green, Halton View, Birchfield
    - Public 5: Broadheath, Ditton, Hale, Kingsway, Riverside
    - Public 9: Culcheth, Glazebury, Croft, Poulton North
    - Public 10: Latchford East, Latchford West, Poulton South
- Public 3: Norton South, Halton Brook, Halton Lea. The Trust did not receive any nominations for this position and therefore it remains vacant. The Trust hope to fill the public governor position during future elections.

- One Staff Governor seat was uncontested with one candidate standing. The area was:
    - Staff Class E: Estates, Administrative & Managerial
    - Staff Class A: Medical & Dental. The Trust did not receive any nominations for this position and therefore it remains vacant. The Trust hopes to fill the Staff Governor position during future elections.

Reports from the contested elections by constituency

Date of Election	Constituencies involved	No of Members in Constituency	No of Seats Contested	Number of Contestants	Election Turnout %
29/06/2015	Public 1: Daresbury, Windmill Hill, Norton North, Castlefields	796	1	4	15.95%
29/06/2015	Public 11: Bewsey, Whitecross, Fairfield, Howley	846	1	2	16.31%
29/06/2015	Public 14: Burtonwood, Winwick, Whittle Hall, Westbrook	589	1	3	17.83%

Work is underway in 2016-2017 to run elections for the vacant Public Governor seats and Staff Governor seat of:

- Public 3: Norton South, Halton Brook, Halton Lea
- Public 9: Culcheth, Glazebury, Croft, Poulton North
- Staff Class A: Medical & Dental

3ii Accountability Report – Remuneration Report

The remuneration report outlines appointments and payments made to trust executive and non-executive directors in year.

Statement from the Chairman of the Nominations and Remuneration Committee

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

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

Remuneration

The committee is responsible to the Board in setting the remuneration and conditions of service include provisions for other benefits as well as arrangements for termination of employment for the executive directors. It also considers all ex gratia payments and redundancy payments over £50k. During the year under review the committee did not approve any special termination arrangements for senior managers, and no such awards have been made to past senior managers.

The Trust does not apply performance related pay conditions linked to executive directors' remuneration and no formal policy exists in setting the remuneration of either executive directors or non-executive directors. However, if a review of executive directors' remuneration was to take place, the committee takes into account executive directors past performance, future objectives, market conditions and comparable remuneration information from trusts within the locality. The chief executive and executive directors participate in annual performance reviews and appraisals undertaken by the 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 the Board committee comprises of the chair and all the non-executive directors with the attendance of the chief executive (except for matters concerning her own employment and conditions) and the Director of HR & OD and Company Secretary. During 2015-16, the committee met four times and attendance at the meetings is set out below:

Committee Member	Attendance (Actual v Max)
Steve McGuirk (Chairman)	4/4
Lynne Lobley	4/4
Mike Lynch (to 30.11.15)	2/3
Ian Jones	4/4
Terry Atherton	4/4
Anita Wainwright	4/4

During the year under review the composition and size of the executive director team was extended to include a Director of Transformation and a Director of Community Engagement – both non-voting roles. The consequential effect of the additional posts resulted in the size of the executive team increasing from seven to nine.

Executive directors' appointments

The committee received notification from two executive directors of their intention to resign from the Trust during the reporting period- Simon Wright, Chief Operating Officer, with effect from 27th September 2015 and Tim Barlow, Director of Finance & Commercial Development, with effect from 30th November 2015.

An agreed process approved the appointment of Sharon Gilligan as Chief Operating Officer (wef 1st December 2015) and Andrea Chadwick as Director of Finance & Commercial Development (wef 1st February 2016). Their appointments were subject to the all necessary pre-employment checks including the receipt of appropriate references and fit and proper person test.

The committee in approving the remuneration of both these roles took into account; the responsibility of roles; market conditions; individuals past performance at previous Trusts and affordability.

Following discussions around the composition and size of the executive team and following the Board evaluation process, the Board agreed that, until such time as a formal process on succession planning could be adopted, each executive director in post would be asked to nominate a deputy, that would require the approval of the chief executive, who would act-up into the role of the executive should the need arise. The Board recognised that this was not necessarily a succession planning process but that it would allow for the committee opportunity to assess the requirements for an executive director vacancy should this be required.

The committee received external advice where necessary from Hill Dickinson LLP.

Non-executive directors' appointments

The Council of Governors Nomination and Remuneration Committee (NARC) meets annually or as required to recommend to the Council of Governors the nomination of appropriate candidates to the posts of non-executive directors, including the chair. The committee also has responsibility for making recommendations to the Council of Governors with regard to the remuneration and allowances, and other terms and conditions, of office of non-executive directors and plays a role in the appraisal process of the chair.

The committee comprises of the Chairman (or deputy chair or failing him the Senior Independent Non-Executive Director when the appointment of the chair or his/her remuneration and allowances/other terms and conditions of office are being discussed), two Public Governors, one Staff Governor and one Partner Governor.

During 2015-16, the Council of Governors, utilising the established NARC, ensured appropriate oversight and decisions relating to the appointment of a replacement Non-Executive Director for Mike Lynch who stepped down during quarter 3 of 2015-16.

Process for appointments of Non-Executive Directors

During the year the council had reviewed the composition of the Board and agreed the areas of experience required from in-coming non-executive directors and consequently a clinically qualified Non-Executive Director was sought to replace Mike Lynch.

Process for appointments of Non-Executive Chair

The Council of Governors approved the appointment of Steve McGuirk as non-executive chair of the Trust during 2014-15 for a period of three years commencing 1 April 2015 and as such there was no requirement during the reporting period to appoint a non-executive chair. The process for the appointment of Mr McGuirk was reported in the 2014-15 Annual Report.

Remuneration of non-executive directors

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

Contractual arrangements for executive and non-executive directors

The Trust's executive directors are not employed under fixed term contractual arrangements and are required to give and receive six months' notice under the terms of their contract of employment. Compensation payments payable to executive directors are in accordance with their contract, which entitles them to 6 months' pay on termination.

Both the employee and employer contribute to the NHS pension scheme and Note 1.3 of the annual accounts provides an explanation of how pension liabilities are treated in the accounts.

Name	Commencement date	Term of Office expiry date	Notice period
Steve McGuirk	01/04/2015	31/03/2018	Three months
Lynne Lobley	01/12/2009	01/12/2016	Three months
Dr Mike Lynch	31/07/2013	Resigned 30/11/2015	Three months
Ian Jones	01/07/2014	30/06/2017	Three months
Terry Atherton	01/07/2014	30/06/2017	Three months
Anita Wainwright	01/01/2015	31/12/2017	Three months

Senior Managers' Remuneration Policy

The Trust does not apply performance related pay conditions linked to executive directors' or non-executive directors' remuneration and no formal policy exists in setting the remuneration of either executive directors or non-executive directors.

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

Components of Remuneration Package of Executive and Non-Executive Directors	Basic pay in accordance with their contract of employment (executive) and letters of appointment (non-executive)
Components of Remuneration that is relevance to the short and long term Strategic Objectives of the trust	The directors do not receive any remuneration tailored towards the achievement of Strategic Objectives.
Explanation of how the Components of Remuneration operate	Basic pay of the executive directors is determined by the Board Nominations and Remuneration Committee, taking into account past performance, future objectives, market conditions and comparable remuneration information from trusts within the locality. Basic pay of the non-executive directors is determined by the Governor Nominations and Remuneration Committee.

Maximum amount that could be paid in respect of the component	Maximum payable is the director's annual salaries as determined by the relevant Nominations and Remuneration Committee.
Explanation of any provisions for recovery	If an individual is overpaid in error, there is a contracted right to recover the overpayment.

During 2015/16 2 Directors (2014/15, 1) earned more than £142,500, the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury and equivalent to the Prime Minister's ministerial and parliamentary salary. In satisfying itself that this remuneration is reasonable the Trust has considered the components of the above policy together with the roles and responsibilities of each individual. It is deemed that salaries for both individuals are reasonable and sufficient to retain and attract suitable candidates for the furtherance of Trust objectives.

The following sets out the amount of remuneration paid to the directors of the Trust for the year ended 31 March 2016.

Annual report on Directors Remuneration - Year ended 31st March 2016 (and comparison year ended 31st March 2015) (Audited)

	2015-2016						2014-2015						
	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual Performance-related Bonuses (in bands of £5,000)	Long-term Performance-related Bonuses (in bands of £5,000)	All Pension-related Benefits (bands of £2500)	Total (bands of £5,000)	Directors' Salary and fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual Performance-related Bonuses (in bands of £5,000)	Long-term Performance-related Bonuses (in bands of £5,000)	All Pension-related benefits (bands of £2500) (4)	Total (bands £5,000)
	£000	£00	£000	£000	£000	**£000**	£000	£000	£00	£000	£000	£000	**£000**
Executive Directors													
Mel Pickup Chief Executive	160-165				22.5-25	**185-190**	160-165					55-57.5	**220-225**
Dr Paul Hughes Medical Director until 31.01.2015							110-115					17.5-20	**130-135**
Karen Dawber Director of Nursing & Governance	110-115				22.5-25	**135-140**	110-115					7.5-10	**120-125**
Prof. Simon Constable Medical Director/Deputy Chief Executive (from 01.03.2016)	145-150	2,100			7.5-10	**155-160**	20-25					7.5-10	**30-35**
Tim Barlow Director of Finance and Commercial Development until 30.11.2015	80-85				25-27.5	**105-110**	120-125					22.5-25	**145-150**
Simon Wright Chief Operating Officer/Deputy Chief Executive until 25.09.2015	55-60				62.5-65	**125-130**	115-120					0-2.5	**120-125**
Jason DaCosta (3) Director of Information Management & Technology	95-100					**95-100**	95-100						**95-100**
Lucy Gardner (1) Director of Transformation from 01.02.2016	15-20					**15-20**							

	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual Performance-related Bonuses (in bands of £5,000)	Long-term Performance-related Bonuses (in bands of £5,000)	All Pension-related Benefits (bands of £2500)	Total (bands of £5,000)	Directors' Salary and fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual Performance-related Bonuses (in bands of £5,000)	Long-term Performance-related Bonuses (in bands of £5,000)	All Pension-related benefits (bands of £2500) (4)	Total (bands £5,000)
	£000	£00	£000	£000	£000	**£000**	£000	£000	£00	£000	£000	£000	**£000**
Roger Wilson Director of Human Resources and Organisational Development from 02.02.2015	105-110				15-17.5	**125-130**	15-20						**15-20**
Andrea Chadwick Director of Finance and Commercial Development from 01.02.2016	15-20				7.5-10	**25-30**							
Sharon Gilligan Chief Operating Officer from 01.12.2015	35-40				10-12.5	**50-55**							
Pat McLaren Director of Community Engagement from 01.12.2015	25-30				77.5-80	**105-110**							
Interim/Acting Executive Directors													
Mark Brearley (1)(2) Interim Director of Transformation/Interim Director of Finance and Commercial Development from 01.07.2015 - until 31.01.2016	85-90					**85-90**							
Mark Partington (1) Interim Director of Transformation from 01.12.2015 - until 31.01.2016	20-25					**20-25**							
Jan Ross (2) Acting Chief Operating Officer from 28.09.2015 - until 30.11.2015	10-15					**10-15**							
Chairman and Non-Executive Directors													
Allan Massey Chairman until 31.03.2015							40-45						**40-45**

	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual Performance-related Bonuses (in bands of £5,000)	Long-term Performance-related Bonuses (in bands of £5,000)	All Pension-related Benefits (bands of £2500)	Total (bands of £5,000)	Directors' Salary and fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual Performance-related Bonuses (in bands of £5,000)	Long-term Performance-related Bonuses (in bands of £5,000)	All Pension-related benefits (bands of £2500) (4)	Total (bands £5,000)
	£000	£00	£000	£000	£000	**£000**	£000	£000	£00	£000	£000	£000	**£000**
Steve McGuirk Chairman from 01.04.2015	40-45					**40-45**							
Lynne Lobley Non-Executive Director	10-15					**10-15**	10-15						**10-15**
Rory Adam Non-Executive Director until 30.11.2014							10-15						**10-15**
Carol Withenshaw Non-Executive Director until 31.03.2015							10-15						**10-15**
Clare Briegal Non-Executive Director until 30.06.2014							0-5						**0-5**
Dr Mike Lynch Non-Executive Director until 30.11.2015	5-10					**5-10**	10-15						**10-15**
Ian Jones Non-Executive Director from 01.07.2014	10-15					**10-15**	5-10						**5-10**
Terry Atherton Non-Executive Director from 01.07.2014	10-15					**10-15**	5-10						**5-10**
Anita Wainwright Non-Executive Director from 01.01.2015	10-15					**10-15**	0-5						**0-5**

Notes:
(1) The individual was engaged via a corporate body. Payments were made to that corporate body rather than the individual directly.
(2) Refers to time in post as a Director.
(3) One fifth of Jason DaCosta's salary is recharged to Warrington CCG.

Expenses paid to Directors and Governors (unaudited)

The Trust is required to report details of expenses paid to Governors and Directors.

Expenses paid to directors of the Trust include all business expenses arising from the normal course of business of the Trust and are paid in accordance with the Trust's policy. Non-Executive Directors are also reimbursed reasonable expenses relating to their work as Directors of the Trust. The total amount of expenses reimbursed to Directors for 2015/16 was £8,393 (2014/15 £8,113). The total number of Directors claiming expenses during their time in office was 13 (2014/15, 11).

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

Expenses are only reimbursed on the basis of actual spend with the exception of mileage rate claims and must be supported, where possible, by original receipts. The total amount of expenses reimbursed to Governors for 2015/16 was £ 1,447 (2014/15 £1,072).

The total number of governors claiming expenses during their time in office was 7 (2014/15, 7).

Pension Entitlements Year ended 31st March 2016 - Audited

Name and title	Real increase in pension at age 60 (bands of £2,500)* £000	Real increase in pension lump sum at age 60 (bands of £2,500)* £000	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase in Cash Equivalent Transfer Value* £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Employer's contribution to stakeholder pension £000
Mel Pickup Chief Executive	0-2.5		60-65	170-175	959	29	1000	
Karen Dawber Director of Nursing & Governance	0-2.5		30-35	85-90	428	22	455	
Simon Constable Medical Director/ Deputy Chief Executive	0-2.5		15-20	50-55	267	8	279	
Tim Barlow Director of Finance & Commercial Development until 30.11.2015	0-2.5		15-20	0	167	26	208	
Simon Wright Chief Operating Officer/ Deputy Chief Executive until 25.09.2015	2.5-5	5-7.5	30-35	90-95	443	50	548	
Roger Wilson Director of Human Resources & Organisational Development	0-2.5		35-40	100-105	606	18	631	
Andrea Chadwick Director of Finance & Commercial Development from 01.02.2016	0-2.5		30-35	85-90	412	8	466	
Sharon Gilllgan Chief Operating Officer from 01.12.2015	0-2.5	0-2.5	20-25		256	9	286	
Pat McLaren** Director of Community Engagement from 01.12.2015	2.5-5	10-12.5	10-15			68	203	
Jan Ross Acting Chief Operating Officer from 28.09.2015 until 30.11.2015	0-2.5		15-20		211		216	

Notes:

*Relates to time in post as a director.

** Pat McLaren re-joined the NHS Pension Scheme in December 2015. There are no comparative figures available for the previous financial year.

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

Explanation of cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and other pension details include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Explanation of real increase in cash equivalent transfer values

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Total remuneration

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

	2015/16 **£000**	**2014/15** **£000**
Remuneration including employers national insurance contribution for Executive and Non-Executive Directors	1,111	993
Employers contribution to pension in relation to executive directors	105	96

Hutton Narrative (unaudited)

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

of the banded remuneration of the highest-paid director in Warrington & Halton Hospitals NHS Foundation Trust in the financial year 2015/16 was £162,500 (2014/15 £162,500).

In 2015/16 the highest-paid director earned 6.96 times (7.02 times in 2014/15) the median remuneration of the workforce, which was £23,363 (£23,132 in 2014/15). As disclosed above, the midpoint of their banded remuneration remained the same during the year under review (2014/15 increased by £5,000).

In 2015/16, 7 employees (21 employees in 2014/15) 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 £164,235 to £251,116 (£166,471 to £249,869 in 2014/15).

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 2016.

Mel Pickup
Chief Executive
25th May 2016

3iii Accountability Report – Staff Report

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

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

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

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

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

Staffing statistics

Average number of employees

Average number of persons	2015/16			2014/15
	Permanently Employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	282	106	388	386
Administration and estates	744	54	798	765
Healthcare assistants and other support staff	790	15	805	775
Nursing, midwifery and health visiting staff	970	3	973	994
Scientific, therapeutic and technical staff	529	25	554	533
Bank and agency staff	0	202	202	162
Total	**3,315**	**405**	**3,720**	**3,615**

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

	Male	Female
Directors (Executive and Non-Executive)	6	8
All employees	755	3,240

Sickness absence

Period Ending	31st March 2015	31stMarch 2016
Cumulative figure	4.42 %	4.69%

The following table shows the number of average days lost per employee which also shows a slight improvement from the previous year:

Staff sickness absence	2015/16	2014/15
Total days lost	54,540	56,569
Total staff years	3,510	3,356
Average working days lost (per WTE)	16	17

Trust Policies and Procedures

During 2015/16 the Trust has reviewed and updated the following policies and procedures:

- Career Break Policy
- Incremental Pay Progression Policy
- Performance Improvement Policy
- Use of Locum Medical and Dental Staff Policy
- Disclosure and Barring Service Policy
- Shared Parental Leave Policy
- Disciplinary Policy
- Gifts and Hospitality Policy and Guidance

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

Equality and Diversity with Emphasis on Disability

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

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

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

- Deaf Resource Centre
- Halton Disability Partnership

- Warrington Carers (WIRED)
- The British Red Cross
- Warrington Health Watch
- Warrington Disability Partnership
- Halton Health Watch
- Halton Carers Centre
- DIAL House Chester
- Elected Governors are active members of the EDSC and DEG

During 2015/2016 the Trust has liaised extensively with additional external stakeholders to increase awareness and understanding of equality issues, these include:

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

The Trust has supported Warrington Disability Awareness Day (DAD) in 2015 to help show empathy and understanding to people with disabilities, both staff and patients alike.

Applications for employment made by disabled people

As a Trust, we have successfully maintained our 2 ticks' accreditation in 2015/2016 to ensure that disabled people have supported access to employment. Our Workforce Equality Analysis Report (WEAR) published in January 2016 was able to demonstrate that the Trust supported applications from disabled staff, and found no evidence of discrimination.

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

The Trust has also demonstrated commitment to providing work experience opportunities to disabled people through working in partnership with the Shaw Trust.

Continuing employment for people who have become disabled during employment.

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

There are various policies in place to assist and protect disabled staff:

- Bullying and Harassment Policy
- Grievance Procedure
- Flexible Working Policy
- Equal Opportunities Policy
- Disability Equality Policy

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

Both Halton Carers Centre and WIRED attended the Trust during Carers Week in June 2015 to speak to staff, patients and Carers. The internal intranet system, The HUB, now has information for staff on financial and practical support for Carers.

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

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

The Trust achieved a status of 'Excelling' in the 2015/2016 Equality Delivery System2 assessment with regards to flexible working considerations for staff.

The Trust offered NCFE qualifications to all staff that could be undertaken at home or online. The NCFE is a leading national awarding organisation for qualifications, apprenticeships, and functional skills.

The Equality Specialist has attended several information sessions on the Workforce Disability Equality Scheme due to come into force in 2017 to ensure support for the career progression of disabled staff within the NHS.

In 2016 the Trust is currently in the process of putting together a pilot scheme to assess changes in IT systems to better support staff with dyslexia.

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

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

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

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

Communication and Engagement with Staff

Building upon staff communications of last year, the Trust has built upon its mantra of open and honest communication. The significant financial challenge the Trust has faced to achieve its efficiency savings and associated cost improvement plan has continued to require the support and understanding of all staff.

The Trust has a range of regular communications with staff such as the monthly team brief open to all staff, the emailed weekly update and a new daily communication on the Trust performance. This year we have also launched our Trusts Behaviours, WE ARE – Working together, Excellent, Accountable, Role models, Embracing Change. The behaviours have been developed in partnership with staff; our 'give us a word' campaign and subsequent focus groups and workshops.

During 2015/16 we introduced a full time staff side Chair and part time Deputy Chair; this recognised the value we as a Trust place on the relationship with staff side and its importance in engaging with staff on

crucial issues. The Staff Side chair attends numerous corporate level meetings and also shares the chair of the Joint Negotiation Consultative Committee, which runs alongside our medical JLNC.

As part of our Team Brief we include performance dashboards looking at our clinical, quality and people performance. Personal emails have been sent out to all staff from the Chief Executive explaining the financial position of the Trust and the measures being taken to take corrective action. Executive Directors regularly 'walk the floor' to spend time with staff to listen to their concerns and this influences decision making in the Trust. 'Bright Idea' sessions have been held as open forums where staff can attend and suggest new ways of working or ideas which may improve the quality of service provided to our patients or result in savings to assist with the financial position in the trust.

A major organisational change occurred in the Trust in 2015/16 with the introduction of a new patient administration system called Lorenzo. This replaced an existing system but the planning and training needed to introduce this system affected almost all of the staff in the Trust. This required a sustained and comprehensive communications strategy which saw the system go live in November 2015.

We also have published information on our website in our easy to navigate Transparency section which provides information ranging from mortality rates to safe staffing levels within a few clicks of any visitor to the site.

Thank you Awards – Winners 2016

PIU took home the "Excellence in Patient Care Award". The received a host of nominations this year from people who use their services. One of their patients put that they are P – Perfect, I – Individual, U – United in their cause to care for their patients.

It was the **Mortuary Team** who were successful in their category of "Supporting Excellence in Patient Care". They were nominated by a colleague following a particularly distressing death of a paediatric patient. Nothing was too much trouble for the team and they were thanked for their upmost care and compassion.

Sarah Ardern won the '"Star of the Future Award" this year. She was a former Apprentice with the Trust and now works in a full-time position in the Staff Engagement Team. Her nominee said that she embodies the idea of a rising star with her commitment, attitude and hard work.

The **Warrington Respiratory Team** won this year's "Excellence in Innovation, Improvement and Efficiency Award" for their work preventing hospital admissions from a very vulnerable group of patients. They have reduced admissions to the hospital and ensure the patient receives the right care.

This year's "Volunteer of the Year Award" went to the **Patient Experience Volunteers (PALS)** who speak to over 50 patients per day to put their minds at rest, answer general queries and help prevent more formal concerns being raised.

The **Lorenzo Team** won a new award this year – the "Outstanding Contribution Award" for all of the hard work and long hours the whole

team has put into ensuring that Lorenzo was implemented into the Trust as smoothly as possible.

Stuart Dutton won this year's "Employee of the Year Award". He received an incredible 15 nominations for the work he has done around his Early Discharge Class that releases patients from the Hospital on average 2 days pre op, instead of the previous 5 days. Stuart was described as an "Inspiration to work with".

This year's "Team of the Year Award" goes to **Helene Hazzard and Sophie Liu** – Intensive Care Unit Nurses. The pair put a lot of long hours and effort into organising a memorial service for the families of all the patients who have passed away on their ward over the year. Their nominee said that "it's all about going above and beyond for the relatives of our patients and their work cannot be understated".

The Trust also celebrated the achievements of staff who had reached 30, 35 or 40 years unbroken service with the hospitals. There were over 30 staff reaching those milestones this year.

Other things we have done in the last 12 months include:

- Launched the Trusts behaviours
- New Staff Extranet with mobile compatibility
- Introduced monthly well-being events
- Introduced innovation breakfasts
- Launched Randomised Coffee Trial

Mandatory Training

Our mandatory training figures have all improved whilst our appraisal rate which is not mandated has reduced slightly.

	2014-2015	2015-2016
Health & Safety	47%	**87%**
Fire Safety	74%	**81%**
Manual Handling	72%	**83%**
Appraisal Rate	71%	**69%**

Health and Safety

The Trust continues to monitor its compliance of the Health and Safety at Work Act regulations via audits of all wards and departments applied to a Risk Management Framework resulting in an annual report to the Quality Committee. The Trust had one visit by the Health and Safety Inspector (HSE) as part of a Regional review of NHS Organisations to review systems and processes applied to sharps injuries. The outcome was that the HSE noted and were happy with the Trust procedures.

Health and Safety is monitored by the Safety and Risk Sub Committee reporting to the Quality Committee to which Staff Side representatives in addition to the Divisional and Specialist Representatives are members.

Occupational Health

Our Occupational Health Team encompasses responsibility for Staff Health and Well-being. The Department is a Safe, Effective, Quality Occupational Health Service (SEQOHS) accredited nurse led unit, with a team of fully qualified occupational health nurses. The department provides employment clearance, vaccination, flu campaigns, well-being and health support, physiotherapy and counselling.

This latter part of this year has seen the appointment of a new Senior Counsellor who will have a broader remit than the previous contractor and will focus on wider mental health issues and resilience. We have also forged greater working relationship with our internal colleagues in dietetics introducing a weight management course and external with the local council reintroducing a smoking cessation service for staff.

The department also received national recognition when they achieved the second highest flu vaccination rate in the country of 81.9% and were shortlisted for a national flu campaign award.

Countering Fraud

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

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

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

The NHS Staff Survey 2015

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

The Trust followed the Care Quality Commission guidance and 850 staff were randomly selected to participate in the survey. The results from the survey are used to compare the Trust with other acute trusts in England and form part of the Trust's Annual Health Check and the Health and Safety Executive standards for workplace stress. Learning from last year we decided to take a mixed distribution approach, allocating paper copies to patient facing roles and electronic distribution to office based staff. There was an improvement in the return rate.

Our findings have remained pretty stable. The majority of our results are in line with the national average. None of the key findings showed any statistically significant change.

This year's survey was sent to a sample of 850 staff and the response rate was 33%. This was an improvement from the previous year's 30% - we tried a mixed distribution method and the Executive Team delivered the surveys to area managers. Feedback suggests staff do connect the outcomes of the action plan and the survey which will be addressed.

Staff survey report overall response rates

	2014		2015		Trust improvement / deterioration in year
	Trust	National Average	Trust	National Average	
Response Rate	30%	42%	33%	41%	Increase by 3%

The survey results for 2015 are based on 32 key findings, compared to 28 last year. Some of the findings have also been altered and were not therefore directly comparable to last years' results. The number of results falling in the best 20%, average 60% and worst 20% of trusts are outlined in the table below.

	2013 (28 key themes)	2014 (29 key themes)	2015 (32 key findings)
Best 20% of trusts, better than average or better than year listed above.	19	9	11
Middle (average) 60% of trusts;	6	18	14
Worst 20% of trusts, worse than average or worse than year listed above.	3	2	7

Areas of significant statistical change

Although there has been some change in results of some of the questions there has been no significantly significant change in any of the key findings. From an internally facing perspective due to both the financial and operational pressures of the last 12 months this is a positive indicator in that there has been no decline and gives a solid basis to build upon.

NHS staff survey 2015 – Trust performance, top four ranking scores

Top 4 Ranking Scores	2014		2015		Trust improvement / deterioration in year
	Trust	National average	Trust	National Average	
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	19%	23%	18%	26%	Overall improvement of 1 percentage points (lower score better)
Percentage of staff experiencing physical violence form staff in the last 12 months	2%	3%	1%	2%	Overall improvement of 1 percentage points
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	87%	93%	87%	Overall improvement of 2 percentage points
Support form immediate managers	3.76	3.65	3.86	3.69	Overall improvement of 0.10

NHS staff survey 2015 – Trust performance, bottom four ranking scores

Bottom 4 Ranking Scores	2014		2015		Trust Improvement/ deterioration in year
	Trust	National average	Trust	National Average	
Quality of non-mandatory training, learning or development	Not asked	N/A	3.92	4.03	
Effective use of patient / service user feedback	3.62	3.56	3.45	3.70	Deterioration of 0.17
Staff recommendation of the organisation as a place to work or receive treatment	3.63	3.67	3.49	3.76	Deterioration of 0.14
Staff satisfaction with the quality of work and patient care they are able to deliver	Not asked	N/A	3.82	3.93	

Conclusions from the staff survey and action plans for the future

Overall, it was not unexpected to see a largely unchanged set of staff survey results in 2015 given the pressures that the system has been under both operationally and financially. The Trust has seen the overall staff engagement score actually increase following last years' dip which was positive to see.

A number of the large transformational change projects ongoing in the organisation, such as the more toward Clinical Business Units (CBU), in part, are intended to address some of the concerns of the staff survey in terms of communication. As were adjustments to the Team Brief and the introduction of our 'Big Conversations' which are Executive lead. We have also conducted an overseas recruitment campaign to address nurse shortages to reduce staffing pressures.

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

In view of the findings above, the Trust's Strategic People Committee will be giving consideration to a range of proposed actions to inform on-going development of action plans for continued sustained improvement. Focus will be given to ensuring the new Trusts behaviours are role modelled, top down, having utilised them for the CBU reorganisation. The focus will also be on development of our Health and Well-being, engagement and Talent management strategies.

Expenditure on Consultancy

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

	31st March 2015	31st March 2016
Total expenditure (£000's)	**618**	**355**

Off-Payroll Engagements

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2016	13
Of which...	
Number that have existed for less than one year at time of reporting.	12
Number that have existed for between one and two years at time of reporting.	1
Number that have existed for between two and three years at time of reporting.	0
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 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	51
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	17
Number for whom assurance has been requested	17
Of which...	
Number for whom assurance has been received	17
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received.	0

All individuals engaged on off payroll arrangements during the year were issued with a checklist to enable the Trust to conduct a risk assessment. Assurances were sought from all 51 individuals as to their tax obligations. In some cases the assurance was requested and not received. For each of those cases the contract had already ended and the individual was no longer engaged by the Trust.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016:

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year.	20

Details of the exceptional circumstances that led to this engagement.

The Trust initially needed some support in the role of Director of Transformation, which was a new and additional Board Level post. The individual was recommended to us as a high-quality former NHS Finance Director and Chief Executive. The Individual filled the role, whilst the Trust made a more sustainable appointment to the role. In the meantime, the Director of Finance and Commercial Development for the Trust secured a new role with a new Trust and the individual also covered this role, until a substantive replacement could be secured. The only means by which we could use the services of this individual was through an Executive Search agency. An individual was engaged as Turnaround Director (July 15 to November 15) and then the same individual was engaged as Interim Director of Finance (December 15 to Jan 16).

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

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

Exit Packages

Staff exit packages

	2015/16						2014/15	
Exit package cost band	**Nr of Compulsory Redundancies**	**Cost of Compulsory Redundancies**	**Nr of Other Agreed Departures**	**Cost of Other Agreed Departures**	**Total Nr**	**Total Value**	**Total Nr**	**Total Value**
		£000		**£000**		**£000**		**£000**
£0,000 – £10,000	0	0	1	5	1	5	0	0
£10,001 - £25,000	0	0	2	36	2	36	0	0
£25,001 - £50,000	0	0	1	44	1	44	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0	0	0
Total nr and value of exit packages by type	**0**	**0**	**4**	**85**	**4**	**85**	**0**	**0**

Number of departures where special payments have been made is 1 at a cost of £5k.

Exit packages: other (non-compulsory) departure payments

	2015/16		2014/15	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	2	36	0	0
Mutually agreed resignations (MARS) contractual costs	1	44	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring Her Majesty's Treasury approval	1	5	0	0
Total	4	85	0	0
Of which:				
Non-contractual payments requiring Her Majesty's Treasury approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

3iv Accountability Report – The Disclosures Set Out In the NHS Foundation Trust Code of Governance

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

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

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

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

There are three areas of the code where the Trust is declaring noncompliance:

Provision A.5.6 requires the council of governors to establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the new provider licence or other matters related to the overall wellbeing of the NHS foundation trust. Whilst the Constitution makes reference to Resolution of Disputes with Board of Directors under clause 9 of annexe 6, the Trust does not currently have in place a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust. The policy will drafted and presented to CoG in May 2016 for approval.

Provision A.5.7 requires that the council of governors ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting of advance meeting agendas and, where possible, using clear, unambiguous language. The council of governors did not have a 12 month rolling cycle of business in place to allow for timely planning and to ensure it discharges its duties and responsibilities. Although agenda setting meetings were generally held between Chairman and Governors, they have not been held during Q4. However there is now a 12 month rolling cycle of business in place aligned to the statutory duties of the governors.

C.3.8 requires the audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical

or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions. Speak out Safely is reflected in the Trust's Incident and Investigations policy and the Audit Committee appoints MIAA as the internal auditor to undertake audits of services, function, processes and policies so that necessary safeguarding are in place. However, there is currently no HR policy in place as required as part of the Freedom to Speak up requirement and the Dignity at Work HR policy is out of date. The HR team will be reviewing and refreshing all policies during quarter 1 of 2016-17.

Additional reporting information

Additional information or statements which fall into other sections within the annual report and accounts are 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 note 5 to 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 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 note 19 of the annual accounts

Related Party Transactions

The Trust has a number of significant contractual relationships with other NHS organisations which are essential to business. A list of the organisations with whom the trust holds the largest contracts is included in note 18 of the accounts.

Appointment of External Auditors

The trust appointed PricewaterhouseCoopers LLP as its external auditor.

3v Accountability Report – Regulatory Ratings

Up to August 2015 Monitor used the Continuity of Services Risk Rating to assess the financial position and robustness of a NHS Foundation Trust. The Continuity of Services Risk Rating incorporated the following measures:

- Liquidity – days of operating costs held in cash or cash equivalents forms, including wholly committed lines of credit available for drawdown.
- Capital Servicing Capacity – the degree to which the organisation's generated income covers its financing obligations.

In August 2015 Monitor published the updated Risk Assessment Framework which replaced the Continuity of Services Risk Rating with a new Financial Sustainability Risk Rating. The purpose of the new Risk Rating was to identify whether the financial position of an NHS Foundation Trust that is a provider of Commissioner Requested Services could place its services at risk and whether there may be wider issues relating to financial efficiency.

The financial sustainability rating incorporates the following measures of financial robustness and efficiency:

- Liquidity – days of operating costs held in cash or cash equivalents forms, including wholly committed lines of credit available for drawdown.
- Capital Servicing Capacity – the degree to which the organisation's generated income covers its financing obligations.
- Income and Expenditure Margin – the degree to which the organization is operating at a surplus or deficit.
- Variance from plan in relation to Income and Expenditure Margin – variance between the planned and actual income and expenditure margin within the year.

Each metric is scored between 1 and 4 and carries a 25% weighting to determine the overall financial sustainability risk rating.

Regulatory implications of the Financial Sustainability Risk Ratings are summarized below:

Risk Rating	Description	Regulatory Activity
4	No evident concerns	None
3	Emerging or minor concern potentially requiring scrutiny	Potential Enhanced Monitoring
2*	Level of risk is material but stable	Potential Enhanced Monitoring
2	Material risk	Potential Investigation
1	Significant risk	Likely investigation and potential appointment of contingency planning team

Note 2* is assigned by Monitor based on whether they have a high degree of confidence in the provider maintaining or improving its financial position.

The performance of the Trust over the last two years is summarised in the table below.

2014/15	**Annual Plan**	**Q1**	**Q2**	**Q3**	**Q4**
Financial Risk Rating	3	2	2	2	2
Governance Risk Rating	Green	Green	Green	Red	Red
2015/16	**Annual Plan**	**Q1**	**Q2**	**Q3**	**Q4**
Financial Risk Rating	2	1	2	1	1
Governance Risk Rating	Green	Red	Red	Red	Red

The financial risk rating was a "Continuity of Services Risk Rating" up to Q1 15/16 then moved to a "Financial Sustainability Risk Rating"

The Trust's two year plan sets out the operational and financial plans for the Trust to ensure sustained delivery of core objectives and targets and meeting out terms of authorisation. In year performance is reported internally on a monthly basis and quarterly to Monitor through upload templates, narrative and formal Board declarations. Monitor issues in year ratings on the basis of these returns.

The actual 2015/16 Financial Sustainability Risk Rating was a rating of 1 which was not in line with the planned rating of 2.

Regulatory Actions

On 6th August 2015 the Trust were issued with an Enforcement Action under the Health and Social Care Act 2012 as it was in breach of certain license conditions and had particular concerns regarding:

- 2014/15 actual deficit.
- Historic and current shortcomings in the delivering of the cost savings programme.
- 2015/16 forecast deficit and a forecast Continuity of Services Risk Rating of 1.
- Absence of a recovery plan to return the Trust to a Continuity of Services Risk Rating of 3 or greater and reliance upon external support to develop a turnaround plan.

The Trust agreed to a series of Undertakings with a commitment to take all reasonable steps to deliver its services on a clinically, operationally and financially sustainable basis including:

- An action plan to reduce the 15/16 deficit and improve its in year financial position beyond that submitted as part of the Annual Planning process.
- An action plan to minimize the 16/17 deficit and seek to move to a position of breakeven.
- The development of a longer term strategic plan that will determine an appropriate strategy to move a position of breakeven whilst remaining clinically and operationally over the longer term period and the steps and actions required to implement that strategy.

Emergency Department/A&E

This has been a very challenging and difficult year which has seen us fail to meet the emergency standards access measure of four hours throughout the year. The Trust continues to work with the Emergency Care Intensive Support Team (ECIST) and in partnership with our health and social care partners to support the performance of the Emergency Department. We have launched Perfect Week initiatives which have brought the whole LHE together and had a positive impact on our ability to improve performance against the four hour A&E national target at those moments in time. Additionally, the start of the Ambulatory Care Pathways through the Ambulatory Care Unit has ensured a continuous focus to meet this standard.

However, this does not represent a systemic solution and a more sustainable recovery plan is needed in 2016/17 which accounts for all agencies playing their ongoing part each and every day and not just over the course of a 'difficult' week. No formal interventions were made by Monitor during 2015/16 in this area.

Cancelled patients not treated within 28 days

For the first time, 2015/16 saw the Trust fail to meet the standard of readmitting within 28 days, patients cancelled by the Trust for their planned care. This is very disappointing and a direct result of the flow and escalation problems we have experienced throughout the year. We will commit to returning to the excellent performance in 2016/17. No formal interventions were made by Monitor during 2015/16 in this area.

3vi Accountability Report – Statement of the Accounting Officer's Responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Warrington & 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 the independent regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Warrington & Halton Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Warrington & 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 *NHS Foundation Trust Annual Reporting Manual* and in particular to:

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

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

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

Signed:

Chief Executive

Date: 25th May 2016

3vii Accountability Report – Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Warrington & 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 & Halton Hospitals NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and accountability

The Board of Directors provides leadership on the overall governance agenda. The Quality Committee is the committee of the Board of Directors that oversees the risk management activity of the Trust and ensures that the correct strategy is adopted for managing risk; controls are present and effective; and action plans are robust for those risks that are scored 15 and above. The executive lead for risk management is the Director of Nursing and Governance. The supporting system for managing risk has been delegated to the Associate Director of Governance, bringing together all aspects of the risk management process and governance systems. Additional support is provided to the Trust's risk management systems through designated Governance Managers and audit and governance leads within divisions.

The Trust has kept under review and updated its Risk Management Strategy, the last revision taking place in May 2015 and will be further updated in May 2016. The Risk Management Strategy provides a framework for managing risk across the trust in line with best practice and Department of Health guidance. The Strategy clearly describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the trust. The Board Committees are supported in their role by their reporting committees and groups which includes quality and clinical governance, infection control, safety and risk and information governance and corporate records, all of which form part of the trust's overall integrated Governance Structure.

Training

Training is provided to staff on risk assessment and management through a number of sources. The Trust's corporate induction programme ensures all new staff (including consultant appointments) are made aware of the Trust's risk management systems and processes and staff are provided with an information leaflet at

the time of induction. Corporate Induction has been revised so that all new starters attend the induction before starting work within the Trust within designated wards, departments and specialties. The Corporate Induction is supported by local induction programmes which, together with the Corporate Induction, provide an indicator on the Trust's induction performance and these indicators are reported to the Strategic People Committee and Board of Directors for assurance purposes. Risk assessment and management training is provided to all levels of staff within the organisation based upon the requirements of the position and role held. In addition to this, Governance drop-in sessions are held to further support staff.

The Trust provides a comprehensive mandatory training programme that covers a wide variety of risk management processes, including but not limited to; health and safety; fire; manual handling; security; information governance; resuscitation; records management and blood transfusion. Mandatory training rates are reported to the Strategic People Committee, the Board of Directors and the Council of Governors through one of its committees, the Quality in Care Committee. Training needs analysis of staff continues to be reviewed to ensure relevant training is directed to those members of staff that require specific training for their role within the trust and that learning, improvement and lessons learned from untoward events are brought to the attention of staff.

Investigation training aligned to root cause analysis is provided and is led by the Associate Director of Governance within the framework of NHS England (formerly National Patient Safety Agency NPSA requirements). The training is underpinned by the required levels of investigation. For serious incidents (level two investigations) the lead investigating officers are outside of the area where the incident has occurred. No person can lead an investigation unless they have received training on the relevant principles.

Control mechanisms including 'lessons learned'

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

Learning and improvement from incidents, complaints, claims and coroners inquests has been a particular focus for the Trust and help to improve internal control. Monthly meetings have been established with key post holders who work closely together, sharing best practice and learning lessons collectively rather than on an individual divisional basis. The Governance Report (incidents, complaints, PALS, Claims, Coroner inquests, external agency, Risk KPIs) is reported to; the Board of Directors; the Quality Committee; the Patient Safety Sub Committee; the Safety and Risk Sub Committee; Divisional Integrated Governance Groups; and shared with the lead Commissioners as part of the Quality Contract. The Report has continued to receive positive comments on its qualitative and quantitative analysis in addition to Learning and Improvements. Lessons for learning are also disseminated to staff using a variety of methods including:

(i) Safety alerts and Safety Briefings

Safety alerts are circulated to raise awareness of risks that may lead to errors and therefore reduce the risk to patients, staff, visitors and contractors in the future. They are produced following a review of incidents or following information provided by staff within the Trust or from external agencies. These form part of Safety Briefings at Shift Handover for clinical staff.

(ii) Revision of policies and changes

A number of polices were revised in line with national reports and in addition as a result identification of common themes within the contributory factors to which examples have been provided below:

- Incident and Investigations
- Safe and Supportive Observations of patients
- Consent to Treatment
- Head Injury
- Standard expected for physiological and neurological patient observations (including blood glucose monitoring)
- Trust standard for writing procedural documents and Approval process

(iii) Risky Business online newsletter

The Risky Business Newsletter which has been in place now for over 4 years covers a wide range of topics including health and safety, security, information governance and consent to name but a few. Changes have been made to the format of the newsletter to an on line application which can be viewed by staff on the Trust's intranet portal.

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

The Trust introduced CIRIS as the integrated governance compliance and monitoring system. The system provides around the clock access to the sources of information should the trust be subject to both internal and external review. The sources of information includes: Level Two Incident Investigations and action plans; NICE Guidance; Part 1 and 2 Risk Registers; Audits; National Confidential Enquiry into Patient Outcome and Deaths (NCEPODs) relevant High Level enquires. The latest being Freedom to Speak Up??

Clinical Effectiveness structures were strengthened in 2015/2016, with a new role developed and the scope and function of the Clinical Effectiveness Group (CEG) reviewed. One of the functions of CEG, is to monitor mortality ratios and drive progress in reducing mortality. The Trust uses the Healthcare Evaluation Data (HED) system to monitor detailed mortality data and wider clinical outcome information; this data is reported to the monthly CEG, which reviews this intelligence and monitors the progress of any associate actions.

The risk and control framework

The risk management framework is set out in the Trust's Risk Management Strategy. The key elements of the strategy include delegated roles and responsibilities in respect of the various elements of the risk management process. Risk Management requires participation, commitment and collaboration from all staff and there is strong focus on training and support given to staff to enable them to fulfil their responsibilities.

There is a robust system in place of risk identification, monitoring and reporting throughout the trust's corporate departments, its divisions through its Integrated Governance Structure. The Trust's risk register is based upon the risks of the organisation and is populated by all services and departments through local risk registers and are monitored and maintained locally within the corporate departments and divisions. This enables risk management decision-making to occur as near as practicable to the risk source. For those risks that cannot be managed locally these are escalated to the appropriate manager and are included in the appropriate corporate departments or divisions risk register.

- **Part 3 Risk Register (all risks with a risk score of below 12) –** All risks below 12 are managed locally by each Ward/Departmental Manager. This can be managed by risk assessments and/or local risk registers and should be reviewed at least annually.

- **Part 2 Risk Register (all risks with a risk score of 12)** – All risks of 12 are placed on CIRIS by the relevant Division/Department. Each risk has an identified Lead who will review the risk to ensure any actions are implemented. The Part 2 Risk Register is reviewed at Safety and Risk Sub Committee at least 3 times a year and monthly at the Patient Safety Sub Committee.
- **Part 1 Risk Register (risks of 15 and above)** – The Part 1 Risk Register known as the Corporate Risk Register is maintained and monitored by the Safety and Risk sub-Committee which meets monthly to assess risk with a risk score of 15 or above. Following review both the Safety and Risk and Patient Safety Sub Committees the Corporate Risk Register, Controls and Action points for the risks are submitted to the Quality Committee which has an overarching role to ensure that significant issues arising review of the register are brought to the attention of the Board of Directors. The Board of Directors receives the Corporate Risk Register with the Board Assurance Framework quarterly during each financial year.

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

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

The Trust encourages stakeholder and partner organisations' participation and has developed an active Patient Experience Group. Partners and Governors are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management. Input from both Warrington Healthwatch and Halton Healthwatch, along with the emissary members of Warrington Overview and Scrutiny Committee has been a welcome addition in providing patient and public involvement on a range of issues.

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

The Board Assurance Framework with the Corporate Risk Register provides the Board of Directors with a holistic overview of strategically significant risks relating to the Trust's operations and where gaps in control, assurance or risk management are identified, action is taken to rectify them. As part of the process of continual review and development, the existing Board Assurance Framework has been strengthened to reflect the requirements to support on-going registration with the CQC, Monitor's Risk Assessment Framework and the Trust's Provider Licence conditions.

External Review and Inspections

A total of 32 external agencies visited the Trust from 1st April 2015 to 31st March 2016. This information is entered into CIRIS web base compliance system once the visit/inspections are known. Information to the outcome of the reviews is reported within the quarterly Governance Report.

The Trust contacted the Royal College of Obstetricians and Gynaecologists (RCOG) as a result of a series of perinatal deaths that occurred in a cluster between March 2013 and March 2014. An action plan had been put in place relating to the management of low risk management in labour. The Review took place in August 2014 to which the subsequent Report identified that the Maternity Unit had a dedicated Medical and Midwifery team with integrity over the care they delivered. The RCOG did not feel the Unit was unsafe.

CQC Inspections

The CQC inspected Warrington and Halton Hospitals NHS Foundation trust from 27th – 29th January 2015. 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

These 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. The CQC then provided a rating by specialty; location and an overall rating for the Trust from the inspection. The Report published July 2015 which was a positive report that tells the story of the compassionate care our Trust delivers and the commitment of the staff who work at the Trust. The Report also reflected the pressures we have seen that we were all open and honest about with the inspectors and that are issues that many hospitals of our size currently face.

A quote from Sir Mike Richards, chief inspector of hospitals, from the introduction to the report:

"The trust had a vision and strategy with clear aims and objectives and a framework for the delivery of them relating to Quality, People and Sustainability. Staff in both hospitals were aware and supportive of the vision and values; they understood the challenges facing the trust and the plans and actions to address them.

"Staff were committed and passionate about their work. They were keen to learn and continuously improve the services they offered to patients. There was good leadership and strengthening governance arrangements across the trust."

The Report also identified pressures:

*"The trust had been under pressure from high numbers of **emergency admissions** through its A&E department. The trust was well aware of its challenges in this regard and was working with partners to resolve this issue.*

*"**Nursing staff** were caring and compassionate and treated patients and those close to them with dignity and respect. Nursing vacancies were covered by bank staff, overtime and agency nurses. Wards and departments were suitably staffed but the trust acknowledged that the current position was not sustainable in the longer term.*

*"**Medical treatment** was delivered by skilled and committed medical staff. However, there was not always enough medical staff to provide timely treatment and review of patients, particularly out of hours. There were a high number of vacancies in some areas."*

Overall Ratings: Requires Improvement

CQC Intelligence Monitoring

The Care Quality Commission Intelligent Monitoring which was based on 150 indicators looking at a range of information including patient experience, staff experience and statistical measures of performance including detailed mortality rates, waiting time and access information, patient feedback and actual CQC inspection results has ceased being published. There is no information as to any replacement of this system at the time of this document being written.

Quality Governance and the move to Business Units

The Trust's new plan to move from three Divisions to two and implementation of CBUs allows us to review the whole process of *Quality (*Safety, Effectiveness and Patient Experience) Governance.

The key to this proposal is the development of a Performance Assessment Framework to facilitate performance monitoring on selected aspects of quality. It is vital that the new system reflects the key deliverables within the context of new structure and incorporates monitoring systems to track exceptions, improvement and changes. Secondary proposals include a further restructuring of the committees [following the approval of the Quality Strategy undertaken early 2015] and the restructuring of personnel within Corporate Nursing and Governance to develop a Quality Governance Team.

The meeting structure will be altered with the introduction of Bilateral Quality/Governance monthly meetings which is central to the process of challenging the two Divisions and Pharmacy on their quality governance data which will then be fed up to the sub committees below :

- Patient Safety & Clinical Effectiveness
- Patient Experience
- Health & Safety
- Infection Control

The sub committees will be held bi-monthly (no meetings January and August) following assurance from the bilateral meetings and will only include exceptions and specific areas of note. In order that the assurance is solid, the recording, displaying and presentation of information starting at Specialty level through CBUs to Divisional, Sub-committee and Board level must be of excellent quality.

Corporate Governance

As a Provider Licence holder, the Trust is required to apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS (Provider Licence Condition FT4 'NHS foundation trust governance arrangements'). To do this, the Trust has regard to guidance from Monitor, the sector regulator for healthcare, including the NHS Foundation Trust Code of Governance which has recently been updated. All directors and governors have signed a declaration indicating their compliance with the "fit and proper persons" test introduced through condition G4 of the provider licence and in accordance with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During 2015/16 the structure of the Executive was amended and the executive team was extended to include a Director of Community Engagement and a Director of Transformation. This provided a more effective organisational leadership and accountability on the quality of care to patients provided by the Trust.

The Trust's integrated governance structure continues to support the trust's Quality-People-Sustainability Framework and has a clear reporting structure to the Board of Directors. Minutes of the meetings of the

Board Committees are presented to the Board and the Chair of each committee has the opportunity to escalate any significant issues to the Board's attention.

As part of the Annual Planning process the Board undertakes a review of compliance with its Provider Licence and has introduced a process of monitoring compliance, which is coupled with the Board Assurance Framework process.

The principal in year risks to compliance with Condition FT4 of the Trust's Provider Licence were:

- Failure to deliver targets for A&E and breaches C-Diff and MRSA
- Non delivery of cost improvement targets and thus inability to deliver original budget
- Failure to deliver a CoSRR of 3 for at least the next 12 months

The principal future risks to compliance with Condition FT4 of the trust's Provider Licence are:

- Failure to deliver targets for A&E and other key operational metrics
- Non delivery of cost improvement targets and meet budget
- Failure to deliver a FSRR of 3 for at least the next 12 months
- Failure to deliver PAS through Lorenzo programme
- Failure to recruit and retain key personnel
- Inability to deliver sustainable services
- Breakdown of key stakeholder relationships

The Trust is required under licence condition FT4(8)(b) to submit a corporate governance statement to Monitor each year as part of its Annual/Strategic Plan submission. This statement confirms the Trust's compliance with condition FT4 at the date of signature and the Trust's anticipated compliance with the condition for the coming year. The statement also outlines any risks to compliance and the actions that the trust is intending to take to manage these risks.
The corporate governance statement takes the form of a template issued by Monitor, and the proposed responses are subject to scrutiny by, individual executive and non-executive directors and senior managers prior to approval of the statement by the Board of Directors.

NHS Pension Scheme

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

Equality, diversity and human rights

The Trust ensures that its obligations under equality, diversity and human rights legislation are complied with via the production of its Equality Diversity Scheme and associated action plan. This is managed through the Equality and Diversity Sub Committee which reports to the Quality Improvement Board. Any risks which arise are included in the Board Assurance Framework.

The Board of Directors and members of Council of Governors, Quality in Care Committee have received Equality and Diversity training.

Carbon Reduction

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

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

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

The Trust has performance management processes in place that review the economy, efficiency and effectiveness of the use of resources. The Executive Team reviews the operational performance of the Trust and leads the Trust's identification and implementation of Cost Improvement Plans (CIPs). Monthly reports to the Board provide updates on performance throughout the year, ensuring service delivery and cost improvements without jeopardising patient safety. Part of the remit of the Strategy & Performance Committee, which meets monthly, is to support the Trust Board in gaining assurances on the economy, efficiency and effectiveness of the use of resources.

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

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by NHS Protect, 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.

Information governance

Risks to information, including information security and data quality risks, are managed and controlled through the use of the Health and Social Care Information Centre's Information Governance Toolkit and the Trust's Risk Management Strategy. The Trust uses the Information Governance Toolkit in conjunction with the CIRIS Risk Management system to inform the work of its IM&T Steering Committee, Information Governance and Corporate Records Sub-Committee and Data Quality and Management Steering Groups respectively. The Trust's Senior Information Risk Owner (SIRO), and chair of the IM&T Steering Committee, is the Director of IM&T. The SIRO acts as the board level lead for information risk within NHS organisations.

Any areas of weakness in relation to the management of information which are identified, or highlighted by internal audit review, are then targeted with action plans to ensure that we continue to strive to be information governance assured. In 2015 we achieved assured status.

The Trust has reported one incident of data loss to the Health and Social Care Information Centre which has been classified as a level 2 Serious Incident Requiring Investigation (IG SIRI). The incident investigation is on-going and the ICO have been notified of actions the Trust has taken in connection with the incident. At this point the ICO has taken no action.

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. 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*.

The following steps have been put in place to assure the Board of Directors that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data.

- The Trust has two specific strategic objectives focussing on quality and safety and patient experience, these being:
  - i) ensure all patients are safe in our care; and
  - ii) give our patients the best possible experience
- The Board has an appointed the Director of Nursing to lead, and advise it, on all matters relating to the preparation of the Trust's annual Quality Report for 2015/16.

In February 2015 we launched our Quality Strategy focusing on three core components: delivering a safe organisation; a clinically effective organisation; and an excellent quality of experience for our patients. The strategy provides assurance that national and local clinical and quality requirements have been identified and processes and systems are in place to implement and monitor quality within the Trust. The strategy is integral to making quality and quality improvement a core responsibility for and owned by all staff and ensuring that they are supported to fulfil this role

Quality has three main elements: patient safety, clinical effectiveness and patient experience (Darzi Report, High Quality Care for All: June 2008). The Trust restructured the committees in line with this approach to ensure that we provide an equal balance and assurance on all aspects of quality within the organisation and that we can measure and improve quality at all levels and throughout all areas of the Trust.

In September 2015 following the launch of the Quality Strategy the Trust held a workshop with members of the Quality Committee we concentrated on information flows between committees and from divisions to Board. The group agreed that it would be beneficial for the Board to receive an integrated performance dashboard which incorporated information on quality; finance and workforce issues.

The Trust has engaged stakeholders in the preparation of the Quality Report including the Council of Governors, Commissioners, Overview and Scrutiny Committee and Healthwatch.

- Preparation of the Quality Report is shared with the Council of Governors Quality in Care Committee throughout the year. This group give a valuable perspective on content, language and presentation.
- **Quality Report Annex – Statement of directors responsibilities** – "The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:
  1. the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/2015 and supporting guidance;
  2. the content of the Quality Report is not inconsistent with internal and external sources of information"

The processes established to maintain and review the effectiveness of the systems of internal control in relation to the Quality Report include:

- Council of Governors of Warrington & Halton Hospitals NHS Foundation Trust engage the external auditors PricewaterhouseCoopers LLP to perform an independent assurance engagement in respect of Warrington & Halton Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and specified performance indicators contained therein.
- The Trust meets monthly with the Commissioners to specifically discuss performance against quality performance measures contained within the Contract for Healthcare services.
- The Lead Commissioner; Lead Overview and Scrutiny Committee provide a statement on the Quality Report.
- The annual internal audit programme agreed by the Audit Committee includes a review of elements of the systems, processes and performance metrics which are included in or support the preparation of the annual Quality Report.
- The 2015/16 plan for the Quality Report has ensured close working and involvement with the Trust's governors through the various stages.
- 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 – this includes submitting to and utilising data from data from the Health and Social Care Information Centre (HSCIC) and a clinically-led benchmarking system called Healthcare Evaluation Data (HED)
- A review of the Trusts Quality Framework has been undertaken in accordance with the requirements of the Internal Audit Plan 2015/16, as approved by the Audit Committee. In line with a commitment to delivering high quality services, the Trust was keen to review the systems and processes in place which together provide assurance on the quality of service delivery. Key structures and processes are required at all levels to monitor trust-wide quality performance. The overall objective of the review was to assess the effectiveness of the Trust's Quality Framework. The internal auditors provided the Trust with "significant assurance" determining that there were some weaknesses however, either their impact would be minimal or they would be unlikely to occur.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that had been applied in maintaining and reviewing the effectiveness of the system of internal control, I have set out below some examples of the work undertaken and the roles of the Board and Committees in this process:

- The Board reviews the Board Assurance Framework quarterly along with the Part 1 Risk Register.
- A programme of Risk Management training for all staff.
- The internal audit plan which is risk based, is reported to the Audit Committee at the beginning of each year. Progress reports are then presented to the Audit Committee at each meeting with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, quickly raise any areas of concern at the Board via a Key Issue Report and minutes are also considered by the Board. She/he also produces an annual report on the work of the Committee.
- The Executive Management Team meet weekly and has a process whereby key issues such as performance management, action plans arising from external reviews and risk management are considered if there is a need.
- All relevant committees have a clear cycle of business and reporting structure to allow issues to be escalated from 'ward to board'.

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

Other improvements made in 2015/16 include:

- Addition of two Directors (non-voting) to the Board.
- The appointment of the Medical Director as Deputy Chief Executive.
- The implementation of the revised protocol for the maintenance and monitoring by the Board of the BAF.
- On-going support from the Trust Secretariat to ensure that the Board and Governors are appropriately supported to deliver their statutory responsibilities.

Board of Directors

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

Audit Committee

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

Clinical Audit

Clinical Audit is an integral part of the Trust's internal control framework. An annual programme of clinical audit is developed involving all clinical business units. Clinical audit priorities are aligned to the Trust's clinical risk profile, compliance requirements under the provisions of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, and national clinical audit priorities or service reviews.

Internal Audit

At the Audit Committee meeting held in April 2016, the Trust's internal auditor has provided an overall opinion of significant assurance, based on their work during the reporting period.

External Audit

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

Challenging financial circumstances throughout 2015/16 resulted in a deterioration in the Trust's financial position against plan and in response, during quarter 2, Monitor (the Regulator) having regard to its enforcement guidance decided to accept Enforcement Undertakings from the Trust pursuant to its powers under s106 of the Health & Social Care Act 2012.

Conclusion

Whilst there were no significant internal control issues or gaps in control identified in 2015-16 and the Trust's internal auditor has provided an overall opinion of significant assurance, based on their work during this period, it would be remiss of me to not highlight that on 6th August 2015 the Trust was issued with an Enforcement Action from the Regulator, Monitor, under the Health and Social Care Act 2012 as it was in breach of certain license conditions. Monitor has particular concerns regarding:

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

Following a meeting with the Regulator, the Trust agreed to a series of Undertakings with a commitment to take all reasonable steps to deliver its services on a clinically, operationally and financially sustainable basis including:

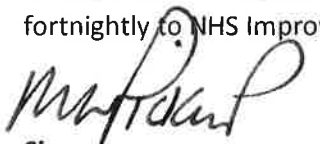
- An action plan to reduce the 15/16 deficit and improve its in year financial position beyond that submitted as part of the Annual Planning process.
- An action plan to minimize the 16/17 deficit and seek to move to a position of breakeven.
- The development of a longer term strategic plan that will determine an appropriate strategy to move a position of breakeven whilst remaining clinically and operationally over the longer term period and the steps and actions required to implement that strategy.

During 2015/16 and moving into the 2016/17 financial year the Trust has strengthened financial governance with an increase in the level of scrutiny of the Trust's finances. For the year ending 31st March 2016 the Trust delivered a financial deficit of £17.3m excluding impairment expenses of £1.0m and a FSR rating of 1. The improvement against the underlying position is a reflection of the increased scrutiny and grip and control measures introduced in the year and also from a review of the Trust's assets which has resulted in an increase to asset lives. Measures that have been introduced include:

- Weekly grip and control meetings led by the Transformation Team to seek income generation and cost reduction opportunities and to ensure that these opportunities are maximised and delivered.
- Daily review and authorisation of non-catalogue, non-spend pay by Executive Directors that has resulted in a reduction in expenditure.
- Daily review of cash levels and rolling 13 week cash flow forecast.
- Increased monitoring of temporary spend (bank, agency, locum, overtime and premium payments) to understand performance, trends and mitigating actions particularly relating to the agency cap.
- Monthly analysis and review of clinical supplies and services for high cost areas that are discussed with managers so that stock is managed and controlled appropriately.

The Trust has an Innovative and Cost Improvement Committee that meets on a monthly basis to review, monitor and manage performance against the annual cost savings target to ensure maximisation of any income generation and cost reduction schemes. This committee reports directly to the Finance & Sustainability Committee that's meets on a monthly basis to monitor and review performance against the Trust's financial and operational targets. The Finance and Sustainability Committee receives a comprehensive finance report that covers all relevant information including income and expenditure, cost savings, capital and cash that provides assurance to the Board on current and forecast financial performance. This committee reports directly to the Board of Directors.

The financial plan for 2016/17 is a deficit of £18.6m and FSR rating of 1. This excludes any Sustainability and Transformation Funding that has been ring fenced for providers of emergency care. The Trust has set a challenging CIP target of £8m which has been allocated to budget holders with clear accountability arrangements. Progress against the identification of schemes and delivery of schemes is being reported fortnightly to NHS Improvement and monthly to the Finance and Sustainability Committee.



Signed:

Chief Executive

Date: 25th May 2016

4 Quality Report

Warrington and Halton Hospitals NHS Foundation Trust

Quality Report

2015-2016

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Glossary

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

Quality Report

Quality is our number one priority.

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

1. Statement of Quality from the Chief Executive

Mel Pickup, Chief Executive

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

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

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

Throughout 2015/2016 progress has been achieved through the hard work, commitment and dedication of every single member of staff. However we have continued to see and treat an increasing number of patients with more complex needs on both an elective and non-elective basis. The trust was aiming to end the year with a deficit of no more than £14.2m but at 31st January the forecast deficit increased to £15.6m. Unfortunately although financial and operational pressures have contributed to the trust completing the year with a deficit of £18.3m, this report clearly evidences that despite this we have continued to maintain our focus on quality for the patients who use our services.

Within the reporting year the trust has continued to achieve all national targets from the operating framework with the exception of the 95% Accident & Emergency 4 hour access target and the referral to treatment waiting time target for admitted patients in quarter four 2016 and non admitted patients in March 2016 . The trust has achieved all quarterly cancer targets including 62 day wait for first treatment and 31 day wait from diagnosis to first treatment.

With regards to health care acquired infections the trust can report that by the end of the year we have reported 33 cases of hospital acquired Clostridium Difficile against a threshold of 27. The 33 cases include 12 cases that have been removed following a joint review with commissioners for contractual purposes which demonstrated that 12 cases were not due to any lapses in care on the part of the trust. Similarly a further 11 cases will be reviewed in May 2016. It is therefore expected that the final number of c. difficile cases will be well within the threshold of 27. The trust can also report 2 cases of hospital acquired MRSA against a threshold of zero for 2015/2016 importantly this is a reduction of 1 case against 2014/2015 where we reported 3 cases of MRSA.

This has been a challenging year but we have worked hard in relation to our quality priorities and I am pleased to report that for2015/2016 we met a 10% reduction in grade 3 & 4 pressure ulcers with no incidences of grade 4 pressure ulcers and a reduction in grade 3 pressure ulcers at 3 confirmed grade 3 pressure ulcers. Importantly I can report that there have been no grade 4 pressure ulcers at the trust for 5 years.

Since 2012 we have continued with our focus on reducing inpatient falls and although we are disappointed to report that we have not achieved the anticipated 5% reduction in falls overall, we are pleased to report that our falls rate per 1000 bed days has decreased during 2015/2016. Importantly the Quality Report evidences that falls resulting in what are classified as harm 'moderate' or catastrophic (such as those resulting in a fracture) have reduced by 37.5% on the previous year.

'Sign up to Safety' aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. Sign up to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives across the NHS. Our sign up to safety goals are to achieve 20% reduction avoidable mortality by 2017; a 30% reduction in moderate falls by 2017 and a 30% reduction in all grades of pressure ulcers by 2017. Last year I reported that sign up to safety objective for pressure ulcers was achieved by the end of year one with a 39.83% reduction in all pressure ulcers. I am pleased to report that we have in year two of this plan achieved 40% reduction in moderate falls which exceeds the original goal of 30% reduction in moderate falls.

We're pleased to report 37.5% reduction in moderate to catastrophic falls this year.

We have also made significant progress towards establishing a high quality and effective mortality review process and have achieved all our quarterly thresholds to date.

Within the reporting year and partially in response to our financial situation a decision was made to review and redesign our internal organisational structures. For over 8 years the trust has operated a '3 Division' Structure; Scheduled Care, Unscheduled Care and Women's, Children's and Support Services which has allowed the trust to establish strong and consistent approaches to governance, operational management, financial control and ultimately the delivery of high quality healthcare. The new structure has been developed collaboratively with the clinical divisions and will facilitate clinical specialities working much more closely within Clinical Business Units (CBU). It embraces the concept of true leadership synergy between a 'triumvirate' which brings together lead doctors, nurses/allied health professionals and managers working seamlessly with the wider corporate teams responsible for the clinical, operational and financial functioning of their CBU. The CBU's are built around the needs of the patients and the pathways that they follow from referral to hospital to their discharge and follow up care. Through innovation and collaboration with partners the trust aims to improve access and quality of care whilst minimising costs.

The CBU's are built around the needs of the patients and their pathways

The Care Quality Commission (CQC) the body responsible for checking that all hospitals in England and Wales meet national standards inspected Warrington and Halton Hospitals NHS Foundation Trust from 27th – 29th January 2015. 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 and well-led.

In July 2015 the CQC published our report and we can report that the CQC rated Halton Hospital and Bath Street Health and Wellbeing Centre as 'Good' and Warrington Hospital as 'Requiring Improvement'. The trust was given an overall rating of 'Requires Improvement' by the CQC. Importantly whilst the inspectors found services were caring, effective and did not observe any examples of unsafe practice during their visit, in certain areas the need for improvement was noted. England's chief inspector of hospitals Professor Mike Richards reported that inspectors found that 'Staff were committed and passionate about their work, keen to learn and continuously improve the services they offered to patients'.

Recently a league table 'Learning from Mistakes League' has been constructed. This scores trusts based on the fairness and effectiveness of the procedures for reporting errors; near misses and incidents; staff confidence and security in reporting they have unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their trust. At a time when there have been highly publicised examples nationally of the unfavourable treatment of so called 'whistleblowers' who 'raise concerns' about patient safety and welfare of staff in some NHS organisations, I am pleased to report that this trust was rated as 'Good' in this assessment.

- SHMI HMSR

Patient Experience 2016/2017

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

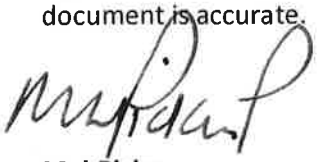
Continue these improvements and show our commitment in providing high quality care to our local communities.

The improvement priorities and quality indicators will be reviewed by the Quality Committee; Quality in Care Committee and recorded via the Quality Dashboard which is reported to board on a monthly basis.

In conclusion, this Quality Report evidences that whilst we have made encouraging progress in improving the care and services we deliver to our patients, we are committed through our priorities and quality measures for 2016/2017 to continue these improvements and show our commitment in providing high quality care to our local communities.

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

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



Mel Pickup

Chief Executive

25th May 2015

Prehaps the most significant change in 2015/2016 has been the trust undergoing a major technology transformation programme after a successful bid for Department of Health funding last year to support the deployment of a new Electronic Patient Record (EPR) system called Lorenzo. Lorenzo went live across our wards and emergency departments on 21st November 2015 followed by outpatient areas on Monday 23rd November 2016. The new EPR is one part of a multi-million pound programme which will revolutionise how patient care is delivered over the coming years at our hospitals and in the trust's services provided in the local community. The objective is to secure a more streamlined service for patients with better access to clinical records by our clinicians and better management of services.

The provision of urgent and emergency care has, at a national level remained very much in the headlines over the last year, and has presented us with significant challenge, Halton General Hospital's new Urgent Care Centre (UCC) opened in July over 9,000 patients have used it and they have given it a five star rating for the care it provides. The centre provides assessment and treatment for anyone suffering from an urgent illness or injury that is not life-threatening, but cannot wait for a routine appointment with their GP. I am also pleased to report that in November 2015 the trauma unit at Warrington Hospital scored the highest marks in Cheshire and Merseyside and finished in the top five of 105 trusts in the first national peer review of trauma centres. The trust was also rated as the best performing trust in the North West for providing hip and knee replacement surgery.

Our Quality Report also provides a detailed review of national and local clinical audits and we are pleased to report that the trust participated in 96% of national audit and 100% of national confidential enquiries that it was eligible to participate in. In 2015-2016 the Trust was involved in conducting 67 clinical research studies in research in oncology, surgery, stroke, reproductive health, cardiology, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

We have engaged throughout the year with our partner organisations to update them on the progress made toward achieving our improvement priorities throughout the year. Early in 2016 we invited our partners to attend an event to discuss the improvement priorities for 2016/2017. We then engaged in a wider programme of consultation with staff, patients and the public.

Our quality improvement priorities for 2016/2017 will be:-

Priority 1 "Every patient has a voice" – implementing Experience of Care Strategy

Priority 2 Pressure Ulcer – reduction

Priority 3 Mortality Review – learning from reviews

Priority 4 MUST Nursing Care Indicator – compliance and outcomes maintaining body weight in patients =>75 years

Our quality indicators for 2016/2017 will be:

Patient Safety 2016/2017

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

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

Clinical Effectiveness 2016/2017

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

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

Introduction

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

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

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

Throughout 2014/2015 we continued to see and treat an increasing number of patients with more complex needs on an elective and non-elective basis. This is significant because part of our original savings plan was to improve productivity as well as to better contain costs from spend on temporary clinical staffing. However as more people attend, more people are required to care for them. This in turn has created significant financial and operational pressure for the trust and thus impacted upon our ability to deliver the full £11.9m savings plan. The trust welcomed the announcement that Monitor - the sector regulator of health care services - has opened an investigation to look into our financial position after declaring a larger than expected deficit plan for the current financial year which has resulted in Monitor undertaking enforcement action. The regulator is working closely with the trust to understand why our finances have changed and the plan to improve them.

During 2015/2016 the trust has reforecast its financial plan, with an anticipated potential revised forecast of a full year deficit of £14.2m. The trust was aiming to end the year with a deficit of no more than £14.2m but at 31st January the forecast deficit increased to £15.6m. This meant that in February and March we were required to generate a surplus of £1.4m, key ways of achieving this is by:-

- Maximise the clinical activity going through scheduled sessions
- Ensure all clinical activity is captured and recording appropriately.
- Order essential non pay only and avoid any discretionary spend
- Restrict training and travel to mandated or essential only
- All non catalogue requisitions are now reviewed by the Chief Executive and rejected if not thought to be essential
- Maximise every chance to identify and achieve any cost saving opportunity

The trust completed the year with a deficit of £18.3m. This means that the cost of service delivery was greater than the income being generated. This was deemed to be in part due to the high level of temporary spending on bank, agency, locum, overtime and additional sessions. The poor financial position was worsened by a failure to deliver the full cost savings target in year. For 2015/2016 the trust identified a Cost Improvement Plan (CIP) target of £10.3m, by the year end the trust delivered a CIP £8.2m which results in a shortfall against the target of £2.1m.

Whilst the current situation has resulted in a trust's Financial Sustainability Risk Rating rating of 1, and a red governance rating, it should be recognized that 67 per cent of all providers forecast a deficit for the end of year and 89 per cent of acute trusts are expecting to overspend. (Kings Fund Quarterly Monitoring Report)

Organisational Structure

In September 2015 and partially in response to our financial situation a decision was made to review and redesign our internal organisational structures based on our clinical synergies. For over 8 years the trust has operated a '3 Division' Structure Scheduled Care, Unscheduled Care and Women's, Children's and Support Services. This structure has allowed the trust to establish strong and consistent approaches to governance, operational management, financial control and ultimately the delivery of high quality healthcare, in line with national standards and expectations. This has been a period of relative stability, clearly policy changes emerge from time to time, but in the main the extent to which external system change directly impacted on the trust and our services was marginal with the exception of achieving Foundation Trust status. Similarly throughout that time the funding has been largely consistent and predictable, although with the early years characterised by investment and the latter years, disinvestment. Today the organisation faces numerous and significant challenges including escalating costs and reduced funding, regulatory oversight and intervention, the challenges of maintaining an adequate workforce, enforcement action by Monitor, a commissioning strategy focused upon the delivery of alternatives to hospital care that fundamentally challenges the role of a District General Hospital, changing expectations of patients and the increasing regulation from inspection bodies like the Care Quality Commission (CQC).

It has therefore been agreed that this adjustment to our organisational structure will allow us to be more responsive to these challenges through improved clinical engagement, strong and resilient leadership at all levels with an emphasis on responsibility and accountability to achieve transformation and innovation. The new structure which has been developed collaboratively with the clinical divisions will facilitate the clinical specialities working more closely within Clinical Business Units (CBU). It embraces the concept of true leadership synergy between the 'triumvirate' which brings together lead doctors, nurses/allied health professionals and managers working seamlessly with the wider corporate teams responsible for the clinical, operational and financial functioning of their CBU. The CBU's are built around the needs of the patients and their pathways and through innovation and collaboration with partners the trust aims to improve access and quality of care whilst minimising costs. Operating under the leadership and management of one of two divisions each CBU will be the vehicle for greater devolvement of accountability and responsibility to allow decision making to take place closer to the patient/professional interface. The transition to the new structure will be finalised by April 2016.

Care Quality Commission Inspection

The Care Quality Commission (CQC) the body responsible for checking that all hospitals in England and Wales meet national standards inspected Warrington and Halton Hospitals NHS Foundation Trust from 27th – 29th January 2015. 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

These 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 July 2015 the CQC published our report which included a rating by specialty; location and an overall rating for the trust from the inspection. The trust can report that the CQC rated Halton Hospital as **good**, Bath Street Health and Wellbeing Centre (in Warrington where several clinic services are provided) as **good** and Warrington Hospital as **requires improvement**. They rated caring and effectiveness in the trust as good across the board in all of its services.

The trust was given an overall rating of **'requires improvement'** by the CQC although inspectors found services were caring, effective and did not observe any examples of unsafe practice during their visit. The trust has already actioned many of the recommendations made by the CQC which include improvements to patient flow and strengthening staffing in key areas where there were long term vacancies. England's chief inspector of hospitals Professor Mike Richards reported that inspectors found that 'Staff were committed and passionate about their work, keen to learn and continuously improve the services they offered to patients. There was good leadership and strengthening governance arrangements across the trust. Nursing staff were caring and compassionate and treated patients and those close to them with dignity and respect. Many areas of good practice were cited in the report including:

- **Nursing care**- Nursing staff were caring and compassionate and treated patients and those close to them with dignity and respect. Nurses were committed to giving people a high standard of care and treatment
- **Medical staffing**- Medical treatment was delivered by skilled and committed medical staff.
- **Dementia care**– The report highlighted excellent practice in the treatment of dementia. The hospital had a purpose built and highly effective ward for patients living with dementia, which was well equipped and well-staffed. Patients with dementia were assessed and admitted to the ward based on the severity of their dementia and managed sensitively
- **Cleanliness and infection control**- There was a high standard of cleanliness throughout the hospitals. Staff were aware of current infection prevention and control guidelines and observed good practice.
- **Nutrition and hydration**- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital.

However the report did raise several areas that the trust needs to make improvements around. Patient flow due to the pressure caused by emergency admissions was highlighted in the report. Inspectors noted the impact it had on patients at the time in terms of waiting. The trust has addressed this as a priority with its partners in health and social care and has improved its A&E performance since January with a return towards the 95% national A&E target – reaching over 94% in May. Unfortunately this improvement did not continue for the remainder of 2015/2016. Intermediate care beds have opened on the Warrington Hospital site which has resulted in improved patient flow.

The trust has also prioritised improving mandatory training compliance across its clinical divisions which was seen as variable in places.

Inspectors also highlighted staffing vacancies in key areas, particularly in medical staffing where the trust has struggled to recruit to some posts where there are national shortages and was dependent on locum staff. However, inspectors noted that all wards and departments were suitably staffed at the time of the inspection. This continues to be a key area of priority for the trust.

National Priorities and Targets

Monitor's analysis of trusts' performance between April 2015 and June 2015 shows that England's 151 Foundation Trusts (the majority of NHS providers) missed a number of national waiting times targets, including in Accident & Emergency, for routine operations and some cancer treatments.

Within the reporting year the trust has continued to achieve all national targets from the operating framework the exception of the 95% Accident & Emergency 4 hour access target and the referral to treatment waiting time target for admitted patients in quarter four 2016 and for non admitted in March 2016. The trust has achieved all quarterly cancer targets including 62 day wait for first treatment and 31 day wait from diagnosis to first treatment.

With regards to health care acquired infections the trust can report that by the end of the year we have reported 33 cases of hospital acquired Clostridium Difficile against a threshold of 27. The 33 cases include 12 cases that have been removed (no lapse in care) for contractual purposes and 11 cases which will be reviewed in May 2016. The trust has also reported 2 cases of hospital acquired MRSA against a threshold of zero for 2015/2016.

Within the reporting year the infection prevention and control team have reviewed the process whereby C-difficile cases are reviewed. This has included strengthening partnership working with the Clinical Commissioning Group and streamlining the investigation tool with input from our lead commissioner. The lead commissioners now attend our internal review meeting which further enhances understanding and learning from cases both internally and externally to the trust. This process has strengthened the case review process facilitating the removal of cases deemed non attributable to the trust from the cases counted for contractual sanctions. Additionally, the medical director's role of director of infection prevention and control will put additional focus on medical engagement in prevention.

Digital Transformation - Lorenzo

The trust has undergone a major technology transformation programme after a successful bid for Department of Health funding last year to support the deployment of a new Electronic Patient Record (EPR) system called Lorenzo. Lorenzo is a nationally available electronic patient record system that is already live in 13 NHS organisations, with a further five planning to deploy over this year. NHS trusts in the North, Midlands and East can make bids for central Department of Health funding for software and deployment costs if they can provide a robust business case for deploying the system. The new EPR is one part of a multi-million pound programme which will revolutionise how patient care is delivered over the coming years at our hospitals and in the trust's services provided in the local community.

Lorenzo went live across our wards and emergency departments on 21st November 2015 followed by outpatient areas on Monday 23rd November 2016. It has replaced many of our current systems including Meditech, Medicorr and Symphony - extending into the medical record. It's one of the biggest changes to ever happen at the hospitals. The objective is to secure a more streamlined service for patients with better access to clinical records by our clinicians and better management of services.

Clearly 2015-2016 has been a challenging year for the trust but we have worked hard to ensure that the patients we support get the right care, when they need it at the right time on the most suitable site.

Improving Quality

Quality is integral to all of our services, business plans and objectives. As we aim to be the most clinically and financially successful healthcare provider in the mid-Mersey region by 2019 we must clearly articulate what this means for the trust and ensure that this is communicated to and developed in partnership with our staff, patients and key stakeholders.

In February 2015 we launched our Quality Strategy focusing on three core components: delivering a safe organisation; a clinically effective organisation; and an excellent quality of experience for our patients. The purpose of this strategy was to provide assurance that national and local clinical and quality requirements have been identified and processes and systems are in place to implement and monitor quality within the trust. The strategy is integral to making quality and quality improvement a core responsibility for and owned by all staff and ensuring that they are supported to fulfil this role

Quality has three main elements: patient safety, clinical effectiveness and patient experience (Darzi Report, High Quality Care for All: June 2008). The trust restructured the committees in line with this approach to ensure that we provide an equal balance and assurance on all aspects of quality within the organisation and that we can measure and improve quality at all levels and throughout all areas of the trust.

In September 2015 following the launch of the Quality Strategy the Trust held a workshop with members of the Quality Committee we concentrated on information flows between committees and from divisions to Board. The workshop style session allowed us to consider how the Board will be assured through its Quality Strategy of the key areas of safety, effectiveness and experience. We focussed on – effectiveness; safety and experience in relation to the following key issues:

- Key quality measures and performance indicators - ward to board
- Supporting structures
- Reporting mechanisms
- Next steps

The group agreed that it would be beneficial for the Board to receive an integrated performance dashboard which incorporated information on quality; finance and workforce issues. This will begin from the 1st April 2016 following further review by the committees of the Board and final approval by the Board.

QUALITY STRATEGY WOKSHOP SEPTEMBER 2015

More recently work has continued on developing the ward to board reporting within the new CBU structure and key to this proposal is the development of a performance assessment framework to facilitate performance monitoring on quality. It is vital that the new system will reflect the key deliverables within the context of new structure and also incorporate monitoring systems to track exceptions, improvements and changes. Secondary proposals include a further restructuring of the committees (following the approval of the Quality Strategy undertaken early 2015) and the restructuring of personnel from corporate nursing and governance to develop a Quality Governance Team.

Ultimately, it is the Board of Directors who, are responsible for overseeing the quality of care being delivered across all services and assuring itself that quality and good health outcomes are being achieved throughout the organisation. Effective governance requires that the board pays equal attention to quality of care as they do to the management of finances and that our processes support the provision of intelligent information to facilitate this.

Urgent Care Services

Although each of our centres specialises in particular aspects of care, we provide outpatient clinics for all our specialties and diagnostic (scanning) services at both Warrington and Halton, so patients can access their initial appointments close to home wherever possible. Over 9,000 patients have used Halton General Hospital's new Urgent Care Centre since it opened in July - and they have given it a five star rating for the care it provides. The Urgent Care Centre service expanded the services of the old Minor Injuries Unit at the hospital in a completely redesigned unit. It provides assessment and treatment for anyone suffering from an urgent illness or injury that is not life-threatening, but cannot wait for a routine appointment with their GP. That means that as well as fractures, cuts, sprains and general injuries, the Urgent Care Centre staff can also provide treatment for illness such as infections, asthma, eye problems and changes in existing health conditions.

Similar to a traditional Accident & Emergency (A&E) department, patients at Runcorn UCC are seen in priority based on severity of ailment, with more urgent conditions being treated sooner. The aim is that on arrival 95% of patients will have an initial assessment within 15 minutes of arrival. 99.82% of patients attending the service so far have been assessed, diagnosed, treated and discharged from the centre within four hours.

Staff are keen to promote the service and encourage local patients to use the centre this winter when demand on A&E services is often at its highest level. The service aims to prevent a lot of Halton patients from needing to travel to A&E and is open from 7am till 10pm, 365 days a year. Patients have given the unit five stars out of five on the NHS Choices website quoting the friendly service, short waiting times and care and compassion shown by the team of staff which includes

nurses, doctors and a GP. In the NHS Friends and Family Test 94.5 % of patients say they would recommend the centre.

The trust was pleased to report that in November 2015 the trauma unit at Warrington Hospital scored the highest marks in Cheshire and Merseyside and finished in the top five of 105 trusts in the first national peer review of trauma centres.

Halton Centre for Sexual Health

Halton Centre for Sexual Health is a centre of excellence. Providing an exceptionally high quality of care which is evidence based. The service sees patients in relation to all aspects of sexual health from asymptomatic to complex cases always ensuring confidentiality and equality for all individuals. They offer a variety of walk in clinics five days a week as well as booked appointments ranging from morning to evening. Positive test results for patients are dealt with appropriately and in a timely manner; all aspects of partner notification are carried out at this time thus preventing onward transmission. This is a specialist service also offering HIV POC testing and management of HIV patients. Our lead consultant is a regional expert in vulvodynia and management of genital dermatological conditions.

The service provides all aspects of support required for the local population:

Testing and treatment for all sexually transmitted infections / HIV testing and management of infection / Management of test results / Partner notification / Screening for asymptomatic clients / Management of genital dermatological conditions / Specialised Vulval clinic

The service are happy to see patients for all aspects of sexual health from asymptomatic to complex cases and encourage referral of patients if any of the following is noticed or the client discloses information to GP or other clinicians about:

Recent unprotected sex / Change of partner / Sexual assault / Use of "Chems" during sex / Men who have sex with men / Sex workers / Repeated UTI / Repeated oral thrush / Unexplained rash / Genital rashes, pains & itch /Genital ulcers / Genital discharge where an STI is a possibility / Genital lumps / Vulval pain & Painful sex / Vulval skin lesions

Patients can also be directed to our web site www.getiton.org.uk for further information on available sexual health services.

Halton Intermediate Care Unit

Halton Intermediate Care Unit (Ward B1) is a 22 bed mixed sex ward for rehabilitation and assessment of adults over the age of 18. Patients are assessed by RARS (Rapid Access and

Rehabilitation Service) and are accepted either directly from the community thus avoiding an acute admission or from acute Trusts for a period of rehabilitation/assessment of needs for discharge.

The unit has an excellent reputation and has been audited by both internal and external agencies to evidence this. This has included CQC announced and unannounced visits with positive feedback, Halton Health Watch again with very positive comments & feedback from patients and relatives. The educational feedback from the trainee nurses has also been positive and the unit is shaping the future nurses to deliver excellent care. A recent DAWES completed by the Trust resulted in a green status for the third time consecutively. The high standard of care on the ward can be further evidenced by the low numbers of complaints, incidents, falls or pressure ulcers. The positive outcomes for patients ensure that the quality of life for those supported by the unit is enhanced.

2.1 Improvement Priorities & Quality Indicators

2.1.1 Improvement Priorities for 2015-2016

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 2014/2015 Quality Report.

We consulted with patients, governors, commissioners, Healthwatch and other external agencies in order to inform the board when determining our priorities for 2015/2016.

The progress of each priority is discussed and red, amber and green (RAG) rated against performance on a quarterly basis. Where possible we include performance indicators to measure and benchmark progress and they are reported on a monthly basis via the Quality Dashboard to the board.

The trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The following section includes a report on progress with our improvement priorities for 2015/2016 which were:

Priority 1 Every patient has a voice - Developing a Patient Experience Strategy

Priority 2 Strengthening Mortality Review

Priority 3 Improving quality of care at the End of Life

Priority 4 Reduction of falls

2.1.1.1 Priority 1. Every patient has a voice – developing a Patient Experience Strategy

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

The publication of the Francis Report (2010) focused on the poor delivery of basic care patients received in Mid Staffordshire NHS Trust. In 2011 this has been followed by the Parliamentary and Health Service Ombudsman, Care and Compassion Report, that focuses on the failings of a number of hospital trusts in the care of older people. Both reports detail failings of care and compassion to patients and go against the core values of this trust.

It is widely acknowledged that the care outlined in both reports is unacceptable and we feel that by having this strategy in place, the trust can ensure that patients are involved and receive an experience that meets and exceeds their physical and emotional needs and expectations. The strategy will demonstrate our commitment in ensuring the patient journey is a positive experience.

We will develop a strategy through involvement with patients, relatives, carers and the public to ensure high quality services are delivered to our patients. The strategy will be structured into achievable work streams and the Patient Experience Committee will decide which work streams will be achieved by the end of the reporting year. Key themes to be agreed including complaints; claims; PALS; Healthwatch; surveys; food; environment.

Goal: – Patient Experience Strategy 2015-2018 developed in conjunction with key stakeholders. We will identify and agree key work streams and timescales for implementation within 2015/2016.

Monitored: Patient Experience Sub Committee and Quality Dashboard

Timeframe: March 2016

Progress 2015/2016 –

Developing a robust Patient Experience Strategy which is fit for purpose requires an all-inclusive consultation with all staff and stakeholders and unfortunately that has delayed production.

A summary version was produced in consultation with governors, members of the board, patient representatives (through Patient Experience Group), allied health professionals and senior nursing staff and following further review by frontline staff was completed in July. Following further consultation, the draft strategy was renamed "Experience of Care Strategy". This is felt to better reflect the involvement of not only patients, but their families, friends and carers. Their experiences of the care of a loved one can also contribute to service improvement as well as improving relationships and communication between staff and the public, improve outcomes of care (e.g. length of stay) and ensure better tailoring of care to meet a patient's needs.

The draft strategy including work streams was approved in March at the Patient Experience Committee and following minor changes was for ratified at the Quality Committee in April 2016.

The evolution of the Patient Experience Committee will support the achievement of the strategy's goals. Moving forward, there needs to be wider engagement of frontline staff. Not only in collecting patient experience data, but in designing the means of collecting it, understanding what it tells us and how it should be presented to maximise its impact and effectiveness. The means to develop staff is a major resource pressure and will need creative solutions.

The strategy has also been updated to include reference to the new CBU structures and this will shape the implementation, we are unsure about what reporting systems the divisions will use it is suggested that it may be a bilateral approach with each CBU having to report on all quality indicators to the divisional leads.

The work streams are:

- Develop a blue print for clinical business units (CBU) to meet the expectations for experience of care measurement
- Developing the capability and skills of staff
- Working together: exploring the connection between staff engagement, morale and the patients' experience of care
- Short term developments - this work stream will see the completion of some short term projects that will enhance experience of care work and demonstrate our commitment to progressing the new strategy. Each of these will be completed in time for the launch of the strategy. These are:
  1. Develop score card/action card for FFT.
  2. Develop a template for local action on receipt of national survey results.
  3. Complete film commissioned by NHS England and based on FFT results, to manage patients' expectations of the A&E department and experience.
  4. Development of key performance indicators for complaints and friends and family.

NB: This will continue as an improvement priority for 2016/2017

A detailed analysis of work and performance monitoring of complaints and patient experience indicators can be found at section 3.

2.1.1.2 Priority 2. Strengthening Mortality Review

Reason for prioritising: The early draft findings of a review conducted by Mersey Internal Audit Agency (at our request), reflects our concerns that despite there being clear processes in place, a

compliance rate of only 40% is being achieved. This then impacts on the amount and value of information gleaned from the reviews, to then drive forward focussed improvement. To address these issues, our Medical Director has gathered together key staff to meet in 2015 to review the current process with the aims of increasing engagement, reintroducing peer review, integrating the centralised and specialty processes and strengthening organisational learning. The following provides a suggested framework including improvements that we aim to achieve by March 2016.

Goal: – Agree trust wide process and improve compliance to >=95% by March 2016.

Monitored: Clinical Effectiveness Sub Committee and Quality Dashboard

Timeframe: March 2016

Progress 2015/2016

We have made significant progress towards establishing a high quality and effective mortality review process which is both trust-wide and standardised in a way that is helpful. This process will also be capable of being individualised to meet the specific needs of any given speciality. Since 1st October 2015, deaths are peer reviewed through a straightforward process which is escalated to the Mortality Review Group (MRG) as necessary and where learning and improvement is the underlying rationale. Such a process need not necessarily be cumbersome or disproportionately time-consuming. Arguably something can be learned from every patient and every death – the nature of that learning may be clinical/technical. Equally it could be about documentation, adherence to policy and best practice or indeed issues of care and compassion. This key element of clinical governance has important implications for quality of care, death certification and clinical coding and will form the basis for key improvement work which incorporates the care of the acutely unwell patient as well as end-of-life care. The MRG is now an effective multidisciplinary group, with a strong medical and CCG presence, chaired by Dr Phil Cantrell, in her role as Associate Medical Director: Quality Governance, within the new Medical Cabinet. We have also developed a North West mortality review network to enable the share and spread of good practice in this area.

NHS England distributed a Mortality Governance Guide to all Medical Directors in December 2015; we are pleased to report that have already implemented the vast majority of their recommendations and will use the guide to support the development of activity still in progress.

We established quarterly improvement targets for mortality review and we are pleased to report the following compliance:-

Quarter	Threshold	Compliance
Q1	45%	75%
Q2	55%	78%
Q3	75%	84%
Q4	95%	72%*

NB: *Overall for YTD 2015/2016 = 77% This is part of an on-going review whereby medical staff are given 30 days to complete reviews as such approved figures will not be available until May 2016.

NB: This will continue as an improvement priority for 2016/2017

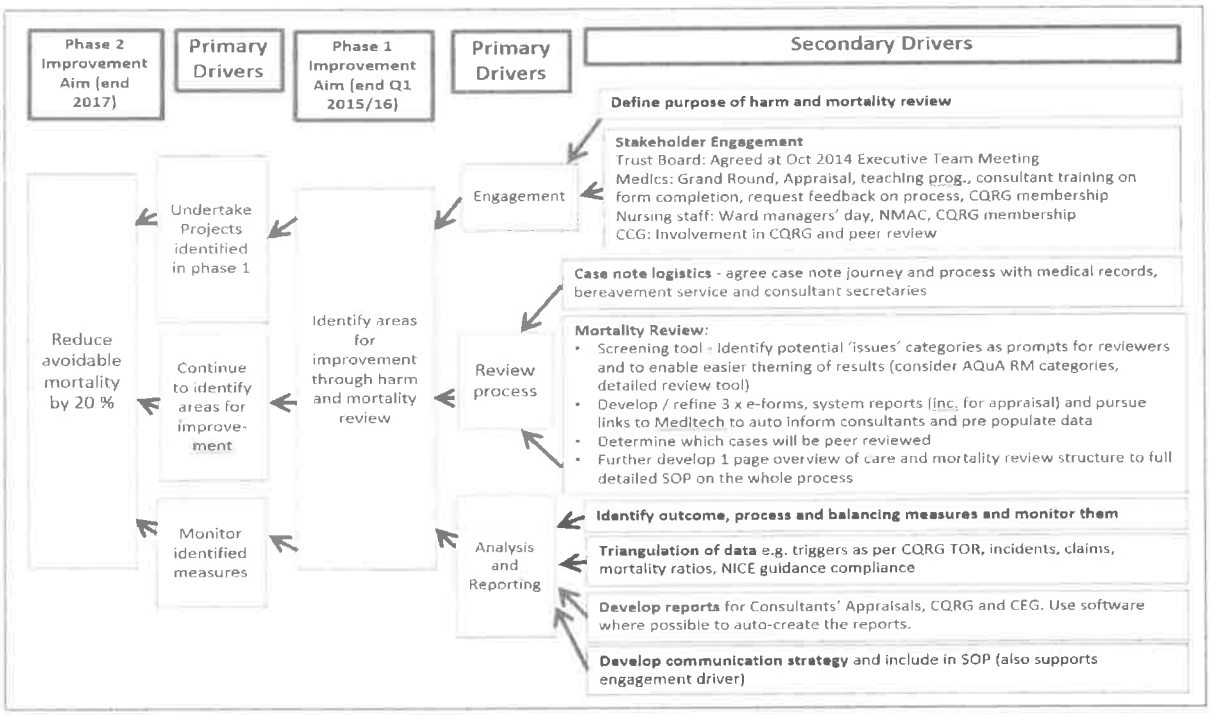
Sign up to Safety – reducing mortality

Reducing avoidable mortality (Mortality Review) was identified as a 'Sign up to Safety' (SU2S) priority when the trust signed up to this three year initiative in 2014/15. Our aim for phase 1 (end of quarter 1 2015/16) was to identify areas for improvement. Whilst we were conducting mortality review at that time and identifying minor aspects of care which could be improved, we were not in a position, by quarter 1 2015/16 to use the findings to drive large improvement projects. Since SU2S

was launched, the trust has undergone significant change, some of which has inadvertently delayed our achievement of this aim, but all of which has underpinned the implementation of a robust system of mortality review. Key developments include:

- A new Medical Director with a change in focus, to consultants peer reviewing all deaths
- The implementation of a new electronic patient record, Lorenzo, which required a change in approach, but then enabled streamlining of the process
- The Mortality Review Group has increased medic, nursing and CCG involvement
- Valuable collaboration with our CCG partners; in the Mortality Review Group (MRG) and in reviewing patients' whole pathways of care
- New Associate Medical Director roles, in Governance (MRG chair) and Service Improvement have lent weight to the successful implementation, for example with the engagement of medics
- Development of an IT system to support mortality review, now into phase two of development
- Integration of corporate and specialty mortality review systems

In quarter 4 2015/2016 we have a robust process in place, an effective multi-sectoral Mortality Review Group and are beginning to use the findings to make significant changes to clinical effectiveness, patient safety and patient experience. We have assessed ourselves against NHS England's Mortality Good Governance Guide (December 2015), are confident that we are aligned to their approach and timescales in this important area and will continue to work towards the phase 2 improvement aim of reducing avoidable mortality by 20%. Strengthening mortality review was a primary driver in achieving improvement in one of the trusts Sign up to Safety priorities.



NB: The version of this driver diagram included in the 2014/15 Quality Account was not the final version submitted to NHS England in the trust's SU2S Plan.

2.1.1.3 Priority 3. Improving the quality of care at the end of life

Reason for prioritising: Care provided at the end of someone's life is about helping someone to live as comfortably as possible with their illness. It is about seeing them as a living person, supporting those closest to them and adding life to days, whether or not days can be added to lives. Our team

want to undertake a review of the current service, to develop and augment skills by a variety of methods, including communication training in essential areas and improved signposting to bereavement services based on individual's needs. Our Palliative Care Team will lead this change to support our colleagues in delivering the impeccable care deserved by the patients of Warrington and Halton and those close to them in their last days of life. Where chronic illness plays a part we want to support patient and those close to them in the months leading up to death, if someone's last illness is unexpected and short that support should still be available. Therefore communication and a combined approach with our community and hospice colleagues is essential.

Monitored: Clinical Effectiveness Sub Committee

Goal: to further develop a skilled and confident workforce to deliver high quality end of life care for patients in our care. Aim to deliver this service in Warrington and Halton hospitals and the community by working and planning our strategy across all healthcare settings. This will be measured through the development of an End of Life Strategy; communication training for staff and the development of an outpatient survey.

Timeframe: March 2016

Progress 2015/2016

The development of an End of Life Strategy aligned to the recent NICE Guidelines on Care of the Dying Adult published in December has provided us with an opportunity to ensure our strategy is aligned to the most up to date national guidance. November has seen the revised Individual Plan of Care and Support for patients at end-of-life continue to be used to support our patients and their loved ones. This is a document that takes into account the five priorities of care identified by the National Leadership Alliance to provide impeccable End of Life Care. Our Trust has been using an initial supportive document since September 2014 and this revision takes into account audit of this and comments from across the hospital, St Rocco's hospice and Warrington community teams. The trust has participated in the biannual Royal College of Physicians Audit of Care of the Dying Adult in Hospital and the results of this will be available in April 2016. This will highlight areas for our on-going education programme. During the reporting year a Palliative Care Educator has been appointed, our response to this national benchmarking will be robust.

During the reporting year the End of Life Steering Group has been re-established and now includes lay patient representatives. The meetings have highlighted areas of good practice and also ways in which concerns relating to end of life care can be discussed within the Group and escalated to the Clinical Effectiveness Group.

Work has been undertaken to improve communication within the service by the development of four Core Communication skills half day courses which have been accessed by hospital, community and hospice staff. 11 hospital band 6 nurses and above have participated in an Intermediate Skills in Palliative Care Course run by St Rocco's Hospice which provides palliative care information not just communication skills specifically and will improve the generalist palliative care skills in the nursing teams at Warrington and Halton Hospitals NHS Foundation Trust. Medical and nursing colleagues are also participating in an on-going Warrington Palliative Medicine Course. The Link Nurse Study day held in November included a communications afternoon allowing those link nurses who attended to improve their skills in a flexible supportive learning environment. A further link nurse day will take place at the end of March. The Warrington wide Integrated Clinical Network is looking at providing on-going core and intermediate communications courses in the next financial year and there are participants from the trust enrolled on an Advanced Communication Skills Course in April 2016.

The outpatient questionnaire continues to be given to patients attending the Palliative Medicine Outpatient Clinics at Warrington and Halton. Small numbers of replies have been received but with positive information.

2.1.1.4 Priority 4. Reduction in Falls

Reason for prioritising: Whilst the reduction of falls was not an improvement priority for 2013/2014 the trust remained focussed on improvements. The trust decided select this as a key priority for 2014/15 with a focus on a 10% reduction in moderate, major and catastrophic harm falls which unfortunately the trust failed to achieve. The trust is committed to continuing the reduction of falls by increased surveillance, risk assessments and review and through the work of the Falls Prevention Group (FPG) and this was supported by key stakeholders at the forward planning events who suggested that this should remain as a priority for 2015/2016.

Monitored: Patient Experience Sub Committee & Quality Dashboard

Goal: In addition to the 10% reduction in moderate, major and catastrophic harm falls the priority includes a 5% reduction in all falls (possibly a stretch target of 10% reduction in all falls)

Timeframe: March 2016

Progress 2015/2016

This trust has identified the reduction of falls as a priority in reducing patient harm in the hospital setting. We recognise the anxiety and distress that in-patient falls cause for both the patient and their family. This can be in the form of physical harm such as broken limbs, but often there is unquantifiable psychological harm done to previously independent people whose confidence is destroyed for the rest of their lives. We believe that patients should be safe in our care and should be protected from avoidable harm wherever possible.

We are committed to continuing the reduction of falls by increased surveillance, risk assessments and review and shared learning through the work of the Falls Prevention Group (FPG). We have also continued to implement the "Falls Change Package" whereby a number of ward-led innovations are embedded into the way our nurses and other staff work to support individual patients who are at risk of falls. To support this approach we have included falls prevention within the Department and Ward Evaluation Scheme (DAWES) which monitors and questions staff knowledge regarding falls prevention and any learning from events that have taken place on the ward.

The wards participate in monthly random audits of falls risk assessment documentation and care planning. These audits are collected centrally and shared in relevant forums.

There have been new ways of working on wards to prevent falls such as our 'call don't fall' campaign and moving nurses stations into bays.

Every fall where a patient suffers harm is looked at by a 72 hour review system which determines if there was anything we could have done differently to prevent the fall.

We are looking at a way in which we can review all avoidable falls that happen in the organisation in order to identify any trends or common factors with solutions to reduce falls. According to NICE a large proportion of inpatient falls are unwitnessed and "found on floor" remains the highest subcategory across our organisation. As such we have implemented initiatives such as bay tagging, commode tagging and 1:1 caring for those patients who are most likely to get up without asking for assistance and risk falling.

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

final severity of harm. Falls data is extracted from datix and included in the Quality Dashboard and monitored on a monthly basis at board.

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

Our journey to date has been very successful with a 57% reduction in **all** falls between 2011 and 2014. At the end of 2014/2015 the trust reported a further 3.8% reduction in all falls. Within the reporting year the trust established four measures namely:-

- A 5% reduction in all approved falls
- Maintain falls per 1000 bed days below 5.6
- A 10% reduction in moderate, major and catastrophic falls
- A further 10% reduction in moderate falls (20% reduction 2014/2016) to meet our sign up to safety improvement objective.

Falls 2013/2014 – 2015/2016

Patient Slips, Trips & Falls	2013/2014	2014/2015	2015/2016
Q1	251	256	253
Q2	256	243	241
Q3	246	230	258
Q4	246	232	213
TOTAL	999	961	965

In 2010 the National Patient Safety Agency (NPSA) "Slips trips and falls data update" stated that acute trusts had requested a benchmark for falls and in response to this a mean rate initially formulated in 2005/6 of 5.6 falls per 1,000 bed days had been provided. However the NPSA cautioned that comparison between organisations may not be particularly helpful for falls prevention and that they would encourage organisations to focus more on improvement over time within their own organisation than on whether the fall rates are higher or lower than in similar organisations. The rationale was based on different reporting cultures and secondly differences in local populations e.g. hospitals serving towns which are popular retirement spots may have higher rates than hospitals serving a younger inner-city population.

In 2012 the Royal College of Physicians presented the results of the inpatient falls pilot 2011. This "Report of the 2011 inpatient falls pilot audit" was commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). They also stated evidence of substantial variation between trusts but that for acute trusts the average reported rate is 5.6 falls per 1000 bed days. In the absence of any benchmarking data the trust has continued to measure its' falls performance in this way as follows.

YEAR	BED DAYS	FALLS (ALL)	FALLS PER 1000 BED DAYS	NATIONAL
2011/2012	194018	1610	8.30	5.6
2012/2013	197003	1520	7.72	5.6
2013/2014	186516	999	5.36	5.6
2014/2015	179667	961	5.35	5.6
2015/2016	186781	965	5.16	5.6

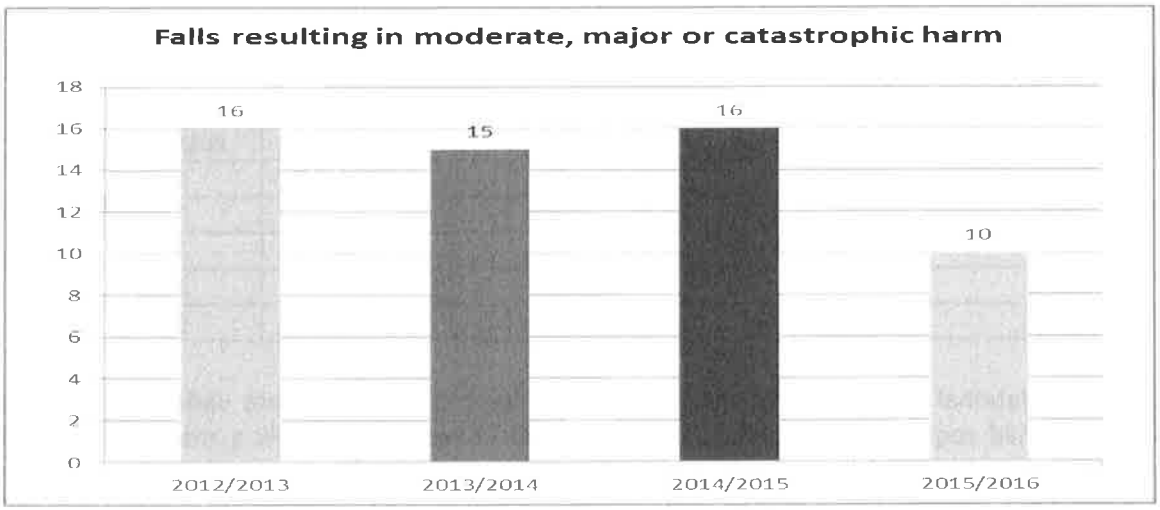
This data indicates that although we have not achieved a 5% reduction in all approved falls we are pleased to report that our falls rate per 1000 bed days has decreased.

YEAR	MODERATE TO CATASTROPHIC HARM THRESHOLD	MODERATE TO CATASTROPHIC HARM ACTUAL REPORTED AT YEAR END
2012/2013	18	16 ACHIEVED
2013/2014	14 (10% REDUCTION)	15 NOT ACHIEVED
2014/2015	13 (10% REDUCTION)	16 NOT ACHIEVED
2015/2016	13 (10%) REDUCTION	10 ACHIEVED

NB It should be noted that this data relates to confirmed year end approved falls.

Since 2012 the focus has remained on reducing moderate to catastrophic falls and as the table shows we achieved a reduction in 2012/2013 we then plateaued at the 2013 rate. Data for the reporting year shows that moderate to catastrophic falls have reduced by 37.5% on the previous year.

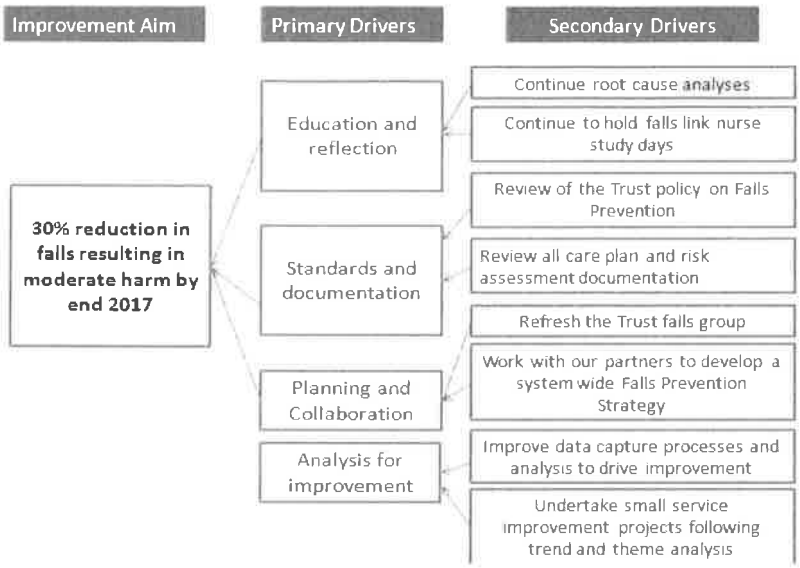
Falls – moderate, major and catastrophic 2011/2012 - 2015/2016



We have monitored falls by ward and noted the most common times that a patient may fall identified to be in the early hours of the morning. Wards have re-examined the activities of staff at that time, as well as at the patterns of night time behaviour for individual patients who are at risk of falling. In addition to this a Safety Walk-round on one of our wards noted that there could be a link between falls in those patients who were frail and elderly and the timings and type of the night-time beverage. We have researched this thoroughly, and are now planning a project group to try and make improvements in that area.

Sign up to Safety – reduction of moderate falls

During 2014/2015 the trust has also identified falls as a Sign up to Safety goal. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. This is something that our trust has been working towards over the last few years. The driver document articulates the trusts strategy for a 30% reduction in moderate falls by 2017.



The trust did agree a 10% reduction in falls where moderate harm occurs by March 2015 for stage one of Sign up to Safety but as with the improvement priority we have failed to reach this threshold. As such we concentrated efforts to reduce moderate falls during 2015/2016 and set a reduction threshold of an additional 10% moderate falls of <=12 by March 2016 (overall 20% reduction for 2014/2016). For this year we can report that there have been 9 moderate falls approved compared to 15 moderate falls in 2013/2014 which constitutes a 40% reduction and as such the trust has achieved this sign up to safety indicator of a 30% reduction by 2017.

2.1.2 Local Quality Indicators 2015/2016

The trust board, in partnership with staff and governors, reviewed performance data relating to quality of care and agreed that in addition to our improvement priorities that our quality indicators for 2015/16 will include:

Safety

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

Clinical Effectiveness

- Dementia
- Advancing Quality
- SHMI HMSR

Patient Experience

- Patient Experience Indicators
- Complaints
- Patient Survey (inpatient and children) Indicators
- Essential ward transfers only

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

2.1.3 Commissioner priorities

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

- Acute Kidney Injury (National)
- Sepsis (National)
- Dementia (National)
- Urgent Emergency Care (National)
- Advancing Quality - Acute Myocardial Infarction; Heart Failure and Pneumonia Stroke (Local)
- Stroke - Sentinel Stroke National Audit Programme (Local)
- Advancing Quality – developmental measures including COPD; Hip and Knee; Hip Fracture; Sepsis; Acute Kidney Injury; Diabetes and Alcoholic Liver Disease (Local)
- Health Inequality CQUIN – Local Health Inequalities applicable to the breast screening programme provided by WHHFT (Specialist Commissioning CQUIN)
- Neonatal intensive care (NIC) - Reducing Clinical Variation. (Specialist Commissioning CQUIN)
- Neonatal Unit Admissions (Specialist Commissioning CQUIN)
- Improved access to maternal breast milk in preterm infants. (Specialist Commissioning CQUIN)
- Improvement in the care and experience of patients with dementia (Local)
- Effective Discharge and Transfer of Care (Local)
- Ward Assessment Scheme (Local)
- Improvement in the care and experience of patients with diabetes by the assessment of the diabetic foot and prevent the risk of developing a foot ulcer or manage any ulceration identified (Local)
- Digital Technology - Procure and implement an integrated health solution (Local)

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

2.1.4 Improvement Priorities and Quality Indicators for 2016–2017

2.1.4.1 Stakeholder Engagement

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

An event held on the 19th February 2016, was attended by, approximately 25 to 30 representatives from key organisations including: governors, Warrington and Halton Clinical Commissioning Groups along with our own staff including non-executive directors.

The aim of the event was to:

- Provide an overview of the Quality Report and our reporting requirements
- Provide an update on progress with quality improvement priorities and quality indicators for 2015/2016
- Planning for improvement priorities for 2016/2017
- Planning for quality indicators for 2016/2017
- Agree and propose a selection of quality improvement priorities and indicators to take back for discussion with the Board.

2.1.4.2 How we identify our priorities

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

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

In addition this we surveyed staff; patients and visitors to ensure that we captured the views of the wider public in relation to the range of priorities that had been identified during the forward planning event.

The data was collated and the quality priorities that received the highest number of votes were presented to Board for final approval.

2.1.4.3 Improvement Priorities for 2016–2017

The trust board, in partnership with staff and governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2016/17 will include:

Priority 1 "Every patient has a voice" – implementing Experience of Care Strategy

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

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

The strategy is structured into work streams and the Patient Experience Sub Committee will decide which work streams will be achieved by the end of the reporting year and will monitor progress until compliance is achieved. Key themes to be agreed including complaints; claims; PALS; Healthwatch; surveys; food; environment.

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

Lead(s):- Quality Improvement Lead Nurse and Complaints Manager

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

Monitored: Patient Experience Sub Committee and Quality Dashboard

Timeframe: March 2017

Priority 2 Pressure Ulcer Reduction

Reason for prioritising: The trust continued to focus on the management and reduction of pressure ulcers as a quality indicator for 2015/2016. The Prevention and Treatment of Pressure Ulcers (NICE Clinical Guideline 29; 2005) offers best practice advice on the care of adults and children with pressure ulcers. Although the trust has strengthened a number of processes including a strong focus on early patient assessment and the documentation of the patient's skin condition on admission as essential to good practice we believe that further work and interventions are required to ensure our patients do not develop pressure ulcers of any grade. Importantly we would like to ensure that mini RCA's are undertaken on all grade 2 pressure ulcers in order to identify avoidable and unavoidable pressure ulcers in addition to making recommendations for changes to practice to further reduce incidence of pressure ulcers.

Lead(s): Tissue Viability Team and Matrons

Monitored: Patient Experience Sub Committee; Patient Safety Sub Committee & Quality Dashboard

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

Timeframe: March 2017

Priority 3 Mortality Review – learning from reviews

Reason for prioritising: Since 1st October 2015, deaths are peer reviewed through a straightforward process which is escalated to the Mortality Review Group (MRG) as necessary and where learning and improvement is the underlying rationale. By quarter 4 2015/2016 we have a robust process in place, an effective multi-sectoral Mortality Review Group and are beginning to use the findings to make significant changes to clinical effectiveness, patient safety and patient experience. We have assessed ourselves against NHS England's Mortality Good Governance Guide (December 2015), are confident that we are aligned to their approach and timescales in this important area and will continue to work towards the phase 2 improvement aim of reducing avoidable mortality by 20%. This will remain a priority for the trust in order to embed mortality review and achieve 100% compliance and to increase learning from the reviews, importantly ensuring a collaborative approach with medical staff who have cases under review.

Lead(s):- Associate Medical Director: Quality Governance and Clinical Effectiveness Manager

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

Monitored: Clinical Effectiveness Sub Committee and Quality Dashboard

Timeframe: March 2017

Priority 4 MUST Nursing Care Indicator – compliance and outcomes maintaining body weight in patients =>75 years

Reason for prioritising: High Quality Care was a local CQUIN for 2013/2014. The care indicators audit was a process which was developed as part of this CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. Reports received throughout 2013/2014 showed exceptional compliance with Falls and Waterlow but concerns over compliance with MUST. Whilst the last two years have seen improvements in all these risk assessments the trust believes that we should continue to focus on increasing compliance with MUST risk assessments and importantly ensuring that patients maintain their body weight during their hospital stay. This is seen as particularly relevant to the elderly frail patient and patients =>75 years of age.

Whilst progress has taken place during 2015/2016 including the development of a new Malnutrition Universal Screening Tool (MUST) e-learning Module the trust has selected this as a priority going forward for 2016/2017.

Lead(s): Matrons and Dietician

Monitored: Patient Experience Sub Committee; Patient Safety Sub Committee & Quality Dashboard

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

Timeframe: March 2017

2.1.4.4 Local Quality Indicators 2016/2017

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 2016/2017 will include:

Patient Safety 2016/2017

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

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

Clinical Effectiveness 2016/2017

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

Patient Experience 2016/2017

- Patient Experience Indicators
- Complaints including satisfaction survey of complaints process

- Complaints reduce number of returned complaints
- Patient Survey Indicators

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

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

2.2. Statements of Assurance from the Board

During 2015/16 the Warrington and Halton Hospitals NHS Foundation Trust provided and/or sub-contracted seven relevant health services.

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

The income generated by the relevant health services reviewed in 2015/16 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 2015/16.

2.2.1 Data Quality

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

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

2.2.2 Participation in Clinical Audit and National Confidential Enquiries

During 2015/16 38 national clinical audits (1 excluded due to lack of IT system) therefore 37 national audits covered and 4 national confidential enquiries covered relevant health services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During 2015/16 Warrington and Halton Hospitals NHS Foundation Trust participated in 35 (96%) national clinical audits and 4 (100%) of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

	National Audits
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
2	Cardiac Rhythm Management (CRM)
3	Bowel cancer (NBOCAP)

	National Audits
4	Rheumatoid and Early Inflammatory Arthritis
5	Emergency Use of Oxygen
6	Paediatric Asthma
7	National Prostate Cancer Audit
8	Procedural Sedation in Adults
9	Vital signs in Children
10	VTE risk in lower limb immobilisation
11	National Diabetes Foot care Audit
12	National Pregnancy in Diabetes Audit
13	National Diabetes Inpatient Audit
14	National Diabetes Adults
15	Elective surgery (National PROMs Programme)
16	National Joint Registry (NJR)
17	Case Mix Programme (CMP)
18	National Cardiac Arrest Audit (NCAA)
19	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
20	National Heart Failure Audit
21	Child health clinical outcome review programme
22	Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
23	National Audit of Intermediate Care
24	National Comparative Audit of Blood Transfusion programme
25	UK Parkinson's Audit (previously known as National Parkinson's Audit)
26	National Emergency Laparotomy Audit (NELA)
27	National Ophthalmology Audit
28	Diabetes (Paediatric) (NPDA)
29	Lung cancer (NLCA)
30	Falls and Fragility Fractures Audit Programme (FFFAP)
31	Inflammatory Bowel Disease (IBD) programme
32	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
33	Sentinel Stroke National Audit Programme (SSNAP)
34	Oesophago-gastric cancer (NAOGC)
35	Neonatal Intensive and Special Care (NNAP)
36	Major Trauma: The Trauma Audit & Research Network (TARN)
37	National Complicated Diverticulitis Audit (CAD)
38	End of Life Care Audit

	National Confidential Enquiries
1	Mental Health - Ongoing
2	Acute Pancreatitis
3	Sepsis
4	Gastrointestinal Haemorrhage

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in during 2015/16 are as follows:

	National Audits
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
2	Cardiac Rhythm Management (CRM)
3	Bowel cancer (NBOCAP)
4	Rheumatoid and Early Inflammatory Arthritis
5	Paediatric Asthma
6	National Prostate Cancer Audit
7	Procedural Sedation in Adults
8	Vital signs in Children
9	VTE risk in lower limb immobilisation
10	National Diabetes Foot care Audit
11	National Pregnancy in Diabetes Audit
12	National Diabetes Inpatient Audit
13	Elective surgery (National PROMs Programme)
14	National Joint Registry (NJR)
15	Case Mix Programme (CMP)
16	National Cardiac Arrest Audit (NCAA)
17	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
18	National Heart Failure Audit
19	Child health clinical outcome review programme
20	Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
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25	Diabetes (Paediatric) (NPDA)
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	National Confidential Enquiries
1	Mental Health - Ongoing
2	Acute Pancreatitis
3	Sepsis
4	Gastrointestinal Haemorrhage

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/16 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits 2015/16

National Clinical Audits	Participated	Data collected	% of cases submitted 2015/2016
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	√	√	Ongoing data collection
Cardiac Rhythm Management (CRM)	√	√	110 Ongoing data collection
Bowel cancer (NBOCAP)	√	√	181 (100%)
Rheumatoid and Early Inflammatory Arthritis	√	√	20/41 (49%)
Emergency Use of Oxygen	**N**	**NA**	**Audit Lead left Trust**
Paediatric Asthma	√	√	30 (100%)
National Prostate Cancer Audit	√	√	42/76 (55%)
Procedural Sedation in Adults	√	√	35 (100%)
Vital signs in Children	√	√	37 (74%)
VTE risk in lower limb immobilisation	√	√	61 (100%)
National Diabetes Foot care Audit	√	√	6 Ongoing data collection
National Pregnancy in Diabetes Audit	√	√	34 Ongoing data collection
National Diabetes Inpatient Audit	√	√	30 (100%)
National Diabetes Adults (Data not collected due to IT facilities)	**NA**	**NA**	**NA**
Elective surgery (National PROMs Programme) *Groin Hernia 37/176* *Hip Replacement 153/202* *Knee Replacement 180/210* *Varicose Vein 10/166*	 √ √ √ √	 √ √ √ √	 380/754 (50.4%) Ongoing data collection
National Joint Registry (NJR)	√	√	Ongoing data collection
Case Mix Programme (CMP)	√	√	602 (100%)
National Cardiac Arrest Audit (NCAA)	√	√	73 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	√	√	Ongoing data collection
National Heart Failure Audit	√	√	92 Ongoing data collection
Clinical outcome review programme	√	√	Ongoing data collection
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	√	√	Ongoing data collection (please see below table)
National Audit of Intermediate Care	**N**	**NA**	**-**

National Clinical Audits	Participated	Data collected	% of cases submitted 2015/2016
National Comparative Audit of Blood Transfusion programme			
2015 Audit of Lower GI Bleeding:	√	√	3 (100%)
2015 Audit of Patient Blood Management in adults undergoing elective, scheduled surgery	√	√	9 (100%)
2016 Audit of red cell and platelet transfusion in adult haematology patients	√	√	27 (100%)
UK Parkinson's Audit			
Patient Management	√	√	22 (100%)
Speech & Language Therapy	√	√	10 (100%)
Physiotherapy	√	√	12 (100%)
Occupational Therapy	√	√	10 (100%)
National Emergency Laparotomy Audit (NELA)	√	√	114 (55%)
Diabetes (Paediatric) (NPDA)	√	√	155 Ongoing data collection
Lung cancer (NLCA)	√	√	200 Ongoing data collection
Falls and Fragility Fractures Audit Programme (FFFAP)			
Falls Audit	√	√	30 (100%)
NHFD	√	√	349 (100%)
Inflammatory Bowel Disease (IBD) programme	√	√	24 Ongoing data collection
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme			
Halton Runcorn Widnes	√	√	66 (100%)
Warrington Wolves	√	√	21 (100%)
Sentinel Stroke National Audit Programme (SSNAP)	√	√	313 (95%) Ongoing data collection
Oesophago-gastric cancer (NAOGC)	√	√	103 (100%) Ongoing data collection
Neonatal Intensive and Special Care (NNAP)	√	√	447 (100%)
Major Trauma: The Trauma Audit & Research Network (TARN)	√	√	217/337 (64%)
National Complicated Diverticulitis Audit (CAD)	-	-	Emailed national body
National Ophthalmology Audit	√	√	New Audit Ongoing data collection data being collected between September 15

National Clinical Audits	Participated	Data collected	% of cases submitted 2015/2016
			to August 16
End of Life Care Audit	√	√	71/80 (89%)

National Confidential Enquiries 2015/16

	Participated	Data collected 2015/2016	% Cases submitted 2015/2016
Mental Health	√	√	Ongoing data collection
Acute Pancreatitis	√	√	3/5 (60%) 1/1 (100%)
Sepsis	√	NA	-
Gastrointestinal Haemorrhage	√	NA	-

2.2.2.1 National Clinical Audits – reviewed

The reports of 21 national clinical audits were reviewed by the provider in 2015 /16 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Action Plans
National Falls Audit 2015	Findings to be presented at Medical Audit Meeting 09.11.15.
	Review work plan and Terms Of Reference (TOR) of Falls Prevention Group.
	Seek Medical representative.
	Review of Falls Prevention Training.
	Review of Patient Risk Assessment Documentation – Underway in line with Lorenzo roll out.
	Medication Assessments to be completed on admission.
	Commence Medication Review as part of Medication Reconciliation – Implement as part of Lorenzo Roll out.
National Bowel Cancer (NBOCAP)	The value of the annual report remains dependent on the quality of data submitted by the contributing multi-disciplinary teams (MDT) and clinical ownership and oversight of the data submitted by each Trust is crucial.
	Data quality in the Audit continues to improve, representing increasing consultant engagement. The new Clinical Audit Platform allows clinician scrutiny of the MDT data upload by providing clear access to the data entered. This be reviewed regularly by the Colorectal Surgeons.
	The cancer data team are working with individual colorectal surgeons to validate data & improve data quality/completeness.
2015 National Audit of Patient Blood Management in Surgical Patients	Post-Operative Transfusion: single unit approach.
	Patient Blood Management: For patients expected to have more than 500mls of blood loss.
	Implement a "one unit" strategy for stable patients.

	Develop a protocol to correct anaemia prior to surgery where possible.
	Pre-operative Anaemia Optimisation.
	Consider the use of Tranexamic acid for this class of patients.
National Pregnancy in Diabetes (NPID)	Fetal Cardiac Echos by 20 weeks - ask midwives to make sure Diabetic is on referral form for scans. Sonographers to put all anomaly scans for diabetics on consultant Obstetric list.
	Diabetes Midwife Best practice.
	Promotion Pre-conception Care (PCC).
	Update article GP magazine.
	Poster board Ante-Natal Clinic (ANC).
	Post Natal/Midwife update.
	Medical and Diabetes Specialist Nurse (DSN) Cover for Medical Obstetric clinic to allow 1 week referral when pregnant and 1 month Pre-conception Care (PCC).
National Audit - Older people Royal College of Emergency Medicine (RCEM)	Re-audit in 3 years once Lorenzo is installed.
National Hip Fracture database	Re-work integrated-care pathway to streamline and make more user friendly to capture data and increase compliance.
	Produce and present findings annually at Trauma & Orthopaedic audit meeting.
	Ortho-geriatric Consultant led early daily ward rounds for early decision making to reduce length of stay.
National Oesophago Gastric Cancer (NAOGC) National Audit	Multi-disciplinary teams (MDTs) should review the results for their organisation to ensure care is consistent with the recommendations in national clinical guidance on patients with Oesophago-gastric (O-G) cancer and high grade dysplasia (HGD). In particular:
	A significant proportion of cases of HGD are still managed by surveillance alone, despite the British Society of Gastroenterology (BSG) recommending that all patients should be considered for active treatment. It is important that OG clinicians referral of patients with HGD to a specialist centre which has experience of treating HGD.
	As surgical mortality rates fall, Trusts should pay particular interest in monitoring their complication rates. Surgeons should prospectively monitor these rates.
	All patients with oesophageal squamous cell carcinoma (SCC) being considered for curative therapy should be discussed with both an oncologist and a surgeon to determine the most appropriate treatment option. Completion rates for palliative chemotherapy remain low.
	Clinicians should carefully assess eligibility of patients for palliative chemotherapy, especially in older patients and patients with a poorer performance status. This assessment should balance clinical considerations with patient choice.
	A significant proportion of patients who receive endoscopic/radiologic palliative treatment for O-G cancer in England do not have an endoscopy record submitted to the Audit. Trusts should review their policies to try and improve data submissions in the future.

	The value of the annual report remains dependent on the quality of data submitted by the contributing multi-disciplinary teams (MDT) and clinical ownership and oversight of the data submitted by each Trust is crucial.
	Data quality in the Audit continues to improve, representing increasing consultant engagement. The new Clinical Audit Platform allows clinician scrutiny of the MDT data upload by providing clear access to the data entered. To be reviewed regularly by the Clinicians.
	The cancer data team are working with individual clinicians to validate data & improve data quality/completeness.
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Spirometers on Respiratory wards.
	Aqua to support Chronic Obstructive Pulmonary Disease.
	Discussions with coding department.
National *Inflammatory bowel disease* (IBD) Audit 2013	Issue PROM's forms to PIU for patient completion.
	Continue to monitor safety and efficacy over the long term and should stop biological therapies in patients who failed to respond to treatment.
	Continue to participate in the National Biological Therapy Audit.
	Disease activity should be routinely assessed and monitored, especially at baseline and again at 3 and 12 month follow-up.
	Encourage patients to complete patient – reported outcome measures (PROMs) at baseline and follow-up.
	Share the findings and recommendations of the audit with MDT, clinical governance and audit meetings, and a local action plan for implementing change where advised.
National Mental Health RCEM Audit.	Re-Audit in one year to ensure RCEM standards are being met.
National Vital signs in Children RCEM Audit.	Quality Improvement Audit Action Plan - not received.
Management and outcomes in Urogynaecology - The British Society of Urogynaecology (BSUG)	Ongoing BSUG (British Society of Urogynaecology) audit and release of national data.
	Encourage post treatment questionnaire completion.
	Re-audit in line with national standards 2015.
National Nephrectomy Audit - Surgeon Outcomes	Quality Improvement Audit Action Plan - not received.
National Paediatric Diabetes Audit (NPDA) 2015 Data	Improve data collection on Cholesterol.
	Improve coverage and data collection on urine Albuminuria.
National Sedation Audit RCEM Audit	Training in the use of Capnography.
	To work with the departmental medical and nursing leads and the Trust Sedation Lead to develop educational materials and opportunities.
	Further training in the use of the Electronic Sedation Logbook.
	To improve the early recognition of patients requiring sedation.
National Acute coronary syndrome or Acute myocardial infarction (MINAP) 2013/2014 Data	Incorporate the GRACE assessment score into the MINAP audit during at least one quarter during 2015/2016 and review the waiting times for angiography in accordance with level of risk.
	Use the above audit to measure compliance with the NICE quality standards for ACS (QS 68, September 2014).

	Review and present annual audit results MINAP 2014 – 2015 when available (Due November – December 2015).
	Agree, design and register the additional ACS audit.
	Continue with National data collection.
National COPD Pulmonary Rehab Audit – Halton	Quality Improvement Audit Action Plan - not received.
National COPD Pulmonary Rehab Audit – Warrington	Review assessment, delivery and review of resistance training provided in rehabilitation sessions.
	Investigate a suitable alternative quality of life tool to replace the CAT scoring.
National Management of	Review Diabetic Ketoacidosis (DKA) chart.
Diabetic Ketoacidosis (DKA)	Present nurse related areas to Medical Ward Managers.
	Present findings to diabetes team and highlight General Internal Medicine (GIM) teams.
National Management and outcomes in Urogynaecology	Ongoing BSUG (British Society of Urogynaecology) audit and release of national data.
The British Society of	Encourage post treatment questionnaire completion.
Urogynaecology (BSUG	Re-audit in line with national standards 2015.
National (BAETS) British Association of Endocrine and Thyroid Surgeons	Quality Improvement Audit Action Plan - not received.

2.2.2.2 Participation in Local Clinical Audits

The reports of 301 local clinical audits were reviewed by the provider in 2015/16 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Action Plans
Advancing Quality Audits	
Fractured Neck of Femur – The ED to Ward Journey	Contact Radiology Department to open discussion towards a solution.
	Document the time when referrals are bleeped through to SHO then re-audit using these times.
	Contact Emergency Department to open the discussion towards a solution.
	Shorten the pathway.
Anaesthetic Audit Audits	
Novice Laryngoscopy	Intubation training list.
	Laryngoscopy guide to be given to new starters.
	Regional CT1 training course with mannequin training.
Perioperative management of Pain after laparotomy	Post op destination for Epidurals.
	Re audit - One Year.
	Intrathecal Diamorphine.
	Rectus Sheath catheters.
Audit of sepsis management in patients who have undergone emergency laparotomy.	Discuss with Accident & Emergency potential ways to improve sepsis risk stratification.
	Audit sepsis management following the implementation of Emergency Laparotomy pathway.
	Inform Accident & Emergency Department of the results of the audit.
	Audit time to theatres from decision, following the implementation of Emergency Laparotomy pathway.

Audit Title	Quality Improvement Action Plans
Childrens Health Audits	
Review of psychology and emotional well-being questionnaire / feedback from parents and patients of paediatric diabetes.	Ensure future practice: Psychological problems in Young People with T1 Diabetes are NOT rare Recognising problems early= early referral to psychology Addressing Psychological problems may improve compliance Importance of supporting families Reducing future complications
Paediatric Asthma	Improve Peak flow compliance – re-educate and emphasise Either to include systolic BP on asthma pathway OR exclude BP as audit criteria. Record reasons as to why observations are not recorded/pathway not followed – all staff. Re-audit within 3 years.
Management of a Newborn where there is known Group B Haemolytic Streptococcus present in either mother or Newborn	All matrons and ward managers to be contacted to disseminate the need for correct filing of the observation charts within the infants notes.
	All Matrons and ward managers to be contacted to disseminate the need to document the reason for missed or late observations in the infant's notes.
	To organise a task and finish group to look at the nationally recommended NEWTTs (New-Born Early Warning Trigger and Track) observation charts with a view to introducing them locally.
	Circulation to all midwifery and neonatal staff of the summary of Audit "what we did well" report.
	Extensive re-audit of a larger group of patients To await task and finish groups first meeting to decide if this is to be of the current observation charts or of the proposed NEWTTs (New-born Early Warning Trigger and Track) charts once introduced.
Emergency Care Audits	
Croup Audit	Ensure the croup pathway is attached to the front sheet for children who present with suspected croup. This will involve educating the ED Paediatric nurses as well as the doctors. Modification of columns on the pathway indicating the time each score is calculated and who scored it. Addition of an observation chart onto the pathway - to be used as a prompt for at least one repeat set of observations for all children before discharge or transfer to the ward. Couple the croup pathway with the advice sheet to prompt staff to hand it out to the parents of discharged children.
Electrocardiogram's (ECG) Audit	Increase the use of ECG technicians during hours. Designated staff member to do ECGs out of hours at triage Improve assessment process to ensure early ECG in all areas of department. Encourage use of assessment pathways. Ensure careful scanning of ECGs to allow accurate recording. Increase number of ECG machines available to one in each clinical area. Explore 24 hour ECG technicians based in the ED.
ICU Audits	
Ventilator Associated Pneumonia Audit	Re-Audit - look into subglottic suction and cuff pressure monitoring.
Tracheostomy in critical care	Audit antibiotic prophylaxis in tracheostomy procedures in critically ill patients. This is being considered by colleagues in the critical care unit.
Medical & Elderly Care Audits	
Overusing SABA's (Short-Acting Beta Agonists) in General Practice Audit	To re-audit the current 50 patients in 6 months' time to see outcomes.
	To aim for 100% of asthmatic patients to have an asthma review every 12 months.
	To aim for 100% of those asthmatic patients overusing SABAs to have their

Audit Title	Quality Improvement Action Plans
	treatment stepped up.
	Reduce the number of patients overusing SABAs.
GTT Audit	Revise gestational diabetes policy in line with National Institute for health Care and Excellence (NICE) 2015
	Launch new gestational guidelines.
	Send paediatricians copy audit to review high number congenital malformations and neonatal complications.
	Agreed to leave Gestational Diabetes mellitus (GDM) pregnancies until term + 6 unless clinical indication for earlier delivery. Communicate this to all staff looking after these ladies.
	Re-audit after new criteria introduced.
Capacity assessment in the context of DNACPR	Educate Staff about the need to discuss DNACPR decisions with patients.
	Update Trust/North West DNACPR policy to reflect change in law.
	Create and make available information on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy for patients & families.
Ophthalmology Audits	
Audit of new referral to diabetic retinopathy clinic	Continue to obtain feedback from patients regards service provided. Audit patients undergoing vitrectomy for doctor to identify preventable causes. Continue to audit patients registered SI/SSI. Re-audit in 12 months.
AMD Service Review	Add date of referral in Rapid Age-Related Macular Degeneration (AMD) referral form.
	Treatment protocol for Eylea and Lucentis.
	Training staff for ICG - (Indocyanine Green).
	Training of Allied health professional for Intravitreal injection
Orthoptic Audits	
Audit of the Orthoptic led service to children and young people with special needs	To audit Visual Impairment (VI) registrations and referral to Visual Impairment (VI) team for Special Educational Needs (SEN) children.
	To audit Special Educational Needs (SEN) children with Visual Field (VF) defects and impact on education.
Audit of the efficacy of the developmental eye movement test in the SPLD clinic	Future audit of Development Eye Movement (DEM) test (and our results following treatment) using patients with type 2 and 4 DEM results.
	Assess and record compliance with treatment (tracking exercises) – email Speech Learning Difficulties (SpLD) Orthoptist to ensure this is done.
Pathology - General Audits	
An audit of compliance with British Committee for Standards in Haematology guidelines for the investigation of newly detected M - Proteins and the management of monoclonal gammopathy of undetermined significant	Circulate BCSH guidelines amongst haematology clinicians.
	To make clinicians aware of current guidelines.
	Remind clinicians to document any variance in management from guidelines and reasons for this variance.
	To allow for better medical record keeping, to allow others to easily establish reasons behind variance from guidelines.
	Document risk classification.
	Allows for a clear management plan based on guidelines.
	Re-Audit in 3 years.
	Document patient leaflets and contact details have been given to the patient.
	To comply with guidelines, improve patient understanding.

Audit Title	Quality Improvement Action Plans
	Re-refer low risk patients to primary care.
	To reduce burden in haematology clinics, to remove burden of hospital appointments from patients.
Pathology - Histopathology Audits	
Barrett's Oesophagus: The diagnostic role of Pathology	Communicate the findings to the Gastro Intestinal (GI) Endoscopists and highlight the importance of providing clinical/endoscopic information in all requests.
	Histopathologists to follow a clear criteria for reporting oesophageal biopsies, consider BSG reporting strategy.
	Findings to be emailed to all staff.
	Ensure that all cases sent should be provided with appropriate clinical details.
Re-Audit on malignant melanoma reporting compliance with RCPath recent guidelines.	To avoid discrepancy between our reports and SSMDT we can write a note in our reports that final American Joint Committee on Cancer (AJCC) 7th/Tumour Node Metastases (TNM) stage will be confirmed in the Multidisciplinary Team (MDT)/ Surgical Specialty Multidisciplinary Team SSMDT.
	Calibrate our microscopes in our department to measure mitoses per square mm.
Pharmacy Audits	
Use of DVT (Deep Vein Thrombosis) pathway looking at use of Doppler ultrasound	Feedback to Primary care regarding use of d-dimer test only in those patients with well score 1 or below and use of Clexane.
	GP bulletin.
	Future audit to review investigations of unprovoked Deep Vein Thrombosis (DVTs).
	Feedback to rest of Trust regarding use of d-dimer test only in those patients with well score 1 or below and use of Clexane General hospital bulletin.
	Re-audit to assess if use of pathway improved.
Radiology Audits	
A re-audit of GP referred lumbar spine x-ray requests	Contact General Practice (GP) surgeries through hospital communication to inform them of the protocols.
	Implement ICE referral questions to deflect inappropriate requests.
	Remind radiographic staff of the protocols involved when vetting requests.
Surgical Audits	
Comparing outcomes for elective & emergency Pilonidal sinus surgery	Suggest excision of midline pits at time of incision and drainage of pilonidal abscess.
	Suggest Bascom's procedure in suitable cases to avoid large wounds and consequent delayed healing.
Re-Audit Venous Thromboembolism (VTE)	Regular training and teaching to medical and ward staff regarding VTE process at the Trust.
	Clear lead to identify person responsible to assess and monitor VTE assessment in the team Admitting clinician (SHO/ SPR).
	Clear signs to be added on the boards/screens to highlight Venous Thromboembolism completion Ward Managers.
	Pop-up windows/ Notifications on patient record system (Lorenzo) if VTE is not assessed and completed by the admitting clinician as reminder.
	IT Team.
STARSurg (Student Audit and research in Surgery)	Re-audit of documentation of Body Mass Index (BMI) on admission in a years' time.
Trauma & Orthopaedic Audits	
Elective Total Hip Replacement (THR) / Total Knee Replacement	How do we record our data and should we mirror Aqua? Include revisions and pre op days in LOS
Urology Audits	

Audit Title	Quality Improvement Action Plans
Mitomycin (MMC) bladder instillation post TURBT	Implementation of Transurethral resection of a bladder tumour (TURBT) proforma, to aid in documentation of post-op plan and to make clear when single dose Mitomycin C (MMC) is indicated post-op.
	Ongoing Training of Nursing Staff in bladder instillation of MMC.
	Re-Audit in 1 year.
Local use of Botulinum A for urinary symptoms	All patients to be taught Intermittent Self Catheterisation (ISC) pre-op.
	Establishment of Nurse led Clinic to review post-op.
	Ensure all patients have adequate trial of alternative treatment prior to Botox.
Women's Health Audits	
Audit of the Management of High Grade Referrals to Colposcopy	Audit cohort's treatment outcomes in line with National Health Service Cervical Screening Programme (NHSCSP) standards in 6 months when Test of Cure (TOC) smear results available: Standard to be audited: 90% of women treated have no dyskaryosis 6/12 after treatment i.e. Double negative result (Cytology Negative and HRHPV status Negative).
	Urgent review of cases of treatment failure to be undertaken by Colposcopists for 2013/14 as per Quality Assurance (QA) request.
	Produce Standard Operating Procedure (SOP) for monitoring definitive treatments for High Grade.
	Produce Standard Operating Procedure (SOP) for upgrading high-grade referrals to 62 day pathway.
	Produce guideline for management of women >50 with Cervical intra-epithelial neoplasia (CIN) incomplete or inconclusive excision
	Clinical Lead, Colposcopy Lead and Assistant General Manager (AGM) review areas of poor performance and produce action plans where needed for improvements in clinical practice: Attendance at Multi-Disciplinary Team (MDT) meetings All Colposcopists to see a minimum of 50 new abnormal cytology referrals per year All Colposcopists to follow "See & Treat" policy All Colposcopists to achieve predictive accuracy standard of 65% for high grades Review practice and identify any training needs to improve quality of excisional.
Parental Survey Newborn Hearing Screening Programme 2014	Provide written and verbal information for parents.
	Hearing Screening Programme updates to Midwifery/Paediatric/Medical staff via training sessions/hand-outs. Use "Quiet" signs when screening is being performed. Use an unoccupied side room or the treatment room if available.
	Perform morning checks on C23, Neonatal ward and Paediatric ward.
	Repeat Audit at the end of 2015.
Postpartum Haemorrhage	Improve use of the trigger phase following Postpartum Haemorrhage (PPH) via peer education email.
	Improve use of fluid balance charts following Post-Partum Haemorrhage (PPH) - via peer education email.
	Re-audit next year- to include more risk factors for PPH in line with National RCOG guidelines.
Unanticipated Admission to Local Neonatal Unit	Further training identified for the staff on the neonatal unit in the reporting of admissions Proforma.
	Further training on identifying the reason for admission on the datix and proforma.
	More robust review of cases where the infant >37 weeks is admitted to the neonatal unit.
	Audit process for the unanticipated admission should be changed to focus on the more acute unwell admissions and lessons that can be learnt. Other criteria captured in the current format to be included in the unit statistics Since this audit was presented a National CQUIN has been adopted with a more formal process of review of admissions in set up at the Trust.

Audit Title	Quality Improvement Action Plans
GTT Audit	Revise gestational diabetes policy in line National Institute for health Care and Excellence (NICE) 2015.
	Launch new gestational guidelines.
	Send paediatrician a copy of the audit to review high number congenital malformations and neonatal complications.
	Agreed to leave Gestational Diabetes mellitus (GDM) pregnancies until term + 6 unless clinical indication for earlier delivery. Communicate this to all staff looking after these ladies. Agreement medical obstetric group at meeting.
	Re-audit after new criteria introduced.
	Reduction in multiple specimen LLETZ (Large loop excision of transformation zone).
Grow Charts	To print out actual Birth Weight on the Child Growth Chart (CGC).
	List of risk factors for Small for Gestational Age (SGA) at all Antenatal Clinics (ANC).
	To facilitate appropriate settings at Halton Antenatal Clinic (ANC) to print out CGC at bookings.
	To endure all medical staff have been trained to generate, complete and interpret Child Growth Chart (CGC).
ENT Audits	
Audit of outpatient follow up appointments.	Improve documentation in notes of radiological results.
	Audit the process of Magnetic Resonance Imaging (MRI) reporting back to the clinician.
	Improve recording of external referral letters electronically.
Tracheostomy Care	Documentation of type of tracheostomy tubes used.
	Tracheostomy tubes to have inner tubes - change from Portex to Shilley or equivalent.
	Availability of Tracheostomy observation charts.

NB: the above table provides examples of local audits details for all local audits can be provided on request from the Clinical Audit Team – on 01925 662736.

KEY:

AE	Emergency care
AMBER	The AMBER care bundle (**a**ssessment, **m**anagement, **b**est practice, **e**ngagement where recovery is uncertain)
BSUG	British Society of Urogynaecology
CG	Clinical Governance
CCG	Clinical Commissioning Groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services
CEM	College of Emergency Medicine
CT	A computerised tomography (CT) scan
Datix	Risk management system
DIGG	Divisional Integrated Governance Group
DNA	Did not attend
DVLA	Driver and Vehicle Licensing Agency
DWARF	Data Warehouse
DySIS	A new type of colposcope
ED	Emergency Department
GP	General Practitioner
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
Kenalog	Injection

MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in UK
MET	Medical emergency team
MSSU	Midstream urine sample
Myringoplasty	Operation to repair the perforation in the eardrum
NCDAH	National Care of the Dying Audit
NDA	National Diabetes Audit
NEWS	NHS early warning score
NICE	National Institute for Health and Care Excellence
NICU	Neonatal intensive care unit
NNAP	National Neonatal Audit Programme
NNU	Neonatal Units
PCR	Polymerase Chain Reaction, a test method used to detect the genes of the virus
PN	Practice Nurse
PROMS	Patient Reported Outcome Measures
RCPath	Royal College of Pathologists
SaBTO	Advisory Committee on the Safety of Blood, Tissues and Organs
SBAR	Situation Background Assessment Recommendation
SHO	Senior house officer
SPLD	Specific learning difficulties
ST	Speciality Training
SpR	Registrar
Thrombocytopenia	A reduction in the platelet count below the normal lower limit
USS	Ultrasound

2.2.3 Participation in Clinical Research and Development.

The number of patients receiving relevant health services provided or sub- contracted by Warrington and Halton Hospitals NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 552.

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 2015-2016 the Trust was involved in conducting 67 clinical research studies in research in oncology, surgery, stroke, reproductive health, cardiology, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

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

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

Most of the research carried out by the Trust is funded by the NIHR. For 2015-2016 the Trust received over £400,000 which funds 9 research nurses to support Principal Investigators with

recruitment and to assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

2.2.4. The CQUIN Framework

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

The aim of the CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing the commissioners to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals. The locally agreed goals, which should be stretching and realistic, are discussed between trust board, commissioners and providers and included within contracts.

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2015/2016 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 2015/16 and for the following 12 month period are available electronically at:
http://www.whh.nhs.uk/page.asp?fldArea=1&fldMenu=5&fldSubMenu=0&fldKey=161

The monetary total for the amount of income in 2015/16, conditional upon achieving quality improvement and innovation goals, was £4,209,259m with a monetary total for the associated payment in 2015/16 of £4,209,195m received. In 2014/15 the trust received a monetary total for the associated CQUIN payment of 4,169,862m with a monetary total for the associated payment in 2014/15 of £3,961,369 received.

The trust achieved full compliance against all of the agreed CQUINs with the exception of one Advancing Quality measure reporting non-compliance with heart failure and partial non-compliance with neonatal unit admissions. The trust had the following CQUIN goals in 2015/2016 which reflected both national priorities and Department of Health initiatives and also reflecting local needs and the views of the patients and commissioners.

CQUIN Report 2015/2016

CQUIN Description Ⓐ **= external audit**	**% of contract value**	**Total estimated value**
Acute Kidney Injury	10%	£420,926
SEPSIS Screening	5%	£210,463
SEPSIS Antibiotic	5%	£210,463
Urgent Emergency Care	20%	£841,852
The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services. Each patient admission can only be included once in each indicator but not necessarily in the same month, as the identification, assessment and referral stages may take place in different months.	6%	£252,556
Dementia – Staff training	1%	£42,093
Dementia - Ensuring carers feel supported	3%	£126,278
Sub-total National CQUINS		

AMI - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	2.1%	£87,553
Heart Failure - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	2.1%	£87,553
Pneumonia - The Appropriate Care Score (ACS) aggregates delivery of several underlying clinical interventions into a single measure of quality.	2.1%	£87,553
Stroke – Sentinel Stroke National Audit Programme	2.1%	£87,553
Specialist Commissioning CQUINs		
(Health Inequality CQUIN) – Local Health Inequalities applicable to the breast screening programme provided by WHHFT. (Year 2 of 2 year CQUIN)		
Neonatal Critical Care – Reducing Clinical Variation		
Neonatal Unit Admissions		
Local CQUINs		
Improvement in the care and experience of patients with dementia. Year 2 of 2 year CQUIN	6.4%	£269,393
Effective Discharge and Transfer of Care - Year 2 of 2 year CQUIN	10.4%	£439,447
Ward Assessment Scheme. Year 2 of 2 year CQUIN	6.4%	£269,393
Improvement in the care and experience of patients with diabetes by the assessment of the diabetic foot and prevent the risk of developing a foot ulcer or manage any ulceration identified. This is intended to be Part 2 of a 2 year CQUIN	6.4%	£269,393
DIGITAL - Procure and Implement an Integrated Health Solution Part 2 of a 2 year CQUIN	12%	£506,795
Sub-total Local		£4,209,259

2.2.5 Care Quality Commission (CQC) Registration

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

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2015-2016.

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 special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/2016:
CQC Spinal (concern)
Warrington and Halton Hospitals NHS Foundation Trust has taken the following action to address the conclusions or requirements reported by the Care Quality Commission. The trust has undertaken a review and successfully responded to seven points raised by the CQC in relation to Spinal Services.

Warrington and Halton Hospitals NHS Foundation Trust has made the following progress by the CQC accepting the response; action plan and additional documents as assurance that the Spinal Surgery at CMTC are safe in the provision of care to patients.

2.2.5.1 CQC new Chief Inspectors Regime (Keogh Framework)

The CQC now lead significantly bigger inspection teams headed up by clinical and other experts that include trained members of the public. They spend longer inspecting hospitals and cover every site that delivers acute services and eight key services areas: A&E; maternity, paediatrics; acute medical and surgical pathways; care for the frail elderly; end of life care; and outpatients. The inspections are a mixture of unannounced and announced and they included inspections in the evenings and weekends when it is recognised patients can experience poor care. The CQC inspected Warrington and Halton Hospitals NHS Foundation Trust from 28 - 29 January 2015. 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 July 2015 the CQC published our report which included a rating by specialty; location and an overall rating for the trust from the inspection.

The trust can report that the CQC rated Halton Hospital as **good**, Bath Street Health and Wellbeing Centre (in Warrington where several clinic services are provided) as **good** and Warrington Hospital as **requires improvement**. They rated caring and effectiveness in the trust as good across the board in all of its services.

The trust was given an overall rating of **'requires improvement'** by the CQC although inspectors found services were caring, effective and did not observe any examples of unsafe practice during their visit. The trust has already actioned many of the recommendations made by the CQC which include improvements to patient flow and strengthening staffing in key areas where there were long term vacancies. England's chief inspector of hospitals Professor Mike Richards reported that inspectors found that 'Staff were committed and passionate about their work, keen to learn and continuously improve the services they offered to patients. There was good leadership and strengthening governance arrangements across the trust. Nursing staff were caring and compassionate and treated patients and those close to them with dignity and respect. Many areas of good practice were cited in the report including:

- **Nursing care**- Nursing staff were caring and compassionate and treated patients and those close to them with dignity and respect. Nurses were committed to giving people a high standard of care and treatment
- **Medical staffing**- Medical treatment was delivered by skilled and committed medical staff.
- **Dementia care**– The report highlighted excellent practice in the treatment of dementia. The hospital had a purpose built and highly effective ward for patients living with dementia,

which was well equipped and well-staffed. Patients with dementia were assessed and admitted to the ward based on the severity of their dementia and managed sensitively

- **Cleanliness and infection control**- There was a high standard of cleanliness throughout the hospitals. Staff were aware of current infection prevention and control guidelines and observed good practice.
- **Nutrition and hydration**- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital.

However the report did raise several areas that the trust needs to make improvements around. Patient flow due to the pressure caused by emergency admissions was highlighted in the report. Inspectors noted the impact it had on patients at the time in terms of waiting. The trust has addressed this as a priority with its partners in health and social care and had improved its A&E performance since January with a return towards the 95% national A&E target – reaching over 94% in June. However in recent months the trust has struggled with a high level of activity which has negated achievement of the 95% national A&E target. Intermediate care beds have opened on the Warrington Hospital site which has resulted in improved patient flow.

The trust has also prioritised improving mandatory training compliance across its clinical divisions which was seen as variable in places

Inspectors also highlighted staffing vacancies in key areas, particularly in medical staffing where the trust has struggled to recruit to some posts where there are national shortages and was dependent on locum staff. However, inspectors noted that all wards and departments were suitably staffed at the time of the inspection. This continues to be a key area of priority for the trust.

2.2.6 Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

which included the patient's valid NHS Number was:

99.64% for admitted patient care
99.84% for outpatient care and
98.67% for accident and emergency care

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

100% for admitted patient care
99.99% for outpatient care
98.85% for accident and emergency care

2.2.6.1 Information Governance

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance Assessment overall score for 2015/2016, was 66% and was graded as "not satisfactory".

Not Satisfactory

During 2016/2017 performance will be monitored by the Information Governance and Corporate Records Group and then reported to the Quality Committee which is a committee of the Trust board.

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

Since the implementation of the Trust's new Patient Administration System, Lorenzo, work has been undertaken to re-write Data Quality Policies. Reporting on the quality of data within the Lorenzo system will be overseen by the Trust's Data Quality and Management Steering Group. During quarter 1 of 2016/17 a data quality reporting schedule will be agreed and this schedule will be routinely monitored to ensure that the requisite data quality best practice mechanisms are in place.

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

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

The trust will be re-launching the Data Quality and Management Steering Group meetings due to the implementation of our new PAS Lorenzo and developing Data Quality reports for all key data items that are used in external Monitor and Department of Health and Clinical Commissioning Group reports.

2.3. Core Quality Indicators 2015/2016.

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

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

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

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

2.3.1a Summary Hospital-Level Mortality Indicator (SHMI)

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

SHMI

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

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

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

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

SHMI – Mortality Rates

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

We monitor mortality ratios on a monthly basis using the HED system and reported a 'higher than expected' score in the rolling 12 month periods from October 2014 to November 2015. However, we are pleased to report that for the period January 2015 to December 2015 our position is now 'as expected' at 109. Our crude death rates remain comparable with local peer trusts, however we will of course continue to progress with the actions in the areas outlined in section 3.3.1.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 105 for the latest data period available (February 2015 to January 2016). This is within the range of 'as expected'.

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding. The key areas of focus in 2015/2016 were:

- Reviewing the trust's care pathways and best practice care bundles to ensure a high standard of care for every patient, every time
- Mortality Review (including collaboration with local peers)
- Ensuring quality and appropriate care at the end of patients' lives
- Promoting the effective management of patients whose conditions deteriorate
- Continue to analyse, understand, report and use mortality and morbidity data to improve outcomes.
- Ensure accurate and comprehensive documentation and coding

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 continuing to monitor this as a quality indicator and reporting progress in the Quality Report 2016/2017.

2.3.1b Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the trust for the reporting period.

Deaths with Palliative Care Coding

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
October 2014 - September 2015	27.5%	23.7%	52.8%	10.1%
July 2014 - June 2015	28.2%	23.1%	47.8%	9.3%
April 2014 – March 2015	27.5%	22.5%	46.2%	7.7%

January 2014 – December 2014	27.6%	22.3%	44.6%	6.7%
October 2013 - September 2014	26.4%	21.7%	46.7%	6.1%
July 2013 - June 2014	30.5%	24.6%	49%	7.4%
April 2013 – March 2014	27.7%	23.6%	48.5%	6.4%
January 2013 – December 2013	22.8%	22%	46.9%	1.3%
October 2012 - September 2013	19.9%	20.9%	44.9%	2.7%
July 2012 - June 2013	18.9%	20.3%	44.1%	4.2%
April 2012 – March 2013	17.2%	19.9%	44%	0.1%
January 2012 – December 2012	14.4%	19.1%	42.7%	0.1%

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

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

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the rate and so the quality of its services by investigating the detail behind the ratio numbers, we identified that our rate of service provision was the lowest in the North West prior to 2012/2013, and we have worked hard to now be in a position in which we compare favourably with local peers. The trust was below the England average but has improved over the years to a steady rate which is comparable with the England average. There has been a recent reduction which is likely to be explained by vacancies in the team and will continue to be monitored.

2.3.2 Patient reported outcome measures (PROMs) for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery. PROMs also exist for varicose vein, however the trust does not undertake this procedure.

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

Patient Reported Outcome Scores.

		Groin hernia	Hip replacement	Knee replacement
Year	**Level**	**Average health gain**	**Average health gain**	**Average health gain**
2013/2014	Trust	0.062	0.415	0.335
2013/2014	England	0.085	0.436	0.323
2013/2014	Highest	0.139	0.544	0.424
2013/2014	Lowest	0.007	0.310	0.214
2012/2013	Trust	0.062	0.428	0.357
2012/2013	England	0.085	0.438	0.318
2012/2013	Highest	0.153	0.539	0.416
2012/2013	Lowest	0.014	0.319	0.209
2011/2012	Trust	0.084	0.438	0.310
2011/2012	England	0.087	0.416	0.302
2011/2012	Highest	0.249	0.668	0.537
2011/2012	Lowest	-0.084	0.282	0.144

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

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that the PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to the Health and Social Care Information Centre by a number of

organisations, including hospital trusts which perform PROMs procedures. PROMs calculate the health gains after surgical treatment using pre and post-operative surveys. The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data as well as linking it to other data sets such as Hospital Episodes Statistics.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions 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 given that the CQC Intelligent Monitoring Report which identified risks associated with PROMs data is no longer published.

2.3.3 Emergency readmissions to hospital within 28 days of discharge

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

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged

0 to 15; and

16 or over,

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

The HSCIC website states: 'This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the next update is due to take place in August 2016'.

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2013/2014	*	*	*	*
2012/2013	*	*	*	*
2011/2012	13.58	10.01	13.58	5.10
2010/2011	12.08	10.15	13.94	5.85
2009/2010	11.77	10.18	14.44	6.38

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

*** Data for 2012/14 is not available from the Information Centre**

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

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

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

*** Data for 2012/14 is not available from the Information Centre**

Data relates to medium sized acute trusts.

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

Warrington and Halton Hospitals NHS Foundation Trust will intends to take the following actions to improve this rate and so the quality of its services, by making changes to the internal scrutiny and review of readmission data, redesigning the discharge service and continuing to develop readmissions software to support access to improved ward based information.

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

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

CQC national inpatient survey – personal needs.

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2014/2015	72.0	68.9	86.1	59.1
2013/2014	69.4	68.7	84.2	54.4
2012/2013	66.7	68.1	84.4	57.4
2011/2012	66.2	67.4	85	56.5
2010/2011	67.4	67.3	82.6	56.7

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

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by reviewing the inpatient survey results constructing an action plan to improve year on year results. This will be supported by local surveys which focus on the above aspects of the patient experience.

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

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

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

DATE	TRUST	HIGHEST	LOWEST	ACUTE TRUSTS
2015	54%	93%	38%	70%
2014	61%	89%	38%	65%
2013	65%	93.9%	39.6%	67%
2012	58%	69%	35%	65%
2011	57%	89%	33%	65%

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2015 national NHS staff survey

conducted by Quality Health on behalf of the trust. Quality Health utilises high quality research methodology which ensures that appropriate sampling is undertaken across all staff groups resulting in a 33% response rate.

280 staff at Warrington and Halton Hospitals NHS Foundation Trust took part in this survey. This is a response rate of 33% which is in the lowest 20% of acute trusts in England, but does indicate a small increase on the 2014 survey which had a response rate of 30%. This year all surveys were delivered in person by either the Chair or an Executive to the area of work and the importance of the questionnaires was explained. The anonymity of the questionnaires was also stressed to staff and that they could be completed in works time. The trusts view is that the results are statistically representative.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve to improve this score and so the quality of its services by using the percentage of staff recommending the trust as a place of work and treatment within the staff survey alongside the quarterly staff friends and family test results. The percentages are compared with the qualitative detail that these surveys also give and action plans are developed as appropriate. The key themes are reported to the bi-lateral divisional meetings to give managerial ownership of the findings. The results are also reported to the Strategic People Committee where an overall report is given on actions taken to improve the scores. The trust is currently in the middle of a large piece of work to introduce a comprehensive values and behaviours framework across the trust and hope that this should improve a number of the factors, improving engagement levels and therefore patient care.

2.3.6 Percentage of admitted patients risk-assessed for Venous Thromboembolism.

The data made available to the National Health Service trust or NHS foundation trust by the National Commissioning Board with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Venous Thromboembolism (VTE) – percentage of risk assessments undertaken

Year	Level	Q1	Q2	Q3	Q4
2015/2016	Trust	96.6%	96.1%	88.56%	88.37%*
	National Average	96%	95.9%	95.5%	**
	Highest	100%	100%	100%	**
	Lowest	86.1%	75%	61.5%	**
2014/2015	Trust	95.70%	95.60%	95.00%	95.93%
	National Average	96.00%	96.10%	96.00%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	87.20%	86.40%	81.00%	79.23%
2013/2014	Trust	95.54%.	95.60%	96.50%	96.00%
	National Average	95.39%	95.69%	95.80%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	78.78%	81.70%	77.70%	79.00%
2012/2013	Trust	95.40%	95.10%	94.00%	93.90%
	National Average	93.40%	93.80%	94.00%	94.20%
	Highest	100%	100%	100%	100%
	Lowest	80.80%	80.90%	84.60%	87.90%
2011/2012	Trust	95.60%	96.20%	95.40%	96.20%
	National Average	81.00%	88.00%	91.00%	93.00%
	Highest	***	***	100%	100%
	Lowest	***	***	32.40%	69.80%

* =Trust internal data only available for this reporting period.
** = This data is not currently available from the Information Centre.
*** = This data has been archived and is unavailable.
\+ = This data has been resubmitted to UNIFY to be published in May 2016

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that the trust has a well-developed system for undertaking risk assessments on admission and ensuring the data is collated corporately and incorporated into the Quality Dashboard for monthly review and monitoring by both the Quality Committee and trust board. More recently in November 2015 the trust has introduced a new **Electronic Patient Record (EPR) system called Lorenzo. Unfortunately whilst Lorenzo offers enormous benefits and opportunities for the trust** there have been since 'go live' issues with managing the data for quality indicators for example dementia and VTE screening from the new system. This has been in relation to refinement of data inputting and data capture systems, education around using the system in addition to the inability to extract reports as required. These are short-term issues and whilst they have had implications for the availability of data, resources have been identified to resolve them quickly and efficiently. It should be noted that the trust is assured that VTE was compliant at >95% for quarter 3 and that patients were not exposed to any increased risk at this time.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by undertaking ward assessments to ensure patients receive risk assessment appropriately and streamlining Lorenzo processes to ensure all risk assessments are logged electronically on completion. The Thromboprophylaxis Nurse Specialist monitors completion of VTE risk assessments and ensures all non-compliance issues are addressed.

2.3.7. Treating Rate of C. difficile per 100,000 bed days amongst patients aged two years and over.

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.

Warrington & Halton NHS Trust Clostridium difficile infections per 100,000 bed days:

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

The Information Centre only provides average by Trust (not by highest and lowest) and 2014/15 data is not currently available.

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

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

- Action plans in place to reduce MRSA and Clostridium difficile
- Health Economy Clostridium difficile action group – audits of primary care prescribing for long-term UTI prophylaxis
- Participation in European Antibiotic Awareness Day

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

Please see section 3.2.1 for further information on improvement actions.

2.3.8 Patient Safety Incidents

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

Patient Safety Incidents – Rate of incidents per 1000 bed days

DATE	TRUST	TRUST NUMBER	MEDIAN	Lowest	Highest
Oct 2014 - Mar 2015	38.6	3584	35.3	3.6	82.2
April 2014 – September 2014	36.89	3339	35.89	0.24	74.96
October 2013 – March 2014	37.1	3513	33.3	5.8	74.9

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

Patient Safety Incidents Severe Harm / Death – Rate

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
Severe Harm & Death October 2014 - March 2015	0.1% (5)	0.5% (non-specialist acutes only)	0.05% (2)	5.19% (128)
Severe Harm & Death April 2014 – September 2014	0.1% (5)	0.5% (non-specialist acutes only)	0% (0)	1.85% (97)
Severe Harm & Death October 2013 – March 2014	0.17% (6)	Clarify scope	0.03% (1)	1.47% (72)
Severe Harm & Death April 2013 – September 2013	1.08% (42)	Clarify scope	0% (0)	3.10% (106)
Severe Harm & Death October 2012 – March 2013	0%	0.05%	0%	0.2%
Severe Harm April 2012 – September 2012	**0.15% (4)	*<1%	0 0%	61 3.1%
Death April 2012 – September 2012	0.0% (1)	*<1%	0 0%	34 1.3%
Severe Harm October 2011 – March 2012	0.2% (4)	*<1%	1 0%	80 3%
Death October 2011 – March 2012	0.0% (0)	*<1%	0 0%	14 0.6%

NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same trusts.
NB - *National = Severe Harm and Death combined. **Please see comments.

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

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

Completed investigations to the appropriate level dependant on the severity of the clinical incidents reported
Shared analysis, learning and improvement identified from clinical incidents across the Trust via the following routes:

- Quarterly Governance Reports
- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Trust wide Risky Business Newsletter
- Amendments to policy

2.3.9 Friends and Family Test – Patient.

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

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

Following a review of the FFT in July 2014 the presentation of the data moved away from using the Net Promoter Score (NPS) as a headline score and now uses the percentage of respondents that would recommend / wouldn't recommend the service.

During the reporting period 1st April 2015 until 31st March 2016 the trust performed above average in comparison with scores for England for inpatient Friends and Family. A comparison of Accident and Emergency data against national average reveals that the A&E performance scores in line with or slightly under the England rate.

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

- Continued development and monitoring of Always Events for 2016/2017
- Ensuring lessons learned from complaints take place
- Undertaking local patient surveys, developing and implementing actions
- Monitoring via DAWES and patient experience indicators and make changes as required.

This indicator is new and not a statutory requirement for 2015/2016.

Friends and Family Net Promoter 2014/2016 (NHS England)

Month	Trust - Inpatient	England - Inpatient	Trust – A&E	England – A&E
April 2015	97%	95.2%	83%	87.5%
May 2015	98%	95.4%	86%	88.3%
June 2015	98%	95.6%	88%	88.4%
July 2015	98%	95.6%	87%	88.2%
August 2015	96%	96%	90%	88%
September 2015	97%	95%	85%	88%
October 2015	96%	95%	86%	87%
November 2015	96%	95%	85%	87%
December 2015	96%	95%	82%	87%
January 2016	94%	95%	76%	86%
February 2016	95%	95%	81%	85%
March 2016	96%	95%	84%	84%
April 2014	76	73	42	55
May 2014	74	73	35	54
June 2014	81	73	41	53
July 2014	76	73	40	53
August 2014	77 (95%)	73 (94%)	45 (80%)	57 (87%)
September 2014	94%	93%	82%	86%
October 2014	95%	94%	85%	87%
November 2014	97%	95%	87%	87%
December 2014	96%	95%	84%	86%
January	96%	94%	87%	88%
February	97%	95%	84%	88%
March 2015	96%	95%	83%	87%

NB: England data - the independent sector is excluded.

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

Our primary objective is the safety of our patients.

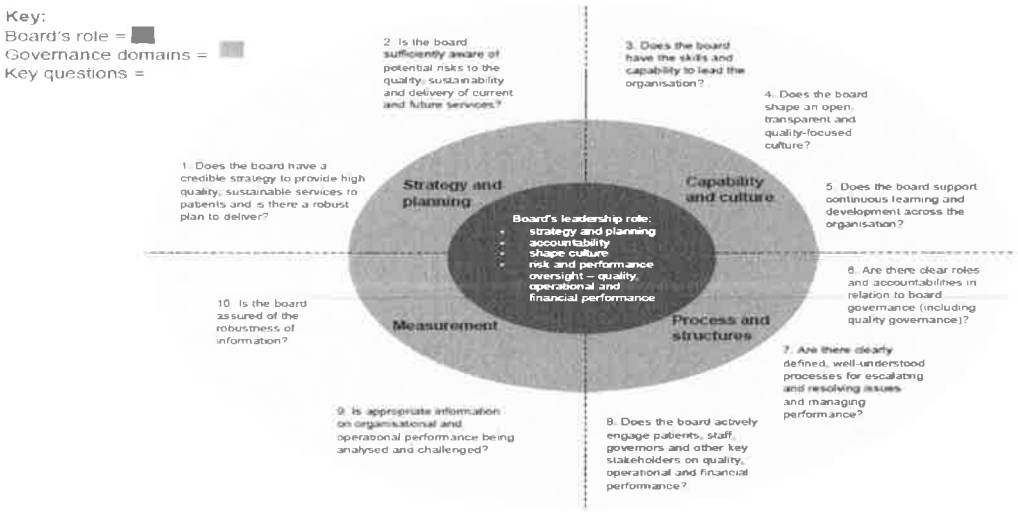
Quality Report Part 3 - Trust Overview of Quality

3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

Our aim is to be a learning organisation that consistently transforms practice by continuous learning in order to provide the best possible health care.

Our Quality Strategy consolidates this approach by defining the combination of structures and processes at and below Board level to lead on trust-wide quality performance to ensure that required standards are achieved. This will be supported and achieved via MONITOR's Governance Framework and ultimately the Well-led framework for Governance reviews by:

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



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

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

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

auditors to undertake audits of quality in order to provide assurance that systems are in place to address national and local clinical and quality requirements to ascertain if they are fit for purpose.

We are also committed to being transparent in relation to patient outcomes; patient experience and staff experience measures so that patients and the public can see how we are performing in these areas. This includes a transparency page on our internet site signposting the public to quality information and includes the monthly publication of Open and Honest Reports outlining the number of pressure ulcers and falls in addition to the results of Friends and Family Test, NHS Safety Thermometer and patient and staff experience surveys.

Transparency - quality and safety information | Warrington & Halton Hospitals

CQC inspections, performance and ratings
National reports from the Care Quality Commission and other bodies about the trust.

Open and honest care
Monthly reports on incidents and harm as part of this pioneering project.

Friends and family test
The latest NHS Friends and Family test results from our hospitals.

Hospital infection
Latest hospital infection figures and historic information.

Consultant outcomes
Information on our individual consultants' outcomes in key specialties.

Mortality rates
Up to date information on mortality rates at our hospitals.

Patient feedback and stories
What our patients say about our services and how we make changes.

Safe staffing levels
Information on staffing levels on the wards in our hospitals.

RCOG maternity review 2014

Information and the report commissioned by the trust on maternity services from the Royal College of Obstetrics and Gynaecology.

More recently a league table 'Learning from Mistakes League' has been drawn together by scoring providers based on the fairness and effectiveness of procedures for reporting errors; near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their trust. The data for 2015/16 which is drawn from the 2015 NHS staff survey and from the National Reporting and Learning System – shows that:

- 18 providers were outstanding
- 102 were good
- 78 gave cause for significant concern
- 32 had a poor reporting culture

We are pleased to report that this trust was rated as **GOOD**.

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

3.1.1 Data Sources

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

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

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

The trust submits data to the NHS Safety Thermometer which was developed as a point of care survey instrument, providing a 'temperature check' on harm that can be used alongside other measures of harm in providing a care environment free of harm for our patients. The trust undertakes a monthly survey on one day of all appropriate patients, to collect data on pressure ulcers, falls, urinary tract infection (UTI) in patients with catheters and VTE. The Safety

Thermometer measures the percentage of patients who have experienced harm in relation to any of these issues and allows the trust to identify weaknesses; make changes to practice and measure improvement.

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

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

3.1.1.1 Lorenzo Electronic Patient Record (EPR) system.

Lorenzo is a nationally available EPR system that is already live in 13 NHS organisations with a further five planning to deploy over the next year. NHS trusts in the North, Midlands and East can make bids for central Department of Health funding for software and deployment costs if they can provide a robust business case for deploying the system. After a process of clinical evaluation from our staff, and financial evaluation, we chose the Lorenzo system and have been successful in our bid for funding.

Our technology transformation programme is now fully underway after our bid for Department of Health funding to support the deployment of the new Lorenzo Electronic Patient Record (EPR) system.

The new EPR is one part of a multi-million pound programme which will revolutionise how patient care is delivered over the coming years at the trust. Currently there are a number of different patient record systems used within the trust's hospitals and community services. In future, the new system will bring together the various pieces of information held about a patient, putting it directly at our fingertips. It will replace the Meditech and Symphony systems and see a significant shift away from paper-based records towards electronic records.

Good use of IT can help improve care for patients. At the moment the efficiency of our teams across the hospitals can be hindered by some of the IT systems which we have had in place for many years. That can impact on the quality of the patient experience and we now have the opportunity to change that. Go-live for the first phase of the system took place as planned in November 2015.

As stated earlier in the report **this was a major technological transformation programme for the trust however whilst Lorenzo offers enormous benefits and opportunities for the trust** there have been since 'go live' issues with managing the data for quality indicators for example dementia and VTE screening from the new Lorenzo system. This has been in relation to refinement of data inputting and data capture systems, education around using the system in addition to the inability to extract reports as required. These are short-term issues and whilst they have had implications for the availability of data, resources have been identified to resolve them quickly and efficiently

3.1.2 Data – Mersey Internal Audit Agency (MIAA) Quality Review

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

To support this process the Director of Nursing and Organisational Development requested our internal auditors MIAA to undertake a review of the trusts quality framework. This work was

finalised at the end of 2015/2016 and MIAA stated that there was **"Significant Assurance"** in trust processes and systems in relation to the implementation of the Quality Strategy / Framework.

The review identified some weaknesses in the design namely Monitor's Well Led Framework was not included because it had not been published at the time the existing Quality Strategy was created, this will be addressed during a planned review of the strategy. It also highlighted poor attendance at the Darzi meetings and this will be addressed through a recent review of the process which will include amalgamating two meetings namely Patient Safety and Clinical Effectiveness into one meeting which will hopefully reduce pressure on staff and improve attendance. The Quality Governance Framework review will also be incorporated into the next planned review of the Quality Strategy.

3.1.3. Quality Dashboard 2015/2016

The clinical indicators in the Quality Dashboard have been reviewed in line with the revised requirements for 2015/2016 in relation to the:-

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

This is part of a wider review of quality to align reporting with the committee structure under safety; effectiveness and experience and reporting to the board to provide assurance on progress. In addition to this the trust has commenced the development of an integrated performance dashboard triangulating data on workforce, quality and finances which will report from April 2016.

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. The Quality Dashboard is produced with the caveat that the data for some of indicators can change month on month. This applies to incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased. These changes are always articulated in the exceptions reports.

This ensures that the board receives monthly information including exceptions reports on all key quality indicators.

Mar-16

Quality Dashboard 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Titles key: IC = inclusion criteria (see key below), YTD = Year to date
Inclusion criteria key: improvement priority (IP), National Quality related CQUINs (C), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks' (CQC), National Patient Safety Priorities (related to sign up to Safety campaign) (SU25).
Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)
Data key: DC = Data capture system under development, QR = Quarterly Reporting
ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
Safety																					
INCIDENTS	MODERATE, MAJOR OR CATASTROPHIC HARM: APPROVED	TBC	QC	8	5	8	21	7	7	8	22	17	2	0	19	5	2	3	10	72	changes monthly
	MODERATE, MAJOR OR CATASTROPHIC HARM: UNDER REVIEW	N/A		0	0	1	1	1	0	3	4	0	1	2	3	8	11	13	32	40	changes monthly
	SERIOUS UNTOWARD INCIDENTS (SUIs) Level 2	N/A		3	1	2	6	3	1	1	5	2	1	0	3	0	0	1	1	16	
HEALTHCARE ACQUIRED INFECTIONS	MRSA	[illegible]	QC, QI	0	0	0	0	0	1	1	2	0	0	0	0	0	0	0	0	2	
	CLOSTRIDIUM DIFFICILE (due to lapses in care)	<=27 per year	QC, QI	0	1	3	4	1	0	3	4	1	1	0	2	0	0	0	0	10	
	CLOSTRIDIUM DIFFICILE (no lapse in care)	None set	N/A	3	4	1	8	0	0	1	1	2	1	0	3	0	0	0	0	12	
	CLOSTRIDIUM DIFFICILE (under review)	None set	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	9	2	11	11	
NEVER EVENTS		0	QC	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
VTE	% OF PATIENTS RISK ASSESSED	>=95%	QC	97.52%	96.21%	96.01%		95.33%	95.77%	94.02%		95.04%	95.03%	97.21%		96.47%	89.71%	88.91%			
	% OF ELIGIBLE PATIENTS HAVING PROPHYLAXIS (SAFETY THERMOMETER)	100%	QC	100.00%	100%	99.82%		100%	100%	99.82%		99.65%	100%	99.47%		100%	99.57%	97.92%			
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (APPROVED)	TBC	QC	4	6	7	17	1	2	0	1	2	0							25	
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (UNDER REVIEW)	N/A	N/A	0	0	2	2	1	3	0	4	0	4							10	
HARM FREE CARE	% OF PATIENTS FREE FROM HARM (SAFETY THERMOMETER)	TBC	OH	97.70%	92.60%	98.34%		95.51%	97.33%	98.52%		96.51%	94.04%	96.26%			98.64%	99.06%			
	% OF PATIENTS FREE FROM HARM (MEDICINES SAFETY THERMOMETER) Quarterly	TBC	QI	100%	97.5%	88.1%		100%	100%	98.5%		100%	97.6%	NO AUDIT		100%	95.9%	97.6%			

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
Effectiveness																					
MORTALITY	HSMR (12 MONTH ROLLING)	[illegible]	QI, IP, QC	104	105	107		109	109	108		107	109	107		105					
	SHMI (12 MONTH ROLLING)	[illegible]	QI, IP, QC	116	115	116		116	115	114		113	113	109							
	TOTAL DEATHS IN HOSPITAL	None set	Reporting only	92	50	107	279	37	31	77	245	88	93	82	263	108	111	103	322	1109	
	MORTALITY PEER REVIEW (NB figures change as reviews are conducted)	[illegible]	IP, SU25	76%	81%	64%	74%	77%	73%	76%	75%	37%	78%	65%	76%	85%	56%			72%	
	REGULATION 28 - PREVENTION OF FUTURE DEATHS REPORT	None set	Reporting only	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	
CARDIAC ARRESTS	Annual: <75 = G, 75 – 55 = A, >55 = Red	See left	QC	4	2	11	17	10	5	6	21	4	9	6	19	14	10	8	32	89	
ADVANCING QUALITY	ACUTE MYOCARDIAL INFARCTION	>=95%	QI, C	93.18%	94.94%	96.83%		97.16%	97.14%	97.01%		97.31%	96.30%	95.71%						95.71%	
	HIP AND KNEE	>=95%	QI	98.51%	99.22%	98.97%		98.85%	99.01%	99.22%		99.33%	99.40%	99.08%						99.08%	
	HEART FAILURE	>=84.1%	QI, C	72.22%	73.17%	75.44%		78.85%	81.15%	82.89%		83.24%	82.32%	81.86%						81.36%	
	PNEUMONIA	>=78.1%	QI, C	80.00%	78.83%	78.65%		78.65%	78.08%	78.47%		77.11%	76.59%							76.59%	
APPROPRIATE DISCHARGE PLANNING FOR PATIENTS WITH AKI		[illegible]	C	[illegible]				[illegible]			20.70%	31%	35%	37%	35%	51%	67%	67%	62%		
SEPSIS SCREENING OF ALL ELIGIBLE PATIENTS ADMITTED TO EMERGENCY AREAS (* to be validated)		[illegible]	C	Quarter one data for establishing baseline				26%	40%	26%	31%	16%	26%	32%	25%	32%*	22%*	12%*	22%*		
SEPSIS SCREENING: ANTIBIOTICS GIVEN WITHIN AN APPROPRIATE TIMESCALE (* to be validated)		[illegible]	C	Quarter 1 establishing indicator detail				15%	23%	0%	15%	22%	27%	33%	27%	25%*	50%*	*	34.62%		
Patient Experience																					
FALLS	ALL FALLS (APPROVED)	913	IP (5% reduction)	83	89	81	253	75	74	92	241	102	91	65	258	72	64	77	213	965	
	FALLS PER 1000 BED DAYS	<=5.6	IP (national benchmark)	4.97	6.22	5.03		4.97	4.53	4.84		5.02	4.60	2.65		3.77	2.14	2.31		5.16	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	<=13	IP (10% reduction)	2	1	2	5	1	0	2	3	2	0	0	2	0	0	0	0	10	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)	N/A		0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2	2	
	MODERATE HARM FALLS (APPROVED)	<=12	SU25 (10% reduction)	1	1	2	4	1	0	3	4	1	0	0	1	0	0	0	0	9	
Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend

PRESSURE ULCERS	GRADE 3 AND 4 HOSPITAL ACQUIRED (AVOIDABLE)	=<5	Q1, 2015 (10% reduction)	1	1	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A		0	1	0	1	0	0	0	0	1	0	1	2	0	0	0	0	3	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A		0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2	
	GRADE 2 HOSPITAL ACQUIRED AVOIDABLE AND UNAVOIDABLE (APPROVED)	=<63	Q1 15% reduction)	15	8	6	29	10	6	5	21	13	11	5	29	9	6	9	24	103	
	GRADE 2 HOSPITAL ACQUIRED AVOIDABLE AND UNAVOIDABLE (APPROVED)	=<59	10% reduction internal stretch target	15	8	6	29	10	6	5	21	13	11	5	29	9	8	9	24	103	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (UNDER REVIEW)	N/A		0	0	0	0	0	0	0	0	0	0	1	1	1	4	10	15	16	
TRANSFERS	OUT OF HOURS TRANSFERS	TBC	PK	1	0	1	2	0	0	DC		DC	DC	DC		DC	DC				
	NON-ESSENTIAL WARD TRANSFERS	TBC	QI	DC	DC	DC		DC	DC	DC		DC	DC	DC		DC	DC				
ALWAYS EVENTS		100%	QI	89%	90%	92%	90%	96%	96%	88%	93%	94%	96%	96%	95%	97%	87%	97%	94%		
DEMENTIA	DEMENTIA ASSESSMENT % (PART 1)	>=90%	C	96.85%	97.62%	95.53%		96.80%	94.86%	94.36%		92.18%	81.30%	26.9%		90.30%	92.78%	90.42%			
	DEMENTIA ASSESSMENT % (PART 2)	>=90%	C	100%	100%	100%		100%	95.12%	100%		85.71%	72.7%	88.9%		96.67%	97.56%	93.85%			
	DEMENTIA ASSESSMENT % (PART 3)	>=90%	C	100%	100%	100%		100%	100%	100%		100%	100%	CCG		CCG	CCG	CCG			
	DEMENTIA - STAFF TRAINING		C	Compliance established at 27.02% and 12% additional 15% for Q2			27.02%				42%	44.50%	46.50%	49.64%	49.64%	51.43%	55.27%	57.39%		57.39%	
CARE INDICATORS RISK ASSESSMENTS	FALLS	>=95%	IP	92%	92%	93%	93%	97%	97%	97%	96%	96%	94%	96%	97%	92%	97%	96%	95%		
	WATERLOW (PRESSURE ULCERS)	>=95%	IP	77%	93%	92%	91%	96%	95%	92%	94%	96%	95%	97%	98%	94%	97%	94%	95%		
	MUST (MALNUTRITION)	>=95%	IP	78%	85%	89%	85%	91%	80%	87%	86%	90%	88%	93%	92%	93%	92%	91%	92%		
	DIABETIC FOOT	Q1 - >=% Q2 - 75% Q3 - 80% Q4 - 95%	C	OR	OR	77.60%	77.60%	72.00%	81.40%		76.80%				95%				98%		
MIXED SEX OCCURENCES		0	QC	8	0	1	7	0	0	0	0	0	3	0	3	3	3	10	16	26	
FRIENDS AND FAMILY (PATIENTS' VIEWS)	STAR RATING	N/A	Reporting only	4.61	4.66	4.70		4.66	4.65	4.72		4.71	4.70	4.73		4.72	4.67	4.69			
	% RECOMMENDING TRUST INPATIENTS	>=95%	IP, Q1, QC	97%	98%	98%		98%	96%	97%		96%	96%	96%		94%	95%				
	% RECOMMENDING TRUST A&E	>=87%	IP, Q1, QC	83%	86%	88%		87%	90%	85%		88%	85%	82%		78%	81%				
	RESPONSE RATE A&E WARRINGTON	Contract target to be agreed	IP, Q1, QC	22.03%	19.47%	13.16%		6.96%	6.49%	20.29%		12.52%	8.51%	3.55%		1.27%	14.3%	10.39%			
	RESPONSE RATE URGENT CARE CENTRE HALTON	Contract target to be agreed	IP, Q1, QC	3.54%	22.91%	24.00%		44.90%	10.86%	17.77%		20.95%	22.34%	4.19%		3.76%	20.8%	10.66%			
Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
FRIENDS AND FAMILY (PATIENTS' VIEWS)	RESPONSE RATE A&E COMBINED	Contract target to be agreed	IP, Q1, QC	17.22%	20.26%	16.11%		17.52%	7.66%	19.58%		14.95%	11.8%	3.74%		2.41%	16.5%	10.49%			
	RESPONSE RATE INPATIENTS	Contract target to be agreed	IP, Q1, QC	30.30%	33.80%	31.44%		31.96%	6.13%	63.10%		35.09%	30%	31.45%		9.64%	38.9%	36.35%			
COMPLAINTS AND CONCERNS	NUMBER OF COMPLAINTS RECEIVED	2014/2015 worked out 10% threshold not	IP	49	22	30	101	24	35	37	96	45	32	23	100	37	44	38	119	416	
	% OF COMPLAINTS RESOLVED WITHIN THE AGREED TIMESCALE	>=94%	IP, QC	100%	97.50%	97.56%	98.08%	97.67%	100%	100%	98.90%	96.15%	97.87%	100%	98.4%	100%	100%	91.67%	96.39%	98.03%	
	NUMBER OF CONCERNS RECEIVED	NOT SET	IP	10	9	27	46	39	19	7	55	4	5	11	20	16	10	9	35	166	
END OF LIFE STRATEGY: STAFF TRAINING (KPI UNDER CONSTRUCTION)		TBC	IP	Training workshops in development, delivery in Q3				Training workshops in development, delivery in Q3													
REDUCING AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL		TBC	C	4 pathways identified, awaiting CCG agreement				Acute and paediatric conditions identified, report shared with CCG				Audit underway & completed							

ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Key: YTD = Year to date, ST = Safety Thermometer (monthly point prevalence survey), IC = Inclusion criteria

Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception* (CE), Quality Account Indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(COC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

3.1.4 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the trust based on performance in 2015/16 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 both locally and nationally of importance to the interests and requirements of patients.

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

Where these indicators have changed from the indicators used in our 2014/2015 report, we have outlined the rationale for why these indicators have changed / removed and where the quality indicators are the same as those used in the 2014/2015 report and refer to historical data, we have checked the data to ensure consistency with the 2014/2015 report.

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

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

The quality indicators for 2015/16 include:

Safety

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

Clinical Effectiveness

- Dementia
- Advancing Quality
- SHMI HMSR

Patient Experience

- Patient Experience Indicators
- Complaints
- Patient Survey (inpatient and children) Indicators
- Essential ward transfers only

3.2 Patient Safety

3.2.1 Infection Control

Healthcare associated infections (HCAIs) are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase a patient's risk of acquiring an infection, but high standards of infection control practice reduce this risk. Although hospital acquired infections are subjected to national mandatory surveillance this trust is committed to reducing the risk of harm associated with these infections and as such selected this as a quality indicator for 2015/2016.

During 2014/2015, the trust threshold was 0 cases of MRSA, the trust reported 3 cases of hospital acquired MRSA bloodstream infection compared to 3 hospital acquired case and 1 MRSA

contaminant in 2013/2014. Within the reporting year and despite the continued focus on managing processes to reduce HCAI during 2015/2016 the trust has been unable to achieve its threshold for MRSA reporting 2 cases of MRSA against a threshold of 0.

During 2014/2015 the trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 26 cases. Within 2015/2016 the trust has reported 31 cases of Clostridium difficile C Diff against a threshold of 27 cases for 2015/2016. However within the reporting year the trust has engaged in partnership working with a CCG panel to review Cdiff cases to exclude some cases from the contractual penalties. This system investigates all hospital apportioned cases of Clostridium difficile and where no lapses in care are identified, cases are removed from those counted for the purpose of contractual sanctions. Following a joint review 12 cases have been removed from contractual sanctions as no lapses in care were identified and a further 11 cases will be reviewed by the panel in May 2016.

CDIFF Monitor Report 2015/2016

2015/16	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Due to lapses in care	0	1	3	4	1	0	3	4	1	1	0	2	0	0	0	0	10
Deemed not to be due to lapse in care	3	4	1	8	0	0	1	1	2	1	0	3	0	0	0	0	12
Under Review	0	0	0	0	0	0	0		0	0	0		0	9	2	11	11
Total C.Diff	3	5	4	12	1	0	4	5	3	2	0	5	0	9	2	11	33

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

- Action plans in place to reduce MRSA and Clostridium difficile
- Revise terminal cleaning guidelines and sign off checklist
- Review and introduce antibiotic prescribing competency assessments
- Assess requirement to limit use of Co-amoxiclav
- Provide additional resources to the Antibiotics Pharmacist
- Re-provide training programme to hand hygiene auditors
- Improve compliance with hand hygiene training strategy (UV light box)
- Strengthen partnership working with the CCG for timely case reviews
- Provide C difficile education session to link staff
- Trust wide mattress audit
- Review condition of all commodes and replace if required
- Develop a deep cleaning programme based on priority
- Ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment

The data for this indicator is from a nationally prescribed data set, the indicator is monitored via the corporate performance report and the Quality Dashboard.

3.2.2 Pressure Ulcers

The trust continued to focus on the management and reduction of pressure ulcers as a quality indicator for 2015/2016. The Prevention and Treatment of Pressure Ulcers (NICE Clinical Guideline 29; 2005) offers best practice advice on the care of adults and children with pressure ulcers. This trust has ensured that our current Pressure Ulcer Management Policy is aligned to and complies with the NICE Guidance recommendations.

The trust has strengthened a number of processes and sees a strong focus on early patient assessment and the documentation of the patient's skin condition on admission as essential to good practice. This is in line with the NICE Guidance and critical to the prevention of pressure ulcers.

The trust also ensures that the correct equipment which conforms to the NICE Guidance is purchased and this includes ensuring that all standard foam mattresses within the trust are made of a high specification pressure reducing foam. The trust hires specialist equipment to meet specific patient needs, these include the dynamic mattress replacement systems such a low air loss therapy, or occasionally air fluidised beds the 471 electric profiling bed frames within the trust also assist in the prevention of pressure ulcers. The majority of beds within the Intensive Care Unit have dynamic mattresses in place, and following assessment staff can order appropriate mattresses.

The Tissue Viability Team also offers advice on specialist equipment for example in relation to bariatric patients (patients with an increased body weight or size) who are at a particular risk and require a collaborative approach to assessment of equipment needs.

Pressure Ulcer Reporting and Monitoring

All pressure ulcers grade 2, 3 and 4 and suspected deep tissue injuries are reported on Datix both hospital and community acquired. All pressure ulcers are photographed by the medical photographer and the images are now available to view on Lorenzo.

Pressure Ulcer Grade Definitions

1	Non blanching Erythema (reddened skin which remains reddened on fingertip pressure)
	Discolouration of the skin, warmth, oedema, hardness or pain. Bruising may indicate deep tissue injury (see below).
2	Partial thickness skin loss or blistering without slough (e.g. very superficial top layer of skin)
3	Full thickness skin loss involving subcutaneous tissue but not extending to underlying structures (may or may not have tracking)
4	Full thickness tissue loss with exposed (or directly palpable) bone, tendon or muscle / Ulcer covered with thick necrotic tissue which masks the true extent of the damage
SDTI	Suspected Deep Tissue Injury: An area of pressure related bruising may indicate deep tissue injury. Observe regularly and re-grade as appropriate. Refer to Tissue Viability Nurse Specialist.

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

Quarterly reports provided via the Governance Report to the Patient Safety Sub Committee and the Quality Committee. Pressure ulcers are within the scope of the Patient Experience Sub Committee. We have worked hard to ensure that pressure ulcers are recorded as those acquired in hospital and those acquired in the community so that we can accurately report and act to improve the incidence of pressure ulcers within the trust. This will also support multiagency work in reducing pressure ulcers in the community.

The Waterlow risk assessment tool and management plan is used for all patients who are admitted to the hospital. The nursing documentation triggers the need to record skin condition on admission to hospital. The patient care plans promote the need to monitor and record skin condition, with additional specific plans put in place if a patient develops a pressure ulcer. Analysis of grade 2 and 3 acquired pressure ulcers reveals the following trends:

- Acuity of illness
- Poor peripheral vascular supply to skin (peripheral vascular disease / inotropic drugs)

- Decrease in mobility
- Poor nutritional status – MUST scores not always completed
- Device related (Plaster of Paris/ splints)
- Patient non-compliance and capacity assessment

Investigation process

The Trust continues to implement its planned programed of actions to further reduce pressure ulcers which include:-

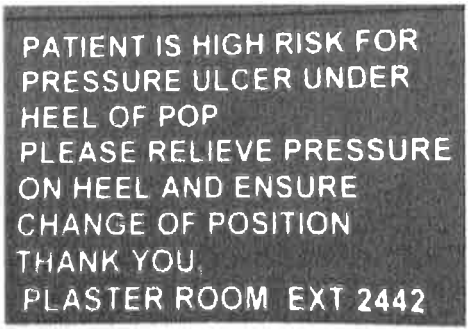
- Root cause analysis is conducted on all Grade 3/4 pressure ulcers which develop within the trust
- As agreed with our commissioners the trust is piloting the 72 hour incident review tool
- Mini investigations of all grade 2 hospital acquired pressure ulcers
- Adult Safeguarding team is now part of the pressure ulcer investigation panel
- A task and finish group led by the Associate Director of Nursing for Scheduled Care focussed on preventing orthopaedic device related pressure ulcers
- Clearer guidance and support around patient non-compliance and capacity
- Bands 1-4 staff will be receiving basic education around nutrition which will include MUST and E-learning is now available
- Standby Phase III mattresses are located on several wards on the Warrington site and in the Porters' Lodge on the Halton site for out of hours use to eliminate delay in obtaining a high risk dynamic mattress
- Repose trolley toppers have been purchased for use on A&E trolleys for high risk patients
- New monthly Pressure Ulcer Prevention training commences January 2015, facilitated by Park House Healthcare.

A task and finish group led by the Associate Director of Nursing for Scheduled Care focussed on preventing orthopaedic device related pressure ulcers. This work has resulted in the **trust eliminating hospital pressure ulcers caused by devices like plaster casts this year with the help of a simple red stripe.**

Pressure ulcers can be caused by plaster casts, splints and other devices when they rub against the skin or when a patient can't be mobile whilst wearing the device for a prolonged period of time. In 2014-2015 the trust saw six cases of severe device-related pressure ulcers so the task and finish group worked on identifying actions to prevent further cases in the future.

One of the key actions has been the addition of a simple red band around all plaster casts worn by patients at greater risk of developing a pressure ulcer.

The simple idea is a visual highlight to staff that extra care needs to be taken with the patient and encourages staff to frequently change the patient's position, encourage them to be mobile and relieve pressure on the cast. This work is supported by the use of



an alert sticker which is placed on the patient notes and indicates a patient at high risk. This will become an electronic alert in Lorenzo.

The red banded cast has been reinforced up by extra training and awareness for staff. The results of the work have meant that there hasn't been a single device related pressure ulcer amongst hospital patients since it was introduced in June last year.

The scheme has also been showcased by senior NHS opinion formers as an idea worth sharing across the health service. It could potentially save hundreds of patients from developing pressure ulcers across the NHS each year.

The initiative has not only made a difference to the quality of care that patients receive, it has also been completely cost neutral for the hospitals. Staff are now sharing their success and ideas with other NHS organisations to spread the best practice developed at Warrington and Halton Hospitals.

It's been part of a programme of work around reducing all pressure ulcers that the hospitals have been prioritising over the last few years.

Progress 2015/2016

Grade 2 Pressure Ulcers

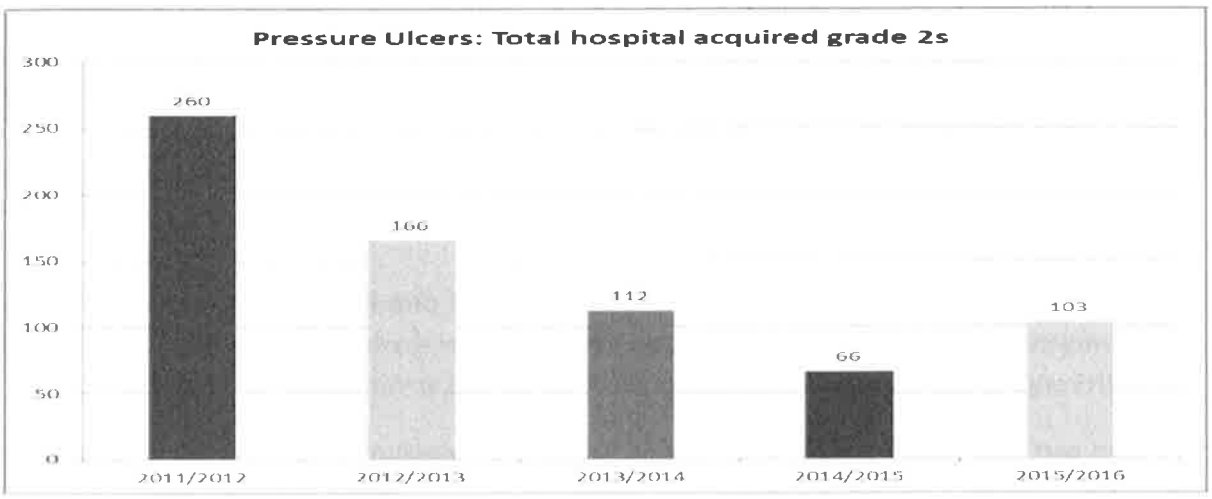
In 2013/2014 we established a 10% reduction for all grade 2 pressure ulcers acquired within the hospital namely a threshold of <=149 pressure ulcers. At year end we reported 112 hospital acquired grade 2 pressure ulcers representing a 24.8% decrease. In 2014/2015 our stated aim was to reduce grade 2 pressure ulcers by 10% equating to = <101 cases with an additional stretch threshold of 20% reduction which equated to =<90 cases. The trust was pleased to report a 41% reduction on the previous year namely 66 cases of this severity and a further 5 cases under review. This represented a 60% decrease in grade 2 pressure ulcers from 2013/2014 to 2014/2015.

		A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	T
GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=63 5%	15	8	6	29	10	6	5	21	13	11	5	29	9	6	9	24	103
GRADE 2 HOSPITAL AVOIDABLE / UNAVOIDABLE (APPROVED)	<=59 10% stretch target	15	8	6	29	10	6	5	21	13	11	5	29	9	6	9	24	103
GRADE 2 HOSPITAL AVOIDABLE / UNAVOIDABLE (UNDER REVIEW)	N/A	0	0	0	0	0	0	0	0	0	0	1	1	1	4	10	15	16

We acknowledged that incidences maybe starting to plateau but remained focused on further reductions by implementing stop the pressure and in depth extended sessions focusing on pressure ulcer grading and reporting including unstageable pressure ulcers, and developing skills in root cause analysis and investigation. As such for 2015/2016 we introduced a threshold of a 5% reduction with a threshold of <=63 and an internal stretch threshold of 10% reduction with a threshold of <=59.

The trust is disappointed to report that despite enormous efforts by staff we have not achieved either threshold but that we are committed to continue this work going forward into 2016/2017.

Pressure Ulcers hospital acquired grade 2: 2011/2012 – 2015/2016

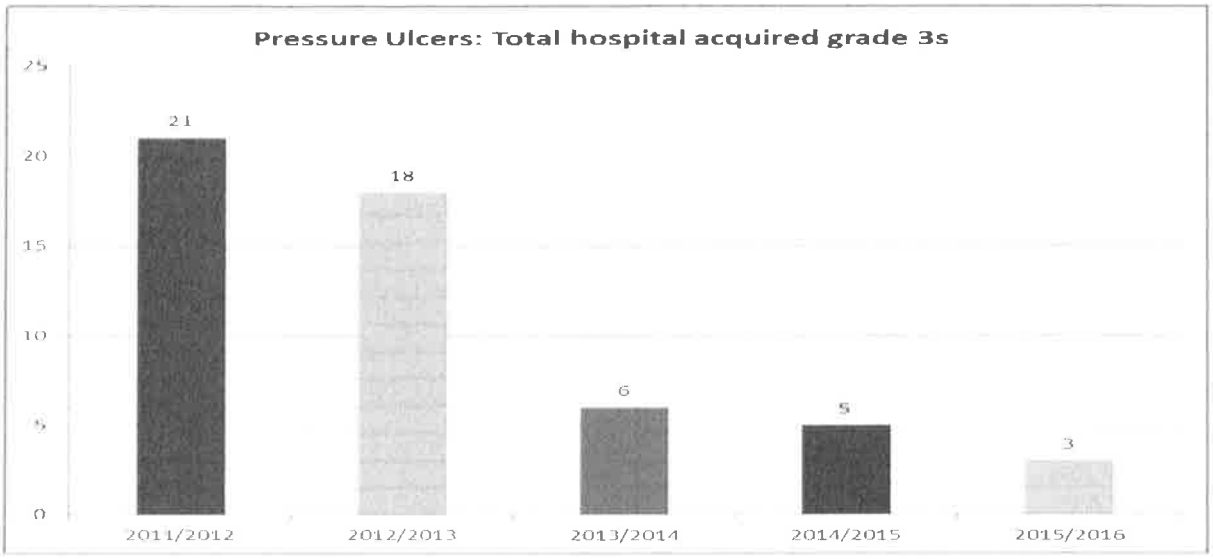


Grade 3 & 4 Pressure Ulcers

In 2013/2014 we established a 10% reduction (threshold 16) for grade 3 & 4 avoidable pressure ulcers acquired within the hospital. By year end we reported 6 confirmed grade 3 avoidable hospital acquired pressures and no grade 4 pressure ulcers which represented a 67% reduction on 2012/2013. In 2014/2015 the trust improvement priority stated that we would maintain or reduce grade 3 and 4 Hospital Acquired (Avoidable) pressure ulcers at the level reported for 2013/2014, this represented <=6 pressure ulcers of this severity. The trust reports for 2014/2015 that 5 confirmed grade 3 avoidable pressure ulcers and no avoidable grade 4 occurred during this period with 1 grade 3 pressure ulcer still under review. In 2015/2016 we again applied a further 10% reduction which equated to a threshold of 5 grade 3 & 4 pressure ulcers. The trust is pleased to report we have met this threshold with no incidences of grade 4 pressure ulcers and a reduction in grade 3 pressure ulcers at 3 confirmed grade 3 pressure ulcers .

		A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	T
GRADE 3 AND 4 HOSPITAL ACQUIRED (AVOIDABLE)	<=5 10% reduction	1	1	1	3	0	0	0	0	0	0	0	0	0	0	0	0	**3**
GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A	0	1	0	1	0	0	0	0	1	0	1	2	0	0	0	0	3
GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2

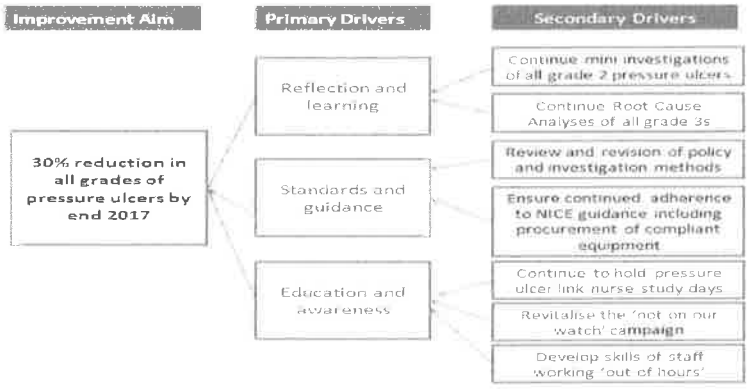
Pressure Ulcers hospital acquired grade 3: 2011/12 – 2015/2016



Avoidable Pressure Ulcer: "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."
Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence"

Sign up to Safety – Pressure Ulcer reduction

During 2014/2015 the trust has also identified pressure ulcers as a Sign up to Safety goal. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. Sign up to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives across the NHS. The driver document articulates the trust's strategy for a 30% reduction in all grades of pressure ulcers by 2017. The trust is pleased to report that it has met this sign up to safety objective for pressure ulcers by the end of year one with a 39.83% reduction in all pressure ulcers.



3.2.3 Nursing Care Indicators – MUST; Waterlow and Falls

The care indicators audit was a process developed as part of the High Quality Care CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. Reports received throughout 2013/2014 showed exceptional compliance with Falls and Waterlow however compliance with MUST despite a temporary improvement failed achieve required levels

The trust identified this as an important barometer of the quality of care and further monitoring as a quality indicator with a threshold established at >=95% for 2014/2015. The results (random sample) from January 2015 indicate that all of the risk assessments have dropped below the threshold and

specifically the reduction in MUST screening to 60% was a concern. In mitigation the Patient Safety Champion moved from 'sampling' patients across 8 wards to sampling all wards.

Risk Assessment Compliance 2013/2015

MONTH	FALLS	WATERLOW	MUST
MARCH 2015	99.3	99.3	93.3
FEBRUARY 2015	100	100	81.8
JANUARY 2015	90	91	60
DECEMBER 2014	99	100	94
NOVEMBER 2014	98	98	83
OCTOBER 2014	99	96	83
SEPTEMBER 2014	98	83	75
AUGUST 2014	98.9	93.3	71.1
JULY 2014	98.8	95.6	81.6
JUNE 2014	95	88.3	60
MAY2014	95	92.7	59.4
APRIL 2014	100	98	57.2
MARCH 2014	100%	98%	57.2%
FEBRUARY 2014	91.1%	90.6%	45.5%
JANUARY 2014	100%	93.3%	68.9%
DECEMBER 2013	93.9%	91.6%	90.60%
NOVEMBER 2013	93.3%	82.2%	60.6%
OCTOBER 2013	93%	88%	73.3%
SEPTEMBER 2013	87%	78.20%	65.9%
AUGUST 2013	92.22%	75.56%	62.22%

The Patient Safety Champion formulated a recovery plan to ensure that all the wards participate in the self-assessment of risk assessments in addition to focussing on completion of the MUST risk assessments which included amending the pressure ulcer RCA tool to identify if the MUST score was correctly completed on admission. The trust continued to monitor this as a quality indicator to board via the quality dashboard for 2015/2016 and can report general improvement but not always to the required threshold.

Risk Assessment Compliance 2015/2016

	APR	MAY	JUNE	Q1	JUL	AUG	SEP	Q2	OCT	NOV	DEC	Q3	JAN	FEB	MAR	Q4
Falls	82%	92%	93%	93%	97%	97%	93%	96%	96%	94%	96%	97%	92%	97%	96%	95%
Waterlow	77%	93%	92%	91%	96%	95%	92%	94%	96%	95%	97%	98%	94%	97%	94%	95%
MUST	78%	85%	89%	85%	91%	80%	87%	86%	90%	88%	93%	92%	93%	92%	91%	92%

Further progress has taken place during 2015/2016 with the development of a new Malnutrition Universal Screening Tool (MUST) e-learning Module. This has been developed to help staff complete this paperwork. This training is relevant for carers on wards and outpatients, and nursing and midwifery staff. The NICE Pathway - Falls in Older People was published in 2015 and recommends:-

- Discontinuing use of the fall risk prediction tools to predict inpatients' risk of falling in hospital
- Regard the following groups of inpatients as being at risk of falling in hospital:
  - all patients aged 65 years or older
  - patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition

Discussions are currently taking place around replacing the current Falls Risk Assessment tool with an outcome based tool which will assess if patients have received the appropriate interventions. During 2016/2017 the trust will focus on compliance with interventions associated with risk assessment to ensure that patients are being managed appropriately.

3.2.4 Falls - Management and Reduction.

The trust has in consultation with stakeholders agreed to include this as an improvement priority for 2015/2016. Please see section 2.1.1.4 Improvement Priorities for 2015/2016 Priority 4.

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

During 2012/2013 the trust targeted improvements on a 10% reduction in medicine errors with a specific focus on reducing insulin related incidents by 5%. By the year end even though it had reduced insulin incidents by 10.5% it was agreed that we should include the development and monitoring of medicine indicators including the safety thermometer as a quality indicator for 2014/2015. The medicines management dashboard was created, and reported via the Medicines Safety Committee. The indicators that are included in the dashboard are medicines reconciliation; discharge prescription turnaround time; outpatient prescription turnaround time; discharge prescriptions reviewed on ward; medication incidents resulting in harm; compliance with the antibiotic formulary; performance against medicines related questions in CQC surveys; medicines related complaints; prescribing audit and the pilot of the medicines safety thermometer.

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

Data can be used as a baseline to direct improvement efforts and then to measure improvement over time. Establishing this data collection is both complex and resource intensive so it was agreed to use quarter one and two for system setup and then begin reporting via the quality dashboard in quarter three. The percentage of medicines safety harm free care was reported on quality dashboard from September 2014 as follows:-

Medication Safety Thermometer - % harm free care 2014/2015

	Threshold	A	M	J	J	A	S	O	N	D	J
Medicines Safety Thermometer % harm free (ST)	TBC	PILOT	PILOT	PILOT	PILOT	PILOT	98.3	99.2	97.4	99.2	98.6

Given the late implementation it was agreed that this would remain as a quality indicator for 2015/2016. The safety thermometer reports indicate a high level of safe care around medication as follows:-

Medication Safety Thermometer - % harm free care 2015/2016

	Threshold	A	M	J	J	A	S	O	N	D	J	F	M
Medicines Safety Thermometer % harm free (ST)	TBC	100%	97.5%	98.1%	100%	100%	98.5%	100%	92.6%	No audit	100%	95.9%	97.6%

It should be noted that there are still some inconsistencies in this tool for example the lower harm free percentage in November was because they assessed ITU who had a number of sedated patients that triggered as harm. However it should be noted that this was the intended outcome for these patients as they were on ITU. The lead contacted Haelo and they advised that they still should be recorded as the harm trigger, however it should be noted that it was not harm as it is the intended treatment.

3.2.6 NPSA 'never events'.

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

- wrong site surgery
- retained instrument post operation
- wrong route administration of chemotherapy

Incidents are considered to be never events if:

- there is evidence that the never event has occurred in the past and is a known source of risk (for example, through reports to the National Reporting and Learning System or other serious incident reporting system)
- there is existing national guidance or safety recommendations, which if followed, would have prevented this type of never event from occurring (for example, for 'Retained foreign object post procedure' the referenced national guidance is related to the peri-operative counting and checking processes that would be expected to occur at the time of the procedure, including suturing after a vaginal birth)
- occurrence of the never event can be easily identified, defined and measured on an ongoing basis.

The threshold for never events is set at zero for contractual purposes and trust is disappointed to report that one never event took place within 2015/2016. A Wrong Site Injection took place on the 8th May 2015. Duty of candour was conducted immediately and documented in the patient's records. The incident was escalated immediately and reported by the Consultant and a Level One Investigation was initiated. Following three meetings at Divisional level an agreement could not be reached, however following a review by the LIO who undertakes medico-legal work, it was confirmed that this should be classified as a Never Event. A number of actions were identified which included:-

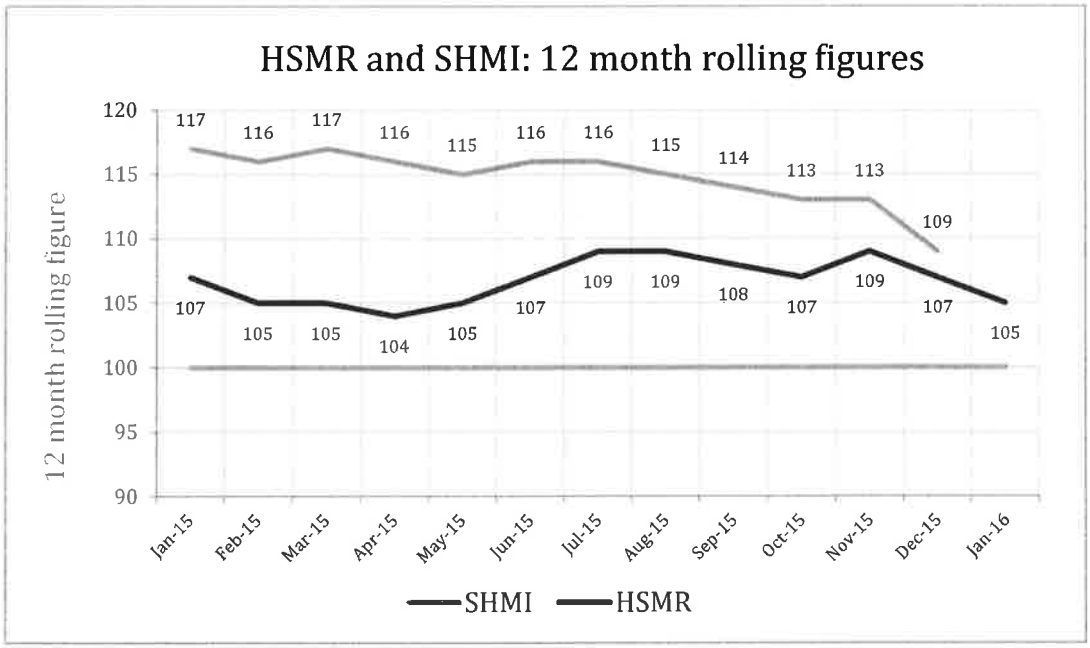
- The surgery list should include a full description of the procedure and desist using the generic term "foot injection"
- The operating surgeon should conduct the WHO checklist. The surgeon should direct the WHO check list; he should state the name of the patient, the operation to be carried out, so that all the team in the room could listen for inconsistencies to planned procedures.
- There should be a process in place for communicating to the whole team any changes made on the day to the original printed list. The changing of the order of patients from the printed surgery list for any reason is a potential risk and needs to be communicated to the team.
- Marked surgical site must be checked as part of the WHO checklist and prior to commencement of the procedure.

The Never Event was signed off as completed on the 4th January 2016.

3.3 Clinical Effectiveness

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

We agreed to continue to monitor and report mortality ratios in 2015/2016 and use the data as an indicator of the quality of care we provide, supporting targeted improvements. The latest published SHMI figure is 114, for the period October 2014 – September 2015. The latest available figures are HSMR 105 for the period February 2015 to January 2016 and SHMI 109 for the period January 2015 to December 2015 (HED system). The chart below shows these rolling 12 month figures since January 2015. The SHMI was in the range of 'higher than expected' until November 2015, however this is now 'as expected' for the period January 2015 – December 2015. The HSMR is 'as expected' throughout this period. Our crude death rates compare favourably with local peer trusts and across the North West.



The Trust has continued its commitment to reducing avoidable mortality. Key developments include:

- Development of pathways such as the Sepsis, Emergency Laparotomy and Acute Kidney Injury Pathways
- Significant progress towards 24/7 service; faster access to senior decision makers and improvements on 7 day cover with key medical specialities such as cardiology and gastroenterology
- Implementation of the revised Individual Plan of Care and support for patient at end-of-life (IPOC)
- Quarterly Mortality Overview Reports presented at Trust Board
- Significant progress towards establishing a high quality and effective mortality peer review process
- Focussed mortality reviews triggered by continual analysis of data e.g. pneumonia
- Valuable collaboration with our CCG partners; in the Mortality Review Group and in reviewing patients' whole pathways of care.
- Development of a North West Mortality Review Network in collaboration with the Advancing Quality Alliance (AQuA)
- Performing well against the recommendations in NHS England's Mortality Governance Guide

- Continuing to develop the relationship between medics and coders, so that they can jointly better understand the impact of how they document and then code this information

We will continue to monitor and report mortality ratios in 2016/2017 and use the data as an indicator of the quality of care we provide, supporting targeted improvements.

3.3.2 Dementia CQUIN

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

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

In 2014/2015 this CQUIN remained a national contractual agreement to ensure that hospitals continued to deliver high quality care to people with dementia. The trust worked hard at implementing the CQUIN and was pleased to report full compliance for 2014/2015.

The trust with stakeholders agreed that we should continue to include dementia CQUIN as a quality indicator for the 2015/2016 Quality Report. As the table reveals our compliance has been somewhat varied from November 2015 which was as a result of data management issues relating to the introduction of Lorenzo. The trust had discussions with our CCGs who accepted that we are experiencing issues with validating data from the new PAS and agreed not to invoke any penalties for under performance on either Part for November and December. Importantly, they accepted our assurances that patients were still being reviewed and assessed as per guidance and that the issue related to data extraction problems. As the table indicates these issues were resolved by January 2016 when the trust was able to evidence compliance as per guidance.

Dementia	A	M	J	J	A	S	O	N	D	J	F	M
Part 1 2013/2014 FIND	90.43	93.14	91.3	92.87	95.12	95.12	95.2	95.13	96.1	97.76	97.36	94.57
Part 1 2014/2015 FIND	94.55	95.69	95.43	94.26	96.59	92.45	92.7	96.61	96.29	96.93	94.81	N/A
Part 1 2015/2016 FIND	96.85	97.62	95.53	96.80	94.86	94.36	92.18	81.30	26.9	90.3	92.78	90.42
Part 2 2013/2014 INVESTIGATE	96.77	100	100	100	100	93.3	100	96.43	96.88	100	100	100
Part 2 2014/2015 INVESTIGATE	100	100	100	100	100	91.89	100	100	97.22	96.77	100	N/A
Part 2 2015/2016 INVESTIGATE	100	100	100	100	100	100	85.71	73	88.9	96.7	97.56	93.85
Part 3 2013/2014 REFER	100	100	100	100	100	100	100	100	100	100	100	100
Part 3 2014/2015 REFER	100	100	100	100	100	100	100	100	100	100	100	N/A
Part 3 2015/2016 REFER	**NB: Responsibility of the CCG to undertake a compliance audit**											

Local CQUIN – Improve the Care of patients with dementia

In 2014/2015 we agreed to implement a local Dementia CQUIN over two years "to improve the care and experience of patients with dementia". In the first year we were successful in establishing an effective foundation for the appropriate management of patients with dementia which offered significant improvements in the quality of care and shorter lengths of stay. This was supported by our successful King's Fund bid under the 'Improving Environment of Care for People with dementia' and the development of the Forget Me Not Unit (FMNU). Since the opening of the Unit we initiated the monitoring of a number of key indicators including falls; pressure ulcers; this is me document and length of stay.

In year two of the CQUIN we have continued to develop this approach by introducing a local stretch target for the National Dementia CQUIN namely to ascertain the % of patients >70yrs (not >75yrs - National) who receive the (FAIRI) assessment. A new dementia dashboard has been constructed which is reviewed by the Patient Experience Sub Committee on a monthly basis.

NOV/DEC 2015

Dementia Dashboard 2015/16

Warrington and Halton Hospitals NHS Foundation Trust

Improvement in the care and experience of patients with dementia. This is Part 2 of a 2 year CQUIN. Introduction - Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with Dementia, their length of stay is longer than peop without dementia and they are vulnerable to experiencing harm during their stay. We have worked toward setting an effective foundation for appropriate management of patients allowing significant improvements in the quality of care and substantial savings in terms of sh lengths of stay. This effective foundation is further supported by the successful King's Fund bid under the "Improving Environment of Care for People with Dementia" to refurbish ward B12. We wish to consolidate the work undertaken in 2014/15 to improve patient care and treatment and the support and advice offered to carers of patients where there is a diagnosis of dementia and we wish to measure the following -

Lead	Target or Indicator		Target	Data collection	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
SK	GENERIC	STAFF TRAINING	Baseline 27% Q2-42%	Elearning Level D				27%	33.52%	32.22%		41.99%	44.50%			50.00%	49.61%			
DC		SUPPORTING CARERS	None set	Postal / Telephone					19.40%	18.40%	18.75%		B12survey	B12survey	B12 survey		B12 survey			
	Admission – The admission process was managed effectively to enhance the patient's experience.																			
DC	COMPLETED "THIS IS ME" DOCUMENT	Patients >65yrs and those listed on the FMN list who have a completed "this is me" document stored within their health records	80% by Q3	Built into LORENZO					86%	86%			91%		90%		100%	100%		
DC		Patients diagnosed with dementia >65yrs and those not on the FMN list who have a completed "this is me" document stored within their health records	80% by Q4	Built into LORENZO																
DC	DEMENTIA AND DELIRIUM - FIND, ASSESS, INVESTIGATE, REFER AND INFORM (FAIR) National CQUIN	FAIR - Finc. Patients aged >=75 years to whom finding is applied following an unplanned admission	90%	BIS	97%	98%	96%	97%	97%	95%	94%		92%	82%	26%					
DC		FAIR - Asses Patients aged >=75 years to whom finding is applied following an unplanned admission	90%	BIS	100%	100%		100%	100%	100%	96%		100%	100%	89%					
DC	DEMENTIA AND DELIRIUM - FIND, ASSESS, INVESTIGATE, REFER AND INFORM (FAIR) Local (stretch) CQUIN	FAIR - Finc. Patients aged >=70 years to whom finding is applied following an unplanned admission	SET BASELINE	BIS					92%	92%	90%		90%	82%	26%					
DC		FAIR - Asses Patients aged >=70 years to whom finding is applied following an unplanned admission	SET BASELINE	BIS					100%	95%	100%			100%	89%					
DC	ADMISSION TO THE FMN UNIT	Patients admitted to unit who do not meet the admission criteria	NUMBER ONLY	MANUAL					0	0			0		1		0	0		
DC		Patients discharged from Trust who were listed for, but never admitted to, the FMN unit	NUMBER ONLY	MANUAL											9		5	3		
DHa	"PARTNER IN CARE" OFFERED	In line with DoH request we will work with patients and their families to introduce a formal "Partners in Care" agreement for patients nursed on FMN unit	MOVEMENT IN NUMBERS	INCLUDE IN THIS IS ME	ONGOING DEVELOPMENT															
	Target or Indicator		Target	Data Collection	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
	Treatment - High Quality, Safe Healthcare was delivered																			
DHa	PATIENT HARMS FMN UNIT	ALL FALLS (APPROVED)	TBA	DATIX	10	12	4	26	12	10	5	27			10		7	2		
		FALLS PER 1000 BED DAYS	TBA	DATIX																
DHa		MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	TBA	DATIX	0	0	0	0	0	0	0	0			1		0	0		
DHa		MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)		DATIX	0	0	0	0	0	0	1	1			0		1	0		
DHa		GRADE 2 PU- HOSPITAL ACQUIRED AVOIDABLE AND UNAVOIDABLE (APPROVED)	SUSTAIN 0%	DATIX	0	0	0	0	0	0	0	0			1		1	0		
DHa		GRADE 3 AND 4 PU- HOSPITAL ACQUIRED (AVOIDABLE)	SUSTAIN 0%	DATIX	0	0	0	0	0	0	0	0			0		0	0		
DHa		GRADE 3 AND 4 PU- HOSPITAL ACQUIRED (UNAVOIDABLE)	SUSTAIN 0%	DATIX	0	0	0	0	0	0	0	0			0		0	0		
DHa		GRADE 3 AND 4 PU-HOSPITAL ACQUIRED (UNDER REVIEW)	SUSTAIN 0%	DATIX	0	0	0	0	0	0	0	0			0		0	0		
DC	LENGTH OF STAY	LENGTH OF STAY OF PATIENTS IN HOSPITAL PRIOR TO ADMISSION ONTO FMN													9.5 days		8.9	0		
DHa	LENGTH OF STAY	REDUCTION IN AVERAGE LENGTH OF STAY OF PATIENTS NURSED ON FMN UNIT	SUSTAIN 0%	DATIX											unavailable		30 days	21.1		
DHa	READMISSION TO FMN	READMISSION TO FMN WITHIN 7 DAYS																		
	Discharge - Patients discharge or end of life plan is managed to ensure all their needs and the needs of their family are met																			
DC	DEMENTIA AND DELIRIUM - FIND, ASSESS, INVESTIGATE, REFER AND INFORM (FAIR) National CQUIN	The proportion of those assessed and referred for further diagnostic advice who have a written care plan on discharge which is shared with GP. National CQUIN >=75 years	90%	SG							100%		100%	100%	89%					
DC		The proportion of those assessed and referred for further diagnostic advice who have a written care plan on discharge which is shared with GP. local CQUIN >=70 years	SET BASELINE	IN							100%		100%	100%	89%					
LV	PALLIATIVE CARE	% Patients appropriately placed on Amber Pathway	TBA	6 monthly Case note review													1%	0%		
LV		% Patients appropriately receiving an end of life care	TBA	6 monthly Case note review											2%		1%	1%		

There has been significant progress within year with the team being shortlisted for the Alzheimer's Society Awards, the appointment of Cognitive Assessment Nurses and future appointment of an activities coordinator. Carer feedback is integral to service improvement and unfortunately the trust had a poor response rate with postal questionnaire as such it has been trialling a telephone carer feedback service which has increased the number of responses. Action plans have been formulated with lessons learned highlighted. Dementia awareness training is now mandatory for all staff and includes an e-learning module for clinical staff coupled with a training leaflet for non clinical staff. By the end of quarter three 50% of staff had completed the training. The Forget me Not Group is currently looking at developing a dementia training needs analysis for staff in the trust.

The Dementia Biannual Report including the dementia dashboard and carer feedback has been completed and submitted to Patient Experience Sub Committee and Board in October 2015 and April 2016.

3.3.2.1 Warrington and Halton Hospitals NHS Trust - Dementia Strategy

At Warrington and Halton Hospitals our staff are dedicated to providing the best possible care for patients with Dementia, our Strategy sets out the framework by which we will achieve this with ten key areas identified which are underpinned by action plans monitored by the Dementia Steering Group.

During 2015/2016 the trust celebrated one year anniversary of the opening of the Forget me Not Ward the trust's new £1 million dementia ward which is leading the way in dementia care after the trust became a beneficiary of monies from the Department of Health in a push to improve dementia care environments. Actress Sally Lindsay of Coronation Street, Mount Pleasant and recent Warrington based Ordinary Lies fame, joined us on the Forget Me Not unit as we celebrated our first anniversary since opening. Sally is an ambassador for the Alzheimer's Society and spent time with patients, visitors and staff whilst with us.

The unit has helped us transform how we care for patients, reducing length of stay, falls and other incidents amongst this vulnerable group of patients. Our campaign continues to spread at pace, and we are regular hosts to visitors from other trusts and organisations who are in the early stages of developing their units and strategies and wish to learn from us – it is great to know that *We Are What Good Looks Like* for other organisations.

The unit is only one part of the work we do around dementia, we also showcased the services that our estates, therapies, nursing, training and Knowledge and Evidence Service teams perform in supporting high quality dementia care.

Dementia Champions

Our dementia champions include trained non-clinical and clinical staff in place at ward and department levels who have received additional training. We have an identified senior medical and senior nursing lead for dementia within the trust. A dementia champion is in place in almost every clinical area. The ward/department based champions come together regularly to gain up to date knowledge and skills in relation to patients with dementia in our hospital which they then cascade to staff in their own clinical area.

Dementia Information

A dementia information leaflet has been produced for patients and their families. Warrington and Halton hospitals recognise the vital role that family members and unpaid carers have as 'experts' in the care of their loved one. We are committed to improving how we work with and support carers to create a care partnership between the person with dementia, their family and Professionals. . The booklet provides information about what patients and carers can expect from the staff here at Warrington and Halton Hospitals Trust with suggested websites and contact details of organisations which can provide more detailed information and support. The booklet also contains a carer feedback survey to assist us with improvements in the care and experience of people with dementia.

The clinical librarian continues to produce the dementia current awareness bulletin on a monthly basis. This bulletin includes recent evidence based research within the dementia community and is disseminated to staff via e mail.

Many wards continue to have dementia information boards within the ward area. The information board contains contact general information for patients and their families together with contact details for voluntary and support agencies and information regarding new services such as the dementia legal service which has recently set up in the local area.

Dementia Training

To determine that appropriate Dementia training is available to staff through locally determined training programme.

We provide the Commissioners with quarterly reports to provide assurance that:

- Numbers of staff who have completed the training are improving each quarter;
- We regularly review overall percentage of staff training.

Dementia Awareness training is now a requirement for **all** staff and the training can be completed via e-learning by accessing the e-Dementia: Introduction to Dementia (Learning Certification). This course is a nationally agreed e-learning tool which provides an introduction to dementia and guidance on supporting those living with dementia, along with their carers. The training enables staff to :-

- Describe dementia, its effect on the brain, and its common signs and symptoms
- Identify some of the complex difficulties experienced by people with dementia
- Challenge some of the common myths and negative attitudes about dementia
- Identify ways of communicating effectively with someone with dementia
- Describe the importance of living well with dementia and how the HCP can facilitate this
- Discuss other sources of support for those with dementia and their carers
- Outline the elements of best quality practice in caring for the individual with dementia, to include end-of-life care

Current results demonstrate >57% compliance with dementia awareness training.

Personalised Care Planning

Our new nursing care booklet includes individual patient assessment relating to the following

- Privacy and dignity
- Nutrition and hydration
- Pain assessment and control
- Communication
- Continence
- Carer and family involvement

The Specialist Nurse for Older People produced a suite of care plans for patients with dementia, delirium or cognitive impairment launched in November 2014, we continue to monitor compliance with these on a regular basis.

Dementia Conference November 2015

We were proud to host our second dementia conference in November 2015. Trust staff, expert national speakers, patients and carers met to learn and share best practice and hear the impact that high quality, compassionate staff interaction has on patients and families. This included clinicians who specialise in dementia care; people living with dementia who have experienced positive and negative hospital care and their recommendations for improving the hospital experience and campaigners for rights of carers of people with dementia and how hospitals can achieve a carer aware workforce. Once again the feedback was positive with delegates stating that the event was "informative and well presented" and that "it was excellent that you included people with dementia and their carers"

Dementia Education Conference April 2015

We hosted our first ever dementia education conference in April 2015. Delegates included trust staff who were joined by expert regional speakers, patients and carers to learn and share best practice and to hear the impact that high quality, compassionate staff interaction has on patients and families.

Dementia Awareness Week

May 2015 saw Dementia Awareness Week take place nationally and we were delighted to take the opportunity to showcase the fantastic work that we have done at the hospitals to improve acute care for patients who have dementia. Representatives from our local Flagship Dementia Friendly School St Gregory's, Halton & Warrington Carers Association, Dementia Alliance, Alzheimer's Society and the Red Cross joined trust staff in promoting the work of the organisation and the agencies that support patients with dementia and their families.

Staff and visitors to the stand were invited to pledge to "Do something new" to help raise awareness and offer support to people with Dementia and their families.

Patient Experience

We have introduced a 'carers card' to the Trust which is offered to all main carers of patients with memory problems to facilitate unrestricted visiting and if appropriate to support in the delivery of care as recommended in our dementia guidance. This and other 'carer aware' initiatives have established the Trusts involvement with a national campaign called 'Johns List' which is a campaign for the right of people with dementia to be supported by their carers in hospital.

Warrington and Halton Hospitals NHS

Carers are welcome Here!

If you are the main carer for a person in the ward who has memory problems please let the staff know who you are and request a Carers Card to enable you to visit outside of hospital visiting hours.

The Observer newspaper supports John's Campaign and has established a dedicated page on the Guardian website which will lists all the hospitals in the UK where carers are welcome, WHHFT is included in the first 100 trusts on this list and the founders of the campaign have agreed to speak at our forthcoming dementia conference.

Enhancing the Healing Environment

We continue to arrange social sessions for the patients on the Forget me not ward and have secured permanent funding for the activities coordinator role. This enables us to provide meaningful activity and occupation for the patients. Providing a sense of achievement and pleasure through person-centred activities can help the person maintain their skills and feel better about themselves and we know that boredom and frustration are common causes of challenging behaviour. This care approach is part of our 'toolbox' of strategies to manage 'challenging behaviour' in a non-pharmacological way as recommended by best practice in NICE guidance.

The trust was delighted to receive a visit from Chris Hopson CEO of NHS Providers to the Forget me Not and STAR wards. NHS Providers helps Foundation Trust's to deliver high quality, patient focused, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

Chris Hopson CEO of NHS Providers visits the Forget Me Not Unit in March 2016

3.3.3 Compliance with regional targets set for Advancing Quality – reducing variation

The table below provides a summary of the trust performance from AQuA which shows compliance with the CQUIN target for this period (October 2008 – present).

Warrington & Halton NHS Trust - Advancing Quality Data*

YEAR	Heart Attack	Heart Failure	Hip & Knee Surgery	Pneumonia	Stroke
Year 1	96%	47%	68%	61%	NRC
Year 2	98%	76%	76%	61%	NRC
Year 3	98%	78%	90%	67%	NRC
Year 4	98%	89%	97%	68%	63%
Year 5	99%	89%	97%	73%	57%
Year 6	97%	84%	96%	72%	55%
Year 7	98%	82%	98%	74%	51%
Year 8	97%	80%	99%	78%	NOT AVAILABLE

- **NRC – No results collected and limited results for new measures so not recorded**
- *** Published on the AQuA's website (refreshed)**

AQUA monitor the quality of services delivered at hospitals through a programme called Advancing Quality. It aims to make sure every patient admitted to a North West hospital is given the same high standard of care no matter which hospital they attend. Each hospital is measured against how many of their patients get the appropriate care they need for the best outcome from their surgery

AQ is also a local CQUIN for the trust and we are performance managed for each agreed condition Pneumonia; Heart Failure and Acute Myocardial Infarction; in order to demonstrate an annual improvement against the targets. The Advancing Quality Group meet on a monthly basis to discuss performance and to provide assurance that all clinical areas are reviewed and ensure appropriate monitoring mechanisms are in place.

During 2015/2016 additional AQ measures were included, including Chronic obstructive pulmonary disease (COPD); Hip Fracture; Sepsis; Hip and Knee; Acute Kidney Injury; Diabetes and Alcoholic Liver Disease.

The trust is pleased to report that it was rated as best performing trust in the North West for providing hip and knee replacement surgery. The North West's health care quality improvement body - AQUA - has scored the trust's services provided at The Cheshire and Merseyside Treatment Centre at Runcorn's Halton General Hospital and at Warrington Hospital as the highest rated against their measures out of 20 hospitals across the region.

Warrington and Halton's hip and knee replacement surgery team scored 97.7% against the measures. They include giving appropriate antibiotics to prevent infection for the right time before and after surgery and providing blood thinning medication to reduce the risk of blood clots developing. Every patient who has a hip and knee replacement has their care monitored and reported through the Advancing Quality programme.

Target or Indicator	Threshold	April	May	June	July	August	September	October	November	December
ACUTE MYOCARDIAL INFARCTION	>=95%	93.18%	94.94%	96.83%	97.16%	97.14%	97.01%	97.31%	96.30%	95.71%
HEART FAILURE	>=84.1%	72.22%	73.17%	75.44%	78.85%	81.15%	82.89%	83.24%	82.32%	81.86%
PNEUMONIA	>=78.1%	80.00%	78.83%	78.65%	78.65%	78.08%	78.47%	77.11%	76.59%	75.53%

"This award from Advancing Quality is a testament to the hard working team. We have a wonderful purpose built unit for orthopaedic care and this award encourages us to continue to provide excellence in care and experience to our local patients."

3.3.4 High level quality care at End of Life.

The trust has in consultation with stakeholders agreed to include this as an improvement priority for 2015/2016. Please see section 2.1.1.3 Improvement Priorities for 2015/2016 Priority 3.

3.4 Patient Experience

Following the publication of the Francis report there is heightened awareness and concern about the experience that patients have in healthcare settings.

The trust supports the ideology that it needs to collect information; be open and transparent about the experience of patients within its care and that information about patient experience should be publically available. Ensuring that people have a positive experience of care is also a key objective within the NHS Outcomes Framework. This trust supports the view that patient experience is as equally important as the other elements of the quality agenda namely clinical effectiveness and patient safety, and that that it should be embedded across our work to improve quality outcomes.

"There is clear evidence that where patients are engaged in their own care and have a good experience of care and treatment, clinical outcomes are better" (NHS England, 2014).

In addition to the development of a Patient Experience Strategy which was established as an improvement priority for this year – section 2.1.1.1, the trust is committed to improving patient experience through implementing and monitoring patient experience indicators as set out in the Quality Report for 2014/2015.

Patient experience indicators for 2015/2016 include:

- Complaints
- Friends and Family Test – inpatients; accident and emergency and maternity services.
- Develop and monitor 'always events', i.e. what must we always do for patients to ensure a quality experience.
- Continue to monitor mixed sex occurrences
- Improvements demonstrated in our In-patient Survey

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

The trust participates in all relevant national surveys, and has a number of local approaches to evaluating the patient experience. Importantly, it continues to build its skills and tools to enable it to collect and analyse different sources of feedback from complaints, patient stories, PALS and local surveys in order to identify key issues that need to be addressed and then put in place improvement plans that deliver an improved experience.

More recently the trust has also developed a suite of patient experience indicators which will allow us to monitor performance on a monthly basis in key areas for example collecting data on the rate of negative comments posted on patient opinion; NHS Choices and/or the CQC Experience Form.

The evidence also demonstrates that "where there are high levels of co-worker support; good job satisfaction, good organisational climate, perceived organisational support, low emotional exhaustion and supervisor support, there are links to good patient-reported experience.

As well as encouraging staff feedback through national and local surveys we support processes to enhance staff wellbeing.

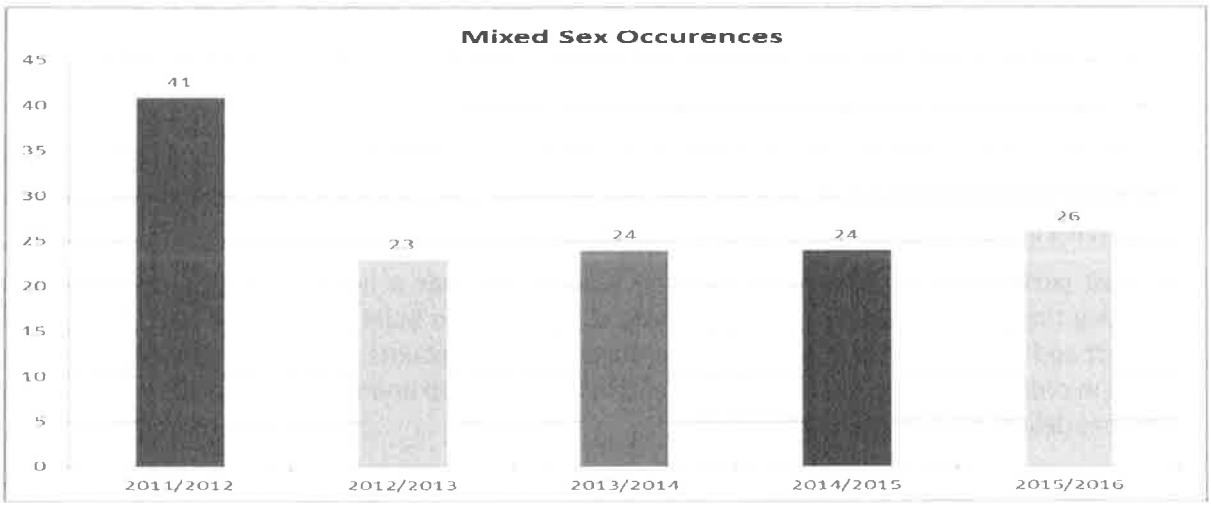
The planned Friends & Family Test which began in 2014 (section 3.4.6) and the staff survey results (section 3.4.4) also provide a barometer of staff experience. We also ensure that staff feedback around the quality of the patient care provided in our organisations is publicly available through, for example Open and Honest, which is available at:
http://www.warringtonandhaltonhospitals.nhs.uk/page.asp?fldArea=1&fldMenu=8&fldSubMenu=7&fldKey=1241
The following section provides an appraisal of progress against the patient experience key priorities.

3.4.1. Eliminating Mixed Sex Accommodation.

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

In 2012/2013 the trust threshold was for full compliance with no reported breaches however, whilst we reported 23 mixed sex occurrence breaches, this was a 44% reduction on 2011/12 when the trust had 41 breaches. For 2013/2014 the trust again established a zero tolerance threshold and it was on target to meet this objective until September 2013. In 2013/2014 the trust can report that following a review as described above that there were no reported breaches for February and March 2014 and a total of 24 breaches by year end. In 2014/2015 the trust was disappointed to report that there were 24 breaches by year end. The trust continued to focus on this quality measure as a patient experience indicator and can report that despite enormous efforts there has been a slight increase with 26 breaches reported for 2015/2016. We reported 10 breaches in March all of which occurred during periods of increased activity and high escalation of beds. Please see graph below for the five year comparison.

Mixed Sex Occurrences – 2011/2012 – 2015/2016



3.4.2. Always Events

In addition to the agreed improvement priorities the trust board in partnership with staff and governors also agreed to focus upon a number of key issues around quality improvement which included the development of "always events."

Always events are aspects of patient care that should always happen for patients to ensure a quality experience. The trust held a number of focus groups including a local healthcare event "Get Engaged" with patients; staff and governors to agree a small number of always events which we developed, piloted and monitored throughout 2014/2015.

It is vital that Always Events are measurable and can be implemented and monitored within current resources/budgets. Some suggestions, while they would demonstrate excellent quality of care, could not be easily introduced or monitored. A process of distillation left us with the following Always Events. We then used the first six months of 2014/2015 to plan implementation and ensure that there was an audit trail inherent in the system. We began monitoring the Always Events in

October 2014 via the Dawes Ward Assessment process and reported them as a quality indicator in the Quality Dashboard through to board.

The Always Events are:

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

The pilot results were very positive and apart from October 2014 when we achieved 84% compliance results to the end of 2014/2015 evidenced 100% compliance. The trust continued to monitor the always events as a quality indicator for 2015/2016 as follows:-

J		A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M
ALWAYS EVENTS	100%	89%	90%	92%	90%	96%	96%	88%	93%	94%	96%	96%	95%	97%	87%	97%

3.4.3 Complaints

In accordance with the *NHS Complaints Regulations* (2009), the Complaints Report(s) annual and quarterly set out a detailed analysis of the nature and number of formal complaints. They also offers feedback from other sources, compliments, NHS Choices and PALS to provide a more rounded picture of the nature of feedback and to emphasise good and bad, with an emphasis on how clinicians and managers are supported by this intelligence in planning service improvement and to celebrate that which is positive and applauded.

Whilst the processes in place to support handling of formal complaints are more robust than in previous years, there remains scope and the will to make improvements and to enhance the performance of the trust in this area.

The policy has been updated and the main changes are:

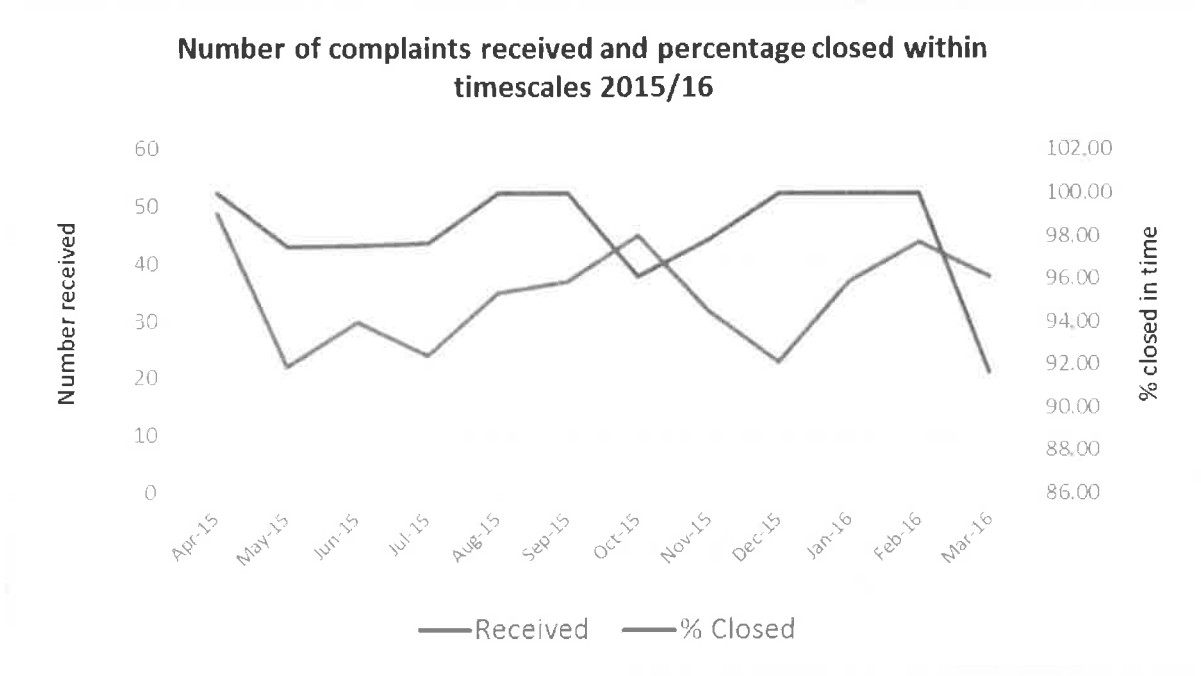
- One timescale of 30 days for all complaints.
- All high risk graded complaints must be subject to a 72 hour review by the receiving CBU/division in order to direct actions taken.

This issue will be re-visited and updated as part of the Complaints Annual Report presented to board in May 2016 and available on request from Patient.ExperienceTeam@whh.nhs.uk

With the organisational reorganisation and setting up of the new clinical business units, the complaints handling process must be adapted to serve these new arrangements. In addition, new timescales have been agreed for closing complaints and the CBU will be held to account for failure to meet these. The corporate organisation of complaints will be subject to changes to facilitate this.

The graph below shows the number of formal complaints received by the trust on a monthly basis and compares this against the number of complaints closed within agreed timescales.

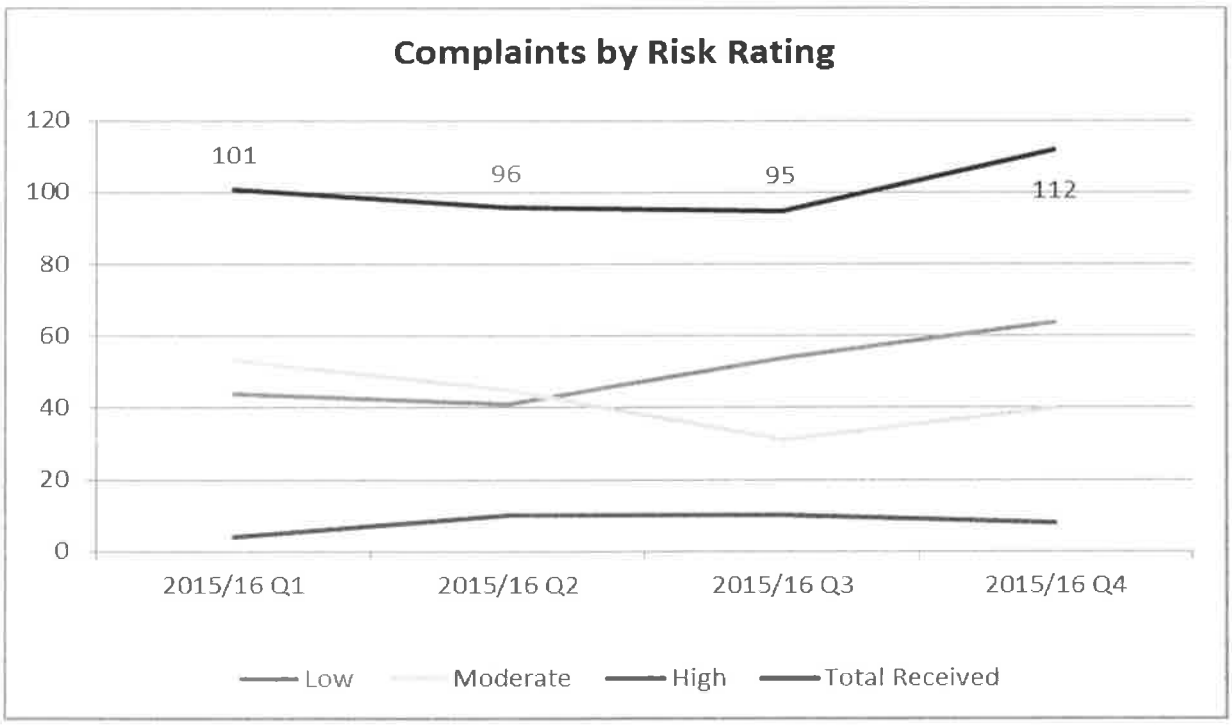
The trust has a contractual target of 94% complaints closed within agreed timescales each month and failure to achieve this has both a negative impact on the complainant and their perception of the trust as well as potentially incurring a financial penalty on the trust.



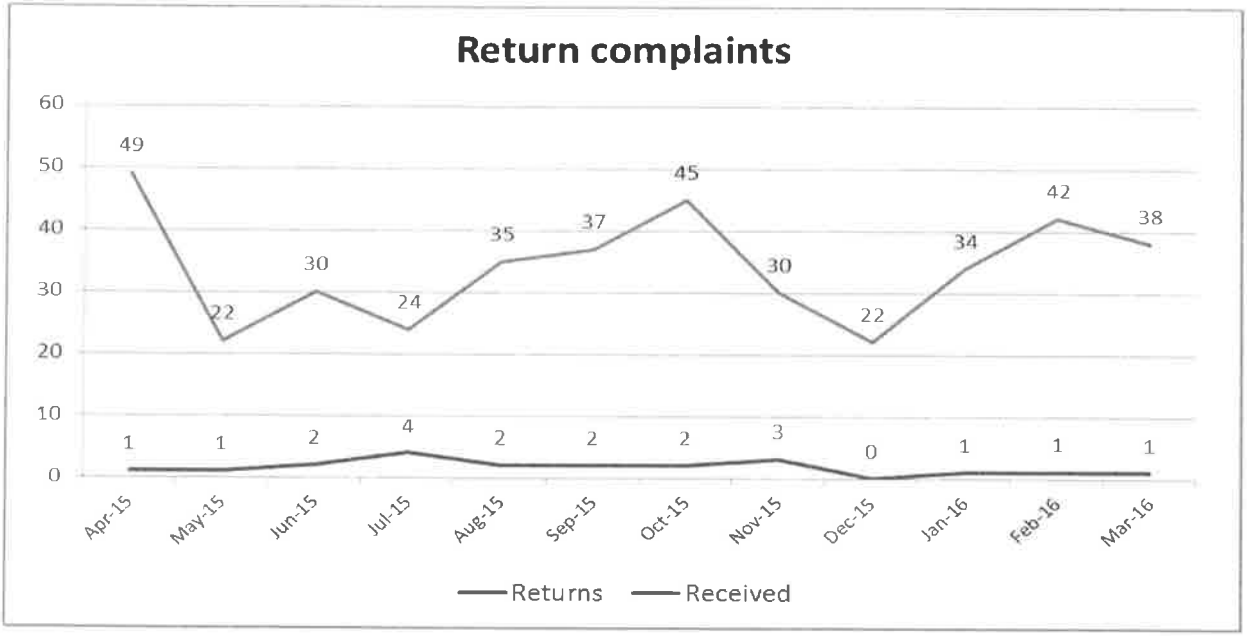
It has been agreed that the trust will initially offer a thirty day timescale on all complaints, regardless of the severity or complexity of the complaint. The CBU will be responsible for completing their response within twenty-five working days in order that a final draft can be quality checked and signed by the Chief Executive and sent within the thirty days. This will be monitored at the bi-lateral meetings.

A complainant may decide to withdraw a formal complaint and this is then reassigned as a concern, during 2015/16 the trust recorded 166 concerns compared to 96 concerns in the previous year. The rise in this number can be attributed to the increased number of concerns raised by the new parking system and problems associated with appointments in the wake of Lorenzo implementation.

Overall Complaints by risk level 2015/2016



Complainants may come back to the trust following receipt of their final response. We call these returns.



All formal complaints were received in the English language with no requests made by a complainant (or enquirers) for the use of the trust Interpreter Service. Within year there is no record of any complaints made by, or on behalf of, people with any disability.

3.4.3.1 Lessons Learned

The following table provides examples of closed complaints and actions taken by the divisions who are responsible for implementing and monitoring lessons learned. Each division has specific systems in place to feedback learning from complaints, firstly during/after the investigations and then through divisional groups, e.g. Divisional Integrated Governance Groups (DIGG, senior nurse/ward manager meetings.

Description of Complaint	Actions	Learning
Scheduled Care: Patient complained that he waited seven hours to go to theatre for his orthopaedic surgery. He wanted to know why he could not have come in at lunch time and not have to fast all day.	Investigated by T&O Matron (Halton). It is routine practice to ask all patients to come in early morning, so that medical/theatre staff can decide the list order the day prior. Matron apologised, saying that this should have been explained to the patient. Action: Day case unit nurse in charge will review next day's list to try to stagger arrival times of patients.	Staff asked to reflect on poor communication and to ensure any patient who can eat and drink is offered refreshment.
Scheduled Care: Wife of deceased patient was unhappy with communication prior to her husband's death in ICU. Despite his asking to be told no details of his prognosis, staff continued to update the patient. Patient's wife felt that there was no compassion and his wishes were	Apologies were made as it was acknowledged that staff did not adhere to patient's desire not to be informed of his clinical prognosis.	Matrons for ICU and the medical ward where the patient was transferred, are conducting a review on how patient's wishes are communicated to clinical teams and identify best practice. This will be shared with clinical teams.

not respected.		
Unscheduled Care: A patient attending at weekend for a cardio-respiratory appointment. The reception being unattended, he waited to be told the doctor was not yet arrived and running late. In the stuffy waiting area, the patient became unwell and collapsed. He eventually left a note and went home.	Since this complaint, a call bell has been made available in the department. Patients can attract the attention of the cardiology technicians and get a prompt response.	Since there are no reception staff out of hours, the team have realised that the nature of the clinic means that the patients might need support and attention while waiting to be seen.
Unscheduled Care: Complainant is unhappy that his sister did not have any fluids for 7 hours and no tube feeds for three days while in hospital.	The guideline for enteral nutrition support in adults (which details the emergency feeding regime) has been uploaded onto the hub. Ward Manager will educate staff members via 1:1 by showing them how to find this information	There is learning for the nursing team who had difficulty accessing the emergency feeding regime on the hospital intranet and contacting colleagues did not result in support and advice.
WCSS: Complainant is unhappy with the care received from a midwife and not being given adequate pain relief following her caesarean section. Patient also had concerns about pain relief on post-natal ward.	Matron investigated the complaint and found that the patient did wait over four hours for analgesia. Matron apologised for this unacceptable delay. Matron found that pain relief could have been improved on post-natal ward. Action: Feedback to all ward staff about the experience the patient had due to ineffective pain relief. A meeting was offered to the patient to discuss her concerns further and discuss actions taken.	Concerns raised with midwife on duty who was asked to reflect on both the delay in analgesia and her "dismissive" attitude toward the patient.
WCSS: Patient was unhappy that her gynaecology operation was cancelled the first time. When she returned she was prepared for surgery only to be told that it had to be cancelled due to her sleep apnoea. Patient lost two day's pay and wanted reimbursing.	Investigated by consultant gynaecologist who apologised for the distress and inconvenience caused. The patient had reminded staff about her condition and it was recorded in the notes. Action: Discussion held with the sister for the oversight who confirmed that the patient should have been reviewed by an anaesthetist to assess if she were suitable for a Halton admission.	The member of staff reflected on this incident and will ensure that she double checks the self-assessment checklist before booking patients in future.

3.4.3.2 Parliamentary and Health Service Ombudsman (PHSO)

The PHSO is a free and independent service, set up by Parliament. Their role is to investigate complaints were individuals feel they have been unfairly treated or have received poor service from government departments; other public organisations and the NHS in England. The PHSO make the final decisions on complaints about these public services for individuals.

Date complaint closed by trust	Outcome WHH	Date PHSO contacted trust/decided to investigate	Current status of case 2015/16	Outcome PHSO
02/10/12	Not upheld	22/03/16	Decision to investigate	Pending
09/01/13	Not upheld	01/04/15	Closed	Not upheld.
10/04/13	Not upheld	23/07/14	Closed 29/05/15	Not upheld
24/07/13	Partly upheld	13/01/14	Closed 23/11/15	The trust contested the original finding and recommendations of the PHSO and sought legal advice. This was a lengthy process of two reports/advisors on behalf of the PHSO and an external report on behalf of the trust. Copies of all the documentation, including action plans went to PHSO, CQC, Monitor and the Trust Development Authority
20/09/13	Partly upheld	01/09/14	Closed 08/07/15	Partly upheld. Action plan includes improvements in avoiding delays in establishing dates for surgery. Provided information about improvements made in complaints and apologised to the complainant.
25/09/13	Partly upheld	23/06/14	Not closed at year end	Partly upheld. Failings were identified in not continuing with antibiotic therapy after discharge and ensuring an early angiogram and an action plan was implemented. Apologies made to the complainant. The action plan was also shared with CQC and monitor.
17/10/13	Partly upheld	21/01/15	Closed	Partly upheld. PHSO found failings in care in not consistently monitoring observations. Action plan completed and apology made to complainant. The complainant also sent his concerns to the Cheshire Constabulary, who reviewed the case, no action was taken.
31/10/13	Not upheld	10/03/14	Closed 15/06/15	Action plan was completed to address issues identified with waiting list and RTT processes. Compliance with Patient Access Policy was monitored and included in local induction.

Date complaint closed by trust	Outcome WHH	Date PHSO contacted trust/decided to investigate	Current status of case 2015/16	Outcome PHSO
13/12/13	Partly upheld	27/04/15	Partly upheld	Partly upheld with regard to complaint handling. The original complaint letter was addressed to women's health in July 2013, but was not received by PET until September 2013. There was also a delay in responding in agreed timescale and no one had contacted the patient to explain this. An action plan and letter of apology sent.
21/01/14	Not upheld	08/01/15	Closed 10/06/15	Partly upheld. Pathway reviewed and concerns from communication issues used for learning. Apologies made to patient.
05/03/14	Not upheld	13/08/15	Closed	Not upheld
18/06/14	Not upheld	24/07/14	Closed 01/06/15	Not upheld
30/06/14	Partly upheld	11/09/14	Decision to investigate	Pending
23/07/14	Partly upheld	18/09/15	Investigation	Pending
09/09/14	Not upheld	27/05/15	Closed 25/01/16	The PHSO investigated the complaint and though they did not uphold any of the concerns regarding care and treatment, they partly upheld the case because of poor complaint handling. This was because the investigator reported an incorrect time that CT scan had been done. The trust apologised to the complainant for the distress this caused.
09/03/15	Partly upheld	02/06/15	Not closed at year end	The PHSO investigated and partly upheld the complaint on concerns about nutritional assessment and failure to extend visiting hours for the family. Recommendations were made and these have been implemented. The trust apologised to the complainant and explained what actions had been taken
27/04/15	Upheld	04/02/16	Decision to investigate	Pending
22/07/15	Partly upheld	22/09/15	Investigation	Pending

Date complaint closed by trust	Outcome WHH	Date PHSO contacted trust/decided to investigate	Current status of case 2015/16	Outcome PHSO
12/06/15	Partly upheld	06/11/15	Decision to investigate	Pending
12/06/15	Not upheld	28/10/15	Closed 19/02/16	Not upheld
09/09/15	Not upheld	03/11/15	Decision to investigate	Pending
01/10/15	Not upheld	19/01/16	Investigation	Pending
04/11/15	Upheld	11/03/16	Decision to investigate	Pending
06/11/15	Not upheld	21/03/16	Decision to investigate	Pending

Evidence of CQC compliance with regulations and outcomes
Monitoring of these is included in the new policy and yearly audits will be done to monitor compliance.

3.4.4 National Survey Results 2015

3.4.4.1 National Inpatient Survey 2015

Listening to patients' views is essential to providing a patient-centred health service. The NHS in patient survey provides the trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

The Care Quality Commission request surveys of NHS healthcare providers every year. The results contribute to assessments of NHS performance and also contribute to regulatory activities such as registration, monitoring ongoing compliance and reviews. Warrington and Halton Hospitals NHS Foundation Trust commission one of the official contractors, Quality Health to undertake these surveys. The initial results of the Inpatient Survey (2015) were received in January 2016. 1250 patients are randomly selected during an inpatient stay in July 2015 and 529 responded (44%).

The Picker institute will coordinate all the national results on behalf of the CQC, who will publish these and include benchmarks against best and worst performance in May 2016. The following are the main headlines:

- 98% of patients surveyed said they were given privacy while being examined or treated in A&E.
- 6% of patients surveyed felt that the specialist they saw in hospital hadn't been given the necessary information about their condition or illness from the referring doctor.
- 66% of those surveyed didn't think they waited a long time to get a bed from the time they arrived in hospital.
- 6% stayed in 3 or more wards during their hospital stay. This is down from 9% in 2014.
- 98% rated the ward either very or fairly clean. None said it was not all clean.
- When patients had important questions to ask 95% of respondents felt that they got answers they could understand from their doctors. 96% of respondents got understandable answers from nurses.
- 81% always had confidence and trust in the doctors and nurses treating them.

- 59% of patients definitely felt they were as involved as much as they wanted to be in decisions about care and treatment. 33% thought they were involved in decisions to some extent.
- 74% definitely agreed that staff did everything they could to help to control pain, while 21% agreed to some extent.
- 64% of respondents said that their discharge was not delayed on the day they went home. The main reason for a delay was waiting for medicines (72%). 7% of those delayed were awaiting an ambulance.
- 10% of respondents didn't feel they got clear written information about medications at discharge.
- 80% were told who to contact if they were worried after leaving hospital.
- 32% of all respondents rated their overall experience as 10/10. Only 9% of respondents rated their experience as 5/10 or less.

In 2014/2015 we selected improvement in low performing indicators from the 2013 In Patient Survey as an improvement priority. We continued to monitor this as a patient experience indicator for 2015/2016 as follows:-

National Inpatient Survey Question	2011	2012	2013	2014	2015	Other trusts
Were you given enough privacy when being examined or treated in the A&E Department? DEFINITELY	73%	67%	66%	73%	76%	79%
From the time you arrived at the hospital did you feel that you had to wait a long time to get to a bed on a ward? DEFINITELY	20%	22%	18%	22%	12%	11%
Did you feel threatened during your stay in hospital by other patients or visitors? YES	3%	2%	5%	4%	3%	3%
How would you rate the hospital food? VERY GOOD / GOOD	46%	41%	50%	57%	63%	61.6%
Were you offered a choice of food? ALWAYS	70%	72%	72%	75%	74%	83%
In your opinion, were there enough nurses on duty to care for you in hospital? ALWAYS/NEARLY ALWAYS	48%	52%	53%	54%	62%	63%%
How much information about your condition or treatment was given to you? NOT ENOUGH	24%	27%	23%	20%	18%	19%
Were you given enough privacy when discussing your condition or treatment? ALWAYS	72%	70%	70%	73%	76%	78%
Do you think the hospital staff did everything they could to help control your pain? DEFINITELY	66%	66%	67%	72%	74%	74%
Beforehand, were you told how you could expect to feel after you had the operation or procedure? COMPLETELY	59%	55%	54%	63%	61%	60%
Delayed discharge due to waiting for doctor	11%	13%	15%	11%	6%	12%
Did a member of staff tell you about any danger signals you should watch for after you went home? COMPLETELY	43%	42%	45%	52%	51%	42%
Overall, did you feel you were treated with respect and dignity while you were in the hospital? ALWAYS	77%	79%	74%	81%	83%	85%
Overall, the rating of your experience was? 1 = POOR – 10 = VERY GOOD 7-10		77%	73%	81%	86.17%	84%

8-10 10		61.5% 21%	65% 26%	72% 30%	75.35% 32%	73.8% 27.3%
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received? NO	27%	13%	18%	26%	29%	25%

The trust is pleased to report continued improvement across a range of indicators including a 6% increase in rating food as good/very good and a 5% increase in rating their overall experience 7-10 on a scale of 1 = poor to 10 = very good. Delayed discharge due to waiting for a doctor decreased from 11% to 5% and when asked if they felt that were there enough nurses on duty to care for you in hospital? ALWAYS/NEARLY ALWAYS this increased by 8% to 62%.

3.4.4.2 Inpatient Surveys – National Patient Experience CQUIN

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

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

(National Patient Experience CQUIN);

CQUIN Inpatient Survey Questions 2011-2015

National Inpatient Survey Question	2011 Results	2012 Results	2013 Results	2014 Results	2015 Results	Other trusts
1. Were you involved as much as you wanted to be in decisions about your care?	47%	48%	57%	53%	59%	57%
2. Did you find a member of hospital staff to talk to about your worries or fears?	38%	31%	41%	42%	41%	41%
3. Were you given enough privacy when discussing your condition or treatment?	72%	70%	70%	73%	76%	78%
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	38%	43.%	40%	44%	45%	38%
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	64%	71%	82%	82%	80%	77%

Historically the composite score for the five questions was data was provided to the trust for the CQUIN, however this measure has been suspended so the data is no longer available. Overall the above table shows an improved response to all trusts in three out of five questions and comparable responses to the other two questions in relation to the 2014 result.

3.4.4.3 National Maternity Survey - Women's Experience of Maternity Care 2015

The National Maternity Survey was undertaken by Quality Health for Warrington and Halton Hospitals NHS Foundation Trust between April and September 2015. The random survey sample was drawn from all women aged 16 and over who had a live birth consecutively between 1st February and 28th February 2015. 114 completed questionnaires were returned from the sample of 300 which equates to a 38% response rate. The report provides an analysis of issues where the Trust is achieving good results as well as areas where management action is required. It also provides comparisons of both the Trust results against those of other Trusts in the Quality Health database who undertook the National Maternity Survey.

The survey examined the experiences across the pathway of care namely Antenatal Care; Labour and Birth; Postnatal Care; Feeding Your Baby and Care at Home after the Birth. Positive issues included 35% of women said they were given a choice about where antenatal check-ups could take place. This is an increase from 25% in 2013. This is within the top 20% of trusts surveyed. Negative issues included 71% of mothers said they got relevant information from midwives, a drop from 79% in 2013. The mother's decision about how to feed their baby was respected by midwives in 87% of cases. Getting consistent advice about feeding their baby is 62% a drop from 78% in 2013. Getting active encouragement and support about feeding their baby is 66% a drop from 77% in 2013. All these scores place the trust in the lower 20% of trusts.

The trust was disappointed to see an overall drop in scores from 2013 to 2015 especially since the Friends and Family feedback was positive (3.4.6) and recommended actions included:-

- Implement systems and undertake audit to proactively measure women's maternity care experience.
- Ensure that the trust, both hospital based and in the community, has a range of resources available to proactively measure women's maternity services care experience. These resources might include rooms available for focus groups, consumables, and the use of incentives or expenses for volunteers and electronic systems to capture data and feedback. Trusts should explore how to work closely with local community and voluntary services.
- Ensure that patient experience data is collected across the whole service pathway, from first contact with health services to up to the postnatal period and beyond according to the needs of individual women.

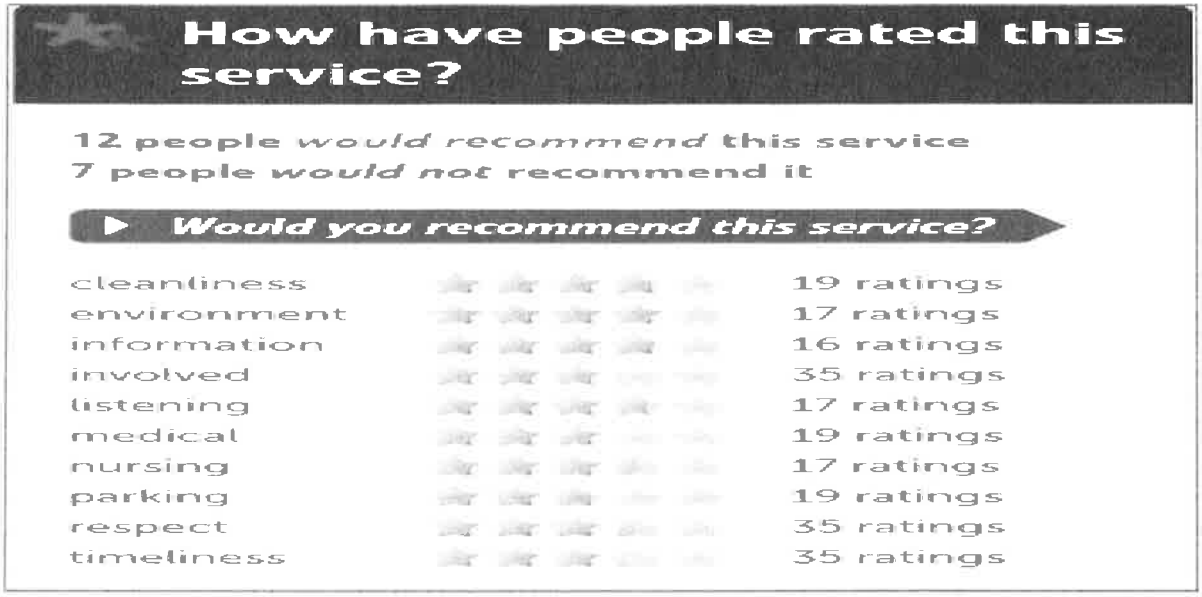
The progress of improvements to practice will be monitored throughout the year to ensure that our plan is being successfully implemented.

3.4.5 Patient Opinion

Patient Opinion was founded in 2005 and is an independent non-profit feedback platform for health services. Its philosophy is to support honest and meaningful conversations between patients and health services with the view that patient feedback can help make health services better. Basically health service users can share their story of using a health service; patient opinion will send their story to staff so that they can learn from it; the trust can offer a response with the ultimate goal being to help staff change services.

Patients can submit their comments directly onto the Patient Opinion website or can post comments on Patient Opinion via a form on the NHS Choices website and both websites publish the comments.

Both websites provide feedback on how users rate the service in terms of whether they would recommend our hospital friends and family if they needed similar care and treatment; cleanliness; staff co-operation; dignity and respect; involvement in decisions; and same sex accommodation.



However, NHS Choices provides an overall star rating of 1 – 5 stars and for 2015/2016 the trust was rated 3 stars by 11 respondents.

The trust is committed to acknowledging all comments and if the service user expresses concerns we will try to address them in our response or encourage the reviewer to contact the PALS Team for further discussions.

3.4.6 Friends and Family

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

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

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

If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses and this is translated into two ratings which are reported through to the board via the Quality Dashboard. The first rating is a star rating to a maximum of 5 stars and the second up to July 2014 is the Net Promoter score up to a maximum of 100.

The results for 2013/2016 are as follows:

Friends and Family scores 2013/16

Month	Star Rating 2013/14	Star Rating 2014/15	Star Rating 2015/2016	Inpatient 2013/2014	Inpatient 2014/2015	Inpatient 2015/2016	A&E 2013/2014	A&E 2014/2015	A&E 2015/2016
April	4.7	4.54	4.61	80	76	97	63	42	83
May	4.7	4.5	4.66	76	74	98	52	35	86
June	4.7	4.58	4.70	80	81	98	54	41	88
July	4.7	4.53	4.66	76	76	98	56	40	87
August	4.5	4.6	4.65	76	77	96	20	80	90
September	4.5	4.59	4.72	77	94	97	46	82	85
October	4.6	4.6	4.71	82	95	96	48	85	86
November	4.6	4.6	4.70	75	97	96	42	87	85
December	4.5	4.59	4.73	71	96	96	35	84	82
January	4.6	4.59	4.72	78	96	94	42	87	76
February	4.66	4.55	4.67	81	97	95	45	84	81
March	4.61	4.61	4.69	79	96	*	39	83	*

***Awaiting publication on NHS England website**

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

The trust will continue to monitor Friends and Family as a patient experience indicator for 2016/2017.

3.4.6.1 Friends and Family – Maternity Services

This CQUIN also required that Friends and Family was rolled out to maternity services. The rollout to maternity services was successfully achieved within the required timescales.

F&F question is asked at four stages along the maternity pathway and the following table indicates the trust performs well in relation to the national average:-

MONTH	TRUST ANTENATAL CARE	ENGLAND ANTENATAL CARE	TRUST BIRTH	ENGLAND BIRTH	TRUST POSTNATAL	ENGLAND POSTNATAL	TRUST POSTNATAL COMMUNITY	ENGLAND POSTNATAL COMMUNITY
MARCH 2016	NA	95	94	96	100	94	NA	98
FEBRUARY 2016	94	95	90	96	95	94	NA	98
JANUARY 2016	NA	96	87	97	95	94	NA	98
DECEMBER 2015	100	95	NA	97	NA	94	100	98
NOVEMBER 2015	91	96	88	96	96	94	NA	98
OCTOBER 2015	97	95	78	96	94	94	100	98
SEPTEMBER 2015	97	95	95	97	95	93	100	98
AUGUST 2015	96	95	95	97	100	94	100	98
JULY 2015	98	94.6	98	96.8	93	94.2	100	97.5
JUNE 2015	96	95.9	98	96.9	98	93.4	100	97.7
MAY 2015	98	95.9	96	97	100	93.3	100	97.8
APRIL 2015	98	95.3	100	97.2	98	93.7	100	97.7
MARCH 2015	100	95	98	97	96	93	100	98
FEBRUARY 2015	89	95	100	97	97	93	NO DATA	98
JANUARY 2015	95	95	100	97	94	93	100	97
DECEMBER 2014	96	96	100	97	97	93	NO DATA	98
NOVEMBER 2014	93	96	100	97	97	93	93	95
OCTOBER 2014	88	95	95	95	95	91	100	96
SEPTEMBER 2014	91	95	94	95	90	91	96	96
AUGUST 2014	57	66	77	78	65	65	-50	76
JULY 2014	50	62	73	77	62	65	71	75

JUNE 2014	42	67	81	77	74	67	67	77
MAY 2014	61	67	65	77	59	65	78	77
APRIL 2014	73	65	74	76	67	64	100	77
MARCH 2014	77	67	80	77	74	64	77	74
FEBRUARY 2014	77	67	63	75	74	64	65	75
JANUARY 2014	80	67	78	78	68	65	73	75
DECEMBER 2013	80	65	79	76	75	66	82	75
NOVEMBER 2013	64	65	72	77	69	66	88	72
OCTOBER 2013	100	64	60	76	47	65	29	71

3.5 Essential Ward Transfers

This project was undertaken in order to identify the level of out of hours ward transfers with a specific focus on non-essential ward transfers. It was agreed that if the trust can reduce the number of non-essential ward transfers that it would provide patients with a positive experience of care. It was agreed that this work should be managed via the Patient Experience Sub Committee. Initially data was collected on patients (exclusions were applied) who had at least one ward move between 22.00 and 07.59. Data was extracted for April – July for 2014/15 and April – July 2015/2016 and a comparison analysis showed a positive 37.06% decrease in transfers from 769 moves to 484 moves. However it was agreed that the out of hours used in this analysis did not conform to the out of hours times stated in the Transfer Policy so a decision was taken to re run the dataset based on the following:-

- Maintain the exclusions
- Change the times to read 23.00 to 06.30 as out of hours
- Capture all ward transfers with a filter for in hours and out of hours.

Unfortunately this project coincided with the implementation of LORENZO and competing priorities with other existing quality initiatives as such we were unable to obtain specialist support to run the datasets and the project has been suspended until appropriate resources can be allocated to it.

3.6 Duty of Candour

The trust has developed a checklist for Duty of Candour which is included in all Level One (moderate harm) and or Level 2 (severe permanent harm or death) investigations. The Investigating Panel as part of the investigation check that Duty of Candour has been followed. The trust also developed staff and patient information leaflets located on the trust internet to advise people about the process.

Duty of Candour also formed part of Medical Mandatory Training in 2013 to 2015. The trust has not at the time of this report ever had any issues brought to its attention where Duty of Candour has not been undertaken as required.

3.7 Sign up to Safety

Sign up to Safety is a new national patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere. We agreed to 3 central commitments when we signed up to safety namely:-

- To describe the actions we will undertake in response to the five Sign up to Safety pledges and agree to publish this on our website for staff, patients and the public to see.
- Turn our proposed actions into a Safety Improvement Plan which will show how the trust intends to save lives and reduce harm for patients over the next 3 years.
- Identify within our Safety Improvement Plan the safety improvement areas that we will focus on.

Our trust agreed to focus upon three key areas namely

- Reducing avoidable mortality
- 30% reduction in moderate falls
- 30% reduction in all grades of pressure ulcers by 2017.

The trust can report that it was successful in achieving a 39.83% reduction in all pressure ulcers in the first year 2014/2015 so has achieved that element of the safety improvement plan which can be found in section 3.2.2. Progress on reducing avoidable mortality can be found in section 2.1.1.2 and progress on reducing falls can be found in section 2.1.1.4.

3.8 Staff Survey Indicators

The most recent NHS Staff Survey results for indicators KF19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF27 (percentage believing that trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard

Please note that the trust has used KF26 not KF19 as the description above is about wellbeing, KF26 matches the descriptor given and makes sense when talking about the Race Equality Standard. The same rationale applies to the second indicator in that the lead has used KS21 not KF27.

In relation to the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26) the trust score was 18%, an improvement on last year and 8% lower than the acute trust overage and puts the trust in the top 20% of acute trusts. The indicator for the percentage of staff believing that the trust provides equal opportunities for career progression or promotion (KF21) was 93% again an improvement on last year and above the national average for acute trusts. The trusts results were in the top 20% of all acute trusts.

3.9 Speak out Safely

Warrington and Halton Hospitals NHS Foundation Trust supports the national Speak Out Safely campaign. This means we encourage any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity.

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

We promise that where staff identify a genuine patient safety concern, we shall not treat them with prejudice and they will not suffer any detriment to their career. Instead, we will support them, fully investigate and, if appropriate, act on their concern. We will also give them feedback about how we have responded to the issue they have raised, as soon as possible.

3.10 Performance against key national priorities (Please see table below)

Performance against the relevant indicators and performance thresholds set out in Appendix A of Monitor's risk assessment framework'. Where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they do not need to be repeated here.

Mar-16

Monitor Access Targets & Outcomes - 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

A&E figure includes walk-in activity from Aug 15

All targets are QUARTERLY

Target or Indicator		Threshold	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	N/A	92.55%	93.48%	93.14%	93.05%	92.05%	93.01%	92.74%	92.57%	92.31%	93.85%	92.65%	92.94%	85.44%	83.16%	81.09%	83.11%
	Non-admitted patients	95%	N/A	97.53%	97.18%	98.13%	97.64%	97.71%	97.52%	97.51%	97.58%	97.91%	96.57%	96.46%	96.92%	96.10%	95.25%	93.57%	94.92%
	Incomplete Pathways	92%	1.0	93.38%	94.30%	93.84%	93.87%	93.10%	93.49%	93.08%	93.23%	92.83%	93.41%	93.72%	93.40%	93.75%	92.63%	92.50%	92.94%
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	87.75%	94.05%	92.68%	91.13%	93.96%	93.17%	91.69%	92.92%	90.74%	86.49%	85.19%	87.53%	81.33%	79.86%	83.70%	81.71%
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0 (Failure for either = failure against the overall target)	88.10%	86.40%	83.80%	86.10%	87.65%	82.00%	82.48%	85.65%	90.00%	85.00%	78.30%	85.06%	83.90%	87.00%	85.00%	85.30%
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%		100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		88.10%	86.00%	81.00%	85.25%	88.90%	86.21%	83.53%	85.71%	92.00%	85.10%	78.30%	86.90%	84.00%	86.00%	85.00%	85.30%
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	100.00%	100.00%	96.00%	98.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	100.00%	100.00%	96.00%	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%
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.70%	93.80%	92.00%	93.00%	95.20%	93.30%	93.10%	93.90%	95.80%	94.90%	93.90%	94.40%	93.60%	93.00%	93.00%	93.20%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		92.80%	98.30%	89.70%	93.20%	93.30%	96.60%	97.90%	95.80%	96.30%	93.50%	93.30%	96.00%	96.40%	91.00%	93.0%	93.47%
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	27 (for the Yr)	1.0 **	0	1	4	4	5	5	8	8	9	10	10	10	10	10	10	10
	Not due to lapses in care			3	7	8	8	8	8	9	9	11	12	12	12	12	12	12	12
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			3	8	12	12	13	13	17	17	20	22	22	22	22	31	33	33
	Under Review			0	0	0	0	0	0	0	0	0	0	0	0	0	9	11	11
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Cumulative
Qtr1: 7 Qtr2: 14
Qtr3: 21 Qtr4: 27

Target or Indicator	Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Date of last CQC inspection	N/A		26/01/2015															
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Overall rating from CQC inspection (as at time of submission)	N/A		Not received at the time of reporting				Requires Improvement											
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A																	
Service Performance Score			2.0	1.0	3.0	1.0	1.0	1.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

We are in breach to a number of regulated activities as a result of the CQC Inspection in January 2015 and the subsequent report to which the Trust reviewed and agreed.

An action plan is in place that is being monitored at Trust, Commissioner, NHS England (North West) and Monitor level.

Until such time that the CQC revisit the Trust and re-inspect our services and provide a subsequent report to say that we are now compliant with the Regulations (or not) the red/amber rating is this section will remain in place.

NHS foundation trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action

18 Weeks Referral to Treatment

Performance is measured on an aggregate (rather than specialty) basis and NHS foundation trusts are required to meet the threshold on a monthly basis.

Consequently, any failure in one month is considered to be a quarterly failure for the purposes of the Risk Assessment Framework.

Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.

Failure against any threshold will score 1.0, but the overall impact will be capped at 2.0

**** Clostridium Difficile**

Monitor's annual de minimis limit for cases of C-Diff is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks

Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

Criteria	Will a score be applied
Where the number of cases is less than or equal to the de minimis limit	No
If a trust exceeds the de minimis limit, but remains within the in-year trajectory# for the national objective	No
If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective	Yes
If a trust exceeds its national objective above the de minimis limit	Yes

Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).

Monitor will not accept a trust's own internal phasing of their annual objective or that agreed with their commissioners.

Please note the cancer targets will not be confirmed for a further 4 weeks and the access policy describes a 4 week process for review of any underperformance requiring validation before submission

3.11 Governors' visits

The Governors' Council has initiated a series of unannounced visits to ward and department areas to observe issues of care and treatment in order to provide assurance to them and, importantly, to their constituents about the quality of service provided by the trust.

A summary, provided by the trust's Lead Governor, is available with section 4.7

3.12 Training & Appraisal

Training and Appraisal Completion

	Target	Year End Results
Mandatory Training		
Health & Safety	85%	87%
Fire Safety	85%	81%
Manual Handling	85%	83%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal		
Non-medical	85% in last 12 months	69%
Medical & Dental staff	85%	80%
Medical & Dental (excluding consultants)	85%	61%
Consultants	85%	88%

Each division and professional group are now being performance monitored on a monthly basis to identify improvements they have made to compliance with training requirements. Divisions have been reminded of the need to make further progress and Clinical Leads will be giving this matter greater priority.

3.13 Quality Report request for External Assurance

Warrington and Halton NHS FT has requested the trust auditors PricewaterhouseCoopers (PwC) to undertake substantive sample testing of two mandated indicators and one local indicator (as selected by the governors) included in the quality report as follows:

Referral to treatment within 18 weeks for patients on incomplete pathway (RTT)
A&E four-hour wait
Complaints Management (local governor selected indicator)
NB: Indicators included in the Quality Report have been marked with ^

3.14 Quality Report amendments post submission for 3rd Party Commentary

Part 1 CEO Statement inserted
Part 2 Halton Centre for Sexual Health & Halton Intermediate Care Unit (inserted page 13)
Page 9 A&E 94% changed from May not June
2.1.1.2 Table - January and February figures amended
2.1.1.4 Moderate – catastrophic falls data inserted
2.2.6 Trust Data Quality - inserted as follows:-

- Which included the patient's valid NHS Number - data
- Which included the patient's valid General Practitioner Registration Code - data
- Warrington and Halton Hospitals NHS Foundation Trust **was not** subject to the Payment by Results

2.3.1a SHMI mortality rates section updated
2.3.6 Q4 data inserted
2.3.9 March data inserted

3.12 Data inserted
3.1.3 Quality Dashboard - 2015/2016 inserted
3.2.3 March data inserted
3.3.1 Graph updated
3.4.3 Graphs - Complaints received and by risk rating
3.4.3.1 Lessons learned – additional narrative on scheduled care and WCSS
3.4.6.1 March data inserted
3.10 Performance against key national priorities – 2015/2016 inserted
4.1 Statement from Warrington CCG inserted
4.2 Statement from Halton CCG inserted
4.3 Statement from Halton Health Policy and Performance Board inserted
4.4 Statement from Warrington Healthwatch inserted
4.6 Statement from Halton Healthwatch inserted
4.7 Statement from the Trust's Council of Governors 2015/2016 inserted
4.7.1 Report on Governor Ward Observation visits 2015/2016 inserted

Part 4 - Quality Report Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees 2015/2016

Statements from the following stakeholders are presented within this document unedited by the trust and are produced verbatim.

4.1 Statement from Warrington Clinical Commissioning Group

NHS
Warrington
Clinical Commissioning Group

☎ 01925 843636
Please Ask For: John Wharton
E-mail: john.wharton@warringtonccg.nhs.uk

Arpley House
110 Birchwood Boulevard
Arpley House
Birchwood
Warrington
WA3 7QH

www.warringtonccg.nhs.uk

Date: 17th May 2016

Karen Dawber
Director of Nursing
Warrington & Halton Hospitals Foundation Trust
Lovely Lane
Warrington
WA51QG

Dear Karen

Re: Quality Account 2015-2016

Many thanks for the submission of the Quality Account for 2015-2016, and for the presentation to local stakeholders with the Local Area Team. This letter provides the response from Warrington CCG to your Quality Account.

The account affirms the work that is being carried out by the Trust and which is regularly discussed through the mechanisms which we have in place; contract monitoring, the established strong focus on quality and the rigorous SUI process are all contributory factors to ensure that both commissioner and provider are working collaboratively to improve care and agree appropriate actions and monitoring when the patient experience has not been to the standard we all aspire too. I believe that these forums continue to build on our relationship and cemented our united approach to delivering high standards of health care to the local population.

Warrington CCG welcomes the work delivered by the Trust in relation to improving patient care for the local population and wishes to continue the healthy relationship that we have for future planning of health care delivery. We also wish to congratulate you for the impressive work which you have carried out, particularly in continued improvement in the Trust's responses to complainants and the positive impact that has on their experience of the Trust. However it is disappointing to note that the Trust did not meet the Mixed Sex Accommodation targets for 3 of the 4 quarters.

The CCG is pleased to see the continued improvement in the area of reducing grade 3 & 4 pressure ulcers but has noted the increase in the number of grade 2 over 2015/16. The CCG will continue to support the partnership approach to this work. Your focus Nursing Care Indicators is positive and allows the monitoring of key quality markers in real time.

Warrington CCG acknowledges the challenging year that the Trust has experienced and its impact on achieving the 95% Accident & Emergency access targets and acknowledges the work the Trust has undertaken to meet the target. The CCG would like to acknowledge the work the Trust has done in reducing the number of avoidable hospital acquired Clostridium

Difficile cases but notes that recurrent themes and trend remain an issue for the Trust and welcome the opportunity to continue support this work during 2016/2017.

Warrington CCG welcomes the establishment of the mortality review group to support the progress of this work and the CCG will continue to support the Trust with this work by attending the mortality review group.

However, Warrington CCG and members of the review panel raised their concerns after noting this section of the account failed to demonstrate how the Trust intends to improve on staff mandatory training and appraisal rates and how the organisation intends to train and develop its staff to meet the future demands of the NHS. The panel were equally disappointed that the trust also failed to evidence how CQUIN schemes had failed to improve patient outcomes as opposed your account focus on the fiscal aspect of the schemes as opposed demonstrating innovative ways of using tax payers' money.

I conclude by informing you that we are looking forward to working with the Trust throughout 2016/17, helping to improve the quality and delivery of services for the local population and ensuring that the provider is working towards delivering the key domains of the CCG'S quality strategy; safety, effectiveness experience and timeliness of interventions remain at the heart of health care provision. Warrington CCG was disappointed that the Trust had not identified the quality priorities for 2016/17 in their presentation to the CCG.

May I conclude this response to take the opportunity in thanking all your staff for their commitment and hard work in delivering health care to the local population.

Yours sincerely

John Wharton
Chief Nurse & Quality Lead
Warrington Clinical Commissioning Group

4.2 Statement from Halton Clinical Commissioning Group

NHS
Halton Clinical Commissioning Group

First Floor
Runcorn Town Hall
Heath Road
Runcorn
Cheshire
WA7 5TD

Tel: 01928 593479
www.haltonccg.nhs.uk

11th May 2016

Karen Dawber
Director of Nursing
Warrington & Halton Hospitals Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Ref: QA/WHHFT/11/16

Dear Karen

Re: Quality Report 2015-2016

Many thanks for the submission of the Quality Account for 2015-2016, and for the presentation to local stakeholders on 19th April 2016. This letter provides the response from NHS Halton CCG to the Quality Account.

NHS Halton CCG has been fully authorised for three years, we have, I hope consolidated our working relationship during this time. NHS Halton CCG is a member of the Contract Quality Group, which scrutinises the key quality indictors in the Quality Schedule and CQUINs in partnership with NHS Warrington CCG, who are the co-ordinating commissioner; these meeting are providing a forum for discussion of quality issues. The Clinical Focus Group meetings are working well and provide the ability to develop and maintain links to your clinicians which has been very useful.

NHS Halton CCG would like to thank the trust and its staff for the support and commitment to the partnership and collaborative work in relation to the One Halton Programme and the development of the Urgent Care Centres locally.

NHS Halton CCG welcomes the work delivered by the Trust in relation to improving care for patients with Dementia, and congratulates you on your continued progress in this area. The CCG notes the delivery against some of your planned improvements targets, and in particular the delivery of the reduction in Grade three Pressure Ulcers and no Grade four pressure ulcers, improved performance against Nursing Care Indicators and good performance in the Hip and Knee clinical areas in Advancing quality. The CCG notes the actions planned for the coming year in those areas where target performance has not been achieved. NHS Halton CCG notes the delivery against some of the commissioner quality priorities and would like to commend the trust on its drive in relation to visible clinical leadership and its new organisational structure.

NHS Halton CCG notes that the Trust has been subject to a Care Quality Commission inspection in this year and thanks the Trust for the level of engagement in relation to the action plan for those areas requiring improvement. The CCG note the progress made in this year in relation to clinical leadership and engagement and the work which is now progressing in relation to organisational culture. The CCG are also pleased to see the planned Quality Priorities for 2016/2017, in particular the further focus on patient experience and reducing mortality.

We look forward to working with the Trust throughout 2016/17, helping to improve the quality of services for our patients through the NHS contractual mechanisms and ensuring lessons are learnt throughout the Trust.

Yours Sincerely

Jan Snoddon
Chief Nurse/Quality Lead
NHS Halton CCG
Email: jan.snoddon@haltonccg.nhs.uk

4.3 Statement from the Halton Health Policy Performance Board

HALTON
BOROUGH COUNCIL

Ms M Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Our Ref	EST
If you telephone please ask for	Emma Sutton-Thompson
Your ref	
Date	5th May 2016
E-mail address	Emma.Sutton-Thompson @halton.gov.uk

Dear Ms Pickup,

Quality Accounts 2015 - 2016

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 19th April that your colleague Karen Dawber 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:

The Board noted the financial position and difficulties the Trust are currently experiencing and the organisational restructuring that is taking place to help address this. Following the CQC Inspection in January 2015 (results published in July 2015) the Board noted that the Trust was rated overall as "requires improvement". There were two elements that received a rating of "good" including Effective and Caring and the Board were pleased to read some of the positive comments from CQC including "Nursing staff were caring and compassionate and treated patients and those close to them with dignity and respect. Nurses were committed to giving people a high standard of care and treatment".

During the year 2015/16 the Trust identified a number of priorities to be achieved during this year. The Board were pleased to note the reduction in Grade 3 pressure ulcers and that there were no grade 4 pressure ulcers. Although the target for Grade 2 pressure ulcers was not achieved, the Board are pleased to see that this continues to be a priority for the Trust.

The Board were pleased to note that under Every Patient Has a Voice, the Trust has developed an Experience of Care Strategy 2015 – 2018 in conjunction with key stakeholders. The Board will be pleased to see progress with this strategy in future quality reports.

It's all happening **IN HALTON**
Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300
www.halton.gov.uk

INVESTOR IN PEOPLE

HALTON
BOROUGH COUNCIL

The Board were pleased to hear about the implementation of the Lorenzo Electronic Patient Record (EPR) system to bring together patient information, replacing two previous systems and moving towards electronic records.

The Board were pleased to note the work the Trust has been progressing around Dementia, including:

- Dementia champions
- The one year anniversary of the Dementia ward
- A new Dementia leaflet for the public
- Dementia conference that took place in November 2015
- Dementia training for staff.

Falls – although the Trust has not achieved their reduction target in falls this year, they still remain below the national average. The Board were pleased to note the continuation of initiatives that have been put in place to help reduce falls, in particular the "Falls Change Package" supporting individual patients who are at risk of falls and the "Call Don't Fall" campaign.

The Board would like to thank Warrington and Halton Hospitals NHS Foundation Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

pp **Councillor Joan Lowe**
Chair, Health Policy and Performance Board

4.4 Statement from Warrington Healthwatch

Healthwatch Warrington
The Gateway
89 Sankey Street
Warrington
WA1 1SR
Tel 01925 246892

contact@healthwatchwarrington.co.uk
www.healthwatchwarrington.co.uk

healthwatch Warrington

18th May 2016

Dear Rosamund,

Re: Warrington and Halton Hospitals NHS Foundation Trust Draft Quality Accounts

Thank you for the opportunity to comment on the Trust's Draft Quality Accounts.

Healthwatch Warrington held an open consultation session on 17th May 2016 to encourage local people and partners to come together and discuss a series of Quality Account drafts.

Those discussed were; 5 Boroughs Partnership NHS Foundation Trust, Warrington and Halton Hospitals NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust.

We asked those attending the consultation session to look at the overall documents, and answer 4 key questions;

- What are the important successes for the Trust?
- What are the important areas for development for the Trust?
- What do you think of the organisation's forward plans for the Trust?
- What can Healthwatch Warrington do/contribute to the Trust?

The Hospital Trust's QA was helpfully presented by Karen Dawber, Director of Nursing, who was able to give context and insight to the overall document.

Throughout the consultation session we collected comments, ideas and questions which are outlined as below;

What are the important successes for the Trust?

- The Dementia Care/Forget Me Not Ward and Dementia work throughout the Hospital received positive comments and feedback from the consultation group and those whom they support e.g. carers, GP patients.
- The group would like to see more evidence within the QA of how the Dementia work at the hospital is working for both patients and families.

- The group felt that there is evidence of a shift in culture and understanding of Dementia and Dementia needs within the hospital trust, which was praised.
- Consultees conveyed that the staff are viewed as very professional within the Trust - a great achievement, from a patient perspective.
- Those attending perceive that overall there has been a significant improvement in the quality of services at the hospital.
- The trust is to be commended for highlighting faults and issues as important as successes. Highlighting this type of evidence can show learning within the Trust and application of new/alternative approaches.

What are the important areas for development?

- With regard to End of Life Care within the Trust the consultation group would like further clarification:
    - Is there a clear communication strategy for patients, families and carers around palliative care? If so, is this applied to everyday work within the Trust?
    - Would it be helpful to involve local partners and stakeholders in End of Life work, and to have a co-ordinated approach for difficult conversations - are any resources or tools being used for this purpose?
    - If not, can partners e.g. Warrington CCG help develop these resources or training as seen in the Difficult Conversations Workshop for professionals delivering the Cancer Rehabilitation Programme (June 2015).
- Consultees felt that there is a need for better internal communications around gaps in the system.
- There seems to be a need for further appropriate training for staff around the use of systems and software (e.g. Lorenzo) to address system gaps and barriers.
- The group felt that there is a need to move towards shared decision making, to encourage patients to understand and engage better with their care. This approach should be implemented during training and ongoing education within the Trust.
- Those consulted felt that there is a need for improved communications and responsiveness of services, e.g. there has been feedback of gaps in timescales or lack of timely interventions within palliative care services.
- Is the potential to develop passports or packs for those patients with capacity issues during hospital stays, e.g. dementia patients?
- It would be good to see better measurement of A&E experiences and evidence. The group emphasised the need for appropriate consultation - this can be difficult in the event of traumatic admissions, bereavements, still

births etc but could be fundamental to improving the delivery of A&E services.

What do you think of the organisation's forward plans?

- General feedback was that the overall forward plans of the Trust are to be commended.

What can Healthwatch Warrington do/contribute?

- Healthwatch Warrington can work with the Hospital Trust to develop a communications strategy between local stakeholders, organisations and the Trust - we are happy to facilitate discussions and information sharing.
- In End of Life care is there the possibility to share approach and resources across services, beyond the Trust?
- The group would like to recommend that the Trust work with Healthwatch Warrington to develop patient resources and approaches to enable patients to participate and engage in their care and treatment, e.g. The 3 Questions Model.

Overall the consultation group would like to offer general encouragement to staff at the Trust and in particular thank Karen Dawber for her assistance and candour in making the QA understandable and relevant to patient exerience. The hospital's services and their patient care are well received and the QA work and plans are to be commended.

We look forward to hearing from you and being involved in future developments.

Regards,

D. Dalby *E. Hayes*

Deborah Dalby
CEO
Healthwatch Warrington

Esstta Hayes
Community Engagement Officer
Healthwatch Warrington

4.5 Statement from Warrington Health and Well Being Overview and Scrutiny Committee

The trust requested a formal Statement from Warrington Health and Well Being on the 17th April 2016 but this was not submitted to the trust.

4.6 Statement from the Halton Healthwatch

Commentary on Warrington & Halton Hospitals NHS FT Quality Account 2015-16

healthwatch Halton

Healthwatch Halton welcomes the opportunity to provide this commentary on Warrington & Halton Hospitals NHS Foundation Trust Quality Account for 2015/16.

From the patient experiences we have gathered over the past year we would state that in general the Trust's Quality Account reflects people's real experiences of using the service.

The report is comprehensive and detailed but some of the detail is difficult to understand and could be presented a more 'user friendly' format.

We note that significant progress has been made during the past year on priority two, 'Strengthening Mortality Review' and this is to be commended, as is the development of the 'End of Life Strategy'.

We would like to acknowledge the Trust's improvement over recent years in reducing falls. We are disappointed to note the failure to meet the target for 2014/15, but are pleased targets have been achieved this year. Similarly, the Trust's work on reducing pressure ulcers over the past few years deserves to be highlighted. Initiatives such as the addition of a red band around plaster casts of patients at risk of developing ulcers are to be praised. It is disappointing that the Trust didn't quite achieve the threshold of a 5% reduction for all grade 2 pressure ulcers in 2015-16 but we are glad to note the continued commitment made to reducing pressure ulcers for 2016-17.

We are pleased to see the development of a robust 'Patient Experience Strategy' and we look forward to being actively involved with this work over the next 12 months.

We are encouraged to see the improvements in monitoring the progress of complaints. The updating of the Trust's complaints policy to include a review of all high risk complaints within 72 hours is also to be highly welcomed.

It is disappointing to note that the 4 hour waiting time target for A&E was not achieved. Although we realise that the Trust is not alone in struggling to manage the increased pressures on A&E departments, we would hope they will work to improve these figures over the next 12 months.

We feel that overall the Trust has set itself improvement priority targets for 2016-17 that should be challenging enough to help drive improvement. We are particularly pleased to note the inclusion of Healthwatch as one of the work streams for priority four 'Every patient has a voice – implementing Experience of Care Strategy'.

During the next 12 months we look forward to continuing to challenge the Trust on key priorities and look forward to working with the Trust to help improve the experience of patients who visit the Trust.

Doreen Shotton & Brian Miller
Healthwatch Halton Quality Account Leads
18/05/16

4.7 Statement from the Trust's Council of Governors 2015/2016

As in previous years, comments are based around the four main questions, which patients may wish to have answered.

Q1 Do the priorities reflect those of the population the Trust serves? Governors believe this is the case. We 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. The Trust has been under increasing operational and financial pressures, as well as difficulties with staffing over the last 12 months, and this has inevitably placed stress on the organisation but despite this, staff continue to show high levels of dedication, commitment and hard work. Each year certain targets are agreed with the hospital's Governors.

The Accident and Emergency department national target for seeing 95% or more patients within four hours was not achieved over the year and has deteriorated further since the previous year. The Governors recognise that the national position on delivery of the A&E target was much the same with only a very small proportion of Foundation Trusts achieving the national target. The Governors also recognise that the problems encountered in A&E were systemic and that issues associated with discharge of patients to intermediate care facilities exacerbated the position together with increasing numbers of patients presenting at A&E and an increasing proportion having complex medical needs. Many patients have also been attending A&E inappropriately either because they are unaware of the alternatives or due to difficulties getting appointments with their local GP. Despite their understanding of the reasons for the Trust falling short of the 95% target, the Governors still feel that more needs to be done to examine the patient flow process as a whole and to target initiatives that will see a more consistent improvement.

The Quality Report highlights the Trust's continued focus on reducing the risk of patients acquiring a pressure ulcer. The Trust's ambitious target for the year for grade 2 pressure ulcers has been missed during 2015/2016, but this was after an outstanding performance in 2014/2015, and the level of grade 3 and 4 pressure ulcers has been better than target.

Whilst the Hospital Standardised Mortality Rate (HSMR) has been "as expected" during recent months, the Summary Hospital Level Mortality Indicator (SHMI) has been running at "higher than expected" for some time". The Governors are reassured however, that the Trust has reviewed the situation and is now carrying out a mortality review of all deaths with a view to better understand the potential causes for the unexpected level. It will be important that the 95% compliance target for these reviews is achieved, but the Governors recognise that there is a commitment on the part of senior staff and look forward to improvements in patient care and safety which can lead to a significant improvement in the mortality rate in the coming year.

The likelihood of acquiring a hospital infection has reduced significantly during the last five years. The Governors were disappointed last year that the Trust had not reduced the cases of MRSA and C. difficile during the year, although this was a trend seen in many trusts in the North West. Governors are pleased that efforts to reduce the number of cases of C.Diff have been successful during the last year. Every effort is made to ensure these infections are not passed from one patient to another. Many of the key clinical performance indicators showed a successful year with improvements in many areas. There have been a few where performance has been slightly short of where everyone would have liked such as falls, Waterlow and MUST scores, but these were improving in the last months of the year and Governors are optimistic that

these will reach target in the near future. There have also been a small number of indicators which have unavailable since late 2015 due to the implementation of the Lorenzo computer system, but in a year of considerable financial pressure, and with an increasingly ageing local population with more and more complex health needs, and having to make substantial savings through a year on year Cost Improvement Programme, the performance achieved has been pleasing. For the coming year, the Governors agree with the priorities established. The establishment of a falls prevention group will help achieve the Trust's objectives on this specific priority. The new patient experience strategy will provide a wider range of better quality information from which to drive improvement. Finally, Governors see the improvement of care at the end of life as an extremely important initiative that the Trust is establishing.

Q2 Are there any important issues missed in the Quality Report? The Governors believe most significant issues have been addressed. The Quality Report is very detailed and thorough and assists them in holding the Non-executive Directors to account. It provides comprehensive information detailing patients' views of the care and treatment they have received although this is to be further enhanced during the coming year.

There is further work to do in the complaints area, and Governors are pleased to note that the development and implementation of the Patient Experience Strategy has again been included in the Trust's priorities for 2016/2017 and there is an intention to set up a patient user group.

Once a month Governors undertake a Ward Observation Visit. These visits have been welcomed by staff, patients and their relatives. Governors are able to receive first hand assurances that the hospital wards are clean and patients are provided with privacy and dignity. Governors ask patients for their views about the quality of the nursing and medical care they receive. The visits have provided Governors with an understanding of how hospital wards function and the high standard of care demanded by our patients and the hospital's inspectors, the Care Quality Commission (CQC). More recently Governors have been looking at monitoring experiences of other parts of the hospital in more detail, such as outpatients and there are plans to carry out a project in A&E

Q3 Has the Trust demonstrated that it has involved patients and the public in the production of the Quality Report? Public, Partner and Staff Governors, Healthwatch and other local stakeholders, have been fully involved in discussing the content of the Quality Report during workshops and in the bi-monthly and dedicated meetings of Governor's Quality in Care Committee. Focus groups have continued this year and the use of online surveys have taken place to find out the views of the Trust members that were also made available to the wider public. Member engagement across the Trust's catchment areas has continued with staff and Governors talking to members in GP practices, town centre shopping areas, outpatient clinics and at large events such as the Hospital's Open Day and Warrington Disability Awareness Day, as well as giving presentations to various organisations. With the new engagement strategy, the Trust will be able to reach a much wider audience of the general public using a magazine insert in local newspapers.

Governors have actively sought to engage with patients and contribute to a process of improving services. This took place during 2015/16 in the area of outpatients which was an area identified as requiring improvement. Governors have involved former inpatients in surveys and spoken to them in a focus group to find out how they think the outpatient department could be improved. These have identified a number of improvements, some very simple, which have the potential to significantly improve scores obtained in the friends and family test. Ways are being sought to ensure that this important work is automatically incorporated into the Trust's own work.

The Quality Report shows that the Trust continues to implement innovations around delivery of recruitment, training and personal development reviews. Governors welcome this as there are still some gaps in this area, but performance is improving with work being carried out by the new Director of Human Resources and Organisational Development. Governors believe the Trust's staff are its most valuable asset and without their commitment and continual personal development it would not be able to deliver safe, high quality, compassionate care to its patients as well as retain staff. The most recent Staff Survey showed that the majority of staff would recommend the Trust as a place to work.

Q4 Is the Quality Report clearly presented for patients and the public? Governors find the format and section headings helpful. The Quality Report contains considerable detail commensurate with the complex and diverse range of services provided by an Acute Hospital Trust. 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, in their Quality in Care Committee, have contributed their views on many aspects of the quality of services provided by our hospitals and endorsed the continued effort to improve the readability and appearance of the Quality Report. Governors encourage all Trust members and others who are interested in our hospitals and their performance to read the Quality Report. Governors have recently visited Salford Royal NHS Foundation Trust to look at their practice to determine if improvements could be made to the format of the data received. We believe that this will lead to further improvements.

4.7.1. Report on Governor ward observation visits - Ward Observation Visits 2015/2016

Governor-led ward observation visits began in October 2011 and have led to an overall broadening of the role of the Governors in this Trust. Whilst the visits were initially viewed with a degree of scepticism, the situation has now completely changed to where the Governor's visits are now welcomed by both staff and patients alike. One Governor takes responsibility for organising the visits together with two to four other Governors. A timetable for monthly ward observation visits is published at the start of each year, but the visits themselves are unannounced. The report is issued to the board and the Care Quality Commission (CQC). The visits are designed to provide assurance to the Trust's Governors that the best possible standard of medical and nursing care is provided to patients in our hospitals. Governors use a checklist to help assess the standard of care being provided. At the start of the visit a check is made of the display boards outside the wards. These contain important information about whether any patients on the ward have recently had a fall, experienced a pressure ulcer, whether there has been a delayed discharge and what the level of staff sickness is on the ward.

The visits start with a discussion with the Ward Manager who helps the Governors understand the issues in their ward. This is then followed by a guided tour of the facility before the Governors are left to speak to patients and staff.

Patient care should be of the highest standard. During the visits Governors speak to patients about their views of the health care with which they are provided. The patients are asked about the food they are given and the noise levels on the wards during the day and at night. They are asked about the nursing and medical care they receive and whether they are satisfied with how they are being treated. The majority of patients that the Governors speak to praise the nursing care very highly and comment on their level of commitment and how hard everybody works. Doctors and other health professionals are also highly praised for their attention to detail and sensitive approach to dealing with the patients in their care. Patients and their

visitors generally feel they have received information about their condition and the treatment they were being given.

During the visits the Governors talk to various members of staff on the wards about their roles. This has been very informative and has helped in the understanding of how the wards are managed and the pressures that staff may experience. Leadership on the wards is crucial and Governors are pleased to report they have seen many examples of outstanding teamwork. Governors pay particular attention to the interaction between the nursing, medical staff and the patients. First names are always used and they have never witnessed a member of staff using an inappropriate term when communicating with a patient. Patient name and information is displayed above their bed and this information indicates whether they are at a high risk of a fall or have dementia. Staff and patient views are always included in the Governor's report and in many instances this has led to the staff suggestions being implemented and the improvements being made.

Governors check that all the staff on a ward, including the doctors, wash their hands and wear gloves and aprons when in direct contact with patients. They check that all medical support staff, health care assistants and nurses use hand gel when they move from patient to patient. Patients are issued with hand wipes prior to being provided with lunch.

Cleanliness has improved drastically over the years to the point at which a spotless ward is now the norm. A check is always made on the cleanliness of the patient toilet areas, bathrooms and the length of the emergency cords. At no time, in the last year, have they voiced concern about the standard of cleaning. All the wards have dedicated domestic staff well led by the Housekeeper whose role is pivotal in the smooth running of the ward. They work tirelessly to maintain a high level of cleanliness. The bathrooms, toilets, floors and all patient areas have been perfectly clean. Spillages are promptly cleaned up and the floors around patient's beds clear of trip hazards or fallen items.

Governors observe whether the curtains around the patient's bed are fully drawn when a doctor or personal care is required. They listen to and observe how patients are spoken to. They record if patients are appropriately dressed and whether they have they been washed, their hair combed and the men shaved. No concerns have been reported in this area. All patients have been presentable and treated with respect and their dignity maintained.

During the year the Governors have visited a number of wards where they have been impressed with what was seen. Notable amongst them was the Maternity Ward where the team were given a tour by the Matron. The area had an atmosphere of calm and good organisation and it was hard to believe that the hospital delivers some 3000 babies a year! Another that was felt to be outstanding was the STAR Ward (short-term assessment and rehabilitation). This ward was primarily being used for elderly patients who had been in the hospital for some time and whilst medically fit were in need of additional support before being sent home. Despite the obvious success of this initiative, the funding for it has subsequently been withdrawn by the CCG and the ward has been closed.

Since the visits inception the concentration has been largely on the more general type of wards. In doing so the Governors realised that many areas of Warrington and Halton were being missed. Some initial visits have now been made to the Outpatients Department. This has required an alternative approach to that used on general wards and a shortened version of the Outpatient Survey has been used to gather valuable information. This methodology is still being trialled and refined.

Conclusion: The Ward Observation visits have become an important part of the role of a Governor. They provide the Trust's Governors with a first-hand assurance that patients from Warrington and Halton are receiving the best possible care. In publishing this report Governors are able to assure the Trust's members, staff and their patients that they believe this to be the case. The Governor visits to the wards have helped them to understand how they are managed and the roles of various staff. It demonstrates to the many patients and staff that their Trust's Governors not only attend committees but want to see and hear for themselves what it is like to be a patient in Warrington Hospital and Halton Hospital.

Annex: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

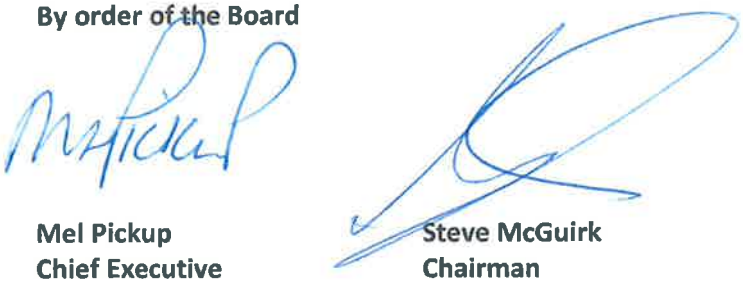
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/2016 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes for the period April 2015 to March 2016 (the period);
    - Papers relating to quality report reported to the Board over the period April 2015 to March 2016; date of statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group dated 26/05/2015 and Halton Clinical Commissioning Group dated 11/05/2016;
    - Feedback from Governors received 09/05/2016.
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated 18/05/2016 and Healthwatch Warrington dated 18/05/2016;
    - Feedback from Overview and Scrutiny Committee Halton Borough Council Health Policy and Performance Board dated 05/05/2016
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 (Complaints: Patient Experience Annual Report – 2015/16);
    - The 2015 national inpatient survey;
    - The 2015 national staff survey;
    - The Head of Internal Audit's annual opinion over the trust's control environment dated.

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



Mel Pickup
Chief Executive

Steve McGuirk
Chairman

25th May 2016

Independent Auditors' Limited Assurance Report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Warrington and Halton Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Warrington and Halton Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria*** (section where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Annex C – page 20
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	Annex C – page 21

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2015/16" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2015/16";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "2015/16 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports 2015/16; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2015 and up to 25 May 2016 (the period);
- Papers relating to quality report reported to the Board over the period April 2015 to the date of signing this limited assurance report;
- Feedback from the Commissioners, Warrington Clinical Commissioning Group dated 17/05/2016 and Halton Clinical Commissioning Group dated 11/05/2016;
- Feedback from Local Healthwatch organisations, Healthwatch Warrington and Healthwatch Halton dated 18/05/2016;
- The 2015 national and local patient survey published in February 2016;
- The 2015 national and local staff survey published in February 2016;
- Care Quality Commission Intelligent Monitoring Reports published in May 2016; and
- The Head of Internal Audit's annual opinion over the Trust's control environment for 2015/16.

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

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

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 2016, 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 save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2015/16";

- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM the "Detailed requirements for quality reports 2015/16 and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Warrington and Halton Hospitals NHS Foundation Trust.

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The Trust reports monthly to Monitor on the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways indicator, based on the waiting time of each patient who has been referred to a consultant but whose treatment is yet to start. The Trust implemented a new system part way through the year which resulted in a number of patients being incorrectly included in the reported information. The Trust has been unable to cleanse this data and, as a result, we have been unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

Conclusion

Because the data required to support the indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways indicator.

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2016:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2015/16";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The "Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator has not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "Detailed guidance for external assurance on quality reports 2015/16".

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
101 Barbirolli Square
Lower Mosley Street
Manchester
M2 3PW
25 May 2016

The maintenance and integrity of the Warrington and Halton Hospitals NHS Foundation Trust website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendix

Glossary

Appraisal	method by which the job performance of an employee is evaluated
Bariatric surgery	(weight loss surgery) includes a variety of procedures performed on people who are obese.
Care quality commission (CQC)	Independent regulator of all health and social care services in England. They inspect these services to make sure that care provided by them meets national standards of quality and safety.
Clinical audit	is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical commissioning group (CCCG)	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clostridium difficile (C diff)	A Clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital. (CMCLRN) Cheshire and Merseyside Comprehensive Local Research Network
Commissioning for Quality and Innovation (CQUIN)	This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Dr Foster	is a provider of healthcare information and benchmarking solutions to enable healthcare organisations to benchmark and monitor performance against key indicators of quality and efficiency.
Friends and Family test (FFT)	Since April 2013, the following FFT question has been asked in all NHS Inpatient and A&E departments across England and, from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care : **"How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?"**
Governance risk rating	MONITOR **publish two risk ratings for each NHS foundation trust, on:** Governance (rated red, amber-red, amber-green or green); and Finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation trusts; they are the direct representatives of local community interests in foundation trusts
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and social care services to influence policy.
Healthcare evaluation data	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.

(HED)	
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
Monitor	assess NHS trusts for foundation trust status and license foundation trusts to ensure they are well-led, in terms of both quality and finances
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by: reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
National inpatient survey	collects feedback on the experiences of over 64,500 people, who were admitted to an NHS hospital in 2012.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service.
National institute of health research (NIHR).	Organisation supporting the NHS.
National patient safety agency (NPSA)	leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care
Never events	are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NNHS outcomes framework	reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. to act

	as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
Open and Honest	North of England Trusts produce and publish monthly reports on key areas of healthcare quality.
Palliative care	focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.
Patient Reported Outcome Measures (PROMs)	provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life
Payment by results (PBR)	provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for casemix.
Riddor	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Secondary users services (SUS)	The Secondary Uses Service is the single, comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services
Safety thermometer	is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
Subarachnoid haemorrhage (SAH)	Subarachnoid haemorrhage is a leakage of blood beneath the arachnoid membrane of the brain, from a major blood vessel. It affects a person suddenly and usually without any prior warning.
Summary hospital-level indicator (SHMI)	reports mortality at trust level across the NHS in England using standard and transparent methodology.
Urinary tract infection (UTI)	is an infection that affects part of the urinary tract
Venous thromboembolism (VTE)	A venous thrombosis or phlebothrombosis is a blood clot (thrombus) that forms within a vein. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolize), and become a life-threatening pulmonary embolism (PE).

5 The Auditor's Report including Certificate

Independent auditors' report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion, Warrington and Halton Hospitals NHS Foundation Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2016 and of its income and expenditure and cash flows for the year then ended 31 March 2016; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

Emphasis of Matter – Going Concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of disclosures made in Note 1 (Accounting Policies) to the financial statements concerning the Trust's ability to continue as a going concern. The 2016/17 planned deficit is £18.6million, with a working capital borrowing requirement of £18.6 million. The ability of the Trust to continue in its current form is reliant on it receiving external financial support, in addition to that already provided in 2015/16, to ensure it is able to meet its liabilities and provide ongoing healthcare services. However, the extent and nature of any further financial support is not yet known. Therefore it is not clear at present how the continuity of the Trust's services will be achieved. These conditions, together with the other matters explained in Note 1 to the financial statements, indicate the existence of material uncertainty, which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

What we have audited

The financial statements comprise:

the Statement of Financial Position as at 31 March 2016;

the Statement of Comprehensive Income for the year then ended;

the Statement of Changes in Taxpayer's Equity for the year then ended;

the Statement of Cash flows for the year then ended; and

the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

Certain required disclosures have been presented elsewhere in the Annual Report, rather than in the notes to the financial statements. These are cross-referenced from the financial statements and are identified as audited.

The financial reporting framework that has been applied in the preparation of the financial statements is the NHS Foundation Trust Annual Reporting Manual 2015/16 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our audit approach

Context

Our 2016 audit was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus were largely unchanged.

Materiality

- Overall materiality: £4,664,700 which represents 2% of total expenditure.
- We performed our audit of the financial information for the Trust at Warrington Hospital site, which is where the finance function is based; and

- We attended the Halton General Hospital site for the purpose of the physical verification of property, plant and equipment.
- In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

Financial position and sustainability;

Management override of control and Risk of fraud in revenue and expenditure recognition; and

Valuation of Property, Plant and Equipment.

The scope of our audit and our areas of focus

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code") and, International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)").

We designed our audit by determining materiality and assessing the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain. As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as "areas of focus" in the table below. We have also set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

Area of focus	*How our audit addressed the area of focus*
Going Concern *The Trust's future business plans are discussed in detail on page 12 of the Performance Report. The Trust's finances for the year ended 31 March 2016 are discussed in detail on pages 19 of the Performance Report – Performance Analysis .* The Trust's overall financial position for the year is a £18.4m deficit which is behind the original budget. Additionally, the Trust requires an additional external financial support in 2016/17 in order to meet its liabilities as they fall due. The Trust's budget for 2016/17 includes this external finance support which has not yet been agreed, in addition to the £11.6m working capital loan already in place. The Trust's financial performance has deteriorated, mainly due to underperformance against CIPs and higher than forecast usage of agency staff, leading to Monitor placing the Trust in enforcement due to a breach of its licence conditions. This has resulted in increased reporting to Monitor in respect of financial governance and sustainability. We have focused on the Trust's five year plan as well as assumptions within the Trust's annual plan for FY17 including levels of assumed cost inflation and delivery against CIP targets and the consequences of the Trust's continued going concern.	In considering the financial performance of the Trust we: • Understood the Trust's FY17 Annual Plan and cash flow forecasts, including the key assumptions within, and applied sensitivities e.g. higher levels of cost inflation, underperformance against CIPs, over the key assumptions on the Trust's forecasts; • Challenged the Trust's ability to achieve its CIP target through consideration of historical delivery of the CIP and, as above, the sensitivity of the FY17 Annual Plan to underperformance in this area. The Trust is forecasting a deficit of £18.6m, which would increase to between £18.7m and £20.3m should the Trust underperform, in line with previous performance levels, of between 10% and 30%; and • Assessed the potential need for additional financial support to enable the Trust to meet its liabilities as they fall due. As disclosed on page 12, the Directors have stated that there has been no indication from the Department of Health that the Trust will not continue to be a going concern although the Trust does require a working capital loan to meet its operational cash obligations which the Directors expect to receive, but, to date, no evidence has been available to support this expectation.

Area of focus	How our audit addressed the area of focus
	As the Trust is dependent upon receiving additional external support, and currently has no agreement in place for this, we have included an Emphasis of Matter within this report.
Management override of control and fraud in revenue and expenditure recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates in relation to the recognition of income and expenditure and notes 2-4 for further information.* We focused on this area because there is a heightened risk due to: • The Trust being under increasing financial pressure; whilst the Trust is looking at ways to maximise revenue and reduce costs, there is significant pressure to report results in line with its annual plan and to demonstrate its ability to reduce its cost base via CIPs. • As all Trusts are under pressure to achieve a breakeven position there is a risk that the Trust could adopt accounting policies or treat income and expenditure transactions in such a way as to lead to material misstatement in the reported deficit position. Given these incentives, we considered the risk of management manipulation in each of the key areas of focus, which are: • recognition of revenue and expenditure; • the inherent complexities in a number of contractual arrangements entered into by the Trust e.g. intra-NHS transactions; • manipulation through non-standard journal transactions; • items of income or expenditure whose value is dependent upon estimates, including the provision for bad debts; and • unrecorded liabilities.	*Income and Expenditure* For income and expenditure transactions close to the year-end we tested, on a sample basis, that the transaction and the associated income and expenditure had been posted to the correct financial year end by tracing them to invoices or other documentary evidence. Our testing did not identify any balances which had been recorded in the incorrect period. For a sample of income from Clinical Commissioning Groups (CCG) income, we obtained and agreed the income received during the year to a signed contract with the CCGs with no exceptions noted. For a sample of income recognised in relation to over performance against contract (i.e. the 'true up' of income) we agreed to year end settlements with no exceptions noted. We evaluated the provision for bad debt and the basis of its calculation by identifying old receivables, agreeing to cash receipt (where possible) or evidence to support their recoverability. From the testing we identified no issues. We performed testing over the risk of unrecorded liabilities by agreeing a sample of payments made and invoices received after the year end to supporting documentation and checking that, where they related to FY16 expenditure, an accrual was recognised appropriately. From the testing we performed we did not identify any unrecorded liabilities as at the year-end date. *Intra-NHS balances* We obtained the Trust's intra-NHS confirmations for debtor, creditor, income and expenditure balances, checked that management had investigated disputed amounts, then discussed with them the results of their investigation and the resolution, which we agreed to correspondence with the counterparty. We then considered the impact, if any, these disputes would have on the value of income and expenditure recognised in FY16 and determined that there was no material impact. *Journals* We tested a sample of manual journal transactions that had been recognised in both income and expenditure, focusing in particular on those recognised near the end of the year or included in accrued/deferred income or prepaid/accrued expenses, by tracing the journal entry to supporting documentation). Our testing confirmed that they were supported by appropriate documentation and that the related income and expenditure was recognised in the correct period.
Valuation of property, plant and equipment *See note 1 to the financial statements for the Directors'*	We obtained and read the relevant sections of the full

Area of focus	How our audit addressed the area of focus
disclosures of the related accounting policies, judgements and estimates relating to property, plant and equipment and note 9 for further information. We focused on this area because property, plant and equipment (PPE) represents the largest balance in the Trust's statement of financial position and is valued at £136m (2014/15: £145m). All property, plant and equipment assets are measured initially cost with land and buildings being subsequently measured at fair value based on periodic valuations. The valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and it is the Trust's policy that these are performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date. The Trust instructed their valuers to provide a full valuation over land and buildings as at 1 April 2016, together with a desktop update valuation as at 31 March 2016. In conjunction with this the Trust instructed their valuers to carry out a remaining useful life assessment of land and buildings to enable the annual depreciation to be calculated. This work resulted in a net reduction of the buildings balance to the value of £11.2m. The valuation of land and buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions therefore our work has focused on whether the valuers' methodology, assumptions and underlying data are appropriately and correctly applied.	valuation performed by the Trust's valuers. We used our valuation specialists to confirm that the valuations methodology and the assumptions used by the Trust's valuation experts were consistent with our expectations, based on our experience of similar valuations. We checked the qualifications, credentials and objectivity of the valuation experts by confirming they are RICS Registered National Valuers. We inquired to confirm there is no other business relationships between the Trust and their valuers that might impair their objectivity. We confirmed the accuracy of the information provided by the Trust to the valuers by: • checking and finding that the portfolio of properties included in the valuation was consistent with the Trust's fixed asset register, which we had tested by reconciling to the general ledger and testing the movements on the fixed asset register; and • agreeing a sample of building floor space areas back to floor plans and to the Estates Return Information Collection data. Following on from our testing of the valuation, we checked whether the change in valuation was correctly reflected in the financial statements and appropriately disclosed in the Annual Report. We found the accounting and the disclosures to be compliant with the NHS Foundation Trust Annual Reporting Manual 2015/16. We physically verified a sample of asset to confirm existence and, in doing so, assessed whether there was any indication of physical obsolescence, which would indicate potential impairments. We noted no such instances.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the trust, the accounting processes and controls, and the environment in which the trust operates.

In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements. We performed most of our audit work at the Warrington Hospital site, which is where the finance function is based; and attended the Halton General Hospital site for the purpose of the physical verification of property, plant and equipment.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

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

Overall materiality	£4,664,700 (2015: £4,384,560)
How we determined it	2% of expenditure
Rationale for benchmark applied	We have applied this benchmark, which is consistent with last year and a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £220,000 (2015: £215,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Other reporting in accordance with the Code

Opinions on other matters prescribed by the Code

In our opinion:

- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements;
- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and
- the part of the Staff Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

Other matters on which we are required to report by exception

We are required to report to you if, in our opinion:

information in the Annual Report is: materially inconsistent with the information in the audited financial statements; or apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or otherwise misleading.	We have no exceptions to report.
the statement given by the directors on page 30, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable and provides the information necessary for members to assess the Trust's performance, business model and strategy is materially inconsistent with our knowledge of the trust acquired in the course of performing our audit.	We have no exceptions to report.
the section of the Annual Report on page 32, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.	We have no exceptions to report.
the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 or is misleading or inconsistent with information of which we are aware from our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.	We have no exceptions to report.

We are also required to report to you if:

we have referred a matter to Monitor under paragraph 6 of Schedule 10 to the NHS Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or	We have no exceptions to report.

deficiency; or	
we have issued a report in the public interest under paragraph 3 of Schedule 10 to the NHS Act 2006.	We have no exceptions to report.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

The Audit Code for NHS Foundation Trusts requires us to report where we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The Trust continues to report significant deficits, £18.4m in 2015/16, without sufficient plans and controls in place to ensure a long-term turnaround. The Trust also has incurred significant costs on Agency staff and does not have a plan to maintain their current provision of services and reduce this cost without breaching Department of Health requirements on Agency spend. In 2014/15, Monitor opened an investigation following financial sustainability concerns arising as a result of an unplanned continuity of services risk rating of 2. Monitor's investigation resulted in the Trust being subject to enforcement action from August 2015. The Trust's position has continued to deteriorate in the year, ending FY16 with a Financial Sustainability Risk Rating (FSRR) of 1 and a Red Governance Rating.

Furthermore, in 2014/15 the Care Quality Commission performed a full inspection of the Warrington and Halton Hospitals service. The CQC report was issued in July 2015 and identified that the Trust required improvement for providing safe, responsive and well led care.

As a result of the matters summarised above, we have been unable to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2016.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Directors' Responsibilities Statement, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Code, and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Warrington and Halton Hospital NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

What an audit of financial statements involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Responsibilities for securing economy, efficiency and effectiveness in the use of resources

Our responsibilities and those of the Trustees

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. We are required under paragraph 1(d) of Schedule 10 to the NHS Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you 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 work in accordance with the Code, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

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.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code.

Fiona Kelsey (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Manchester
25 May 2016

(a) The maintenance and integrity of the Warrington and Halton Hospital NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

6 Foreword to the Accounts

Foreword to the accounts for the year 1st April 2015 to 31st March 2016

Warrington and Halton Hospitals NHS Foundation Trust

These accounts, for the year ended 31st March 2016, 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.

Signed:

Chief Executive

Date: 25th May 2016

7 Primary financial statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31st MARCH 2016

	NOTE	2015/16 £000	2014/15 £000
Income from activities	3	196,856	201,418
Other operating income	3	22,182	18,559
Operating income	3	**219,038**	**219,977**
Operating expenses	4	(233,325)	(222,256)
OPERATING DEFICIT		**(14,287)**	**(2,279)**
FINANCE INCOME / (COSTS)			
Finance income - interest receivable	6	25	37
Finance expense - interest payable	7	(88)	(15)
PDC dividends payable		(3,925)	(4,233)
NET FINANCE COSTS		**(3,988)**	**(4,211)**
DEFICIT FOR THE FINANCIAL YEAR		**(18,275)**	**(6,490)**
Other comprehensive (expense) / income			
Items that will not be reclassified to income and expenditure			
Gain from transfer by absorption from demising bodies	9	0	0
Impairment losses on property, plant and equipment	9	(16,475)	(218)
Revaluation gains on property, plant and equipment	9	6,265	10,349
Asset disposals for which there was an existing reserve	9	0	0
TOTAL COMPREHENSIVE (EXPENSE) / INCOME FOR THE YEAR		**(28,485)**	**3,641**

The notes on pages 5 to 44 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31st MARCH 2016

	NOTE	31st March 2016 £000	31st March 2015 £000
NON-CURRENT ASSETS			
Intangible assets	8	2,319	567
Property, plant and equipment	9	133,041	143,354
Trade and other receivables	11	994	1,083
Total non-current assets		**136,354**	**145,004**
CURRENT ASSETS			
Inventories	10	3,435	3,312
Trade and other receivables	11	9,167	10,942
Cash and cash equivalents	12	2,583	4,511
Total current assets		**15,185**	**18,765**
CURRENT LIABILITIES			
Trade and other payables	13	(22,314)	(20,888)
Borrowings	14	(430)	(185)
Other liabilities	16	(2,092)	(974)
Provisions	17	(364)	(335)
Total current liabilities		**(25,200)**	**(22,382)**
Total assets less current liabilities		**126,339**	**141,387**
NON-CURRENT LIABILITIES			
Borrowings	14	(16,701)	(703)
Provisions	17	(1,334)	(1,395)
Total non-current liabilities		**(18,035)**	**(2,098)**
TOTAL ASSETS EMPLOYED		**108,304**	**139,289**
TAXPAYERS' EQUITY			
Public dividend capital		87,742	90,242
Revaluation reserve		34,269	45,077
Income and expenditure reserve		(13,707)	3,970
TOTAL TAXPAYERS' EQUITY		**108,304**	**139,289**

The primary accounts on pages 1 to 4 and the notes on pages 5 to 44 were approved by the Board of Directors on 25th May 2016 and signed on its behalf by Mel Pickup, Chief Executive.

Signed: ..... **Date: 25th May 2016**

Mel Pickup

Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31ST MARCH 2016

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1st April 2015	139,289	90,242	45,077	3,970
Deficit for the year	(18,275)	0	0	(18,275)
Transfers between reserves	0	0	(598)	598
Impairment losses on property, plant and equipment	(16,475)	0	(16,475)	0
Revaluations (property, plant and equipment)	6,265	0	6,265	0
Other reserve movements (asset disposals)	0	0	0	0
Transfers by modified absorption	0	0	0	0
Total comprehensive expense for the year	**(28,485)**	**0**	**(10,808)**	**(17,677)**
Public Dividend Capital received	0	0	0	0
Public Dividend Capital repaid	(2,500)	(2,500)	0	0
Taxpayers' equity as at 31st March 2016	**108,304**	**87,742**	**34,269**	**(13,707)**

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1st April 2014	135,469	90,063	35,808	9,598
Deficit for the year	(6,490)	0	0	(6,490)
Transfers between reserves	0	0	(862)	862
Impairment losses on property, plant and equipment	(218)	0	(218)	0
Revaluations (property, plant and equipment)	10,349	0	10,349	0
Other reserve movements (asset disposals)	0	0	0	0
Transfers by modified absorption	0	0	0	0
Total comprehensive income / (expense) for the year	**3,641**	**0**	**9,269**	**(5,628)**
Public Dividend Capital received	179	179	0	0
Public Dividend Capital repaid	0	0	0	0
Taxpayers' equity as at 31st March 2015	**139,289**	**90,242**	**45,077**	**3,970**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED

31st MARCH 2016

	NOTE	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating deficit from continuing operations		(14,287)	(2,279)
Non-cash income and expense			
Depreciation and amortisation	4	4,848	6,086
Impairments	4	1,596	1,208
Reversal of impairments	3	(631)	(492)
(Gain)/Loss on disposal		102	19
Non-cash donations credited to income		(39)	(281)
Increase/(Decrease) in trade and other receivables		2,243	(2,946)
Increase in inventories	10	(123)	(543)
Increase in trade and other payables		2,975	1,554
Increase/(Decrease) in other liabilities	16	1,118	(379)
Decrease in provisions	17	(32)	(61)
Other movements in operating cash flows		(4)	5
Net cash (used in) / generated from operations		**(2,234)**	**1,891**
Cash flows from investing activities			
Interest received	6	25	37
Purchase of intangible assets		(1,312)	(289)
Purchase of property, plant and equipment		(7,089)	(6,097)
Sales of property, plant and equipment		91	5
Receipt of cash donations to purchase capital assets		4	50
Net cash used in investing activities		**(8,281)**	**(6,294)**
Cash flows from financing activities			
Public Dividend Capital received		0	179
Repayment of PDC		(2,500)	0
Loans received from Department of Health		15,800	0
Capital elements of finance lease rental payments		(291)	0
Interest paid on late payment of debt	7	(1)	(6)
Interest element of finance lease	7	(41)	(9)
Public Dividend Capital dividend paid		(4,380)	(4,206)
Net cash used in financing activities		**8,587**	**(4,042)**
Decrease in cash and cash equivalents		(1,928)	(8,445)
Cash and cash equivalents as at 1st April		4,511	12,956
Cash and cash equivalents as at 31st March	12	**2,583**	**4,511**

NOTES TO THE ACCOUNTS

1. Accounting policies and other information

Basis of preparation

Monitor has directed that the accounts of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16 (FT ARM) which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

Going concern

The Board approved the 2016/17 Annual Plan for submission to Monitor.

The 2016/17 income and expenditure included in the annual plan have been constructed using national guidance on tariff and inflationary factors. Income plans are based on anticipated activity levels with commissioners including tariff inflation and expenditure plans are based on current budgets adjusted for the impact of changes in activity levels, activity and quality related cost pressures, national inflationary assumptions and the cost savings requirement. The 2016/17 planned deficit is £18.6million, with a working capital borrowing requirement of £18.6 million. The Trust believes that it has been realistic in its assessment of efficiency targets that aim for a cost saving target of £8.0 million. The Trust believes that this forward plan provides a realistic assessment of the Trust's position.

During 2015/16 two loans were drawn down from the Department of Health, totalling £15.8m. As a result of this in May 2018 payment of £14.5m will be required to the Department of Health to repay these loans. The 2016/17 Annual Plan also requires loans from the Department of Health of £18.6m. There is currently no long term plan in place to ensure that the Trust is able to manage these repayments without incurring additional debts.

The capital plan is based on an in year spend of £6.7m, which the Trust forecasts will be possible using the funding loans referred to above and the carry forward of the 2015/16 capital underspend so there is no requirement for a capital loan. The capital plan does not include the impact of the Estates Strategy programme that may be undertaken in year.

The Trust believes that this plan is a realistic assessment of the Trust's 2016/17 financial position.

The Trust has a governance structure that means the Finance & Sustainability Committee monitors financial performance and oversees the necessary corrective action, supplemented by the Innovation and Cost Improvement Committee that monitor progress towards the cost savings target. These committees are supplemented by additional scrutiny of the finances through Executive led review initiatives.

1. Accounting policies and other information (continued)
Going concern (continued)

The preparation of the income and expenditure budgets and cash flow statements is predicated on many national and local factors and assumptions regarding both income and expenditure and profiled accordingly.

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

- 15/16 forecast outturn.
- Changes in activity resulting from changes in demographic and demand.
- National Payment by Results rules and regulations.
- Commissioning intentions.
- National tariff prices.

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

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

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

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

Notwithstanding the 2016/17 planned deficit referred to above, the Trust does not have any evidence indicating that the going concern basis is not appropriate as the Trust has not been informed by Monitor that there is any prospect of intervention or dissolution within the next 12 months.

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

Taking the above into account, the Directors believe that it is appropriate to prepare the financial statements on a going concern basis.

1.1 Key sources of judgement and estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the critical judgements that management have made in the process of applying the entity's accounting policies, together with the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Provisions

The pension provision relating to former employees, including directors, have been calculated using the life expectancy estimates from the Government's actuarial tables.

The legal claims provision relates to employer and public liability claims and expected costs are advised by the NHS Litigation Authority. The Trust accepts financial liability for the value of each claim up to the excess defined within the policy.

Provision for impairment of receivables

A provision for impairment of receivables has been made for amounts which are uncertain to be received from NHS and non-NHS organisations as at 31st March 2016. The provision includes 21.9% (18.9% for 2014/15) of accrued Injury Cost Recovery (ICR) income to reflect the average value of claims withdrawn as advised by the Department of Health's Compensation Recovery Unit (CRU).

Asset valuations and lives

The value and remaining useful lives of land and building assets are estimated by Cushman & Wakefield who provide professional valuation services. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost based on modern equivalent for specialised operational property (property rarely sold on the open market) and Existing Use Value for non-specialised operational property.

1.1 Key sources of judgement and estimation uncertainty (continued)
Asset valuations and lives (continued)

For 2015/16 the Trust instructed Cushman & Wakefield to provide a full revaluation for land and buildings and a review of asset lives for buildings as at 1st April 2015. The changes have been reflected with the 2015/16 annual accounts. A further desktop revaluation exercise was completed by Cushman & Wakefield with a prospective date of 31st March 2016, which was applied to the accounts on 31st March 2016. A full asset valuation is undertaken every five years with an annual desk top valuation being undertaken in the intervening years. Market Value was used in arriving at fair value for the assets subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

Software licences are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Employee benefits

The cost of annual leave entitlement not taken is accrued at the year end. Accruals are calculated using a sample of Trust employees based on actual point of their salary band.

1.2 Income

Income is recognised when and to the extent that performance occurs, and is measured at the fair value of the consideration receivable.

The main source of income for the Trust is from NHS commissioners for the provision of healthcare services. This income is recognised either on discharge of patient or value of partially completed activity as at 31st March 2016 for all NHS commissioners.

Where income is received for a specific activity that is to be delivered in a future financial year that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income under the ICR Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Health's CRU that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision to reflect the average value of claims withdrawn (21.9%).

The main source of other operating income is from Health Education England, NHS Trusts, NHS Foundation Trusts, Health and Social Care Information Centre (via Department of Health) and Local Authorities.

1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded defined benefit scheme that covers NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional cost is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as an intangible asset or an item of property, plant and equipment.

1.5 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset, if it meets the above conditions.

Measurement

Intangible assets are initially recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

1.5 Intangible assets (continued)
Measurement (continued)

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- a number of items which collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

The whole of a site is designated as the property asset with the land, the separate buildings upon it and the external works being the main components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is initially measured at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

1.6 Property, plant and equipment (continued)
Valuation (continued)

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and where it would meet the location requirements of the service being provided an alternative site valuation can be used. The Trust commissioned Cushman & Wakefield to undertake a full valuation and review of assets lives as at 1st April 2015 and further review of values as at 31st March 2016. The impact of this exercise is reflected in the accounts for 2015/16. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date. Fair values are determined as follows:

Land and non specialised buildings - market value for existing use.
Specialised buildings - depreciated replacement cost.
Equipment - depreciated historical cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation, revaluations and impairments

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

1.6 Property, plant and equipment (continued)
Revaluation gains and losses (continued)

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments

At the end of the financial year the Trust reviews whether there is any indication that any of its assets have suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses, and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve, where at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments, such as unforeseen obsolescence, are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains and classed as other operating income.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met.

The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales and the sale must be highly probable i.e. management are committed to a plan to sell the asset, an active programme has begun to find a buyer and complete the sale, the asset is being actively marketed at a reasonable price, the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6 Property, plant and equipment (continued)

Donated, government grant and other grant funded assets

Donated, government grant and other grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited in full to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Contingent rents are recognised in operating expenses in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula, which is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.9 Cash and cash equivalents

Cash is defined as cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. Interest earned on bank accounts is recorded as interest receivable in the periods to which it relates. Balances exclude monies held in bank accounts belonging to patients (Note 12).

1.10 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provision and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.37% (1.30% in 2014/15) in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution (Note 4) to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to operating expenses. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 17 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and, in return, receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of successful claims are charged to operating expenses as and when they become due.

1.11 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.12 Corporation tax

Warrington and Halton Hospitals NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is temporarily exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA). Accordingly, the Trust will become within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare and where the profits exceed £50,000 per annum. However, there is no tax liability in respect of the current financial year (£nil in 2014/15).

1.13 Foreign exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at fair value through income and expenditure) are translated at the spot exchange rate on 31st March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.14 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with requirements of HM Treasury's FReM. Details of third party assets are given in Note 12 to the accounts.

1.15 Public dividend capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets, over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard (IAS) 32.

1.15 Public dividend capital (PDC) and PDC dividend (continued)

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (ii) average daily cleared cash balances held with Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the unaudited version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in operating expenses on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.17 Consolidation

The NHS Foundation Trust is the corporate Trustee to Warrington & Halton Hospitals NHS FT Charitable Fund. The Foundation Trust has assessed it's relationship to the charitable fund and determined it to be subsidiary because the Foundation Trust is exposed too, or has rights to, variable returns and other benefits for itself, patients and staff from it's involvement with the charitable fund and has the ability to effect those returns another benefits through it's power over the fund.

The charitable fund's statutory accounts are prepared to 31st March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charities assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trusts accounting policies: and
- eliminate intra-group transactions, balances, gain and losses.

For 2015/16 the Trust has opted not to consolidate charitable funds with the main Trust Accounts because they are immaterial. This will be reviewed each year for appropriateness.

1.18 Other Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published accounts of the subsidiaries for the year except where a subsidiary's financial year end is before 1st January or after 1st July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Subsidiaries classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

1.19 Interests in other entities

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence and are recognised in the Trust's financial statement using equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trusts share of the entities profit or loss or other gains and losses (e.g. revaluation gains on the entities property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g. share dividends are received by the Trust from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and "fair value less costs to sell".

Joint ventures

Joint ventures are arrangements in which the Trust has a 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 a 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 it's sale of the assets, liabilities, income and expenses.

1.20 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities that arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in 1.7.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or has expired.

Classification and measurement

Financial assets are categorised as fair value through income and expenditure, loans and receivables or available for sale financial assets.

Financial liabilities are classified as fair value through income and expenditure or as other financial liabilities.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets and financial liabilities at fair value through income and expenditure are financial assets or financial liabilities held for trading. The Trust does not hold any financial assets or financial liabilities at fair value through income and expenditure.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market and are included in current assets.

The Trust's loans and receivables comprise: an interim revenue support and capital loan from the Department of Health, cash at bank and in hand, NHS receivables and part of accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

1.20 Financial instruments and financial liabilities (continued)

Available for sale financial assets

The Trust does not hold any available for sale financial assets.

Other financial liabilities at amortised cost

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the Statement of Comprehensive Income.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at fair value through income and expenditure are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of the impaired receivables provision account (Note 11).

At each period end the Trust reviews trade receivables for recoverability and makes a provision for those debts which it believes recovery of the amount outstanding is doubtful. Amounts are written off on a quarterly basis following approval from the Trust's Audit Committee.

1.21 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The Trust's chief operating decision maker, responsible for providing strategic direction and decisions, allocating resources and assessing performance of the operating segments, is the Board of Directors.

1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

1.23 Accounting standards and amendments issued but not yet adopted in the FT ARM

The effective date of the following standards are disclosed after the standard's names; these amendments or new standards are not yet adopted by the European Union.

IFRS 11 (amendment) - Acquisition of an interest in a joint operation. Published by the IASB in May 2014 and expected to be effective from 2016/17.

IAS 16 (amendment) and IAS 38 (amendment) - Depreciation and amortisation. Published by the IASB in May 2014 and expected to be effective from 2016/17.

IAS 16 (amendment) and IAS 41 (amendment) - Bearer plants. Published by the IASB in June 2014 and expected to be effective from 2016/17.

IAS 27 (amendment) - Equity method in separate financial statements. Published by the IASB in August 2014 and expected to be effective from 2016/17.

IFRS 10 (amendment) and IAS 28 (amendment) - Sale or contribution of assets. Published by the IASB in September 2014 and expected to be effective from 2016/17.

IFRS 10 (amendment) and IAS 28 (amendment) - Investment entities applying the consolidation exception. Published by the IASB in December 2014 and expected to be effective from 2016/17.

IAS 1 (amendment) - Disclosure initiative. Published by the IASB in December 2014 and expected to be effective from 2016/17.

IFRS 15 - Revenue from contracts with customers. Published by the IASB in May 2014 and expected to be effective from 2017/18.

Annual improvements to IFRS: 2012-15 cycle. Published by the IASB in July 2014 and expected to be effective from 2017/18.

IFRS 9 Financial Instruments. Published by the IASB in July 2014 and expected to be effective from 2018/19.

IFRS - International Financial Reporting Standard
IFRIC - International Financial Reporting Interpretations Committee
IAS - International Accounting Standard
IASB - International Accounting Standards Board

2. Operating segments

The Trust considers the Board of Directors to be the chief operating decision maker (CODM) because it regularly reviews operating results, makes decisions about where resources are allocated as a result and assesses performance.

Income arising from the following segments is reported monthly to the Board on a distinct and separate basis and therefore they have been disclosed separately in the table below:

- Scheduled Care
- Unscheduled Care
- Women's Children's & Support Services

· Other services

2. Operating segments (continued)

The Trust provides NHS healthcare services to the general public, the majority of whom are registered with a GP Practice in England, and the above detailed segments are the key operational segments that the Trust uses to make management decisions.

Segment	2015/16 £000	2014/15 £000
Scheduled Care	68,510	69,294
Unscheduled Care	62,650	63,744
Women's, Children's & Support Services	45,282	47,775
Other services	42,596	39,164
Total operating income	**219,038**	**219,977**

Income from other services relates to patient care income not attributed to a particular segment and includes private patient income, ICR income, education and training income and other operating income received for the provision of goods and services.

The Trust has two external customers who individually generate income amounting to more than 10% of the Trust's total income. NHS Warrington CCG generated income of £112.0m (51%) (2014/15 - £113.9m & 52%) and NHS Halton CCG generated income of £44.3m (20%) (2014/15 - £47.1m & 21%)

The Trust does not report expenditure, total assets or liabilities attributable to each operating segment to the Board. Consequently expenditure, total assets and liabilities attributable to each operating segment are not disclosed in this note.

3. Operating income

Income from activities

	2015/16 £000	2014/15 £000
Income for commissioner requested services		
Elective income	36,709	38,885
Non elective income	55,615	56,811
Outpatient income	33,080	33,794
A & E income	11,125	10,280
Other NHS clinical income (1)	56,641	60,219
Additional income for the delivery of healthcare services (2)	2,500	0
Income for non-commissioner requested services		
Private patient income	102	77
Other non-protected clinical income (3)	1,084	1,352
Total income from activities	**196,856**	**201,418**
Other operating income		
Education and training	8,061	8,499
Non-patient care services to other bodies	867	859
Charitable and other donations (4)	190	1,101
Reversal of impairments	631	492
Profit on disposal of property, plant and equipment (5)	44	0
Received from other bodies (6)	2,529	0
Other (7)	9,860	7,608
Total other operating income	**22,182**	**18,559**
Total operating income	**219,038**	**219,977**

(1) Other NHS clinical income includes income received in respect of pathology, radiology, audiology, system resilience monies, national tariff payment system, excluded drugs, breast screening services, neo-natal services, maternity, critical care, chemotherapy and palliative care.

(2) Additional income for the delivery of healthcare services relates to a transfer of capital to revenue of £2.5m the Trust made in February 2016.

(3) Other non-protected clinical income relates to ICR income received from the CRU.

(4) Charitable donations includes money received from NHS Halton CCG in relation to the redevelopment of the Urgent Care centre at Halton Hospital totalling £0.2m for 2015/16 (£0.7m for 2014/15)

(5) Profit on disposal relates to items of surplus medical equipment that were sold at auction.

(6) Received from other bodies is in relation to income from the Health and Social Care Information Centre (HSCIC) for the Lorenzo project which is a patient care system. The payments were received from the Department for Health.

(7) Other operating income of £9.9m (£7.6m in 2014/15) includes income in respect of staff recharges, clinical tests, catering, estate recharges, lease income and other miscellaneous income recharged to other NHS bodies.

3. Operating income (continued)

Income from activities by type	2015/16 £000	2014/15 £000
NHS Clinical Commissioning Groups	179,149	184,661
NHS England	12,158	10,294
NHS Other (8)	(65)	3,016
Local Authorities	1,928	2,018
Non NHS: private and overseas patients	102	77
CRU income	1,084	1,352
Department of Health (2)	2,500	0
Total	**196,856**	**201,418**

(8) NHS Other includes income from other Foundation Trusts, NHS Trusts and Public Health England.

Overseas visitors (relating to patients charged directly by the NHS Foundation Trust)

	2015/16 £000	2014/15 £000
Income recognised this year	33	23
Cash payments received in-year	31	15
Amounts added to provision for impairment of receivables	6	8
Amounts written off in-year	2	1

Operating lease income

The Trust has in place the following significant operating leases as a lessor.

Company	Lease Commencement Date	Lease Expiry Date	Lease Description
Gentian (Warrington) Limited	01/01/2001	31/12/2030	Lease of Land at Warrington General Hospital
Fresenius Medical Care Renal Services Limited	01/07/2008	30/06/2068	Rental of premises at Halton General Hospital

Operating lease income	2015/16 £000	2014/15 £000
Rents recognised as income in the year	255	232
Total	**255**	**232**

Operating lease income (continued)

Future minimum lease receipts due	2015/16 £000	2014/15 £000
- not later than one year	212	232
- later than one year and not later than five years	846	797
- later than five years	6,610	6,682
Total	**7,668**	**7,711**

4. Operating expenses	2015/16 £000	2014/15 £000
Services from NHS Trusts	342	253
Employee costs - executive directors	1,216	964
Employee costs - non-executive directors	111	121
Employee costs – staff	161,333	153,375
Drug costs	15,831	13,666
Supplies and services - clinical (excluding drug costs)	19,182	20,950
Supplies and services - general	2,874	2,565
Establishment	1,865	2,066
Transport (business travel only)	269	286
Transport (other)	749	727
Premises - business rates to local authorities	910	945
Premises - other	8,019	8,142
Rentals under operating leases	1,293	613
Increase in bad debt provision	101	30
Change in provisions discount rate	(7)	51
Depreciation on property, plant and equipment	4,606	6,009
Amortisation of intangible assets	242	77
Impairments of property, plant and equipment	1,596	1,208
Loss on disposal of property, plant and equipment (1)	146	19
Audit fees - statutory audit - PricewaterhouseCoopers LLP	70	52
All other non-audit services - PricewaterhouseCoopers LLP	8	8
Clinical negligence premiums	9,605	6,449
Legal fees	243	116
Consultancy costs	355	618
Internal audit costs (not included in employee expenses)	77	92
Training courses and conferences	785	725
Patient travel	20	20
Redundancy	85	0
Commercial insurance	95	92
Losses, ex gratia & special payments - not included within employee expenses	16	52
Other (2)	1,288	1,965
TOTAL	**233,325**	**222,256**

4. Operating expenses (continued)

(1) Mainly relates to the disposal of a Magnetic Resonance Imaging (MRI) scanner.

(2) Other expenditure includes early retirement costs, carbon reduction commitment allowances, personal and permanent injury benefits, patient expenses and the movement in the annual leave accrual.

The external auditors' liability is limited to £1m. The scope of work for the external auditors is to provide a statutory audit to the Trust. This will be conducted in accordance with the Audit Code for NHS Foundation Trusts (the Audit Code) issued by Monitor in accordance with paragraph 24 of schedule 7 of the National Health Service Act 2006. The scope of the work is for the external auditors to be satisfied that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The external auditors are to provide their opinion on the accounts.

The Late Payment of Commercial Debts (Interest) Act 1998

The total paid within 2015/16 for late payment of commercial debt was £564 (£948 in 2014/15)

Better payment practice code (BPPC)

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

Performance for the financial year is contained in the table below:

	2015/16 Number	2015/16 £000	2014/15 Number	2014/15 £000
Non-NHS trade invoices paid in the year	47,088	73,698	49,754	65,629
Non NHS trade invoices paid within target	12,882	35,275	20,449	37,105
Percentage of non-NHS trade invoices paid within agreed payment terms or in 30 days	**27%**	**48%**	**41%**	**57%**
NHS trade invoices paid in the year	1,767	14,069	1,877	15,720
NHS trade invoices paid within target	394	7,925	584	8,179
Percentage of NHS trade invoices paid within agreed payment terms or in 30 days	**22%**	**56%**	**31%**	**52%**

Operating lease expenditure

The Trust has in place the following significant operating leases as a lessee.

4. Operating expenses (continued)

Operating lease expenditure

Company	Lease Start Date	Lease Expiry Date	Lease Description
Amas Limited (was previously Quondam Estates Limited)	08/06/2000	07/06/2030	Lease for pharmacy at Warrington Hospital
Gentian (Warrington) Limited	01/01/2001	31/12/2030	Lease for office space at Warrington Hospital
Gentian (Warrington) Limited	01/01/2001	31/12/2030	Lease for staff areas at Warrington Hospital
PtS Property Limited	13/08/2015	12/08/2020	Lease for parking spaces at Warrington Hospital
Shawbrook Asset Finance	31/05/2011	30/05/2016	Lease for mobile digital mammography equipment
Shawbrook Asset Finance	31/05/2011	30/05/2016	Lease for mobile breast screening trailer
DeLage Landen Leasing Limited	19/04/2013	18/04/2018	Lease for mammography equipment at the Bath Street Health & Wellbeing Centre
Genmed	01/04/2015	31/03/2019	Lease of endoscopes
Portakabin Limited	01/06/2013	01/06/2016	Lease of urgent care portakabin
Portakabin Limited	06/05/2015	06/05/2017	Lease of HR training dept portakabin
Portakabin Limited	30/04/2014	30/04/2016	Lease of clinical waste store portakabin
Siemens Financial Services Limited	01/11/2015	31/10/2020	Lease of ultrasound machine
NHS BSA Leasing Solution	01/07/2015	30/06/2022	Lease of MRI scanner

Payments recognised in expenditure

	2015/16 £000	2014/15 £000
Minimum lease payments	1,251	597
Contingent rents	42	16
Total	**1,293**	**613**

4. Operating expenses (continued)

Arrangements containing an operating lease

	2015/16 £000	2014/15 £000
Future minimum lease payments due:		
- not later than one year	1,189	534
- later than one year and not later than five years	3,032	1,130
- later than five years	1,675	1,615
Total	**5,896**	**3,279**

5. Employee expenses

	2015/16 Permanently Employed	2015/16 Other	2015/16 Total	2014/15 Total
	£000	£000	£000	£000
Salaries and wages	123,350	1,186	124,536	121,058
Social security costs	9,273	0	9,273	9,131
Pension costs (employer contributions to NHS Pensions)	13,249	0	13,249	12,713
Termination benefits	0	0	0	0
Bank and agency staff	0	15,957	15,957	11,562
Total employee benefit expenses	**145,872**	**17,143**	**163,015**	**154,464**
Less costs capitalised as part of assets	(381)	0	(381)	(125)
Total per employee expenses in Note 4.	**145,491**	**17,143**	**162,634**	**154,339**

Employee costs include staff costs of £381k (£125k in 2014/15) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses in Note 4. The employee expenses note is for executive director, staff costs and redundancy payments only. It excludes non executive directors.

Average number of persons

	2015/16 Permanently Employed	2015/16 Other	2015/16 Total	2014/15 Total
	Number	Number	Number	Number
Medical and dental	282	106	388	386
Administration and estates	744	54	798	765
Healthcare assistants and other support staff	790	15	805	775
Nursing, midwifery and health visiting staff	970	3	973	994
Scientific, therapeutic and technical staff	529	25	554	533
Bank and agency staff	0	202	202	162
Total	**3,315**	**405**	**3,720**	**3,615**

5. Employee expenses (continued)

Staff exit packages

	2015/16						2014/15	
Exit package cost band	Number of Compulsory Redundancies	Cost of Compulsory Redundancies	Number of Other Agreed Departures	Cost of Other Agreed Departures	Total Number	Total Value	Total Number	Total Value
		£000		£000		£000		£000
£0 - £10,000	0	0	1	5	1	5	0	0
£10,001 - £25,000	0	0	2	36	2	36	0	0
£25,001 - £50,000	0	0	1	44	1	44	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0	0	0
Total number and value of exit packages by type	**0**	**0**	**4**	**85**	**4**	**85**	**0**	**0**

Number of departures where special payments have been made is 1 at a cost of £5k.

5. Employee expenses (continued)

Exit packages: other (non-compulsory) departure payments

	2015/16		2014/15	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	2	36	0	0
Mutually agreed resignations (MARS) contractual costs	1	44	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring Her Majesty's Treasury approval	1	5	0	0
Total	**4**	**85**	**0**	**0**
Of which:				
Non-contractual payments requiring Her Majesty's Treasury approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

5. Employee expenses (continued)

Executive directors' remuneration and other benefits

	2015/16 £000	2014/15 £000
Highest paid director's remuneration	165	165
Other directors' remuneration	841	607
Total directors' remuneration	**1,006**	**772**
Employer contributions to NHS Pension Scheme for highest paid director	24	23
Employer contributions to NHS Pension Scheme for all other directors	81	73
Total employer contributions to NHS Pension Scheme	**105**	**96**
Number of directors to whom benefits are accruing under the NHS Pension Scheme during the year	10	8

The total of accrued pension and lump sum held under the NHS Pension Scheme as at 31st March 2016 for the highest paid director was £61k and £175k respectively (£58K and £174k as at 31st March 2015).

Full details of Directors' remuneration and other benefits are set out in the NHS Foundation Trust's Remuneration Report within the Annual Report.

Employee benefits

An accrual in respect of the cost of annual leave entitlement carried forward at the Statement of Financial Position date of £592k has been provided for within the accounts (£754k as at 31st March 2015).

Early retirements due to ill-health

Three members of staff retired early on ill health grounds during the year at an additional cost of £117k (Eight members of staff at a cost of £352k for the year ending 31st March 2015). The cost of ill health retirements are borne by the NHS Business Services Authority - Pensions Division.

Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

5. Employee expenses (continued)
Pension Costs (continued)

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31st March 2016, is based on valuation data as 31st March 2015, updated to 31st March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31st March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The expected value of contributions to the plan for the next annual reporting period to include both employee and employer contributions is £2.187m.

c) Scheme provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and the best of the last three pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

5. Employee expenses (continued)
Pension Costs (continued)

With effect from 1st April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum up to a maximum amount permitted under HMRC rules. This new provision is know as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30th September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI). Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase Additional Voluntary Contributions (AVCs) run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

6. Finance income - interest receivable	**2015/16 £000**	**2014/15 £000**
Interest from bank accounts	25	37
Total	**25**	**37**

7. Finance expense - interest payable	**2015/16 £000**	**2014/15 £000**
Department of Health Loan	46	0
Interest on Late Payment of Debt	1	1
Interest on Finance Leases	41	9
Interest Other	0	5
Total	**88**	**15**

8. Intangible assets

	Software licences £000
Cost as at 1st April 2015	802
Additions - purchased	1,312
Additions - donated	25
Impairments	0
Reclassifications	1,022
Disposals	0
Cost as at 31st March 2016	**3,161**

Accumulated Amortisation as at 1st April 2015	235
Charged during the year	242
Reclassifications	365
Disposals	0
Accumulated Amortisation as at 31st March 2016	**842**
Cost as at 1st April 2014	500
Additions - purchased	289
Impairments	0
Reclassifications	78
Disposals	(65)
Cost as at 31st March 2015	**802**
Accumulated Amortisation as at 1st April 2014	184
Charged during the year	77
Reclassifications	39
Disposals	(65)
Accumulated Amortisation as at 31st March 2015	**235**

All intangible assets are owned.

Economic life of intangible assets

	Minimum Life Years	Maximum Life Years
Software licences	5	8

9. Property, plant and equipment

Current Year	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 1st April 2015	**166,191**	**20,181**	**118,850**	**1,322**	**614**	**17,387**	**72**	**7,326**	**439**
Transfers by absorption - modified*	0	0	0	0	0	0	0	0	0
Additions - purchased	5,612	0	684	517	639	681	29	2,672	390
Additions - leased	692	0	0	0	0	0	0	692	0
Additions - donated	14	0	0	0	0	12	0	2	0
Impairments charge to the revaluation reserve	(16,475)	(7,706)	(8,396)	(373)	0	0	0	0	0
Reclassifications	(1,022)	0	0	0	0	0	0	(1,022)	0
Revaluation surpluses	6,265	0	6,219	46	0	0	0	0	0
Disposals	(539)	0	0	0	0	(539)	0	0	0
Cost or valuation as at 31st March 2016	**160,738**	**12,475**	**117,357**	**1,512**	**1,253**	**17,541**	**101**	**9,670**	**829**
Accumulated Depreciation as at 1st April 2015	22,837	0	10,388	131	0	8,902	18	3,165	233
Charged during the year	4,606	0	1,985	30	0	1,427	12	1,088	64
Impairments recognised in operating expenses	1,596	0	1,384	212	0	0	0	0	0
Reversal of impairments credited to operating income	(631)	0	(559)	(72)	0	0	0	0	0
Reclassifications	(365)	0	0	0	0	0	0	(365)	0
Disposals	(346)	0	0	0	0	(346)	0	0	0
Accumulated Depreciation as at 31st March 2016	**27,697**	**0**	**13,198**	**301**	**0**	**9,983**	**30**	**3,888**	**297**
NBV as at 31st March 2016	**133,041**	**12,475**	**104,159**	**1,211**	**1,253**	**7,558**	**71**	**5,782**	**532**
Prior Year									
Cost or valuation as at 1st April 2014	**177,545**	**19,181**	**120,790**	**1,319**	**0**	**28,551**	**62**	**6,804**	**838**
Transfers by absorption - modified*	0	0	0	0	0	0	0	0	0
Additions - purchased	6,260	0	3,156	0	614	906	10	1,551	23
Additions - leased	880	0	0	0	0	0	0	880	0
Additions - donated	281	0	104	0	0	177	0	0	0
Impairments charged to revaluation reserve	(218)	0	(218)	0	0	0	0	0	0
Reclassifications	(78)	0	0	0	0	(78)	0	0	0
Revaluation surpluses	10,349	1,000	9,189	160	0	0	0	0	0

9. Property, plant and equipment (continued)

Disposals	(28,828)	0	(14,171)	(157)	0	(12,169)	0	(1,909)	(422)
Cost or valuation as at 31st March 2015	**166,191**	**20,181**	**118,850**	**1,322**	**614**	**17,387**	**72**	**7,326**	**439**
Accumulated Depreciation as at 1st April 2014	44,958	0	20,276	247	0	19,404	9	4,400	622
Charged during the year	6,009	0	3,686	42	0	1,565	9	674	33
Impairments recognised in operating expenses	1,208	0	1,090	0	0	118	0	0	0
Reversal of impairments credited to operating income	(492)	0	(492)	0	0	0	0	0	0
Reclassifications	(39)	0	0	0	0	(39)	0	0	0
Disposals	(28,807)	0	(14,172)	(158)	0	(12,146)	0	(1,909)	(422)
Accumulated Depreciation as at 31st March 2015	**22,837**	**0**	**10,388**	**131**	**0**	**8,902**	**18**	**3,165**	**233**
NBV as at 31st March 2015	**143,354**	**20,181**	**108,462**	**1,191**	**614**	**8,485**	**54**	**4,161**	**206**
Property, plant and equipment financing									
Net book value (NBV) as at 31st March 2016									
Purchased	130,098	12,475	102,324	1,211	1,253	7,038	71	5,194	532
Finance Leased	588	0	0	0	0	0	0	588	0
Government Granted	802	0	562	0	0	240	0	0	0
Donated	1,553	0	1,273	0	0	280	0	0	0
Total NBV as at 31st March 2016	**133,041**	**12,475**	**104,159**	**1,211**	**1,253**	**7,558**	**71**	**5,782**	**532**
Net book value (NBV) as at 31st March 2015									
Purchased	139,940	20,181	106,574	1,191	614	7,881	54	3,304	141
Finance Leased	857	0	0	0	0	0	0	857	0
Government Granted	879	0	588	0	0	291	0	0	0
Donated	1,678	0	1,300	0	0	313	0	0	65
Total NBV as at 31st March 2015	**143,354**	**20,181**	**108,462**	**1,191**	**614**	**8,485**	**54**	**4,161**	**206**

There is no element of land included within buildings or dwellings in the above classifications.

9. Property, plant and equipment (continued)

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 Existing Use Value for non-specialised operational property. No building indices have been applied as research into building costs implies the fair value of the buildings has not increased.

For 2015/16 the Trust instructed Cushman & Wakefield to provide a full revaluation for land and buildings and a review of asset lives for buildings as at 1st April 2015. The changes have been reflected with the 2015/16 annual accounts. A further desktop revaluation exercise was completed by Cushman & Wakefield with a prospective date of 31st March 2016, which was applied to the accounts on 31st March 2016. A full asset valuation is undertaken every five years with an annual desk top valuation being undertaken in the intervening years. Market Value was used in arriving at fair value for the assets subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

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. Of the £6,896k upward valuation £631k related to assets that had previously been impaired, therefore £631k has been reversed in 2015/16 and is classed as other operating income.

The table below shows the impact of the revaluations as at 1st April 2015 and 31st March 2016.

Revaluations Arising from Cushman & Wakefield Valuers Report on Land & Buildings

	As at 1st April 2015	As at 31st March 2016	Total for 2015/16
	£000	£000	£000
Downward Revaluations	(14,984)	(3,087)	(18,071)
Upward Revaluations	6,765	131	6,896
	(8,219)	(2,956)	(11,175)
Downward Revaluations:			
Taken to Revaluation Reserve	(13,786)	(2,689)	(16,475)
Impairment taken to I&E	(1,198)	(398)	(1,596)
	(14,984)	(3,087)	(18,071)
Upward Revaluations:			
Taken to Revaluation Reserve	6,223	42	6,265
Reversal of Impairment taken to I&E	542	89	631
	6,765	131	6,896

9. Property, plant and equipment (continued)

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.
The following table discloses the range of economic lives of various assets.

	Minimum Life Years	Maximum Life Years
Land	250	250
Buildings excluding dwellings	1	83
Dwellings	36	41
Plant and machinery	1	13
Information technology	1	8
Furniture and fittings	1	10
Transport and equipment	4	10

Contractual Capital Commitments

The Trust has contractual capital commitments of £1.8m as at 31st March 2016 (£1.1m as at 31st March 2015). This includes, £1.0m for estates work, £0.4m for installation of new IT systems and £0.4m for new software.

Capital Developments

The Trust has spent £7.7m on capital schemes during 2015/16. This has been split across:

	£m
Estates	2.2
IM&T	4.5
Medical Equipment	0.8
Service Developments	0.2
	7.7

Estates
During 2015/16 various enhancements have been made to the buildings of the Trust. These include fire and electrical upgrades as well as other building related improvements.

IM&T
During 2015/16 there have been various IT enhancements, in particular improvements to mobile working and new patient care systems.

Medical Equipment
During 2015/16 the Trust has replaced various piece of medical equipment, including new equipment for Theatres, Ultrasound Machines, Monitoring systems and Defibrillators.

9. Property, plant and equipment (continued)

Services Developments

During 2015/16 the Trust renovated the Maxillofacial/Orthodontic surgeries at Halton Hospital including the replacement of three Treatment Chairs.

10. Inventories	**2015/16 £000**	**2014/15 £000**
Drugs, medical supplies and consumable items	3,435	3,312
Total	**3,435**	**3,312**

Inventories recognised in expenditure

The total expenditure on items classed as inventories recognised in expenditure during the year was £37.7m (£34.4m in 2014/15). The Trust incurred stock losses of £0.04m which is reported as drugs expenditure in the year (£0.03m in 2014/15). The value of inventories purchased but not used as at 31st March 2016 was £3.4m as per the table above (£3.3m in 2014/15).

11. Trade and other receivables	**2015/16 £000**	**2014/15 £000**
NHS receivables	1,717	5,607
Provision for impairment of receivables	(385)	(321)
Prepayments	1,261	940
Accrued income	3,142	882
PDC receivable	379	0
VAT receivable	426	585
Other receivables	2,627	3,249
Trade and other receivables - current	**9,167**	**10,942**
Provision for impairment of receivables	(281)	(253)
Other receivables	1,275	1,336
Trade and other receivables - non-current	**994**	**1,083**
Total	**10,161**	**12,025**

Provision for impairment of receivables	**2015/16 £000**	**2014/15 £000**
As at 1st April	574	550
Increase in provision	101	30
Amounts utilised	(9)	(6)
As at 31st March	**666**	**574**

11. Trade and other receivables (continued)

Ageing of impaired receivables	2015/16 Trade receivables £000	2015/16 Other receivables * £000	2014/15 Trade receivables £000	2014/15 Other receivables * £000
0 - 30 days	0	0	0	0
30 - 60 days	0	0	0	0
60 - 90 days	0	0	0	0
90 - 180 days	0	0	0	0
Over 180 days	3	63	3	50
Total	**3**	**63**	**3**	**50**
Ageing of non-impaired receivables past their due date				
0 - 30 days	718	75	1,281	326
30 - 60 days	192	7	(286)	306
60 - 90 days	23	61	740	26
90 - 180 days	77	36	428	101
Over 180 days	140	94	1,386	60
Total	**1,150**	**273**	**3,549**	**819**

*Excludes provision for impairment of receivables in respect of income due from the CRU of £600k (£521k in 2014/15).

The Trust reviews all outstanding receivables at the end of the reporting year and makes a provision for those debts where it believes recovery of the outstanding amount is unlikely. Decisions are made after taking into consideration previous experience of the debtor, the age of the debt, the risk associated with that particular class of debtor and discussions with the debt management team of the Trust's shared business services provider.

12. Cash and cash equivalents

	2015/16 £000	2014/15 £000
As at 1st April	4,511	12,956
Net change in year	(1,928)	(8,445)
As at 31st March	**2,583**	**4,511**
Made up of:		
Cash at commercial banks and in hand	17	25
Cash with the Government Banking Service	2,566	4,486
Cash and cash equivalents as at 31st March	**2,583**	**4,511**
Third party assets held by the Trust	**39**	**43**

12. Cash and cash equivalents

At the end of the financial year the Trust held £39k (£43k in 2014/15) 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 cash at bank and in hand figure reported in the accounts.

13. Trade and other payables

	2015/16 £000	2014/15 £000
Current		
NHS trade payables	3,979	2,351
Amounts due to other related parties	2,646	1,780
Trade payables capital	126	1,599
Other trade payables	6,057	6,576
Other payables	126	74
Accruals	6,662	5,765
PDC payable	0	76
Social security costs (NI)	1,319	1,348
Other taxes payable (PAYE)	1,399	1,319
Total trade and other payables	**22,314**	**20,888**

14. Borrowings

	2015/16 £000	2014/15 £000
Current		
Obligations under finance leases	323	185
Loans from the Department of Health	107	0
Total current borrowing	**430**	**185**
Non-current		
Obligations under finance leases	1,008	703
Loans from the Department of Health	15,693	0
Total non-current borrowing	**16,701**	**703**

During 2015/16 the Trust obtained two loans from the Department of Health. The first loan was a working capital loan for £14.2m at an interest rate of 1.5% to be repaid in full on 18th May 2018. The second loan was a capital loan for £1.6m at an interest rate of 1.78% to be repaid in twice yearly instalments over the next 15 years, with the first repayment due on 18th August 2016.

15. Finance Leases

	2015/16 £000	2014/15 £000
Gross lease liabilities		
of which liabilities are due:		
- not later than one year;	372	214
- later than one year and not later than five years;	1,037	749
- later than five years.	0	0
Finance charges allocated to future periods	(78)	(75)
	1,331	**888**
Net lease liabilities		
of which payable:		
- not later than one year;	323	185
- later than one year and not later than five years;	1,008	703
- later than five years.	0	0
Total of future minimum sublease payments to be received at the reporting date	**1,331**	**888**

16. Other liabilities

	2015/16 £000	2014/15 £000
Current		
Deferred income	2,092	974
Total other current liabilities	**2,092**	**974**

17. Provisions

	2015/16			
	Total £000	Legal £000	Other £000	Pensions £000
As at 1st April 2015	1,730	122	84	1,524
Change in the discount rate	(7)	0	0	(7)
Arising during the year	261	205	0	56
Utilised during the year	(242)	(37)	(84)	(121)
Reversed unused	(44)	(44)	0	0
As at 31st March 2016	**1,698**	**246**	**0**	**1,452**
Expected timing of cash flows:				
Within one year	364	246	0	118
Between one and five years	453	0	0	453
After five years	881	0	0	881
Total	**1,698**	**246**	**0**	**1,452**

17. Provisions (continued)

	2014/15			
	Total	Legal	Other	Pensions
	£000	£000	£000	£000
As at 1st April 2014	1,791	150	134	1,507
Change in the discount rate	51	0	0	51
Arising during the year	210	99	5	106
Utilised during the year	(209)	(63)	(6)	(140)
Reversed unused	(113)	(64)	(49)	0
As at 31st March 2015	**1,730**	**122**	**84**	**1,524**
Expected timing of cash flows:				
Within one year	335	122	79	134
Between one and five years	427	0	0	427
After five years	968	0	5	963
Total	**1,730**	**122**	**84**	**1,524**

Pensions provision relates to early retirement costs in line with the NHS Business Service Authority - Pensions Division. Legal claims relates to third party legal claims advised by the NHS Litigation Authority. These claims are generally expected to be settled within 1 year but may exceptionally take 2 years to settle.

Clinical negligence and employee liabilities

£93.3m is included in the provisions of the NHS Litigation Authority as at 31st March 2016 in respect of clinical negligence and employer's liabilities of the Trust (£46.3m as at 31st March 2015).

18. Related party disclosures

Warrington and Halton Hospitals NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. Monitor the Regulator of NHS Foundation Trusts does not prepare group accounts; instead Monitor prepares NHS Foundation Trust Consolidated Accounts for further consolidation into the Whole of Government Accounts. Monitor has powers to control NHS Foundation Trusts but its results are not incorporated within the consolidated accounts and it cannot be considered to be the parent undertaking for Foundation Trusts. Although there are a number of consolidation steps between the Trust's Accounts and Whole of Government Accounts, the Trust's ultimate parent is HM Government.

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they fall under the common control of HM Government and Parliament. The Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups (CCGs), local authorities, central government departments, executive agencies, non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Trust has had a number of transactions with WGA bodies. When the total transactions with a given counterparty are collectively significant, they are listed below.

18. Related party disclosures (continued)

Related party relationships primarily based on income from the counterparty (healthcare services)

Related party	2015/16 Receivables £000	2015/16 Payables £000	2014/15 Receivables £000	2014/15 Payables £000
Betsi Cadwaladr University Health Board	67	0	160	0
Halton Borough Council	281	82	194	12
NHS England	1,597	81	822	231
NHS Halton CCG	0	766	291	2
NHS Knowsley CCG	142	1	0	388
NHS Liverpool CCG	1	52	117	3
NHS Salford CCG	5	35	16	2
NHS St Helens CCG	0	496	0	449
NHS Vale Royal CCG	8	246	0	56
NHS Warrington CCG	1,445	0	3,753	0
NHS West Cheshire CCG	64	0	0	214
NHS Wigan Borough CCG	10	296	35	2
Warrington Borough Council	107	43	118	0

Related party	2015/16 Income £000	2015/16 Expenditure £000	2014/15 Income £000	2014/15 Expenditure £000
Betsi Cadwaladr University Health Board	37	0	1,001	0
Halton Borough Council	1,665	390	2,107	442
NHS England	12,440	33	10,746	67
NHS Halton CCG	44,341	0	47,140	4
NHS Knowsley CCG	228	0	212	0
NHS Liverpool CCG	565	0	776	0
NHS Salford CCG	1,483	0	1,488	0
NHS St Helens CCG	8,501	0	9,487	0
NHS Vale Royal CCG	2,261	0	2,527	0
NHS Warrington CCG	112,056	0	113,891	0
NHS West Cheshire CCG	4,242	0	4,224	6
NHS Wigan Borough CCG	2,873	0	3,313	0
Warrington Borough Council	290	536	350	595

18. Related party disclosures (continued)

Other related party relationships primarily based on income from the counterparty (non healthcare services)

Related party	2015/16 Receivables £000	2015/16 Payables £000	2014/15 Receivables £000	2014/15 Payables £000
5 Boroughs Partnership NHS Foundation Trust	153	5	263	3
Bridgewater Community Healthcare NHS Trust	0	0	0	0
Bridgewater Community Healthcare NHS Foundation Trust	323	319	322	84
Health Education England	18	119	0	1
Royal Liverpool & Broadgreen University Hospitals NHS Trust	202	172	25	126
Department for Health	379	46	571	1,300

Related party	2015/16 Income £000	2015/16 Expenditure £000	2014/15 Income £000	2014/15 Expenditure £000
5 Boroughs Partnership NHS Foundation Trust	2,286	0	1,582	10
Bridgewater Community Healthcare NHS Trust	0	0	1,061	53
Bridgewater Community Healthcare NHS Foundation Trust	1,359	531	763	125
Health Education England	7,513	0	6,755	0
Royal Liverpool & Broadgreen University Hospitals NHS Trust	822	371	700	480
Department for Health	5,029	3,925	553	4,239

These relationships are based on the supply of staff, estates services, clinical tests, pharmacy services and education to the other party, other than Health Education England, which has provided the Trust with funding primarily for education and training purposes.

The Trust made a Public Dividend Capital payment to the Department of Health totalling £4.3m (£4.2m in 2014/15). It also received Public Dividend Capital of £0.0m (£0.2m in 2014/15) from the Department of Health and repaid £2.5m (£0.0m 2014/15).

18. Related party disclosures (continued)

Related party relationships primarily based on expenditure with the counterparty

Related party	2015/16 Receivables £000	2015/16 Payables £000	2014/15 Receivables £000	2014/15 Payables £000
HM Revenue & Customs (VAT, NIC and PAYE)	426	2,718	585	2,667
NHS Blood and Transplant	0	3	14	0
NHS Litigation Authority	0	0	0	5
NHS Pension Scheme	0	1,816	0	1,778
NHS Professionals	9	1,718	40	1,273
St Helens and Knowsley Teaching Hospitals NHS Trust	5	1,051	5	804

Related party	2015/16 Income £000	2015/16 Expenditure £000	2014/15 Income £000	2014/15 Expenditure £000
HM Revenue & Customs (Employer's NIC)	0	9,280	0	9,140
NHS Blood and Transplant	0	15	14	4
NHS Litigation Authority	0	9,605	0	6,449
NHS Pension Scheme	0	13,249	0	12,713
NHS Professionals	4	7,086	40	5,613
St Helens and Knowsley Teaching Hospitals NHS Trust	172	9,285	174	8,504

The majority of expenditure with St Helens and Knowsley Teaching Hospitals NHS Trust comprises of staff recharges and payments for clinical supplies and services; income is mainly from the provision of staff and services.

Future commitments with related parties

2016/17 anticipated contract values with the main commissioners are listed below:

Related party	£000
NHS Warrington CCG	112,530
NHS Halton CCG	44,966
NHS England	10,926
NHS St Helens CCG	8,939
NHS West Cheshire CCG	3,995
NHS Wigan Borough CCG	2,898
NHS Vale Royal CCG	2,309
NHS Salford CCG	1,444
NHS Liverpool CCG	598
NHS East Cheshire CCG	321

18. Related party disclosures (continued)
Future commitments with related parties (continued)

NHS Trafford CCG	281
NHS Knowsley CCG	217
NHS South Cheshire CCG	164
NHS Wirral CCG	97

Charitable related parties

Warrington and Halton Hospitals NHS Foundation Trust (charitable fund with registered charity number 1051858) is a subsidiary of the Trust and therefore a related party. The Trust is the Charity's Corporate Trustee which means that the Trust's Board of Directors is charged with the governance of the Charity. The Charity's sole activity is the funding of charitable capital and revenue items for the benefit of our patients.

The Trust has received £229k in payments from the Charity within the financial year under review (£381k in 2014/15). The Charity's reserves balance as at 31st March 2016 was £547k (£590k as at 31st March 2015) with net outgoing resources of £83k for 2015/16 (£42k in 2014/15).

Other related parties

The Trust has no subsidiaries or associates and is not involved in any joint ventures.

Key management personnel

During the financial year under review, no member of either the Board or senior management team, and no other party closely related to these individuals, has undertaken any material transactions with Warrington and Halton Hospitals NHS Foundation Trust.

19. Financial instruments

Liquidity risk

The Trust's net operating costs are incurred under annual service level agreements/contracts with commissioners which are financed from resources voted annually by Parliament. The Trust receives such income in accordance with national tariff payment system, which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff Procedure cost. Monthly payments are received from commissioners based on the annual contract values; this arrangement reduces liquidity risk.

The Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form.

Interest-rate risk

All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest and the Trust is not therefore exposed to significant interest-rate risk.

Credit risk

The main source of income for the Trust is from Clinical Commissioning Groups in respect of healthcare services provided under agreements. The credit risk associated with such customers is very low.

19. Financial instruments (continued)
Credit risk (continued)

The Trust has minimal exposure to credit risk as all cash balances are held within the Governments Banking Services (GBS) account which generates additional cash through an applied interest rate. The Trust does not hold cash in any other investment institution on a short or long term basis.

Before entering into new contracts with non-NHS customers, checks are made regarding creditworthiness. The Trust also regularly reviews debtor balances and has a comprehensive system in place for pursuing past due debt. Non-NHS customers represent a small proportion of income and the Trust is not exposed to significant credit risk in this regard.

There are no amounts held as collateral against these balances.

An analysis of aged and impaired receivables is disclosed in Note 11.

The movement in the provision for impaired receivables during the year is disclosed in Note 11. Of those assets which require a provision for their impairment £66k (£53k in 2014/15) are impaired financial assets.

There are no (£0 in 2014/15) financial assets that would otherwise be past due or impaired whose terms have been renegotiated.

Currency risk

The Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

All financial assets and liabilities are held in sterling and are shown at book value, which is not significantly different from fair value.

19.1 Financial assets by category

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total
	£000	£000	£000	£000	£000
Assets as per Statement of Financial Position as at 31st March 2016					
Embedded derivatives	0	0	0	0	0
Trade and other receivables excluding non-financial assets	5,319	0	0	0	5,319
Other investments	0	0	0	0	0
Other financial assets	0	0	0	0	0
Cash and cash equivalents at bank and in hand	2,583	0	0	0	2,583
Total as at 31st March 2016	**7,902**	**0**	**0**	**0**	**7,902**

19.1 Financial assets by category (continued)

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total
	£000	£000	£000	£000	£000
Assets as per Statement of Financial Position as at 31st March 2015					
Embedded derivatives	0	0	0	0	0
Trade and other receivables excluding non financial assets	8,753	0	0	0	8,753
Other investments	0	0	0	0	0
Other financial assets	0	0	0	0	0
Cash and cash equivalents at bank and in hand	4,511	0	0	0	4,511
Total as at 31st March 2015	**13,264**	**0**	**0**	**0**	**13,264**

19.2 Financial liabilities by category

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per Statement of Financial Position as at 31st March 2016			
Embedded derivatives	0	0	0
Borrowings excluding finance lease and PFI liabilities	15,800	0	15,800
Obligations under finance leases	1,331	0	1,331
Obligations under PFI, LIFT and other service concession contracts	0	0	0
Trade and other payables excluding non financial liabilities	20,247	0	20,247
Other financial liabilities	0	0	0
Provisions under contract	1,698	0	1,698
Total as at 31st March 2016	**39,076**	**0**	**39,076**

19.2 Financial liabilities by category (continued)

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per Statement of Financial Position as at 31st March 2015			
Embedded derivatives	0	0	0
Borrowings excluding finance lease and PFI liabilities	0	0	0
Obligations under finance leases	888	0	888
Obligations under PFI, LIFT and other service concession contracts	0	0	0
Trade and other payables excluding non financial liabilities	16,685	0	16,685
Other financial liabilities	0	0	0
Provisions under contract	0	0	0
Total as at 31st March 2015	**17,573**	**0**	**17,573**

19.3 Maturity of financial liabilities

	2015/16 £000	2014/15 £000
In one year or less	22,375	16,870
In more than one year but not more than two years	453	192
In more than two years but not more than five years	16,248	511
In more than five years	0	0
Total	**39,076**	**17,573**

19.4 Fair values of financial assets and liabilities

All non current financial assets and liabilities are held at fair value.

20. Losses and special payments

	2015/16		2014/15	
	Total number of cases	Total value of cases £000	Total number of cases	Total value of cases £000
Losses				
Cash losses	8	6	9	2
Fruitless payments	5	0	2	0
Bad debts and claims abandoned	6	3	23	6
Stores losses and damage to property	12	40	7	71
Total losses	**31**	**49**	**41**	**79**
Special payments				
Extra-contractual payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Compensation payments	0	0	0	0
Special severance payments	1	5	0	0
Ex-gratia payments	32	70	51	143
Total special payments	**33**	**75**	**51**	**143**
Total losses and special payments	**64**	**124**	**92**	**222**
Compensation payments received		**27**		**5**

There were no individual cases exceeding £300k in either the current year or the prior year.

21. Off Payroll Arrangements

For all off-payroll engagements as at 31st March 2016 for more than £220 per day and that last for longer than six months

	2015/16
Number of existing engagements as at 31st March 2016	13
Of which:	
Number that have existed for less than one year at the time of reporting	12
Number that have existed for between one and two years at the time of reporting	1
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

All 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 assurance has been sought.

21. Off Payroll Arrangements

For all new off-payroll engagements or those that reached six months in duration between 1st April 2015 and 31st March 2016 for more than £220 per day and that last for longer than six months

	2015/16
Number of new engagements, or those that reached six months in duration between 1st April 2015 and 31st March 2016	51
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	17
Number for whom assurance has been requested	17
Of which:	
Number for whom assurance has been received	17
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

The Trust has engaged some off payroll workers without a contractual clause allowing the Trust to seek assurance as to their tax obligations. However we have still sought such assurances.

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1st April 2015 and 31st March 2016

	2015/16
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	20

The Trust initially needed some support in the role of Director of Transformation, which was a new and additional Board Level post. The individual was recommended to us as a high-quality former NHS Finance Director and Chief Executive. The Individual filled the role, whilst the Trust made a more sustainable appointment to the role. In the meantime, the Director of Finance and Commercial Development for the Trust, secured a new role with a new Trust and the individual also covered this role, until a substantive replacement could be secured. The only means by which we could use the services of this individual was through an Executive Search agency.

An individual was engaged as Turnaround Director (July 15 to November 15) and then the same individual was engaged as Interim Director of Finance (December 15 to Jan 16)