

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2022–23





**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

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National Health Service Act 2006

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1 Overview of the Trust

1.1 Chairman and Chief Executive's Introduction

We have had yet another extraordinary year at Warrington and Halton Teaching Hospitals during 2022-23. It is fair to say that we continue to operate in an increasingly tough landscape, facing relentless pressures, like much of the NHS up and down the country.

Therefore, we must first give sincere thanks to our circa 5,000-strong workforce, and to our volunteers, and commend them for their unwavering commitment, dedication and resilience. Their efforts continue to directly benefit our patients and local communities and embody the ethos of the Trust in the form of our five values – working together, excellence, inclusive, kind, and embracing change.

We have remained committed to restoration and recovery throughout the year, recognising that this will be a focus of Trusts across the country for several years to come as we continue to deal with the aftermath of the COVID-19 pandemic.

We have continued to work collaboratively with others, particularly with emerging place partnerships in Warrington and Halton, and with the Cheshire and Merseyside Integrated Care Board following its formal establishment in July 2022. We play our full part in the leadership of our health and social care system, in the best interest of all of the communities we collectively serve.

A remarkable amount has been achieved and we have remained focused on our three strategic aims of quality, people, and sustainability. We would like to share some key highlights:



Steve McGuirk
CBE DL QFSM,
Chairman



Professor Simon Constable FRCP,
Chief Executive

QUALITY

We will always put our patients first, delivering safe and effective care and an excellent patient experience



Delivery has been an unabated focus across the Trust, against a backdrop of continued COVID-19 cases, high Emergency Department attendances, high bed occupancy rates, and high numbers of patients with 'no criteria to reside'. We have complied with all national elective restoration and recovery guidance and continued to prioritise urgent cancer and elective activity. We have also focused strongly on discharge, both that which is within our own control as well as working with health and care partners. We know that there is more to do in this regard.

We have continued a significant programme of estates and infrastructure developments, with July 2022 seeing the opening of our Same Day Emergency Care unit following a £6.3m investment. The unit has seen an average of 820 patients per month since opening its doors. This was followed by our newly refurbished children and young people's outpatient department which opened in September 2022.

As part of our commitment to providing services in the heart of communities, we were pleased to open the Halton Health Hub in October 2022. Located at Runcorn Shopping City, the hub provides ophthalmology, audiology and dietetics services and makes the Trust the first in the country to provide services in a shopping centre. We will continue to explore ways in which we can deliver more clinical services closer to home

In a similar vein, we were pleased to conclude the second phase of our breast screening service relocation plans following another extensive public consultation. This has seen remaining clinical services based in the ageing and outdated Kendrick Wing at Warrington Hospital relocated to Bath Street Health and Wellbeing Centre.

Clinical research at the Trust continues to flourish, having gone from strength to strength and contributed to several major research studies. We recruited the highest number of volunteers to a commercial COVID-19 vaccine study and secured a 'global first' by recruiting the first volunteer for an international gastroenterology study looking at adults with moderate to severe ulcerative colitis. We launched Pathway to Research, aiming to sign up members of our local population to engage in healthcare research, and were shortlisted for 'Research Collaboration of the Year' in the North West Coast Research and Innovation Awards 2022.

As a significant marker of excellence in care quality, we were also pleased to receive numerous accreditations for our services, including Anaesthesia Clinical Services Accreditation (ACSA), Joint Advisory Group (JAG) Accreditation for Gastrointestinal Endoscopy, Resuscitation Council UK accreditation as a Newborn Life Support Training Centre, and Family Integrated Care accreditation, facilitating a partnership between parents and staff to promote parent-infant interactions and to build parent confidence.





PEOPLE

We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future

March 2023 saw the return of our **Thank You Awards** event, with our first in-person event since the pandemic. It exceeded expectations and was a tremendous way to recognise and value outstanding individuals and teams from across the organisation. We had another record-breaking year for nominations, with more than 350 received, and also for the amount of sponsorship gratefully secured from our partner organisations to make the event possible in the first place. We also continued with our programme of monthly You Made a Difference Awards, recognising those who go above and beyond.

Our four staff networks continued to grow and become further embedded, and we announced plans to set up a Women's Network. Following our 2022 NHS Staff Survey results, we also began developing plans to hear more from specific staff groups such as those aged between 16-30, and to create a Staff Voice group, made up of representatives from all areas of the organisation and truly honouring diversity in all of its glory.

From a governor perspective, we held elections in November 2022 and appointed new staff and public governors. We continued to support the role of governors across the organisation with the development of induction materials and a comprehensive induction programme.

We were pleased to be recognised for our commitment to equality, diversity, and inclusion, with three formal accreditations secured – Disability Confident Leader, Cheshire and Merseyside Navajo Charter Mark, and Stonewall Diversity Champions Accreditation. We also made a commitment to strive to achieve the NHS North West Anti-Racist Organisation Framework Accreditation and look forward to progressing this.

It would be remiss not to mention industrial action. March 2023 saw the first wave of industrial action take place at the Trust in many years, with junior doctors staging a 72-hour walkout as part of a national dispute. We worked hard to make sure that patient safety was maintained throughout this period.

SUSTAINABILITY

We will work in partnership with others to achieve social and economic wellbeing in our communities



In terms of finance, we recorded an adjusted deficit of £7.9m for 2022-23, which was £2.5m away from our £5.4m deficit plan for the year. This movement from plan was approved by the Cheshire and Merseyside Integrated Care Board and NHS England. We continued to invest significantly in our annual capital programme, with £25.6m planned spend and £25.5m actual spend for the year.

We approved a new two-year strategy for the organisation in March 2023, following a significant period of engagement internally and externally. The strategy sets out our ambitions and plans for the coming years to achieve our vision of being a great place to receive healthcare, work and learn.



Looking ahead

We will continue to invest significantly in estates and infrastructure initiatives for the benefit of our staff and patients. This includes the £3m Living Well Hub in Warrington Town Centre, the £15m Community Diagnostic Centre enhanced provision in Halton over the next two years, and the commencement of procuring a new electronic patient record system.

We will be refining our strategic estates plan to set out our future direction of travel for addressing the issues faced with our ageing estate and facilities. We know that we cannot go on indefinitely making the best use of what we have currently got, and that the people of Warrington and Halton deserve modern care provided in fit-for-purpose environments.

2023-24 is looking very challenging financially for the Trust, with current plans showing a £15.7m deficit and £17.9m efficiency savings to be made. Targets for activity recovery remain a challenge on our resources, both workforce and financially.

Looking forward, we will continue to deliver to the best of our ability for the people of Warrington and Halton and commit to playing the fullest of parts, both within local place partnerships and within the Cheshire and Merseyside Integrated Care System.

Steve McGuirk CBE DL QFSM,
Chairman

29th June 2023

Professor Simon Constable FRCP,
Chief Executive

29th June 2023

1.2 About the Trust

The Trust comprises two acute (secondary) care hospitals across two sites in the boroughs of Warrington and Halton and provides services across a number of community hubs. Services are delivered by our workforce of around 5,000 staff, many of who live in the boroughs we serve.

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

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

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

The Trust and its place in the Wider Health Economy

The Trust is part of the Cheshire and Merseyside Integrated Care System which is known as NHS Cheshire and Merseyside. This is one of 42 systems created nationwide on 1st July 2022 by the Health and Care act (2022) to replace over 100 Clinical Commissioning Groups.

Within this context Warrington and Halton operate as place-based partnerships which aim to develop a plan to address the broader health, public health and social care needs of the local population and design the delivery of integrated services to address these. These partnerships are known as Warrington Together and One Halton and involve the NHS, local authorities, community and voluntary organisations plus local residents and people who use health and social care services.

The purpose of this Performance Overview is to give the reader a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year. The Trust provides district general services, with all the services required to treat patients with a range of complex medical and surgical conditions and provides a full range of expert inpatient and outpatient services. Warrington Hospital is home to our emergency department and maternity services as well as specialist critical care, cardiac and surgical units.

Halton Hospital is located in Runcorn and is where the majority of elective and diagnostic care is delivered. The Runcorn Urgent Treatment Centre is also located here. Halton Hospital comprises two distinct buildings, the Captain Sir Tom Moore (formerly known as Cheshire and Merseyside Treatment Centre) and Nightingale (formerly known as Halton General) buildings. Some chemotherapy services are also provided on the site at the CanTreat Chemotherapy Centre and the site is home to the Delamere Macmillan Unit.

Although each site focuses on particular aspects of care, outpatient clinics for all specialties and diagnostic services are provided at both Warrington and Halton hospitals so patients can access their appointments closer to home wherever possible.

The hospital sites are eight miles apart and are easily accessible being very close to the North West motorway networks.



Services provided at Warrington Hospital include:

Emergency Department (A&E), surgical services, general medicine, children's services (paediatrics), cardiac care and cardiac catheter lab, stroke care, cancer care, elderly care, maternity, gynaecology, neonatal, orthopaedic trauma, critical care and ophthalmology.

Support services include: Occupational therapy, pathology, physiotherapy, pharmacy, dietetics, outpatient services, diagnostic services, radiology and a range of specialist nursing services.

Services provided at Halton Hospital include:

Nightingale building: General surgery, urology, endoscopy, step down care, cancer care, programmed investigations unit, renal dialysis, chemotherapy and cancer support, a full range of outpatient services. Also located here:

- Halton Clinical Research Unit
- Runcorn Urgent Treatment Centre which provides care and treatment for illness and injuries that are not life or limb-threatening but require urgent attention. Open 8am to 9pm, seven days a week.

Captain Sir Tom Moore building: Orthopaedic surgery, urology and gynaecology surgeries, cancer surgeries, post-anaesthetic care unit.

Support services include: Breast care centre, occupational therapy, physiotherapy, dietetics, outpatient services, diagnostic services and a range of specialist nursing services. The pretreatment centre (pre-operative and swabbing service) is located on the Halton site.

Community Hubs

Through a network of community hubs, virtual service offers and mobile facilities we also provide a range of outpatient services in the local community. This is a step towards ensuring services are delivered in the right place to improve access to quality care and address health inequalities.

Examples include:

- Bath Street Health and Wellbeing Centre, Warrington
- Halton Health Hub, Runcorn Shopping City
- Mobile Screening Services
- Virtual Wards – using advances in technology and infrastructure to enable patients to receive the care they need at home rather than in hospital
- Virtual consultations – offering video outpatient appointments to enable flexible and responsive care



Trust key headlines in 2022-23



Served a population of **330,000** across both Halton and Warrington boroughs.



Employed around **5,000 staff** comprising 74 nationalities.

Delivered **2,568K babies** in hospital and in the community.



Delivered **61,936** procedures and stays.

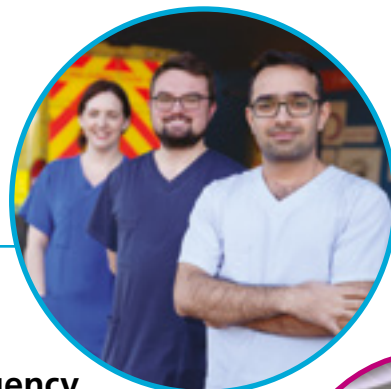


Delivered **90,375** individual new outpatients appointments each year.



Operated **692 beds** – assessment beds and trolleys – across both sites.

Provided **121,000 episodes of emergency care** – 86,752 episodes at the Emergency Department and 34,935 at the Runcorn Urgent Treatment Centre Department.

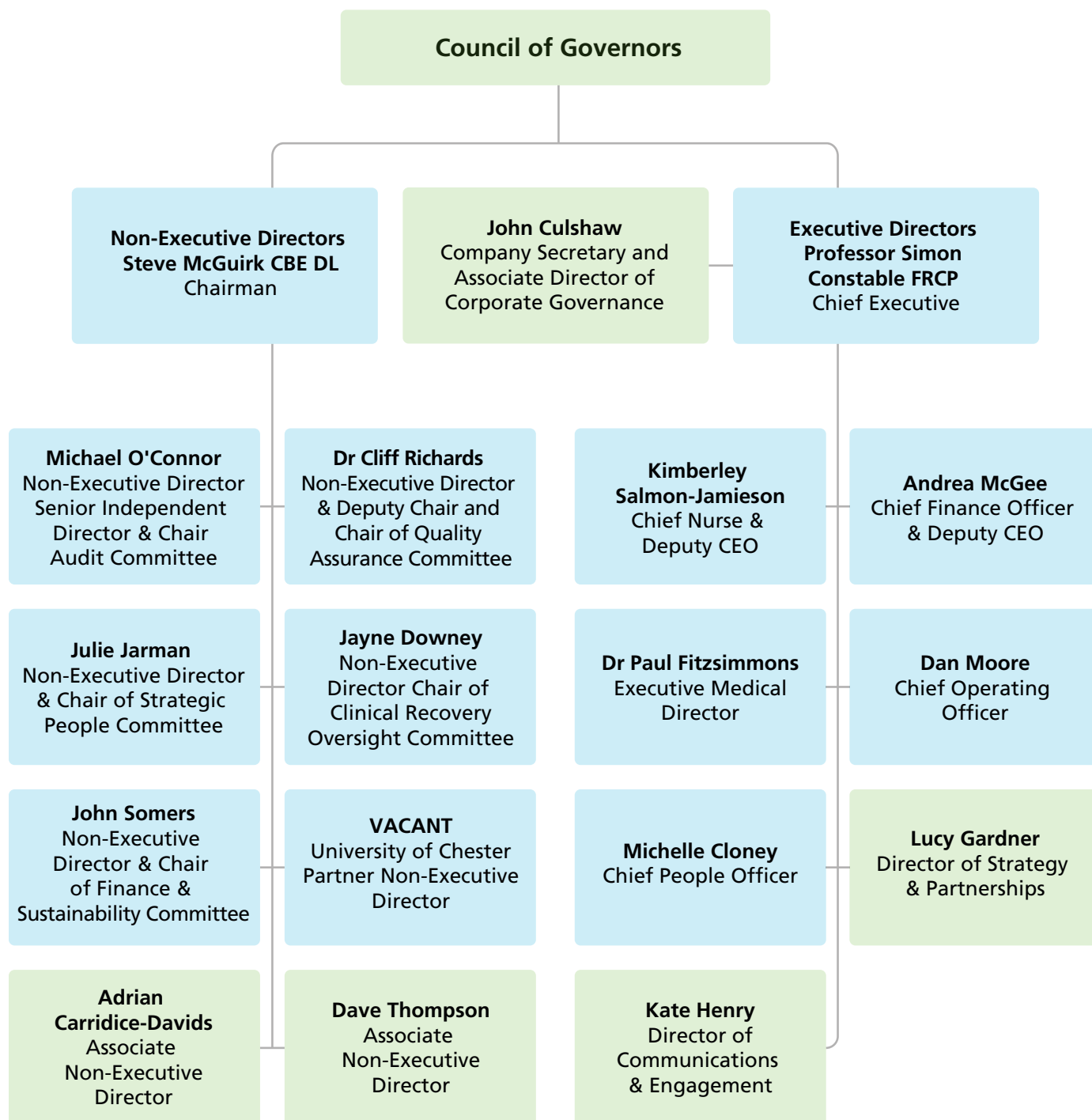


Had an annual turnover of **£347 million**.



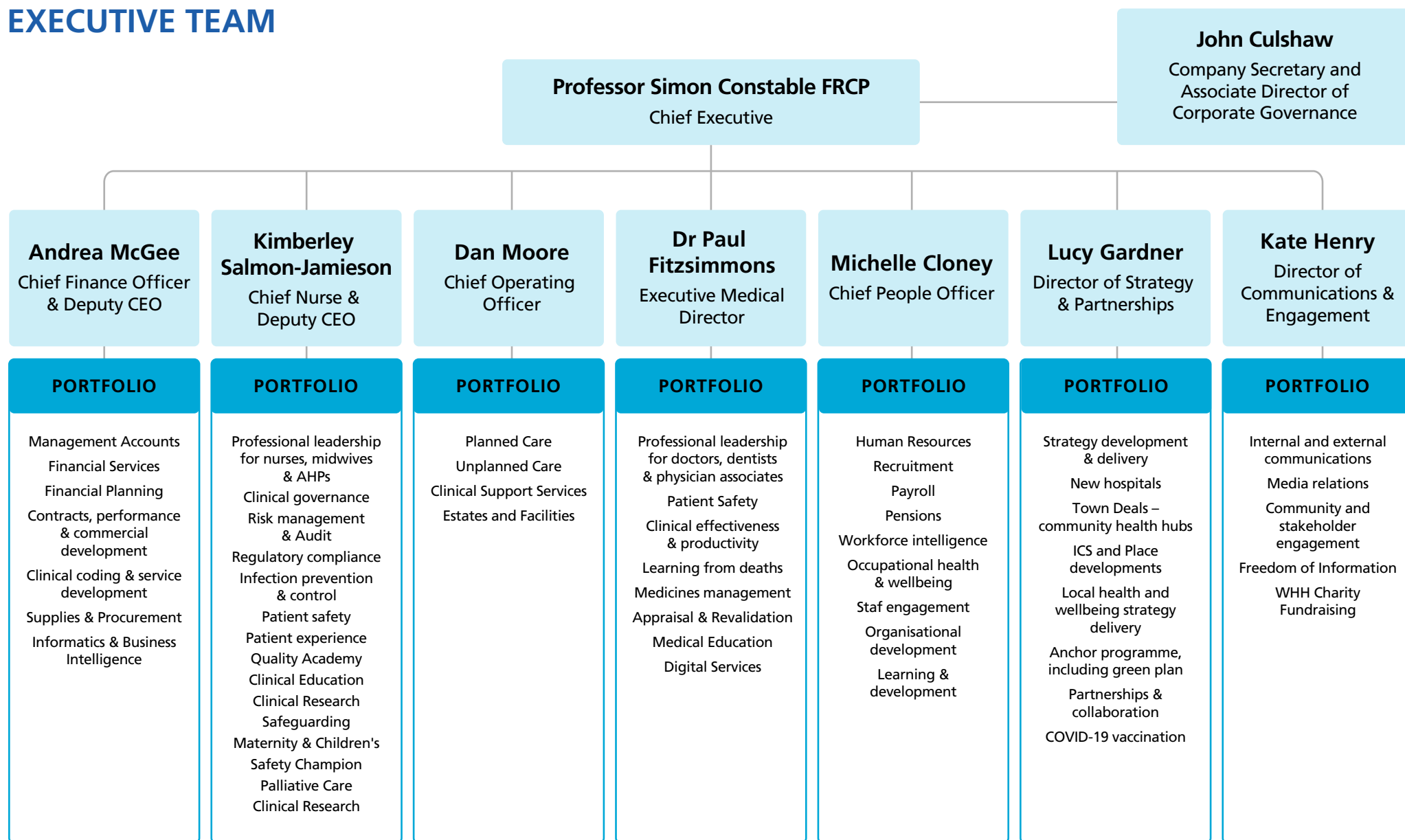
How the Trust is organised

TRUST BOARD

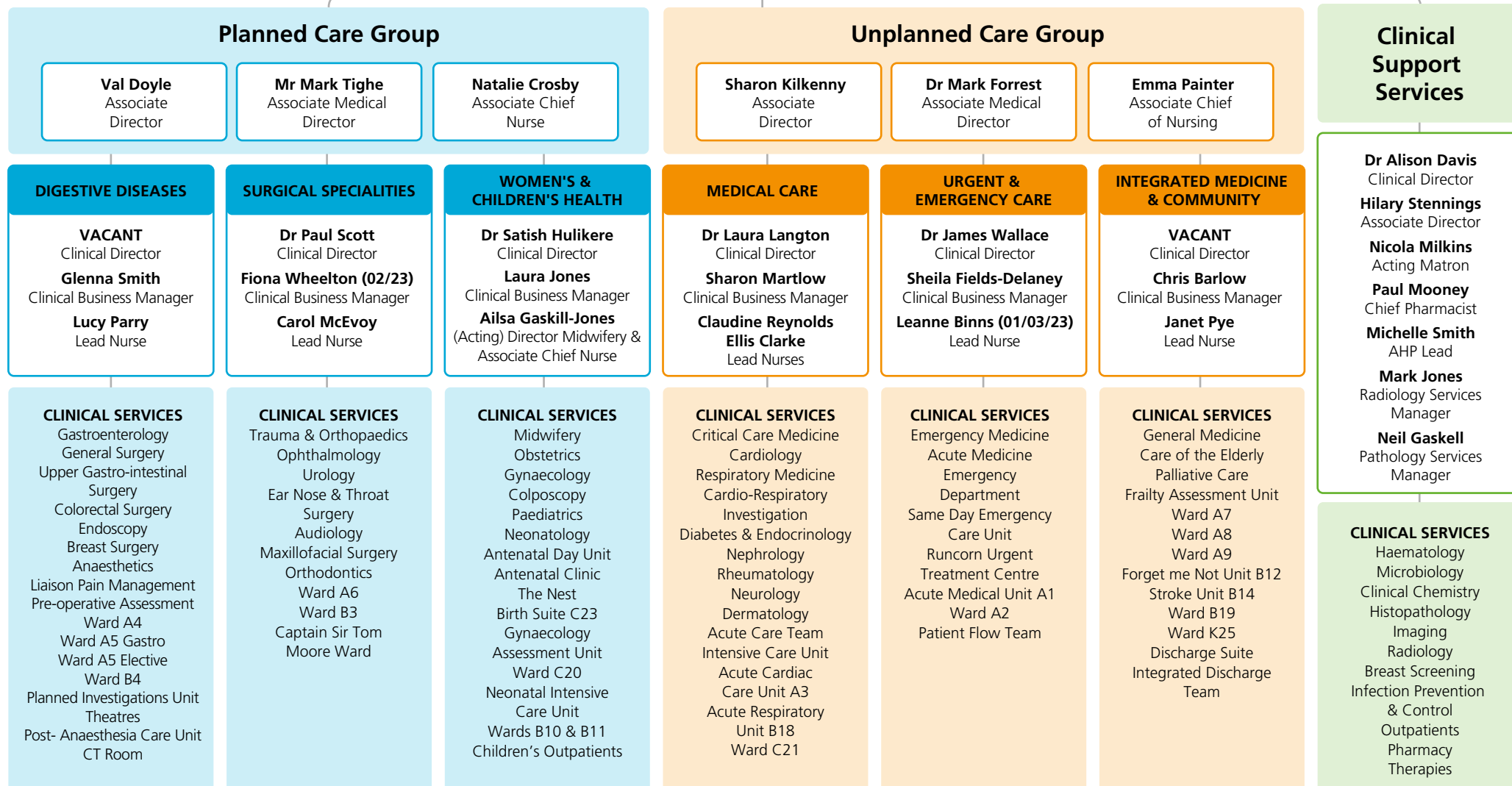
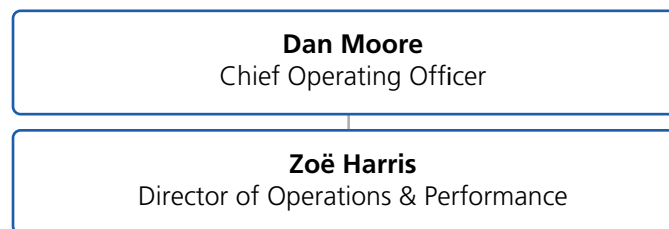


Voting members
 Non-voting members

EXECUTIVE TEAM



CARE GROUPS AND CLINICAL BUSINESS UNITS



Our mission, vision, aims and values

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our Aims



QUALITY

We will always put our patients first, delivering safe and effective care and an excellent patient experience



PEOPLE

We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future



SUSTAINABILITY

We will work in partnership with others to achieve social and economic wellbeing in our communities

Our Values



Working Together



Excellence



Inclusive



Kind



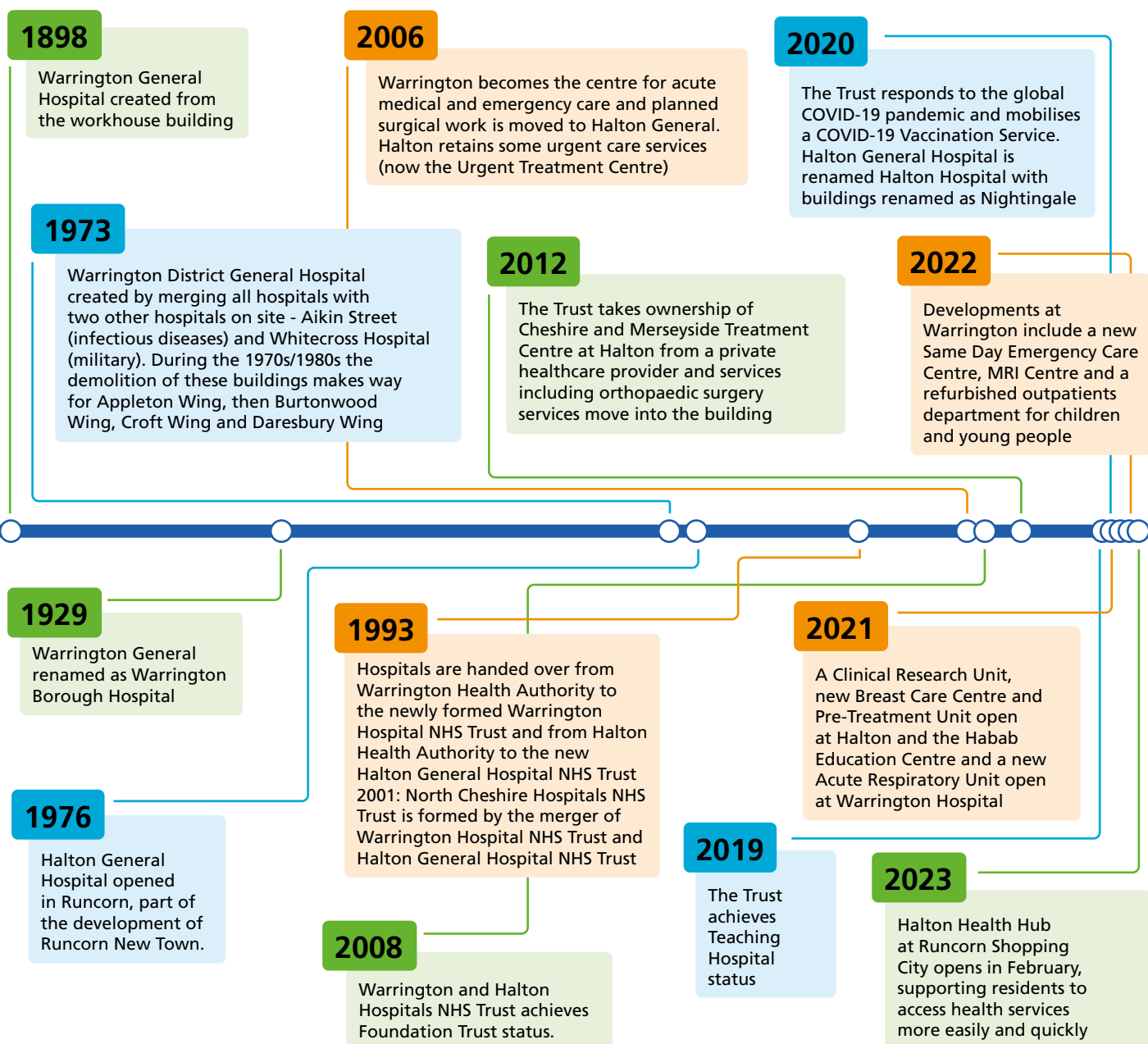
Embracing Change

1.3 A brief history of the Trust and its statutory background

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

In 2008 we were awarded Foundation Trust status and currently have just under 15k (14,905) members. The Trust achieved Teaching Hospital status in November 2019 and was renamed Warrington and Halton Teaching Hospitals NHS Foundation Trust. The Care Quality Commission rated the Trust 'GOOD' in 2019, with critical care achieving an 'Outstanding' rating for care.

A brief history of Warrington and Halton hospitals



1.4 The future of the Trust – vision

Our vision for the future of the Trust is to be a great place to receive healthcare, work and learn. We are committed to providing high quality, safe, and sustainable services, delivered by staff who are trained and supported to deliver their best work and we will work with our partners, across all levels of health and social care, the voluntary sector and the independent sector, to achieve this and meet the needs of our local population. We have three strategic aims framed around Quality, People and Sustainability, which underpin our vision.

Our future vision is encapsulated within our New Hospitals programme, which seeks to create modern, compliant, cost effective and future proofed estates, allowing us to change and adapt how and where we deliver care to set the foundations for the future of Warrington and Halton. This vision has been well established within Trust strategy and an expression of interest was submitted for the Trust to be considered in the Government’s New Hospitals Programme.

We are continuing to make progress by investing wisely in existing estate to support long-term plans and making the most appropriate and effective use of the clinical space we have. Successes include funding secured with partners to open community hubs, refurbishment of clinical areas and replacement of ageing equipment.

Over the past year we have delivered upwards of £10 million of capital projects to create new estate and enhance existing facilities. This has included the completion of our Same Day Emergency Care Unit alongside our A&E department, and the delivery of a new, purpose-built outpatient facility within Runcorn Shopping City – the Halton Health Hub. These initiatives will improve the quality of the service we deliver to our residents, reduce waiting times, and enhance access to clinical expertise, all whilst improving staff and patient satisfaction and delivering on our new hospitals vision.

This year we commenced construction to enable delivery of additional services in 2023/24 at both Halton General Hospital and the Halton Health Hub through the national Community Diagnostic Centre Programme. This involves the creation of state-of-the-art imaging and diagnostic suite to reduce waits and improve access to diagnostic services, whilst enhancing our offer to local residents and those within Cheshire and Merseyside. Our strategy to deliver the new hospitals programme is unique in that it will support the regeneration of the towns of Warrington and Runcorn, whilst tackling health inequalities, deprivation and supporting new growth, development and prosperity of the local communities.

Our workforce is our greatest strength, and we know that getting things right for our staff is the best way for us to achieve our vision. The new infrastructure will create the physical conditions for staff to provide excellent patient care, in an environment where people want to be cared for and somewhere where people want to work.

As part of the Trust’s wider green plan, the commitment to reducing harmful pollution and carbon emissions – to the tune of 11K tonnes per year – is central to planned infrastructure development.

The vision for our hospitals

Warrington Hospital: To create a new and future-proofed hospital, replacing ageing and outdated facilities with a modern, sustainable, compliant estate which reflects the town’s population growth (4th biggest population increase in the north west since 2001), with a focus on unplanned and emergency care.

Halton Hospital: To redevelop the Halton Hospital site (through an extension to the newest estate, Captain Sir Tom Moore Building) to create a hospital and wellbeing campus with a focus on planned care.

New hospitals and facilities at both Warrington and Halton, and health hubs in accessible locations throughout the communities are vital to ensure we are able to:

1. Address health inequalities
2. Provide high quality clinical facilities to meet growing demands
3. Level up communities by providing equal access to a dedicated diagnostic and elective centre for Cheshire and Merseyside
4. Future proof estate, facilities and services
5. Deliver a green and sustainable future
6. Innovate the way we work

1.5 Principal Risks

The key issues and risks that could affect the Trust in delivering its objectives are as below.

These risks are recorded on the Board Assurance Framework and are scrutinised bi-monthly by the Board Committees who each have allocated risks, the Audit Committee receives the BAF in full. These risks vary on an ongoing basis and are downgraded or upgraded as a result of changing circumstances and the implementation of mitigations. These risks are valid on 31st March 2023. The organisation has identified the following strategic risks (Red risks rated at 15 and above) and details of the full Board Assurance Framework including mitigations can be found in the Trust Board papers here: [Board Meetings and Papers :: Warrington and Halton Hospitals NHS Trust \(whh.nhs.uk\)](#)

In January 2023, the Board approved the Trust's Risk Appetite Statement:

The risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings. The Trust has defined the Risk Appetite Statement specifically for five types of risk: Quality, People, Finance & Sustainability, Regulation and Reputation.

Further work is to be completed during the 2023/24 financial year to allocate specific risk appetite to each of the strategic risks.

Warrington & Halton Teaching Hospitals NHS FT – Risk Appetite Statement

WHH is an ambitious organisation – ambitious for its patients, its workforce and for the communities it serves.

Our goal is to provide high quality care that put patients first, is both safe and effective and delivers an excellent patient experience. Alongside this, we aim to be the best place to work, with a diverse and engaged workforce, fit for now and the future. Together with our partners in the health and social care system, we will design our services to be fit for purpose, more integrated in order to achieve social and economic wellbeing in our communities.

The NHS unquestionably faces unprecedented economic and operational challenges, but these challenges are magnified at a local level by additional demographic factors, as well as specific WHH issues. The latter includes, for example, an aging estate on both our hospital sites. Achieving our goals, whilst meeting these challenges, will require significant change as well as extensive collaboration with partners across the NHS family and across the wider, public and third sectors. This degree of change brings significant opportunity but, correspondingly, it requires us to take more risk. Thus, we must endeavour to strike the best balance between the two.

Accordingly, we will continue to be guided by our risk management policy in order to understand and control risk. We will continue to develop our corporate risk register to monitor significant operational risks. We will also continue to apply our board assurance framework to monitor strategic risks and ensure that the risks we take are consistent with the risk appetite set by the Board.

Our risk appetite, therefore, represents a collective agreement, understanding and decision by the Board about the level of risk that we are prepared to accept, after balancing the potential opportunities and threats any given situation presents.

To ensure clarity, we have broken down our approach to expressing our risk appetite into the five main types of risk facing the majority of NHS provider organisations within our own context and terminology: namely, quality; financial and operational sustainability; regulation; people; and reputation.

Quality

Providing the best care and treatment we can is our purpose. We will actively avoid risks to the quality of clinical services and will take a cautious and balanced approach. Where innovation may improve quality of care we will however be more open to risk. When making significant decisions about our services, we will assess and record any risks affecting safety, patient experience and clinical effectiveness, and apply the necessary control measures. The impact of changes on quality will be monitored continuously and reported using both quantitative data and qualitative intelligence.



People

We aim to provide a supportive and inclusive culture and working environment, in which both individuals and teams can thrive. We recruit, develop and train current as well as future staff. To achieve our goals in respect of quality services and financial sustainability we will need to take significant decisions about services that will affect our people and may impact their working arrangements. We are therefore open to risk where we can demonstrate longer-term benefits to patients from our decisions. In arriving at those decisions, we will engage with our staff to shape our proposals, in order to maximise the positive impact on patient care and mitigate any potential adverse impact on staff.

Financial and Operational Sustainability

We aim to be a highly productive organisation that consistently delivers on all our constitutional performance standards whilst demonstrating public value for money with integrity and probity. We aim to continuously improve and innovate in the best interests of our patients, staff and communities. We are therefore open to seek out risk through innovative approaches, subject to appropriate procedures and controls.

Regulation

Our first aim is to provide safe and effective patient care, alongside an efficient use of resources. We use our regulated status to provide assurance of the quality of the services that we provide, the environment that we operate within and our efficiency. Our regulatory environment assists us in promoting outstanding patient care, working in collaboration with health and social care partners. We are therefore open to this risk.

Reputation

We are an outward-looking organisation and are determined to contribute fully to partnership working within our system and beyond – for example, with other health and social care organisations, local authorities, education partners, and the voluntary, community and faith sectors. Involvement of patients and the public is important to us, and we proactively include them and their representatives as part of our decision-making processes. We are open to reputational risk in that we may take decisions which may attract challenge when we can clearly demonstrate that they will achieve at least the same, if not better, outcomes for our patients, workforce, and the communities we serve.

Risk ID	Executive Lead	Risk Description Strategic Objective at Risk	Current	Rating	Target Rating	Monitoring Committee
224	Daniel Moore	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety	1	25 (5x5)	8 (2x4)	Clinical Recovery Oversight Committee
1215	Daniel Moore	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the Trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans	1	25 (5x5)	6 (3x2)	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care	1	20 (5x4)	12 (4x3)	Quality Assurance Committee
134	Andrea McGee	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (5x4)	10 (5x2)	Finance & Sustainability Committee
1134	Michelle Cloney	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	20 (4x5)	8 (4x2)	Strategic People Committee
1114	Dr Paul Fitzsimmons	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and nonclinical services and a potential failure to meet statutory obligations	1	16 (4x4)	8 (2x4)	Finance & Sustainability Committee

Risk ID	Executive Lead	Risk Description Strategic Objective at Risk	Current	Rating	Target Rating	Monitoring Committee
1275	Kimberley Salmon-Jamieson	If we do not prevent nosocomial COVID-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation	1	16 (4x4)	5 (5x1)	Quality Assurance Committee
1372	Dr Paul Fitzsimmons	If the Trust is unable to procure a new Electronic Patient Record then, then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (4x4)	8 (2x4)	Finance & Sustainability Committee
1757	Michelle Cloney	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	2	16 (4x4)	8 (4x2)	Strategic People Committee
125	Daniel Moore	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	1	15 (3x5)	4 (4x1)	Executive Management Team
145	Prof Simon Constable	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position	3	12 (3x4)	8 (4x2)	Executive Management Team

Appendix 1

Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.

Strategic Objective 2: We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future

Strategic Objective 3: We will... Work in partnership with others to achieve social and economic wellbeing in our communities.

1.6 Going Concern Disclosure

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.





Performance Analysis

2.1 Performance measures, KPIs, links to risk and uncertainties

The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed at least annually.

The PAF sets out the approach the Trust undertakes in ensuring there are effective systems in place to monitor, manage and improve performance. Prompt reviews will be undertaken where performance is deteriorating, and appropriate actions will be implemented to bring performance back to an acceptable level.

The PAF:

1. Sets out clear lines of accountability and responsibility for delivery of performance from Ward to Board.
2. Ensures performance objectives are agreed and transparent measurements are set to monitor performance against these standards, targets and plans.
3. Ensures performance delivery is focused and is seen as a continual process which is embedded in all aspects of organisational activity.
4. Provides assurance to the Board, Governors, Stakeholders and the Public that the organisation has strong systems in place to deliver the highest standards of patient care.
5. Supports the achievement of the Trust objectives.
6. Supports the delivery of the requirements of the Trust Foundation Licence, NHS Improvement Oversight Framework and the NHS Standard Contract.
7. Provides focus on and assurance of best value for money ensuring that services meet the needs of the local population and local health economy.
8. Supports the delivery of an engaged and motivated workforce with the right skills and capacity to provide consistent, good quality care.
9. Recognises good performance and improvement and shares good practice.
10. Sets out the process for managing performance risks/issues with a balance between challenge and support.

The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with explanation from the Executive Directors. The Trust Board may request one or more performance improvement actions where there is a concern with any area of performance.

KPIs within the Board IPR are reviewed and agreed annually by Board Committees with approval from the Trust Board. KPIs may be changed in year with the support of the appropriate Board Committee and the approval of the Trust Board.

The IPR Dashboard contains the following elements which are designed to provide the Trust Board with assurance around the performance of the Trust against the KPIs and to highlight areas of improvement and good practice:

1. Exception Report – the front section of the document is an exception report which summarises all KPIs by both Assurance and Variation Category. This is followed by a report of KPIs consistently failing to meet set targets, and KPIs indicating special cause variation of a concerning nature.
2. High Level Summary – the IPR is split into four key areas: Quality, Access & Performance, Workforce and Finance. A high-level summary is provided for each of these areas.
3. Assurance and Variation Movements – this section details areas of special cause variation across all KPIs using Statistical Process Control (SPC) Assurance and Variation Icons (supported by NHS England as part of the “Making Data Count” initiative).
4. Dashboard – The dashboard details current and historic levels of performance, reasons for under performance and/or performance deterioration and detail of actions and investigations underway to improve performance against the KPI. The dashboard contains Statistical Process Control charts which look at data over time to determine if a process is within control or not, or whether there is special cause variation which requires action.

There is an annual rolling programme of auditing of KPIs to ensure there is assurance around the quality of the data and reporting processes which is facilitated by the Trust’s internal auditors MIAA.

Trust Strategic Objectives

The Performance Assurance Framework tracks the key performance indicators required to achieve the Trust's 12 Strategic Objectives:



QUALITY

We will always put our patients first, delivering safe and effective care and an excellent patient experience



PEOPLE

We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future



SUSTAINABILITY

We will work in partnership with others to achieve social and economic wellbeing in our communities

1

Patient safety

We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.

5

Looking after our people

We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.

9

Working in partnership

We will work collaboratively to provide sustainable, high quality acute services and to support prevention and integrated care in the community.

2

Clinical effectiveness

We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients.

6

Innovating the way we work

We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.

10

Working responsibly

We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.

3

Patient experience

We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.

7

Growing our workforce for the future

We will support personal and professional development, ensuring equal access to opportunities, and nurturing, growing and developing diverse teams.

11

Sustainable estate and digitally enabled

We will provide our services in a fit for purpose estate, supported by the realisation of digital opportunities.

4

Research, development and innovation

We will work in partnership on high quality clinical research for the benefit of patients, public and staff.

8

Belonging in WHH

We will enable staff to have a voice through the development of a just and learning culture.

12

Financial sustainability

We will develop and delivering financial sustainability plans with our staff, system partners and stakeholders.



Key Performance Indicators

Operations – Access & Performance Finance

1. Diagnostic Waiting Times six Weeks
2. RTT – Open Pathways
3. RTT – Number of Patients Waiting 52+ Weeks
4. A&E Waiting Times – National Target
5. A&E Waiting Times – ICS Trajectory
6. A&E Waiting Times – Over 12 Hours
7. Cancer 14 Days
8. Breast Symptoms 14 Days
9. Cancer 28 Days Faster Diagnostic
10. Cancer 31 Days First Treatment
11. Cancer 31 Days Subsequent Surgery
12. Cancer 31 Days Subsequent Drug
13. Cancer 62 Days Urgent
14. Cancer 62 Days Screening
15. Ambulance Handovers within 15 minutes
16. Ambulance Handovers 30 to <60 minutes
17. Ambulance Handovers at 60 minutes or more
18. Discharge Summaries – % sent within 24hrs
19. Discharge Summaries – Number NOT sent within seven days
20. Cancelled Operations on the day for a non-clinical reason
21. Cancelled Operations – Not offered a date for readmission within 28 days
22. Urgent Operations – Cancelled for a 2nd time
23. Super Stranded Patients
24. COVID-19 Recovery Elective Activity
25. COVID-19 Recovery Diagnostic Activity
26. COVID-19 Recovery Outpatient Activity
27. % Patients seen in the fracture clinic within 72 hours
28. % Patients referred to long COVID service not assessed within 15 weeks
29. % Zero-day length of stay admissions (as a proportion of total)
30. Reduction in Outpatient Follow Ups
31. COVID-19 Recovery Cancer First Treatment
32. % Patients discharged to their usual place of residence
33. Theatre list scheduling and optimisation

Finance

1. Trust Financial Position
2. Cash Balance
3. Capital Programme
4. Better Payment Practice Code
5. 'Agency Ceiling' – Agency Spending (Monthly)
6. Cost Improvement Programme Performance to date
7. Cost Improvement Programme – Plans in Progress (In Year)
8. Cost Improvement Programme – Plans in Progress (Recurrent)

2.2 Detailed analysis and explanation of the financial and operational performance

Performance against equality of service delivery

The Trust continues to strengthen its performance against equality of service from an experience and inclusion perspective. Information relating

to ethnicity, deprivation and other protected characteristics is accessible as part of the Key Performance Indicator dashboards. Further developments are planned with the aim of being able to review and monitor disparities in waiting lists/times/DNAs between different patient groups.

Summary Activity (Data vs 2019–20 as being most representative year pre-COVID-19 pandemic)

Activity	2022/23	% Change 22/23 vs 19/20	2021/22	% Change 21/22 vs 19/20	2019/20
Elective Inpatient Discharges	2910	-26.50%	3317	-16.22%	3959
Elective Day Cases Discharges	26489	-3.27%	24540	-10.39%	27384
Non-Elective Discharges	32522	-24.81%	30188	-30.21%	43253
New Outpatient Attendances (including virtual)	90227	-10.02%	91885	-8.37%	100279
A&E Attendances	121686	8.29%	122330	8.86%	112369



Delivering the four-hour standard

4-hr performance including Widnes Walk-ins activity – All department types, both sides

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
A&E & MIU (Including Widnes Walk-in)	% Departed <=4hrs	>=95%	74.04%	74.44%	73.82%	74.10%	74.27%	76.31%	74.58%	75.04%	74.95%	67.31%	59.44%	67.07%	68.69%	69.82%	67.73%	68.70%	71.22%
	* Number of attendances		12254	12732	12340	37326	12319	11537	11383	35239	12353	12357	13151	37861	11051	10661	12267	33979	144405
	* Number of patients breaching 4hrs		3181	3254	3231	9666	3170	2733	2893	8796	3094	4039	5334	12467	3460	3217	3958	10635	41564

4-hr performance excluding Widnes Walk-ins activity – All department types, both sides

Local Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
A&E & MIU (Excluding Widnes Walk-in)	% Departed <=4hrs	>=95%	69.72%	70.50%	69.53%	69.92%	70.10%	72.10%	70.71%	70.95%	71.46%	63.80%	55.14%	63.28%	64.53%	65.13%	62.52%	63.99%	67.02%
	* Number of attendances		10045	10685	10384	31114	10346	9702	9662	29710	10317	10512	11073	31902	9473	9045	10454	28972	121698
	* Number of patients breaching 4hrs		3042	3152	3164	9358	3093	2707	2830	8630	2944	3805	4967	11716	3360	3154	3918	10432	40136

The delivery of the four-hour urgent care standard was impacted across year by the continuing effect of COVID-19 presentations, high emergency department attendances combined with high bed occupancy resulting in challenges in flow out of the emergency department. Warrington is consistently ranked in the lower middle of the national league tables.

Performance was impacted by a high number of patients with 'no clinical right to reside' with circa 25% of the available acute general adult beds being occupied by a patient with no clinical right to reside. The Trust continues to work closely with community and local authority partners to overcome these challenges as well as increasing bed capacity to meet the increased demand for services.

Same Day Emergency Care Unit (SDEC) opened in July 2022 and has seen an average of 820 patients per month with a conversion rate of 15.5%, creating increased capacity outside of the emergency department to see and treat more patients.

Diagnostics waiting times

The diagnostic performance against the target of less than 1% of patients waiting more than 6-weeks for a diagnostic test has not been achieved across all modalities. Radiology has fully recovered within year and Endoscopy remains on a recovery trajectory. Challenges remain for Echo and Sleep studies with recovery plans being implemented.

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
Diagnostics – 6+ Week Waiters	% of Patients Waiting 6+ Weeks	<1%	19.17%	14.79%	14.53%	16.24%	14.90%	21.46%	23.19%	19.94%	24.11%	24.09%	28.93%	25.71%	26.75%	21.54%	22.31%	23.46%	21.47%
	* Number of attendances		8077	7598	7311	22986	7005	6859	7646	21510	7864	8210	8038	24112	8150	8516	9029	25695	94303
	* Number of patients breaching 4hrs		1548	1124	1062	3734	1044	1472	1773	4289	1896	1978	2325	6199	2180	1834	2014	6028	20250

Referral to Treatment (RTT) waiting times

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
RTT – 18 Weeks	Incomplete Pathways % <18 Weeks	>=90%	66.49%	68.76%	66.18%		62.72%	62.45%	60.53%		61.67%	60.62%	57.30%		58.27%	57.55%	56.17%		
	* Number of incomplete pathways		23763	24516	24268		25201	26975	27326		28555	29070	29044		29616	29622	30450		
	* Number of patients waiting 18+ weeks		7962	7658	8208		9395	10130	10786		10946	11447	12402		12359	12575	13347		
	* Number of patients waiting 52+ weeks	0	1096	1185	1298		1421	1448	1636		1587	1621	1459		1358	1416	1571		

The Trust did not achieve the 18-week Referral to Treatment standard in 2022–23 due to the ongoing impact of the COVID19 pandemic and the focus on recovery for clinical priority patients and long waiting patients.

Throughout the year the Trust has complied with all national elective restoration and recovery guidance and participated in the National Clinical Validation programme, completing the programme of work within the expected timescales. The Trust continues to undertake a recovery elective programme with:

1. Urgent cancer and elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable patients.
2. Prioritisation of P2, 52 – and 78-week breeches for scheduling into capacity
3. 2023–24 planning submission in line with national guidance for reduction of waiting lists has been completed.
4. Harm assurance piece being undertaken on all 52-week breeches to identify any risk of harm for patients who have waited a long time during the pandemic.

National Discharge Policy – No criteria to reside

In March 2020 the National Policy Hospital Discharge and Community Support: Policy and Operating Model was published and provided discharge-to-assess funding via the NHS to help cover the cost of rehabilitation and reablement care following discharge from hospital. There is a continued policy requirement that Health and Social Care systems will build upon this work referenced in the revised guidance; Hospital Discharge and Community Support Guidance published on 31st March 2022.

Whilst funding arrangements have changed, the essence of the policy requires trusts to adopt the discharge-to-assess principles where full assessment of need, especially long-term, need takes place in a more appropriate setting outside the hospital delivering:

1. A reduction the length of stay for people in acute care.
2. Improvements in people’s outcomes following a period of rehabilitation and recovery.
3. A minimised need for long-term care at the end of a person’s rehabilitation. Central to the approach is the stratification of patients’ needs firstly into their right to reside and then onto simplified pathways (pathway 1 for home, pathway 2 for rehabilitation and pathway 3 for care homes) and the establishment of a transfer hub to oversee the initial assessment of need and co-ordination of discharge.

The policy and new operating model sets an ambition that people with no criteria to reside are discharged within two hours of being determined not to have a criterion to reside. Achieving the ambitions for people, ensuring system flow, and supporting our system vision to support people to live well and independently at home requires investment in the hospital discharge team function and additional community service capacity so people can be discharged to the right destination.

The Warrington and Halton system strategy of developing integrated care aims to help support people to:

1. receive the right care in the right location at the right time.
2. a ‘home first’ focus wherever possible.
3. ensure that stays in acute settings are for the right length of time, and that people move.
4. from an acute setting, to continue their recuperation most appropriate to their needs.
5. ensures system capacity is optimised for those who need the care most.

The vital role that the Hospital Transfer of Care Hub (formerly Discharge Team), reablement at home and domiciliary care plays is largely acknowledged however there are significant challenges with the current staffing model within the team. Investment proposals have been progressed to build on current good practice and deliver:

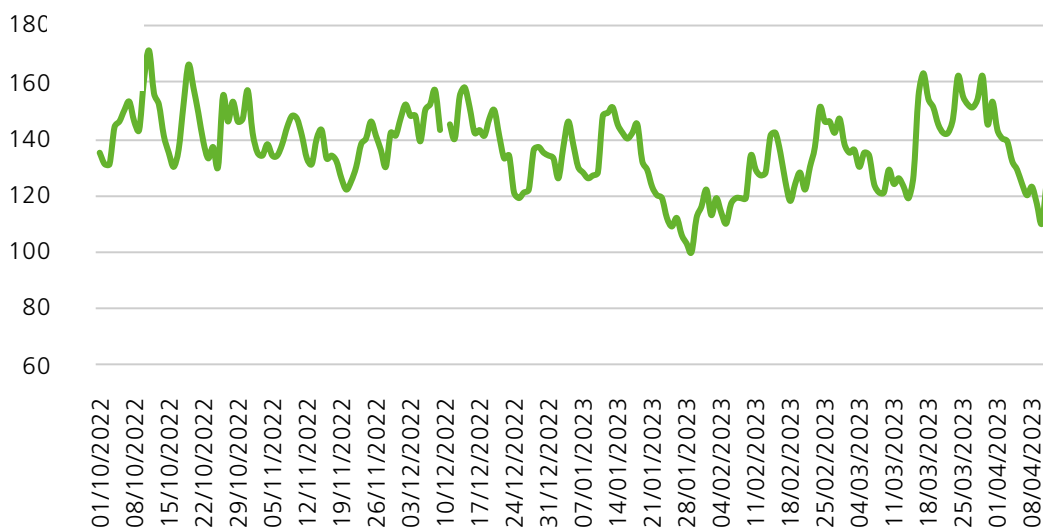
1. Change the discharge model to a ‘pull’ model – the team actively seeks out patients with no criteria to reside and plans their transfer.
2. Diversify the skill mix within the team, creating case manager roles as single points of contact for wards and families for discharge planning and co-ordination.
3. Build on the transfer hub established to optimise resources towards ensuring the right amount of care is provided in the right place and enhancing from a five to a 7-day service.
4. Enhancement of the staffing establishment in ICAHT and domiciliary care to promote independence and optimise flow achieving a next day discharge for 80% of patients.

The number of patients with a ‘clinical no right to reside’ has remained higher than the national average. In year, extensive partnership working across the health and social care economy ensured that patients were supported to return home or on to more appropriate care settings once their acute care was complete, thus ensuring that beds remained available for incoming patients.

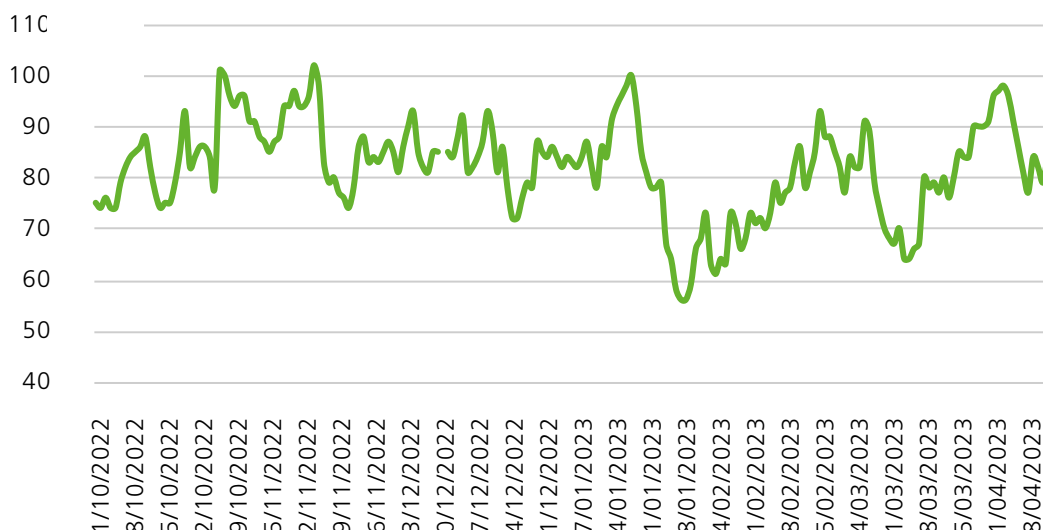
The successful discharge of frail, older patients following emergency admission to hospital relies on effective joint working between NHS, social care partners and the independent sector. Early assessment and review using the most appropriate multi-disciplinary team at the point of entry to urgent and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

The charts below show the number of patients who have a no clinical right to reside and the number who are over 21 days and classified as super stranded.

No Right to Reside



LOS 21+days No Right to Reside



Cancer waiting time and Regulatory Requirements

The Trust has seen a challenging year with regards to Cancer Performance but has maintained good compliance against the 31-day and 31-day subsequent treatment standards, and performance against the 62-day screening standard which recovered in May 22 and has remained recovered.

The 62-day standard and 28-day Faster Diagnosis standards remain difficult to achieve although this is in line with the overall Cancer Alliance and National picture.

The 62-day backlog size remains under the trajectory which is encouraging and is also one of the smallest backlogs in the Alliance, deemed not be an overall risk at that level.

The 104-day backlog has ceased to be monitored at a national level but will continue to be monitored by the organisation as good practice for this group of patients.

There are several key initiatives such as the Faster Diagnosis Framework Programme (formerly RDS) and the revised FIT pathway pilot in place which continue to make progress against performance and the patient experience.

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	
All Cancers: 31-day wait for second or subsequent treatment	Surgery	Numerator	7	18	18	43	17	15	22	54	5	20	8	33	12	13	8	33	163	
		Denominator	7	18	18	43	17	15	22	54	5	20	8	33	12	13	8	33	163	
		94%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Anti Cancer Drug Treatments	Numerator	2	6	4	12	1	10	2	13	3	10	3	16	7	3	8	18	59	
		Denominator	2	6	4	12	1	10	2	13	3	10	3	16	7	3	8	18	59	
		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%	100.00%	100.00%
	Radiotherapy	94%																		
All Cancers: 62-day wait for first treatment	From urgent GP referral – post local breach re-allocation	Numerator	47.0	40.5	38.0	125.5	39.5	38.5	38.5	116.5	44.0	40.0	31.0	115.0	31.5	30.0	28.5	90.0	447.0	
		Denominator	57.0	48.0	59.5	164.5	55.0	54.5	52.5	162.0	61.0	57.5	42.0	160.5	53.0	49.5	52.5	155.0	642.0	
			85%	82.46%	84.38%	63.87%	76.29%	71.82%	70.64%	73.33%	71.91%	72.13%	69.57%	73.81%	71.65%	59.43%	60.61%	54.29%	58.06%	69.63%
	From NHS Cancer Screening Service referral – post local breach re-allocation	Numerator	2.0	16.0	18.5	36.5	9.0	10.0	9.5	28.5	8.0	10.5	15.5	34.0	14.5	7.0	9.5	31.0	130.0	
		Denominator	3.5	18.0	18.5	40.0	9.5	10.0	9.5	29.0	8.0	10.5	15.5	34.0	16.0	7.0	9.5	32.5	135.5	
			90%	57.14%	88.89%	100.00%	91.25%	94.74%	100.00%	100.00%	98.28%	100.00%	100.00%	100.00%	100.00%	90.63%	100.00%	100.00%	95.38%	95.94%

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
All Cancers: 31-day Wait From Diagnosis To First Treatment	Numerator	88	90	90	268	73	78	67	218	67	85	65	217	83	68	66	217	920	
	Denominator	88	90	92	270	74	78	67	219	68	87	66	221	85	69	72	226	936	
	96%	100.00%	100.00%	97.83%	99.26%	98.65%	100.00%	100.00%	99.54%	98.53%	97.70%	98.48%	98.19%	97.65%	98.55%	91.67%	96.02%	98.29%	
Cancer: Two Week Wait From Referral To Date First Seen	All Cancers Numerator	879	972	919	2770	894	1004	960	2858	1008	972	814	2794	928	1029	781	2738	11160	
	All Cancers Denominator	1059	1104	1014	3177	1033	1170	1080	3283	1130	1099	956	3185	1110	1156	1124	3390	13035	
	93%	83.00%	88.04%	90.63%	87.19%	86.54%	85.81%	88.89%	87.05%	89.20%	88.44%	85.15%	87.72%	83.60%	89.01%	69.48%	80.77%	85.62%	
Symptomatic Breast Patients (Cancer Not Initially Suspected)	Numerator	33	21	32	86	45	74	49	168	47	45	45	137	26	27	7	60	451	
	Denominator	36	23	33	92	51	79	53	183	48	45	45	138	29	36	51	116	529	
	93%	91.67%	91.30%	96.97%	93.48%	88.24%	93.67%	92.45%	91.80%	97.92%	100.00%	100.00%	99.28%	89.66%	75.00%	13.73%	51.72%	85.26%	
All Cancers: 62-day wait for First treatment - Consultant Upgrade	Numerator	25.5	25.0	34.0	84.5	24.5	27.0	17.0	68.5	11.5	11.0	8.5	31.0	15.5	4.5	12.5	32.5	216.5	
	Denominator	26.5	28.0	37.0	91.5	27.0	28.0	18.5	73.5	11.5	11.0	10.5	33.0	15.5	4.5	13.0	33.0	231.0	
		96.23%	89.29%	91.89%	92.35%	90.74%	96.43%	91.89%	93.20%	100.00%	100.00%	80.95%	93.94%	100.00%	100.00%	96.15%	98.48%	93.72%	
28-day Faster Diagnosis	Numerator	803.0	848.0	740.0	2391.0	747.0	1211.0	794.0	2752.0	761.0	861.0	621.0	2243.0	731.0	797.0	766.0	2294.0	9680.0	
	Denominator	1146.0	1127.0	983.0	3256.0	968.0	1244.0	1115.0	3327.0	1061.0	1218.0	854.0	3133.0	1143.0	1059.0	1047.0	3249.0	12965.0	
	75%	70.07%	75.24%	75.28%	73.43%	77.17%	97.35%	71.21%	82.72%	71.72%	70.69%	72.72%	71.59%	63.95%	75.26%	73.16%	70.61%	74.66%	



2.3 Financial performance

The Trust's resources are managed within a financial governance framework that incorporates systems of financial control, budgetary control and the financial responsibilities for individuals outlined within the Trust's Corporate Governance policies and procedures. Financial and quality governance arrangements incorporate benchmarking activities and an internal audit function to ensure the economic, efficient and effective use of resources, including value for money.

Financial performance is reported into the non-executive led Finance and Sustainability Committee, which meets monthly. Standing items on the agenda includes the monthly financial position, CIP position, capital schemes and in the first half of 2022/23 a COVID-19 expenditure report to ensure regular review of any financial challenges and implementation of recovery measures.

The Executive Team reviews and monitors the operational performance of the Trust. The Trust has a Use of Resources Group, which is led by the Chief Finance Officer & Deputy Chief Executive. Use of Resources is a workstream supporting the Trust's programme of 'Moving to Outstanding' CQC rating.

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 Scheme of Delegation. In addition, there is a robust system for developing and routinely reviewing policies and procedures and staff are appropriately updated and guided or trained on their application.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by counter fraud. Reports are presented to the Audit Committee in each meeting. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the regulators. The Trust recorded an adjusted deficit of £7.9m which is £2.5m away from the £5.4m deficit plan. This adjusted deficit is the value which NHSE/I monitors the Trust against and the movement from plan was approved by the ICS and the national team.

The annual capital programme was £25.6m and the actual spend for the year was £25.5m.

The cash balance at the end of the year was £34.9m which will be utilised to fund the annual leave accrual, new EPCMS and delayed capital creditors.

[\(For detailed report please see the accounts section\)](#)



2.4 How equality of service delivery to different groups has been promoted through the organisation

As a public sector organisation, all NHS Trusts are required to demonstrate how they meet the Public Sector Equality Duty as outlined in section 149 of the Equality Act 2010.

The Trust ensures it provides equality of access to its patients, workforce and members of the public. It is committed to furthering equality, diversity, inclusion and human rights and works in partnership with a variety of external partners and advocacy groups. This allows for a greater understanding of the local population, health needs and barriers to accessing health care which leads to addressing potential health inequalities across the boroughs that we serve. At Warrington and Halton Teaching Hospitals (WHH), adherence to the Public Sector Specific Equality Duties are through the production of the Workforce Equality Analysis Report and the Equality Duty Assurance Report which is published annually on the Trust website.

In addition to the Equality Act 2010 and Human Rights Act 1998, the Armed Forces Act 2021 further enshrines the Armed Forces Covenant into law to help prevent service personnel and veterans being disadvantaged when accessing public services.

The Act introduces a duty to have 'due regard' to the principles of the Armed Forces Covenant, as follows:

- a. the unique obligations of, and sacrifices made by, the armed forces.
- b. the principle that it is desirable to remove disadvantages arising for service people from membership, or former membership, of the armed forces.
- c. the principle that special provision for service people may be justified by the effects on such people of membership, or former membership, of the armed forces.

WHH considers the element of 'due regard' associated with the Armed Forces Act 2021 in its equality analysis and considerations process. Progress and achievements against the Armed Forces Act 2021 are reported through the Equality Duty Assurance Report annually to demonstrate progress against the Act and its duties.

In April 2022 the Trust in line with the specific duties of the Public Sector Equality Duty reviewed and refreshed its equality objectives. Part of this review included the formation of two new strategies:

- Workforce Equality, Diversity and Inclusion Strategy 2022–2025
- Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy 2022–2025

The two strategies provide an approach to delivering on the expectations of the Public Sector Equality Duty and Armed Forces Act 2021 whilst supporting the delivery of the organisations commitment to being an inclusive employer and outstanding place to receive healthcare. The content of the strategies were informed by national reports, regulated reporting such as the Workforce Equality Standards and known health inequality data to ensure they delivered meaningful impact.

The Workforce Equality, Diversity and Inclusion Strategy 2022–2025 sets out the WHH commitment to be the best place to work, creating a culture of belonging for all. The Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy 2022–2025 was designed with our patients and communities at its centre, acknowledging the role WHH plays in ensuring our hospitals are accessible and that our services address health inequalities in our community.

The Workforce Equality, Diversity and Inclusion Sub Committee and Patient Equality, Diversity and Inclusion Sub Committee are chaired by the Chief People Officer and Deputy Chief Nurse, respectively. Both committees in turn ensure oversight of the equality, diversity and inclusion agenda via respective Board committees with escalations reported to the Board of Directors as required. The Sub-Committees have internal and external stakeholder membership, with active involvement from patient representatives, staff networks and members of third sector bodies.

The Trust complies with the Equality Delivery System (EDS) reporting which is in place for both patients and service users and workforce. The Trust participated in the pilot for the refreshed EDS 2022 framework which was completed in the 2022/23 financial year. EDS grading is completed on an annual basis is graded in collaboration with community partners, key stakeholders and the wider public. This is published annually and is available on the Trust website.

A commitment to undertaking equality analysis ensures that our policies, strategies, functions and any services we deliver endeavour not to lead to an unfavourable effect on different people. Equality analysis also helps to identify any positive action we can take to promote equality of opportunity and access for our patients, workforce and communities.

Equality Impact Assessments (EIA) are used as a tool for Warrington and Halton Teaching Hospitals (WHH) to evidence that it is paying 'due regard' to the general aims of the Public Sector Equality Duty, Armed Forces Act 2021 and Human Rights Act 1998.

In 2022–2023 the Trust refreshed its EIA process to adopt a two-stage EIA process ensuring that EIAs are meaningful and enable the organisation to actively eliminate discrimination, harassment, and victimisation, foster good relations between people who share a protected characteristic and those who don't and advance equality of opportunity between all. The updated process also puts ownership on the authors requirement to identify both positive and negative impacts with learnings shared widely.

The Trust also ensures that due regard is given to other vulnerable groups where evidence shows potential barriers to healthcare or where health inequalities are known, such as, but not limited to:

- Carers
- Deprived Communities
- Armed Forces and Military Veterans

The Trust is confident in securing the views of its patients, their families and our workforce and this is evidenced by the following:

1. Trust Friends and Family Test Scores – Inpatient, Emergency Department, Maternity and Outpatients
2. National Patient Survey Results
3. Patient feedback reported through Patient Experience and Inclusion Team and local
4. Community Partners and Healthwatch
5. National NHS Staff Survey – completed on an annual basis
6. National People Pulse Surveys – completed on a quarterly basis

Scores and data collated from the Friends and Family Test, survey results and subsequent action plans and key themes identified through engagement with the public and community partners are reported monthly to the Patient Experience Sub-Committee. The Trust assesses feedback from the Friends and Family Test and National Surveys by protected characteristic to review if there are any disproportionate impact on patients' experience. Learnings from patient feedback and results are presented to the Patient Experience Sub-Committee and are used in patient stories, enabling continued learning across the Trust.



Data and qualitative information collated from the National NHS Staff Survey and People Pulse Surveys are reported to the Operational People Committee and Workforce Equality, Diversity and Inclusion Sub-Committee to monitor findings and subsequent action plan progress. This includes breaking down the results by protected characteristic to identify any disproportionate impacts, this is supported by the Trust Staff Networks of which there are four:

1. Multi-Ethnic Staff Network
2. PROGRESS Staff Network – supporting the LGBTQIA+ Community
3. Disability Awareness Network
4. Armed Forces and Military Veterans Community Staff Network



The Trust in 2022/23 was successfully recognised for its work in the equality, diversity and inclusion agenda. This included the attainment of three equality related accreditations in addition to those already achieved:

1. **Disability Confident Leader (Level 3)** – part of the UK Government Scheme recognising our commitment to supporting people living with a disability or long-term health condition to access and thrive in work.
2. **In-Trust Cheshire and Merseyside Navajo Charter Mark** for the LGBTQIA+ community. This accreditation recognises the commitment WHH continues to make to improve the experience and health outcomes of the LGBTQIA+ community – both for our patients and our workforce.
3. **Stonewall Diversity Champions Accreditation** – this accreditation recognises our commitment to continue to improve our policies, procedures and workstreams to positively impact on the LGBTQIA+ community.



The Trust in 2022/23 also made a commitment to strive to achieve the NHS North West Anti-Racist Organisation Framework Accreditation – highlighting that WHH is an inclusive organisation with zero tolerance to any form of discrimination, harassment and victimisation.

2.5 Customer satisfaction scores

The National Adult Inpatient Survey has been an annual requirement since 2002 by the Care Quality Commission (CQC) which looks at the experiences of adults that have been an inpatient at Warrington and Halton Teaching Hospitals (WHH) during November 2021. The aim is to obtain detailed patient feedback on the standards of service and care, this can then be used to help set priorities for delivering a better service for patients and the public. The results are also used by the CQC to measure and monitor performance at both regional and national levels. The results are also used by the CQC as intelligence to monitor, influence and add weight at inspection planning stages to identify possible areas or fields to look at on inspection.

At WHH the survey is undertaken by IQVIA on behalf of the Trust with sampling completed by the WHH Data Warehouse Team. They follow the national guidance issued on the NHS Patient Survey Programme by the CQC on behalf of NHS England and the Department of Health and Social Care.

The Trust response rate for 2021 was 39%, a 2% decrease in comparison to the 2020 response rate (41%). The national average response rate for this survey was 39%, this is made up of a mix of Specialist, Acute and Community Trusts.

The survey is made up of 10 sections, which are:

1. Admission to hospital
2. The hospital and ward
3. Doctors
4. Nurses
5. Your care and treatment
6. Operations and procedures
7. Leaving hospital
8. Feedback on the quality of your care
9. Respect and dignity
10. Overall Experience

The results of the National Inpatient Survey 2021 have been analysed in direct comparison to the results of the same survey undertaken in 2020 to ascertain where improvements have been made and to highlight areas of improvement. Results have been broken down into sections and rag rated according to performance. Table one below demonstrates where the results have improved, stayed the same or improved in the 2021 survey from the 2020 survey.



Table 1 – National Inpatient Survey Results 2021 compared to 2020

	Questions – Declining performance trajectory	Questions – Static performance	Questions – Improving performance trajectory	Questions – New question so unable to compare	Total
Admission to hospital	0	2	0	0	2
The hospital and the ward	1	5	3	4	13
Doctors	0	3	0	0	3
Nurses	0	4	0	0	4
Care and treatment	0	7	0	1	8
Operations and procedures	0	0	3	0	3
Leaving hospital	3	6	1	1	11
Feedback on care	0	1	0	0	1
Respect and dignity	0	1	0	0	1
Overall experience	0	1	0	0	1
Total	1	30	7	6	

Overall results demonstrate a secure picture

- 4 questions demonstrating a decline in performance
- 30 questions demonstrating a static performance
- 7 questions demonstrating an improvement in performance
- 6 questions are new to the 2021 survey therefore unable to directly compare performance

Analysis of the survey results in 2021 have demonstrated a decline in performance in relation to seven questions detailed in table one. These areas are as follows:

- **Question 9: Did patients get enough help from staff to wash or keep themselves clean?**
The survey results for 2021 indicate a reduction in performance from a score of 9.0 to 8.3, a reduction of 0.6.
- **Question 37: Did hospital staff discuss additional equipment of changes to patients' homes after leaving hospital?**
The survey results for 2021 indicate a reduction in performance from a score of 9.3 to 8.3, a reduction of 1.0.

- **Question 41: In relation to medication to take home were patients given an explanation in relation to?**
 - The purpose of the medicine
 - Side effects
 - How to take medication
 - Written information about the medicine
 - Given the medication, but no information

The survey results for 2021 indicate an overall reduction in performance from a score of 5.0 to 4.3, a reduction of 0.7.

- **Question 43: Did hospital staff tell you who to contact if they were worried about their condition after they left the hospital?**
The survey results for 2021 indicate a reduction in performance from a score of 8.1 to 7.4, a reduction of 0.6.

Analysis of the survey results in 2021 have demonstrated an improvement in relation to seven questions detailed in table one. These areas are as follows:

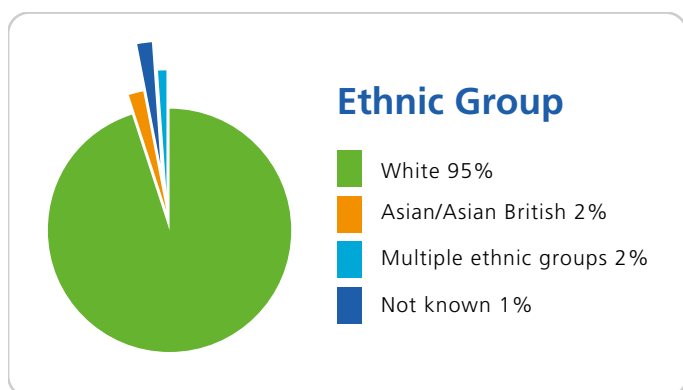
- Patients being prevented from sleeping at night by noise from staff indicates moved up by how much?
- Patients being prevented from sleeping at night by hospital lighting
- Patients getting enough help from staff to eat their meals
- Staff adequately answering questions posed by patients about the operations or procedures before they take place
- Staff explaining to patients how they might feel after an operation or procedure
Staff explaining how well an operation or procedure may have gone
- Staff giving information to patients about what they should or should not do after leaving hospital

The respondent demographic characteristics recorded for the National Adult Inpatient Survey 2021 are:

1. **Ethnicity**
2. **Religion**
3. **Long term conditions** – physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more
4. **Sex** – At birth you were registered as...”
5. **Age**

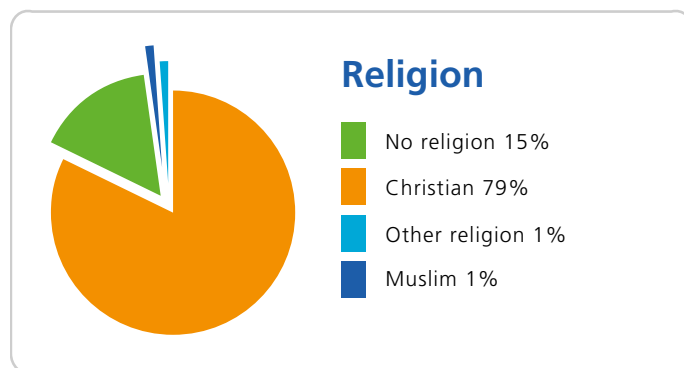
Ethnicity

Of those surveyed 94% stated their ethnicity was ‘White’ – this is made up of English/Welsh/Scottish/Northern Irish/British/Irish and any other White background.



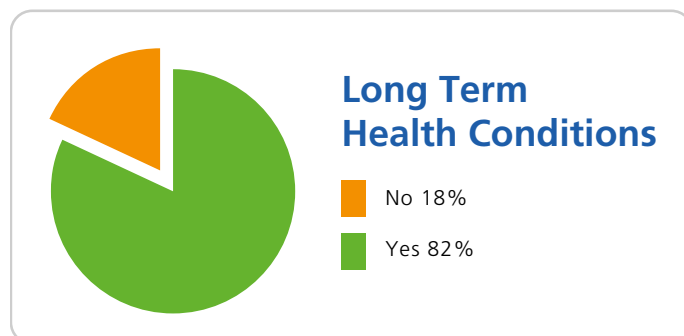
Religion

Of those surveyed 79% stated their religion as ‘Christian’ followed by 15% stating they did not identify with any religion.



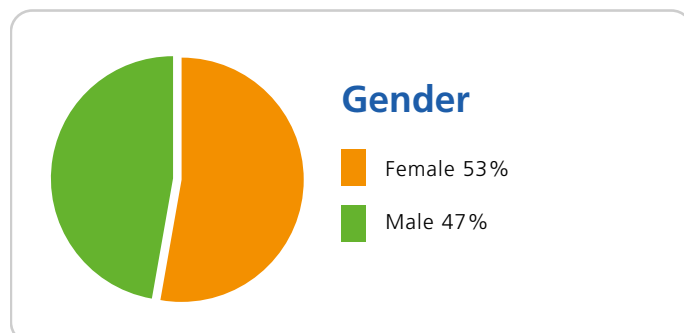
Long Term Conditions

Of those surveyed 82% of respondents said they have physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more.



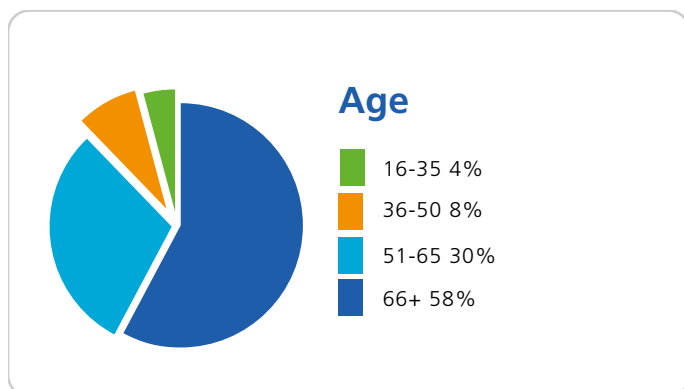
Sex and Gender

Of those surveyed 52% of participants identified as female with 47% identifying as male. There were no participants who stated their gender is different from the sex they were registered with at birth.



Age

Of those surveyed 58% stated they were over 66 years of age followed by 30% stating they were aged between 51 and 65.



Accessibility Formats:

The 2021 online survey included the following accessible formats:

- Change font size
- Change background colour
- Screen-reader compatible
- Other language options
- British Sign Language (BSL)

By request, contractors were also able to supply:

- A helpline – utilising LanguageLine Solutions® for interpretation.
- Large-print questionnaires
- Easy Read format
- Braille

Dissent posters were also displayed in common languages across the Trust.



2.6 Risk profile

As part of the Board Assurance Framework, key strategic risks are identified and linked to the Trust's three core strategic objectives:



QUALITY

We will always put our patients first, delivering safe and effective care and an excellent patient experience



PEOPLE

We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future



SUSTAINABILITY

We will work in partnership with others to achieve social and economic wellbeing in our communities



The Trust opened the year with 18 strategic risks it felt could affect the achieving of its objectives. Three of these risks were rated at a score of 25 which is the highest score on the on Trust's adopted risk grading method. A further eight risks were rated 20, five rated 16, one rated 15, one rated 12.

The Trust closed the financial year with 11 strategic risks it felt could affect the Trust in achieving its objectives. Two of these risks scored 25, three were rated 20, four rated 16, one rated 15 and one rated 12.

The existing risks described in the Annual Governance Statement continue to be acknowledged as the principal risks to the Trust with likely new risks emerging in the new year.

The Board Approved the Trusts Risk Appetite Statement at its meeting on 25th January 2023, full details can be found within the Annual Governance Statement. Further work is scheduled for 2023/24 to allocate specific risk appetite for each of the Trusts strategic risks.

2.7 Environment

The Trust recognises the scale of the issue that climate change presents in our community. As a healthcare provider it acknowledges its responsibility to minimise contributions to climate change and integrate sustainability into the organisation, reducing the potential risks for the local population. WHH's Green Plan outlines the commitments to embedding sustainability throughout its entire operation.

This Green Plan will serve as an organisation-wide strategy that establishes strategic objectives and targets for delivering sustainable healthcare within the Trust over the next five years. The Plan will highlight some of the key successes to date and build upon these actions with targets and ambitions for the future. It will stand as the central document to guide the Trust's sustainable development over the next five years. It will be the guide to reducing the environmental impact including carbon emissions, waste and air pollution, reducing costs and building social value in the community.



2.8 Information about social, community, anti-bribery and human rights issues

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

A person commits an offence if:

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

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 regarding our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

The Trust has a non-pay budget of £85m (inclusive of drugs at £18m) of which over £60m per annum is spent on goods and services.

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

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

The standard NHS Terms and Conditions of Contract which form the basis of all orders and contracts with supplier have a specific clause contained within them relating to modern slavery that determine that suppliers (and their sub-contractors) will:

- Comply with the Modern Slavery Act 2015.
- Implement due diligence policies for its sub-contractors.
- Respond promptly to all slavery and trafficking due diligence questionnaires.
- At the request of the Trust, prepare and deliver an annual slavery and trafficking report setting out steps to ensure slavery and trafficking is not taking place within its supply chain.
- Implement a system for all employees to ensure compliance with the Slavery Act.

The Trust's Procurement Team has contacted each of its top 250 suppliers to request confirmation that they are compliant with the Act. As part of this work Procurement also issued the Supplier Code of Conduct to all suppliers used across the organisation inclusive of pharmaceutical suppliers.

As part of the Trust's commitment to ensuring that we do not trade with organisations who do not meet the requirements of the Act, suppliers will be required to provide a copy of their annual Modern Slavery Action Statutory Statement detailing actions undertaken to ensure they meet and enforce the requirements of the Act. This will only apply to suppliers defined as a "commercial organisation" in accordance with the Act:

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

The Trust's Procurement team is committed to raising awareness with all suppliers by ensuring that all suppliers the Trust trades with are aware of our commitment to ensure compliance with the Act. As part of the Trust's ongoing procurement processes, when trading with new suppliers, and prior to establishing the supplier on Trust systems, the supplier will be requested to confirm in writing that they are compliant with the Act.

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

The Trust employs around 5,000 staff comprising 74 nationalities. Most of these staff are employed and paid under national pay arrangements established under Agenda for Change or Medical and Dental provisions. A small number of staff, which comprises the Trust Board and very senior managers, are employed under local pay and terms and conditions of service which are established by the Remuneration Committee of the Board.

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

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

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

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

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

The Trust employs an Equality and Diversity Specialist who will take the lead on the Modern Slavery Act and where possible the Trust does support awareness raising events both locally and nationally on such matters as disability, LGBTQIA+, honour crime and forced marriages. In relation to fraud risks to the organisation, the Trust agrees an annual counter fraud plan using a nominated and nationally Accredited Local Counter Fraud Specialist (LCFS) via its Internal Audit provider Mersey Internal Audit Agency (MIAA). The MIAA counter fraud specialist provided services in line with the agreed work plan which is approved at the Audit committee.

Regular monitoring of counter fraud activity is undertaken via the Trust's Audit Committee via progress reports and an annual report of counter fraud activity. This monitoring process includes the identification of any fraudulent activity against the Trust. During 22/23 MIAA commenced investigations into four potential fraud issues, of which three cases were closed and one remains open. There were also two cases carried forward from the previous years of which one remains open and one has been closed.

2.9 Any important events since year end

There were no events after the reporting period that require disclosure.



Professor Simon Constable FRCP,
Chief Executive

29th June 2023



Accountability Report

**Directors' report, Remuneration report,
Staff report, the disclosures set out in the
NHS Foundation Trust Code of Governance,
NHS Oversight Framework, Statement of
Accounting Officer's responsibilities and
Annual Governance Statement**

3.1 Directors' report

Board of Directors

Between 1st April 2022 and 31st March 2023, there were six ordinary and three extraordinary meetings of the Board of Directors.

In compliance with the requirements of the Health and Social Care Act 2012, the Board holds part of its meetings in public, followed by a private business section. Meetings of the Board of Directors are held bi-monthly, with a private Board Development Session held on the months in between formal meetings.

Board meetings are facilitated as hybrid meetings, whereby members and guests have the opportunity to attend in person or via video-conferencing utilising Microsoft Teams software.

The Board has overall responsibility for the strategic direction of the Trust, taking into account the views of the Council of Governors. Executive and Non-Executive Directors have an open invitation to attend meetings of the Council of Governors. The Board is responsible for ensuring that the day-to-day operation of the Trust is as effective, economical and efficient as possible and that all areas of identified risk are managed appropriately.

A detailed Schedule of Reservation and Delegation of Powers is in place, and it sets out explicitly those decisions which are reserved for the Board, those that may be determined by standing committees, and those that are delegated to managers.

The Trust has an established Governance structure with the following Committees, each chaired by a Non-Executive Director, with the exception of the Nominations and Remuneration Committee and the Charitable Funds Committee which are chaired by the Trust Chairman. The Committees were established to provide assurance to the Board of Directors:

- Nominations and Remuneration Committee.
- Audit Committee.
- Charitable Funds Committee.
- Finance & Sustainability Committee.
- Strategic People Committee.
- Quality Assurance Committee; and
- Clinical Recovery Oversight Committee (established in April 2021 – disestablished 29th March 2023)

The balance, completeness and appropriateness of the members of the Board is reviewed periodically and when vacancies arise among Executive or Non-Executive Directors.



Chair and CEO

Steve McGuirk CBE, QFSM, DL Chairman

Steve joined the Trust as chairman in April 2015 and has since been reappointed for further terms of office until March 2026. He previously served as Chief Fire Officer and Chief Executive of Cheshire and then Greater Manchester Fire and Rescue Services, and was president of the Chief Fire Officers Association.

He was Deputy Lieutenant for Greater Manchester and has extensive experience in governance of public authorities.

At WHH Steve is chair of the:

- Trust Board of Directors
- Council of Governors
- Board Nominations and Remuneration Committee
- Governor Nominations and Remuneration Committee

Steve, who lives in Warrington, is a trustee of the Fire Research and Training Trust and an assessor for the Queen's Award for Voluntary Service. He is also a Strategic Advisory Board member for the National Leadership Centre.

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.



Professor Simon Constable FRCP Chief Executive

Simon was appointed Chief Executive of Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) in November 2019.

A consultant physician and clinical pharmacologist by background, Simon joined the Trust as Executive Medical Director in February 2015.

Prior to taking up the post at WHH, he 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 has held several clinical leadership roles at the Royal Liverpool and Broadgreen University Hospitals, and is a visiting professor at the University of Chester. He studied medicine at Guy's and St Thomas' Hospitals in London, before undertaking postgraduate training in the UK and New Zealand.

Directors of the Trust

– The non-executive directors

Steve McGuirk CBE, QFSM, DL (see page 51)

Dr Cliff Richards, MBE Deputy Chair

Cliff joined the Trust as a non-executive director having previously been chair of Halton CCG from 2012 until retirement in 2017. He was appointed as Deputy Chair of the Trust in November 2022.

He was also previously the inaugural chair of Merseyside CCG Network, and chair of Cheshire and Merseyside Urgent and Emergency Network.

He undertook GP training before joining Brookvale Practice in Runcorn as a partner in 1983, which he led until 2014. He has been a trainer and appraiser, and a member of several regional forums including Cheshire and Merseyside Cancer Network.

Cliff has a strong patient focus through his GP career and other leadership and commissioning roles. He was awarded an MBE in recognition of his contribution to services to health in Cheshire and Merseyside.



Michael O'Connor Senior Independent Director

Mike is a partner with an international law firm and joined the Trust's board in November 2021.

He has practiced as a commercial lawyer for more than 30 years and has a wide range of experience and knowledge representing commercial business and public sector bodies. Mike is the Trust's Senior Independent Director, as appointed by the Trust Board in

consolidation with the Council of Governors in November 2022. Mike led his firm's infrastructure projects group for 15 years and was head of its Manchester office for three years.

Mike, who lives in Warrington, was a non-executive at North West Ambulance Services NHS Trust for seven years.

He has chaired the Bridgewater Hall board of trustees for six years and is also chair of a medical charity providing services to music and contemporary arts festivals.



Julie Jarman (from 1st January 2022)

Julie joined the board of Warrington and Halton Hospitals NHS Foundation Trust as a non-executive director in January 2022.

She has a background in community development and has spent most of her career in the voluntary sector, working on anti-poverty projects both in the UK and in international development.

For many years Julie was the England Country Director for Oxfam's UK Poverty Programme. More recently, she was

responsible for strategy at the Equalities and Human Rights Commission.

In her current role Julie works for Stockport Borough Council as Head of Fair and Inclusive Stockport. Prior to joining Warrington and Halton Hospitals she was a non-executive director of Greater Manchester Mental Health Foundation Trust for seven years.

Julie has a strong interest in mental health, equalities and population health, and sits on the Board of Trustees for three charities including Mind in Salford.



Jayne Downey (from 1st May 2022)

Jayne started as an associate non-executive director of the Trust in November 2011, and was appointed as a non-executive director of the Board in May 2022.

Jayne has almost 40 years' nursing experience and has worked across a number of nursing specialities including orthopaedics, general surgery and A&E.

She previously worked at Warrington and Halton Hospitals between 2004 and 2007 as Head of Governance and Risk Management.

Prior to that she held director of nursing positions in both specialist and commissioning NHS organisations, having moved into nurse management at a specialist orthopaedic hospital in 1998.

Originally from Widnes, Jayne has a clear passion for nursing, governance and quality. She qualified as an enrolled nurse in 1985 and subsequently as a registered nurse in 1989.

Jayne has worked at both local and national levels across public and private health care sectors supporting organisations with risk management and CQC compliance, including responsibility for supporting organisations in achieving and maintaining CQC 'outstanding' ratings.



John Somers (from 1st August 2022)

John joined the board as a non-executive director in October 2022.

He is an experienced leader who has more than 22 years' board level experience in public and private sector organisations.

For the past 14 years he has worked in various senior NHS roles across commissioning, community services and acute hospital care.

His most recent position until retirement was as Chief Executive Officer of Sheffield Children's NHS Foundation Trust, which he joined in 2014.

John held a regional leadership role in an Integrated Care System and a local leadership role in a Place-based Accountable Care Partnership with a track record of successfully delivering transformational change by partnership working. He also worked as an executive reviewer for the CQC.

John, who trained as a chartered accountant, has a passion for the NHS and is keen to utilise his experience to improve services for the residents of Warrington and Halton.



Margaret Bamforth (until 30th April 2022)

Margaret qualified from Liverpool Medical School and completed her training as a child and adolescent psychiatrist in Manchester. She practiced as a consultant child and adolescent psychiatrist in Halton for 22 years, before retiring from clinical practice. She has always had a strong interest in medical education and continued to

work as an Associate Postgraduate Dean for Mersey Deanery and subsequently HENW, following her retirement. She has an interest in leadership.

Margaret has lived in Lymm for over 30 years and her three sons attended Lymm High School. She has strong links to the local community, both through her personal and work commitments. Margaret's Term of Office was extended for a second term of office in April 2019 for a further three years to April 2022.



Professor John Alcolado
(Partner non-executive director from
1st December 2021 until January 2023)

Professor John Alcolado is the Executive Dean of the Faculty of Medicine & Life Sciences at the University of Chester and joined the Trust in December 2021. He has been responsible for leading the development of the new GMC accredited Graduate Entry Medicine programme at Chester Medical School.

Previously he was Head of Graduate Entry Medicine at the University of Nottingham. He has extensive experience in medical education and NHS leadership, including being Associate Medical Director (Academic) and Director of the Foundation School in north east London. John remains clinically active as a consultant physician in endocrinology, Diabetes and acute medicine. He is a GMC Associate and sits on Medical Practitioner Tribunal Service (MPTS) fitness to practice cases.



Terry Atherton
(to September 2022)

Terry Atherton joined the Trust Board as a non-executive director in July 2014, was Deputy Chair of the Trust and Chair of the Finance & Sustainability Committee. Terry worked for NatWest Bank for 35 years leading large teams and profit centres across the north west and North Wales. For the last 14 years he has worked with the both the public and private sector in a number of Board positions in a non-executive capacity. Terry was appointed Chair of Trafford Primary Care Trust in 2009 and following

the national NHS reorganisations, he became vice chair of the cluster of 10 Greater Manchester PCTs with specific responsibilities for oversight of the workforce of 2,700 and of service redesign initiatives. He was appointed in January 2013 as independent chair of the Morecambe Bay "Better Care Together" Programme before joining the Trust. Terry lives in Cheshire. Terry's Term of Office was extended for a second Term of Office in June 2017 for a further three years to June 2020, which was extended for a third Term of Office until 30th June 2021 and a further extension until 30th September 2022.



The Associate Non-executive Directors

Adrian Carridice-Davids

Adrian joined the Trust in November 2021 as an associate non-executive director.

He has held senior roles in the third and public sectors where he was responsible for initiatives that addressed both physical and social regeneration.

Adrian previously served as a non-executive director in the NHS in Lincolnshire and Blackpool, and in the housing sector for 10 years where he served as risk and audit chair.

As a business consultant he worked on government contracts developing strategic partnerships to address youth facilities provision and services for our aging population. He also served as advisor to the Government Office for the North West.

Adrian has managed trans-European structural funds supporting neighbourhoods across Europe and worked with the British Embassy/Consulate in China and India to support the development of micro businesses.

He is committed to empowering communities to take more responsibility for their health and assisting in developing services focused on prevention.



Dave Thompson MBE DL

Dave is Chief Executive of Warrington Disability Partnership and joined the Trust as an associate non-executive director in November 2021.

As well as founding the internationally recognised user-led charity he is also founder and event co-ordinator of Disability Awareness Day, the world's largest annual voluntary-led disability exhibition.

In 2015 Dave retired from a 20-year NHS career where he worked in governance, nursing and quality. He was Assistant Director of Inclusion and Partnerships for 10 years.

Dave has chaired the NHS North West Equality, Diversity and Inclusion Forum as well as national and international conferences on disability, independent living and equality, diversity and inclusion. He has presented lectures and training to more than 60,000 staff from statutory, private and third sectors.

A full-time wheelchair user since 1989 following a spinal cord injury, Dave has a unique understanding of healthcare services from three perspectives – patient, senior management and as a service provider.



The Executive Directors

Professor Simon Constable – Chief Executive (see page 51)

Andrea McGee
Chief Finance Officer &
Deputy Chief Executive

Andrea has worked in the NHS for nearly 30 years and joined the Trust in February 2016.

She was appointed Deputy Chief Executive in addition to her Chief Finance Officer role in 2020.

A qualified accountant (ACCA), Andrea was previously Director of Finance and Information at Calderstones Partnership NHS FT.

During her time with the NHS she has gained experience working within acute, mental health, learning disability, community and ambulance services and has led finance, procurement, estates and information teams.

She is currently vice chair of the National Finance Academy Leadership Group and chair of the Cheshire and Merseyside Procurement Steering Group, as well as being a member of the Cheshire and Merseyside ICS Finance Committee.

Andrea is a strong supporter of staff development and has received personal and team awards for finance staff development in the north west and nationally.



Kimberley Salmon-Jamieson
Chief Nurse & Deputy Chief Executive

Kimberley was appointed Deputy Chief Executive in 2020 in addition to her roles as Chief Nurse and Director of Infection, Prevention and Control at WHH.

She joined the Trust in 2016, having held senior leadership positions at two separate acute trusts in Greater Manchester. Prior to that she held a senior nursing role at Central Manchester Foundation Trust (now MFT) in 2008.

Kimberley began her career at Salford Royal Hospitals, undertaking a variety of roles before completing an MSc in clinical nursing. She was awarded sponsorship in 2016-17 to undertake the Health and Social Care Strategic Leadership Programme at the University of Yale's Global Health Leadership Institute.

Kimberley's unremitting focus is on patient-centred quality and safety improvement. She is passionate about the engagement of clinical staff in leadership and the nurturing of newly qualified employees to encourage professional development opportunities and increase the diversity of the workforce.



Daniel Moore Chief Operating Officer

Dan was appointed Chief Operating Officer in January 2021, having previously joined Warrington and Halton Teaching Hospitals NHS Foundation Trust in 2018 as its Director of Operations and Performance.

His role is to oversee operational delivery and performance achievement across the Trust.

Prior to his current role, Dan held a number of senior operational positions within the NHS. During that time he worked in operations management across acute hospital trusts in Greater Manchester and Cheshire.

Throughout his career, Dan has maintained a keen interest in furthering his academic knowledge; he holds a Master's in Business Administration (MBA) from Manchester Business School, and a BSc in operational management from Lancaster University Management School.



Michelle Cloney Chief People Officer

Michelle was appointed Director of Human Resources and Organisational Development in November 2017, having undertaken the role in an interim position in March 2017.

Prior to joining the Trust she was Associate Director of Workforce at Pennine Lancashire Transformation Programme and Senior Responsible Officer for Workforce, Organisational Development and Leadership, working across organisational boundaries within East Lancashire and Blackburn with Darwen.

Michelle started her NHS career in nursing in 1984 and developed a passion for working with teams to deliver excellent care to patients and service users. Moving into HR and OD in 1997, she gained extensive knowledge and experience including the management of HR services, employee engagement, staff health and wellbeing, equality, diversity and inclusion.

Michelle is committed to supporting staff to put patients at the heart of all we do and to enable them to recognise the Trust as a great place to work and receive care.



Dr Paul Fitzsimmons Executive Medical Director

Director Paul joined the Trust in Paul joined the Trust in December 2021 from Liverpool University Hospitals Foundation Trust where he was the Deputy Executive Medical Director for five years.

A consultant geriatrician and stroke physician by background, he studied medicine at Manchester University before undertaking postgraduate training in the north west.

Paul is also the Trust's Caldicott Guardian and Executive Lead for Digital.

Prior to joining Warrington and Halton Teaching Hospitals NHS Foundation Trust, Paul was a Healthcare Leadership Fellow at the Health Foundation and Ashridge University. He has extensive experience of delivering quality improvement, patient safety initiatives, digital clinical programmes and hospital service reconfigurations.



Lucy Gardner

Director of Strategy & Partnerships

Lucy joined the Trust in February 2016 from her role as a director at Ernst & Young's healthcare advisory practice.

She has held a number of operational management positions within the NHS and subsequently, in her role at Earnest & Young, led largescale change programmes to deliver significant financial, quality and performance benefits within healthcare.

Since joining WHH, Lucy has led the development and delivery of the

Trust's strategy, as well as key strategic programmes including our new hospitals bid and securing funding to deliver a new health and wellbeing hub in Warrington town centre.

Lucy started her career 17 years ago as an NHS general management trainee, gaining a master's degree in health and social care leadership and management.

She is committed to developing others and working in partnership with other organisations and individuals to not only deliver outstanding healthcare, but also to enable wider regeneration.



Kate Henry

Director of Communications & Engagement (from October 2022)

Kate joined the Trust in October 2022 and brings a wealth of experience in internal and external communication, engagement and consultation, crisis and reputation management, and marketing and branding.

She has led award-winning teams nationally and locally in the NHS over the past 17 years, including in roles focused on communicating and engaging about organisational and service change, quality improvement, and research and innovation. Kate's

most recent NHS role was as director of communications at a mental health and community services provider, after which she worked as a consultant advising private and third sector organisations on strategic communications.

Kate has an MSc in corporate communications and reputation management from Manchester Business School and a CMI Level 7 diploma in strategic management and leadership.

She is passionate about effective internal communication and engagement, and the impact that this has on patient care.

Kate is also executive lead for the Trust's charity.



Pat McLaren

Director of Communications & Engagement (to October 2022)

Pat joined the Trust in December 2015 as Director of Communications and Engagement and executive lead for Fundraising and her responsibilities included expanding, involving and supporting our relationships with the communities and people who use, work, visit, volunteer, support, commission, partner or donate to our hospitals in Warrington and Halton. Originally qualifying as a biomedical scientist, Pat

moved into communications, marketing and engagement in the healthcare and health sciences sectors and has lived and worked in healthcare across the UK, USA, Middle East, India, Pakistan and Australia with all types of organisations from private sector global brands to public sector organisations. She was the executive lead for fundraising, responsible for developing fundraising and engagement strategies and governance of the hospitals' charity in line with Charity Commission Guidance.



Significant interests of directors or governors

Register of Interests

A register of significant interests of directors and governors which may conflict with their responsibilities is available on the Trust's website here:

[Statutory information :: Warrington and Halton Hospitals NHS Trust \(whh.nhs.uk\)](https://www.whh.nhs.uk)

Board Member Terms of Appointment

Board Member	Term of Appointment
Steve McGuirk (Chairman)	First Term 01.04.2015 – 31.03.2018 Second Term 01.04.2018 – 31.03.2021 Third Term 01.04.2021 – 31.03.2023 (appointed for a further term in November 2022 effective 01.04.2023 – 31.03.2026)
Prof Simon Constable CEO	Medical Director from 01.02.2015 Chief Executive from 14.11.2019
Dr Cliff Richards	First Term 10.06.2019 – 09.06.2022 Second term 10.06.2022 – 09.06.2025
Michael O'Connor	From 01.11.2021
Julie Jarman	From 01.01.2022
Jayne Downey	From 01.11.2021, voting from 01.05.2022
John Somers	From 01.10.2022
Terry Atherton	First Term 01.07.2014 – 30.06.2017 Second Term 01.07.2017 – 30.06.2020 12-month extension 01.07.2020 – 30.06.2021 12-month extension 01.07.2021 – 30.09.2022
Margaret Bamforth	First Term 21.04.2016 – 20.04.2019 Second Term 21.04.2019 – 30.04.2022
Prof John Alcolado (partner NED)	01.12.2021 – 31.10.2022
Andrea McGee	From 01.02.2016
Kimberley Salmon-Jamieson	From 07.09.2016
Daniel Moore	From 20.01.2021
Michelle Cloney	From 01.11.2017, voting from 01.11.2021
Dr Paul Fitzsimmons	From 01.12.2021

Non-Voting Members Term of Appointment

Adrian Carridice-Davids	From 01.11.2021
Dave Thompson	From 01.11.2021
Pat McLaren	01.12.2015 – 30.09.2022
Lucy Gardner	From 01.02.2016
Kate Henry	From 01.10.2022

Attendance at Board of Director Meetings and Sub-Committees

1st April 2022 – 31 March 2023

Board Member	Trust Board 6 meetings & 3 Extraordinary meetings	Audit Committee 4 meetings	Quality Assurance Committee 10 meetings	Finance & Sustainability Committee 11 meetings	Strategic People Committee 5 meetings	Clinical Recovery Oversight Committee
	Attendance (Actual/Max)					
Non-Executive Directors						
Steve McGuirk (Chairman)	9/9	–	–	–	–	–
Dr Cliff Richards	9/9	5/5	10/12	–	–	9/10
Michael O'Connor	8/9	5/5	–	–	7/7	–
Julie Jarman	9/9	4/5	–	11/11	7/7	–
Jayne Downey	9/9	4/5	11/11	–	–	7/10
John Somers	–	2/2	–	6/6	–	–
Terry Atherton	3/6	3/3	–	5/5	–	5/5
Margaret Bamforth	N/A	–	–	–	–	1/1
Prof John Alcolado	6/6	–	–	–	–	–
Executive Directors (Voting)						
Prof Simon Constable	8/9	–	–	–	–	–
Andrea McGee	8/9	4/5	11/12	11/11	6/7	–
Kimberley Salmon-Jamieson	8/9	–	11/12	9/11	6/7	3/10
Daniel Moore	8/9	–	7/12	9/11	7/7	10/10
Michelle Cloney	9/9	–	11/12	9/11	7/7	–
Dr Paul Fitzsimmons	9/9	–	9/12	8/11	7/7	6/10

The Work of the Audit Committee

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

During the reporting period, the Committee has been composed of at least three Non-Executive Directors with a quorum of two. During the year the Committee met five times. Non-Executive Michael O'Connor holds the position of Chair of the Audit Committee. The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by members of the Committee. The Chair of the Trust is not a member of the Audit Committee in line with best practice.

Regular attendees at the Committee Meetings were the Trust's external auditors Grant Thornton (External Auditors from January 2017), Mersey Internal Audit Agency (MIAA – Internal Audit and Counter-Fraud Services), the Chief Finance Officer & Deputy Chief Executive, the Director of Integrated Governance and Quality and the Company Secretary.

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

1. High Assurance was provided in the following: Key Financial Controls (Accounts receivable and Accounts Payable)
2. Substantial Assurance was provided in the following: Waiting List Initiatives, Waiting List Managements, Payroll, Ockenden, Risk Management Core, Key Financial Controls (Treasury Management & General Ledger), Mortality (21/22) Data Security & Protection Toolkit (DSPT) submission (assessment against self-assessment)
3. Moderate Assurance was provided in the following: Data Security & Protection Toolkit (DSPT) submission (assessment against national Data Guardian Standards), Digital Systems (Clinical Safety)
4. Limited Assurance was provided in the following: Sepsis, Critical Applications (Badger Net Maternity)

There were no areas reported as providing no assurance.



Governance and Risk Management

During the Year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks, approved the Trust's Risk Appetite Statement and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and at Committee meetings bi-monthly in year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board. Each strategic risk is allocated to a committee for focused oversight and scrutiny.

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

System of Internal Control

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

Internal Audit Activities

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

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented regularly to the Committee by Internal

Audit throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

External Audit

Grant Thornton LLP commenced its initial three-year term as Auditors to the Trust in January 2017. The company then commenced a two-year term in October 2020, following a competitive procurement exercise and recommendation by the Council of Governors. The contract contained the option to extend for additional years and following support from the Audit Committee and approval by the Council of Governors, an extension up to 30th September 2024 was agreed.

During the year, the Auditors reported on the 2022–23 Financial Statements, no material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Trust and representatives of Grant Thornton have attended each Audit Committee meeting.

Grant Thornton have since audited these 2022–23 Financial Statements and their report and opinion is enclosed herein.

Anti-Fraud Activity

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

Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-Fraud, Bribery and Corruption Policy. During 22/23 MIAA commenced investigations into four potential fraud issues, of which three cases were closed and one remains open. There were also two cases carried forward from the previous years of which one remains open, and one has been closed.

The Foundation Trust Governors and Membership following elections November 2022 and changes to the Constitution approved by Trust Board 29th March 2023

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

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

Governor Elections

Public and Staff Governor elections were held between 21st October – 25th November 2022, to appoint or renew governor terms of seven Public Governors and two Staff Governors. Details of the current composition of the Council of Governors as of 31st March 2023 is detailed below.

Governors are appointed for a term of three years and are eligible for re-election or re-appointment at the end of their initial term, for two further terms (nine years in total).

Understanding the views of the governors, members and the public

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

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

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

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

(GNARC) met to extend the appointment of the Chair and supported the Chairman’s appraisal. The Chairman’s appraisal is a 360-evaluation comprising Governors, Non-Executive and Executive Directors and is reported formally by the Lead Governor to the Council of Governors. The role of this committee is outlined in more detail in the Remuneration Report.

The Council of Governors receive copies of all Board meeting agendas 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. Governors also attend Board Committees as observers which helps the Governors to discharge their duty in holding the non-executive directors, individually and collectively, to account for the performance of the Board. They provide a formal written report to the Council of Governors with their views about the manner in which the respective Non-executive Director chaired the meeting.

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

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

The Council has the following statutory powers and responsibilities:

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

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

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

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

Other meetings and involvement

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

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



Composition of the Council of Governors – 31st March 2023

Constituency (5 public)	Governor	Term (of 3)	Term Ends
Warrington North – 5 seats	Norman Holding	3	30/11/2024
	Gillian McKinnon	1	30/11/2025
	Keith Bland	3	30/11/2025
	Colin Jenkins	2	30/11/2023
	Anne Robinson	3	30/11/2025
Warrington South – 5 seats	Diane Nield	1	30/11/2025
	Sue Fitzpatrick	1	30/11/2023
	Paul Bradshaw	2	30/11/2023
	Mark Britton	1	30/11/2025
	Nigel Richardson	1	30/11/2024
Halton – 5 seats	Linda Mills	2	30/11/2024
	Edward Rawlinson	1	30/11/2025
	John Fagan	1	30/11/2024
	Nathan Fitzpatrick	1	30/11/2024
	Colin McKenzie	2	30/11/2025
Rest of England – two seats	Kevin Keith	1	30/11/2023
	VACANT		
STAFF (5)		Term (of 3)	Term Ends
Medical and Dental	Akash Ganguly	1	20/11/2024
Nursing and Midwifery	Jonathan Cliffe	1	30/11/2025
Staff – Support	Julie Astbury	1	30/11/2023
Clinical Scientist or Allied Health Professionals	VACANT		
Estates, Administration, Managerial	Gemma Leach	1	30/11/2025
Constituency (Partners – APPOINTED BY TRUST – 6)		DATE	N/A
Halton Borough Council	Cllr Alan Lowe	06/2021	
Warrington Borough Council	Cllr Paul Warburton	06/2021	
Warrington Sikh Gurdwara	Kuldeep Singh Dhillon	01/2021	
Warrington and Vale Royal College	Nichola Newton	06/2019	
Education Sector	VACANT		
Private Sector	VACANT		

The Council of Governors

Membership & Attendance of the Council of Governors and Sub-Committees as of 31st March 2023

Governor	Council of Governors	Governors Nominations & Remuneration Committee
Steve McGuirk, Chair	4/5	2/3
Julie Jarman, Non-Executive Director (from 01.01.22)	4/5	–
Dr Cliff Richards, Non-Executive Director	5/5	2/2
Michael O'Connor, Non-Executive Director	4/5	–
Prof John Alcolado, Non-Executive Director (to 31.12.22)	0/4	–
Margaret Bamforth, Non-Executive Director (to 20.04.22)	N/A	–
Terry Atherton, Non-Executive Director & Deputy Chair (to 30.09.22)	3/3	–
John Somers, Non-Executive Director (from 01.10.22)	2/3	–
Jayne Downey, Non-Executive Director (from 01.05.22)	4/5	–
Warrington North		
Norman Holding, LEAD Governor	4/5	3/3
Colin Jenkins	4/5	2/2
Anne Robinson	5/5	–
Nigel Richardson	3/5	–
Kerry Maloney (to 30.11.22.)	1/2	–
Gillian McKinnon (from 01.12.22)	1/1	–
Keith Bland MBE	4/5	–
Warrington South		
Sue Fitzpatrick	3/5	1/1
Janice Howe	2/3	–
Paul Bradshaw	4/5	–
Diane Nield (from 01.12.22)	1/1	–
Mark Britton (from 01.12.22)	1/1	–
Halton		
John Fagan (from 01.12.21)	5/5	–
Linda Mills	2/5	–
Nathan Fitzpatrick	3/5	–
Colin McKenzie	4/5	–
Edward Rawlinson (from 01.12.22)	1/1	–
Rest of England		
Kevin Keith	5/5	–
Staff Governors		
Mark Ashton Estates, Administrative & Managerial (to 30.11.21)	1/1	–
Gemma Leach, Estates, Administrative & Managerial (from 01.12.22)	1/1	–
Lesley Mills, Nursing and Midwifery	0/5	–
Julie Astbury, Staff Support	5/5	–
Louise Spence, Clinical Scientist/Allied Health Professionals (to 30.11.22)	4/4	–
Akash Ganguly, Medical and Dental	5/5	–
Partner Governors		
Cllr Paul Warburton, Warrington Borough Council	5/5	–
Cllr Alan Lowe, Halton Borough Council	4/5	–
Nichola Newton, Warrington and Vale Royal College	2/5	–
Kuldeep Singh-Dhillon, Warrington Sikh-Gurdwara	2/5	1/1

Changes to the Foundation Trust Constitution in Year

As per Article 45 'Amendments to the Constitution' the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the request. In year, three amendments were made to the Trust's Constitution:

1. Constituency Changes

- The merger of Runcorn & Widnes public constituencies for the Halton (including Weaver Vale) constituency
- The increase of elected public governors from Rest of England constituency from one to two.

2. Strengthening of sections

- Eligibility to be a Governor, and
- Termination of office and removal of Governors

3. Extending the Term of Office of the Chair

- Non-Executives (excluding the Chair) may serve up to a maximum of nine years'
- The Chair shall be eligible for appointment for three, three-year terms of office, and in exceptional circumstances a further term of three years. The Chair shall not be appointed to that office for a total period which exceeds twelve years in aggregate.

Governors Register of Interests

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

Governors may be contacted at:

Warrington and Halton Teaching Hospitals
NHS Foundation Trust Foundation Trust Office
Ground Floor, Kendrick Wing Warrington
Hospital Lovely Lane Warrington WA5 1QG

Telephone – 01925 662139

E-Mail – whh.foundation@nhs.net

The Foundation Trust Membership

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

At its meeting on 29th March 2023, the Trust Board approved changes to the Constitution regarding public constituencies, on recommendation by the Council of Governors, specifically the merger of the Runcorn & Widnes public constituencies to form the Halton constituency.

The Foundation Trust membership comprises public and staff members, the figures for current membership constituencies as at 31st March 2023, are detailed below:

Constituency Membership 31st March 2023

Warrington North	2462
Warrington South	2582
Halton (inc Weaver Vale)	3434
Rest of England	1462
Total Public	9940
Staff	4965
Total membership	14905

* Staff membership figures are calculated as per the rules set out Annex 2 The Staff Constituency of the WHH Constitution

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

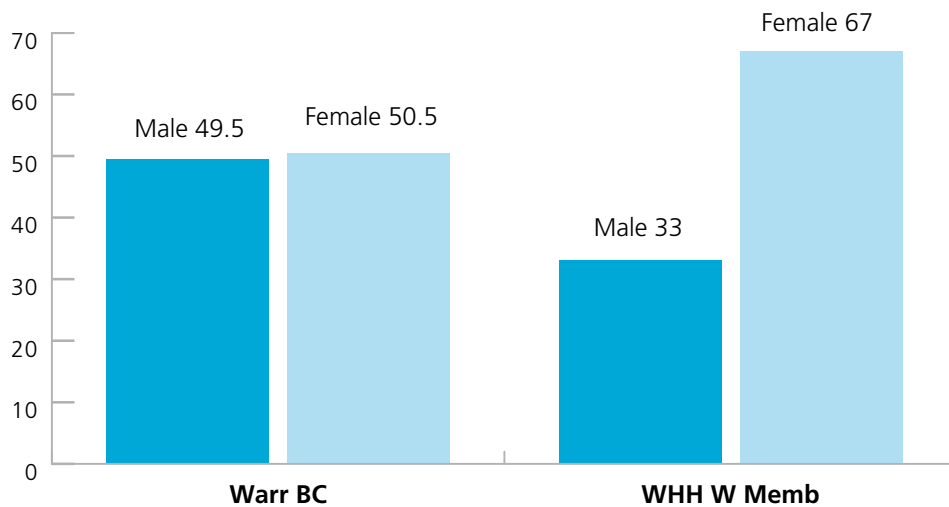
1. Medical
2. Nursing and Midwifery
3. Support
4. Clinical Scientist or Allied Health Professional
5. Estates, Administrative and Managerial

Membership demographics

*Demographic profile vs borough profile %, data sources: Local Government Association, census 2011 and WHH FT Database.

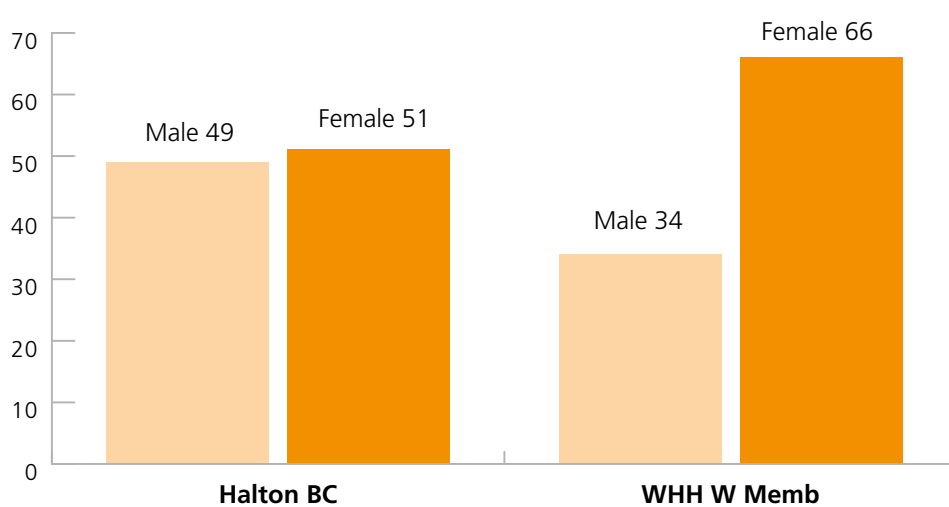
Gender Distribution

Warr BC vs WHH Warr Memb



Gender Distribution

Halton BC vs WHH Warr Memb



Ethnicity	Warr BC	WHH Warr memb.	Halton BC	WHH Halton memb.
Asian (Chinese, Indian, Pakistani, other Asian)	1.5	1.5	1	0
Black (Black Africa, Black Caribbean)	0.5	0.2	0.1	0
Mixed (Mixed Asian/White, Mixed Black/White African/Caribbean, Mixed Other)	2.3	0.5	1	0
White (British, Irish, Other)	95.7	96	98.9	8
Not declared	0	2.0	0	0.8

3.2 NHS Improvement's Well-Led Framework

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

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

The CQC carried out a Well-Led Assessment between 30th April – 2nd May 2019. It rated the Trust **GOOD** for Well-Led because:

1. Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the services for patients and staff.
2. The Trust had a well embedded vision and values which were well understood by staff. The Trust had refreshed its strategy which was focused on sustainability of services and aligned to local plans within the wider health economy.
3. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
4. Leaders operated effective governance processes, throughout the service and with partner organisations.

5. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The Trust had made improvements to its risk management since the last inspection.
6. The Trust collected reliable data and analysed it. The Trust had a good range of reports and dashboards for staff to understand performance, make decisions and improvements.
7. Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
8. The Trust was committed to continually learning and improving services. Staff received training in quality improvement methodology and were encouraged to share learning.

The Annual Governance Statement within this report outlines the review of leadership and governance in line with NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance, internal control and Board assurance. Work on self and external assessment continues and these assurances can be found in the Annual Governance Statement.

The Trust can confirm that there are no material inconsistencies between:

9. The Annual Governance Statement.
10. The Corporate Governance Statement.
11. Annual report; and
12. Reports from the CQC planned and responsive reviews of the Trust and any consequent action plans developed by the Trust.



3.3 Statement of cost allocation HM Treasury

We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

3.4 Political donations

There were no donations of a political nature in the period.

3.5 Better payment Practice Code

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

Performance for the financial year is contained in the table below:

	2022/23	2022/23
	Number	£000
Non NHS trade invoices paid in the period	44,259	127,228
Non NHS trade invoices paid within target	40,633	118,216
Percentage of non-NHS trade invoices paid within agreed payment terms or in 30 days	92%	93%
NHS trade invoices paid in the period	2,217	17,811
NHS trade invoices paid within target	1,701	14,692
Percentage of NHS trade invoices paid within agreed payment terms or in 30 days	77%	82%

The total paid within 2022/23 for late payment of commercial debt was £4k (£0k in 2021/22).

3.6 Interest payments

In year, the Trust made payments totalling £4,070.10 for the late payment of invoices. There are no accrued charges as at 31st March 2023.

3.7 Stakeholder Relations

Development of services involving other local services/agencies and involvement in local initiatives

As part of our documented, strategic intention to play a more significant role as an Anchor Institution within the boroughs of Halton and Warrington, the Trust has delivered and is leading a number of key strategic projects at 'place' designed to enhance social value, reduce the organisation's carbon footprint and address identified health inequalities within our local communities. The Halton Health Hub, a standalone outpatient unit situated within Shopping City in Runcorn, opened in November 2022 and provides a range of services including optometry, orthoptics, audiology and dietetics for adults and children. The Hub also provides space for partners to deliver preventative and early intervention services, such as a drop-in vaccine outreach service for COVID-19 and flu vaccinations provided by Halton Borough Council, and primary care services offered by our local GPs. We continue to work with additional providers in the area to expand this offer where beneficial for our population.

The Trust is working in close partnership with a wide group of stakeholders to develop two new Health and Wellbeing/Education Hubs in Warrington and Runcorn town centres. The Warrington Living Well Hub is due to open in late Autumn of 2023 with the Runcorn Hub following in Winter 2024. Both Hub projects are funded from central government's Towns' Fund initiative as part of the 'Levelling Up' agenda. These specifically target areas of high deprivation, the aim being economic regeneration. They will deliver targeted services from a range of providers to support the integration of physical and mental health with social care, wellbeing, voluntary and third-sector services and education to support a reduction in health inequalities.

The Living Well Hub will address health inequalities in Warrington through the provision of a range of services focused on prevention and early intervention in a town centre location. The Hub will be a key project for the local health and care system by working collaboratively to support early intervention and the prevention of ill health. Over time, it will reduce demand for health and social care services by empowering people to take greater responsibility for their own personal health and wellbeing and linking them to appropriate support within their local communities. The project has been co-designed with patients and system partners through extensive engagement.

The Runcorn Health and Education Hub will be delivered in partnership with Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare, Halton Borough Council, voluntary and third sector partners and Riverside College. It will deliver services targeting populations of high need, including young people and families, and those with long term conditions from the heart of Runcorn Old Town. In addition to health and care services, flexible education facilities will support the growth of our future workforce, helping local people into local jobs.

Advances in digital technology and the improvements in NHS IT infrastructure means the Trust has been able to introduce Virtual Wards. These allow patients to receive the care they need at home, including in care homes, safely and conveniently rather than in hospital. The development of virtual wards has been underpinned by partnership working across secondary, community and primary care to ensure a quality service is provided.

Health research plays an integral part in how the NHS develops services and continues to provide high quality healthcare for our population. It is vital in providing the evidence we need to transform services, enabling earlier diagnosis, more effective treatments, prevention of ill health, better outcomes and faster returns to everyday life. Meanwhile, research is also beneficial to healthcare professionals who are able to develop imaginative solutions for real challenges facing the NHS, improving care and increasing job satisfaction.

Through our research alliance with Liverpool University Hospitals NHS Foundation Trust and the National Institute for Health Research (NIHR) Clinical Research Network, North West Coast, we continue to enhance our clinical research capabilities and give access to clinical trials for local people, while ensuring we benefit from the expertise of our research partners.

Consultation with large groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas

A formal public consultation exercise was carried out through May and June 2022 relating to the relocation and consolidation of Warrington's breast screening services. It was proposed that Warrington's breast screening service be consolidated at a single site, the Bath Street Health and Wellbeing Centre, involving a relocation of the breast screening service from Warrington Hospital.

Following completion of the consultation, a panel of 'Experts by Experience' service users (with a special interest in the breast service) convened at Bath Street to meet the landlord's project manager, review the plans and test out the outcomes of the consultation. This was a diverse group comprising public governors, breast screening service users, those with a breast cancer diagnosis and those with profound physical disabilities. All feedback was taken by the project management team.

The consultation process and outcomes were received by Warrington Health Scrutiny Committee, Warrington Health and Wellbeing Board, Halton Health Policy and Performance Board, Halton Health and Wellbeing Board, St Helens Adult Social Care and Health Scrutiny Committee, the former NHS Warrington CCG, Warrington Together, WHH Executive Team, NHS England Specialised Commissioning (NHSSC being the commissioner of the breast screening service at the time).

The Trust's commitment to becoming an Anchor organisation requires it to listen to and understand the experiences of its populations. This takes place in a diverse range of accessible, inclusive formats from informal engagement to formal public consultation and is operated through the patient and public participation and involvement programme as well as the strategy development programme.

The Trust will continue to exceed the regulatory requirements of consultation and engagement across all service redesign projects.

Descriptions of significant partnerships and alliances entered into by the NHS foundation trust to facilitate the delivery of improved healthcare.

The Trust has established strong and positive partnerships with many organisations and institutions at national level, regional – Cheshire and Merseyside – level and more locally at 'place' level – Halton and Warrington boroughs. At Cheshire and Merseyside level the Trust is a core and active member of Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST), within which the Trust CEO leads the work to develop and improve clinical pathways across the region. Active partnerships at 'place' level include all local acute healthcare providers, local authorities, NHS Cheshire & Merseyside, Bridgewater Community Healthcare, Mersey Care, primary care, local colleges and universities and local third sector organisations.

Examples include active engagement in both Warrington and Halton's Place Based Partnership Boards, underpinned by input into supporting workstreams. Within Warrington, this has resulted in the Trust leading a specific programme of work to develop a new health and care system-wide digital platform to improve access to the multiple service offers across the town. From a Cheshire and Merseyside perspective, the Trust has taken the opportunities system reforms have created to work with partners across a wide geographical footprint to enhance care for patients. Supported by a Cheshire and Merseyside initiative, the Trust will be expanding the existing maternity provision to implement the national Maternity Model for Treating Tobacco Dependence, including implementation of the regional smoke free pregnancy pathway which recommends carbon monoxide (CO) testing of all pregnant women at antenatal booking appointment; CO testing at 36 weeks; referral to a stop smoking service/specialist based on an opt out system; and training on CO monitor use and Very Brief Advice (VBA) for all relevant maternity staff.

The Trust is committed to using the system and partnership approaches that have emerged over the past few years to support its recovery from the COVID-19 pandemic and future direction. The Trust has a history of being innovative and working in partnership with others to maximise opportunities to improve patient care and has committed to working together with other acute and specialist trusts across Cheshire and Merseyside to improve the quality of care delivered to patients. This is beginning to deliver benefits for Warrington and Halton patients, as well as patients in surrounding areas. For example, work is underway with the Cheshire and Merseyside Pathology Network to maximise the benefits of delivering pathology services at scale across a wider footprint.



The Trust continues to work in partnership with Liverpool University Hospitals NHS FT and the Clinical Research Network Northwest Coast (CRN NWC) to enhance clinical research and improve participation in research trials across Warrington and Halton. Evidence shows that patients that choose to take part in research become more engaged with their own health and care and often require fewer clinical appointments. The Halton Clinical Research Unit (HCRU) is a large, open ward space with room for beds across three bays with an additional two private rooms. The unit is staffed by a multi-disciplinary team of research practitioners including doctors, research nurses, pharmacy, microbiology and pathology, and administrators to deliver trials to the people of Warrington and Halton. The HCRU opened its doors to research participants in March 2021, launching with a COVID-19 vaccine study. The unit has since delivered two further vaccine studies with another on the way.

Partnership working extends beyond healthcare organisations, enabling the Trust to truly address health inequalities in the broadest sense across a range of areas. The Trust recognises the role it can play in preventing illness and addressing health inequalities and as such continues to expand and explore further opportunities to support the prevention agenda working with multiple partners, including voluntary and third sector partners. For example, by working with Warrington and Vale Royal College, the Trust has established a Supported Internship Scheme to support the recruitment of students with special educational needs and disabilities (SEND) into placements across roles at the Trust. The aim of the project is to support the students to develop work-based skills so they can go onto apply for and secure future employment. Additionally, through our partnership work with Halton Borough Council and Runcorn Shopping City we are demonstrating the value of partnership working with commercial organisations to contribute to regeneration of our most deprived neighbourhoods.

The Trust, working in partnership and with support from our commissioners, local government, educators including the University of Chester, social care, third sector partners and local MPs, have developed a clear vision for the future of the Trust's hospital estate. A compelling and cost-efficient case for the investment required to build a new hospital in Warrington and redevelop the Halton hospital site (through an extension to the newest estate, Captain Sir Tom Moore Building) has been developed. This describes a vision for future-proofed, adaptable and appropriate healthcare facilities. These principles have been well embedded since our previous strategy, gaining strong support across Cheshire and Merseyside.

By working in partnership, the Trust has already realised a number of funding opportunities to progress this work outside of traditional NHS England / Department of Health funding. This includes working in partnership with our local One Public Estate board, through relationships developed with Liverpool City Region, and opportunities presented working with our local councils and Housing Associations.

There are many more examples of partnerships and alliances which facilitate the delivery of improved healthcare. An example is demonstrated through the Warrington Wellbeing workers, who through a pilot project, are supporting the Trust's Integrated Discharge Team to ensure a holistic patient centred approach is offered to patients on discharge from hospital. Through use of social prescribing, the wellbeing workers are able to support patients to live happier, healthier and independently for longer, whilst reducing the changes of readmission following discharge following hospital care. Another example is evident in the work with primary care and partners in community health to explore and develop new pathways to support improved urgent and emergency care through rapid access to diagnostic testing and results. This is part of the new Community Diagnostic Centre project. Finally, development of a joint strategy and delivery plan for improved collaboration with local universities, is helping to strengthen the local healthcare education offer and create new pathways into healthcare professions.



Professor Simon Constable FRCP,
Chief Executive

29th June 2023



4

Remuneration

4.1 Annual Statement on remuneration

Statement from the Chair of the Nominations & Remuneration Committee

The Board of Directors delegates the responsibility to a Board Nominations and Remuneration Committee (NARC) 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.

The membership of the Committee consists of the Trust Chair and all Non-Executive Directors. The Chief Executive, Trust Secretary and Chief People Officer also attend as appropriate.

During the period 2022/2023, the Committee met on three occasions.

Member	Attendance (Actual v Max)
Steve McGuirk, Chairman Non-Executive Director & Chair	3/3
Dr Cliff Richards, Non-Executive Director (wef 10.06.2019)	3/3
Mike O'Connor, Non-Executive Director	3/3
Terry Atherton, Non-Executive Director	1/3
Jayne Downey, Non-Executive Director	2/3
Julie Jarman	2/3
Prof John Alcolado	1/3

Nominations

In year the Committee considered and approved the following:

1. Process for the appointment of the Director of Communications & Engagement
2. Appointment of the Director of Communications & Engagement

Remuneration

In year the Committee considered and approved the following:

1. Remuneration of the Chief People Officer
2. Senior Pay Body Review recommendation for VSM pay uplift

4.2 Senior Manager Remuneration Policy

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

The Trust does not consult with employees when preparing the senior managers remuneration policy. However, the pay and conditions of all employees are taken into account when setting the remuneration policy for senior managers.

The Trust's executive pay structure is very simple and only includes basic pay for the Chief Executive Officer and Deputy Chief Executive Officer roles. All pay is taxed at source and there are no bonus payments. Salaries are benchmarked against the NHS Providers national report and similar Trusts in the Cheshire and Merseyside and wider north west region. All new appointments are sourced at the benchmark level and adjustments are made only if the market rate or existing salary indicates this is necessary. Where salaries of very senior managers exceed £150K per annum, these have been reviewed and found to be appropriate with market rate, maintain relativities with other very senior manager posts and to match pay in the jobs from which individuals were recruited.

Performance Appraisal

Performance of the Executive Directors is assessed and managed through regular appraisal against predetermined objectives along with one to one reviews with the Chief Executive. Similarly, the Chairman conducts both one-to-ones and a formal appraisal with the Chief Executive. Any deficit in performance is identified during these regular meetings. Serious performance issues are managed via our organisational performance capability management policy. Performance of the Non-Executive Directors is assessed and managed through regular appraisal by the Chairman against predetermined objectives along with regular one to one reviews with each NED.

Provisions for Termination of Contract

There are no special contractual compensation provisions for early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the Agenda for Change (AfC): NHS Terms and Conditions of Service Handbook (Section 16). For those above the minimum retirement age, early termination by reason of redundancy is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme. The principles for determining how payments for loss of office will be approached, including: how each component will be calculated and whether, and if so how, the circumstances of the loss of office and the senior manager's performance are relevant to any exercise of discretion would all be considered on a case by case basis by the Nominations and Remuneration Committee and would be approved by NHS England in advance. The Trust is required to report what constitutes the senior managers' Remuneration Policy in tabular format set out on the next page. At the date of completion of this Annual Report there have been no changes to this policy and no future changes are anticipated.

Components of Remuneration Package of Executive and Non-Executive Directors

Basic pay in accordance with their contract of employment (Executive) and letters of appointment (non-executive).

Components of Remuneration that is relevant to the short and long term Strategic Objectives of the Trust

The Directors do not receive any remuneration tailored towards the achievement of Strategic Objectives.

Explanation of how the Components of Remuneration operate

Basic pay of the Executive Directors is determined by the Board Nominations and Remuneration Committee, taking into account past performance, future objectives, market conditions and comparable remuneration information from Trusts within the locality. Basic pay of the Non-Executive Directors is determined by the Governor Nominations and Remuneration Committee.

Maximum amount that could be paid in respect of the component

Maximum payable is the Director's annual salaries as determined by the relevant Nominations and Remuneration Committee.

Payment for loss of office

Notice periods are included in all Directors' contracts and is currently set at six months. Payments in lieu of notice are contained within the contract of employment and are subject to tax and national insurance deductions. Payments made other than through notice periods are set out in the Organisational Change policy i.e. through redundancy/mutually agreed severance schemes. All payments to any staff member outside contractual terms are scrutinised by the Board's Nominations and Remuneration Committee.

Explanation of any provisions for recovery

If an individual is overpaid in error, there is a contracted right to recover the overpayment.

Diversity & Inclusion

The Trust has a Workforce Equality, Diversity and Inclusion (EDI) Strategy 2022-2025 and an Equality and Diversity policy in place which is used as a reference point for equality and diversity. Both governance documents highlight the importance of equality impact analysis in the form of an Equality Impact Assessment being completed for all policies and procedures. This is therefore relevant to all policies pertaining to remuneration, for example, the Trust Organisation Change policy.

In addition, the Trust's Workforce EDI Strategy includes objectives focused on improving and reviewing the Trusts approach to attraction, recruitment and retention, ensuring processes are fair, equitable and continue to promote diversity. This is and will continue to be a consideration for the Nominations and Remuneration Committee in its decision making.

The Trust completes its Gender Pay Gap reporting on an annual basis by the Workforce EDI Team which is reviewed at the Workforce EDI Sub-Committee and ratified at the Strategic People Committee on behalf of the Trust Board. This is reported annually on the Trust website and can be found here: <https://whh.nhs.uk/about-us/corporate-publications-and-statutoryinformation/equality-diversity-and-human-rights>

All progress relating to objectives of the Workforce EDI Strategy 2022-2025 are monitored and reported to the Workforce Equality, Diversity and Inclusion Sub-Committee and Strategic People Committee for assurance. A copy of the Trust's Workforce EDI Strategy 2022-2025 can be found here: <https://online.flippingbook.com/view/283716120/>



4.3 Annual Report on remuneration

Annual report on Directors Remuneration – Year ended 31st March 2023 (and comparison year ended 31st March 2022) (Audited)

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.



SENIOR MANAGERS REMUNERATION 2022/23 (and comparison 2021/22 - audited)

Includes salary sacrifice

	2022/23						2021/22					
	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 £2,500)	Total (bands of £5,000)	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 £2,500)	Total (bands of £5,000)
	£000's	£	£000's	£000's	£000's	£	£000's	£	£000's	£000's	£000's	£
Executive Directors												
Prof Simon Constable, Chief Executive	190–195	0	0	0	55–57.5	245–250	185–190				35–37.5	220–225
Andrea McGee, Chief Finance Officer & Deputy Chief Exec	155–160	0	0	0	115–117.5	270–275	145–150				22.5–25	170–175
Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Exec	145–150	0	0	0	105–107.5	250–255	130–135				5–7.5	140–145
Dan Moore, Chief Operating Officer	125–130	0	0	0	5–7.5	135–140	120–125				72.5–75	195–200
Michelle Cloney, Chief People Officer	120–125	0	0	0	97.5–100	220–225	110–115				22.5–25	135–140
Dr Paul Fitzsimmons, Medical Director	190–195	0	0	0	37.5–40	225–230	60–65				17.5–20	80–85
Lucy Gardner, Director of Strategy & Partnership	125–130	0	0	0	32.5–35	160–165	125–130				30–32.5	155–160

	2022/23						2021/22					
	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 £2,500)	Total (bands of £5,000)	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 £2,500)	Total (bands of £5,000)
	£000's	£	£000's	£000's	£000's	£	£000's	£	£000's	£000's	£000's	£
Kate Henry, Director of Communications & Engagement from October 2022	55–60	0	0	0	0	55–60	0				0	0
Pat McLaren, Director of Communications & Engagement until 15th October 2022	55–60	0	0	0	0	55–60	105–110				37.5–40	140–145
Chairman and Non-Executive Directors												
Steve McGuirk, Chairman	45–50	0	0	0	0	45–50	40–45					40–45
Dr Cliff Richards, Non-Executive Director	10–15	0	0	0	0	10–15	10–15					10–15
Michael O'Connor, Non-Executive Director from November 2021	10–15	0	0	0	0	10–15	5–10					5–10
Julie Jarman, Non-Executive Director from January 2022	10–15	0	0	0	0	10–15	0–5					0–5
Jayne Downey, Non-Executive Director from April 2022	10–15	0	0	0	0	10–15	0					0

	2022/23						2021/22					
	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 £2,500)	Total (bands of £5,000)	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 £2,500)	Total (bands of £5,000)
	£000's	£	£000's	£000's	£000's	£	£000's	£	£000's	£000's	£000's	£
John Somers, Non-Executive Director from August 2022	5-10	0	0	0	0	5-10	0					0
Terry Atherton, Non-Executive Director until September 2022	5-10	0	0	0	0	5-10	10-15					10-15
Dr Margaret Bamforth, Non-Executive Director until April 2022	0-5	0	0	0	0	0-5	10-15					10-15
Adrian Carridice-Davids, Associate Non-Executive Director from November 2021	5-10	0	0	0	0	5-10	0-5					0-5
David Thompson, Associate Non-Executive Director from November 2021	5-10	0	0	0	0	5-10	0-5					0-5

Notes:

Note 1 Kate Henry pensionable information is zero as we have no pensionable data for 21/22

Pension Entitlements Year ended 31st March 2023 (Audited)

Name and title	Real increase in pension at age 60 (bands of £2,500)*	Real increase in pension lump sum at age 60 (bands of £2,500)*	Total accrued pension at age 60 at 31st March 2023 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31st March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2022	Real increase in Cash Equivalent Transfer Value*	Cash Equivalent Transfer Value at 31st March 2023	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Prof Simon Constable, Chief Executive	2.5–5	2.5–5	30–35	50–55	488	49	567	0
Andrea McGee, Chief Finance Officer & Deputy Chief Executive	5–7.5	7.5–10	65–70	130–135	1,054	112	1,220	0
Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Exec	5–7.5	7.5–10	55–60	105–110	816	95	956	0
Dan Moore, Chief Operating Officer	0–2.5	0	25–30	40–45	328	0	352	0
Dr Paul Fitzsimmons, Medical Director	2.5–5	0–2.5	35–40	55–60	459	21	513	0
Michelle Cloney, Chief People Officer	5–7.5	7.5–10	55–60	125–130	1,065	111	1,226	0
Lucy Gardner, Director of Strategy & Partnership	2.5–5	0	15–20	5–10	149	10	181	0
Kate Henry, Director of Communication & Engagement from 1st October 2022	0	0	0	0	0	0	226	0
Pat McLaren, Director of Communication & Engagement until 15th October 2022	0–2.5	0	20–25	60–65	514	0	27	0

Notes:

Kate Henry pensionable information is zero as we have no pensionable data for 21/22.

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors. The benefits and related CETVs do not allow for a potential future adjustment for some eligible employees arising from the McCloud judgement.

Total remuneration

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

	2022/23	2021/22
	£000	£000
Remuneration including employers' national insurance contribution for Executive and Non-Executive Directors	1,477	1,372
Employers' contribution to pension in relation to executive directors	145	137

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.



4.4 Remuneration Report

Expenses paid to Directors and Governors (Unaudited)

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

Expenses paid to Governors are made in accordance with the Trust's constitution and related to the work as Governors of the Trust. Governors do not receive any other payments from the Trust. All Governors have a responsibility to ensure that they incur only reasonable expenses, which includes travel costs for attendance at, for example, Council of Governors and committee meetings held at the Trust or for attendance at training courses and conferences and that the cost to the Trust is kept as low as possible. The table below states the total amount of expenses reimbursed to Directors and Governors for 2022/23 and comparative figures for 2021/22.

	Number in Office	Number claiming expenses during the year	Total expenses Claimed	Number in Office	Number claiming expenses during the year	Total expenses Claimed
	2022/23	2022/23	2022/23	2021/22	2021/22	2021/22
	Number	Number	£	Number	Number	£
Directors	20	15	1500	21	3	500
Governors	25	00	00	27	1	26
Total						

Fair Pay Multiple (Audited)

Financial year 21/22 recalculated based on 22/23 pay elements

2022/23	25th Percentile	Median	75th Percentile
Salary component of pay	£21,878	£28,946	£49,975
Total Pay and benefits excluding pension benefits	£26,790	£35,023	£49,975
Pay and benefits excluding pension: pay ratio for highest paid director	7.19 :1	5.5 :1	3.85 :1
2021/22	25th Percentile	Median	75th Percentile
Salary component of pay	£19,783	£31,151	£45,282
Total Pay and benefits excluding pension benefits	£23,434	£31,534	£45,839
Pay and benefits excluding pension: pay ratio for highest paid director	8.00:1	5.95:1	4.09:1
Salary component of pay	£19,783	£31,151	£45,282

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the organisation in the financial year 2022-23 was £192,500 (2021-22 £187,500). This is a change between years of 2.67%.

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

For employees of the Trust as a whole, the range of remuneration in 2022-23 was £6,000 to £352,107 (2021-22 £6,000 to £213,454). The percentage change in the average employee remuneration between years is 10.6%. 56 employees received remuneration in excess of the highest-paid director in 2022-23 (2021-22: 30 employees).

Expenditure on Consultancy

The Trust has incurred the following expenditure on consultancy services:

	2022/23	2021/22
Total expenditure (£000's)	286	656

Expenditure of £286k (£656k in 2021/22) was for the provision of Trust management advice and assistance outside the "business as usual" environment and covers strategy, financial, organisation and change management and IM&T services.



Professor Simon Constable FRCP,
Chief Executive
29th June 2023





Staff Report Introduction

The Trust recognises that its workforce is central to achieving its mission of 'being outstanding for our patients, communities and each other'. By harnessing the talents of the workforce and creating the conditions for staff to provide excellent care, the Trust believes it will be recognised as 'outstanding' – somewhere where people want to work.

People Strategy

The Trust's People Strategy 2022 – 2025 has been of prime focus having been launched in 2022. The strategy is aligned to the NHS People Plan, NHS People Promise and the NHS Future of HR and OD report, creating an overarching strategic People delivery plan for 2022 – 2025.

Our strategic objective for our workforce is to 'be the best place to work with a diverse and engaged workforce that is fit for now and the future'. We will achieve this strategic objective through the four People Pillars set out in the People Strategy:

- **Looking After WHH People** – We will prioritise the safety, health and wellbeing of our people to ensure work has a positive impact through the recognition and appreciation of our people, and by providing the best patient and staff experience.
- **Innovating the Way we Work** – We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.
- **Growing our WHH Workforce for the Future** – We will support personal and professional development ensuring equal access to opportunities, and will nurture, grow and develop diverse teams with a shared purpose to care for our patients.
- **Belonging in WHH** – We will enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

The Trust has continued to deliver against its people objectives, recognising their importance in supporting the workforce. Successes to date include:

1. Kindness, civility, and respect campaign launched.
2. 'Wellbeing Wednesday' introduced across the organisation.
3. Gratitude and appreciation cards implemented.
4. Long Service recognition awards delivered as a joint event with WHH volunteers in December 2021.
5. Refreshed approach to Exit Interviews using information collected to inform retention initiatives including agile and flexible working.
6. Development of a range of financial wellbeing initiatives to support the workforce including implementation of Wagestream, uniform and toy swap shops.
7. Reciprocal mentoring implemented to support EDI objectives.
8. Implementation of Your Future, Your Way nursing programme to support leaders of the future.
9. Career development programme implemented with Staff Networks leading to individual securing promotions internally as a result of support.
10. Shadow Board approach implemented with second cohort in 2023-2024.
11. Rugby League Cares initiative implemented to support and enhance current OD offer with teams.
12. Affina journey and approach implemented across teams within the organisation to support with workforce recovery post-pandemic.
13. Enabling staff voice through the development of the Freedom to Speak Up channel and FTSU Champions across the organisation.
14. Removing barriers to accessing Staff Networks by developing and implementing a Staff Network framework which includes time off for Staff Network duties.
15. Self-compassion at work programme implemented in partnership with Dr Amanda Super.

We continue to strive to be the best place to work with a diverse and engaged workforce that is fit for now and for the future.

5.1 Analysis of staff costs

	2022/23 Total £000s	2021/22 Total £000s
Salaries and wages	170,235	161,712
Social security costs	16,956	15,344
Apprenticeship levy	808	772
Pension costs (employer contributions to NHS Pensions)	18,994	18,429
Pension costs (other)	106	88
Pension costs (employer contributions paid by NHSE on Provider's behalf (6.3%))	8,337	8,117
Termination benefits	91	46
Temporary Staff – external bank	25,771	21,829
Temporary Staff – agency /contract staff	14,795	12,735
Total employee benefit expenses	256,093	239,072
Less costs capitalised as part of assets	(1,048)	(656)
Total per employee expenses	255,045	238,416

5.2 Analysis of average staff numbers

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

Staff Category	2022-23		2021-22		2020-21	
	Permanently Employed	Other	Permanently Employed	Other	Permanently Employed	Other
Medical and dental	201	117	201	120	196	121
Administration and estates	1166	33	1,154	64	1122	58
Healthcare assistants and other support	672	14	679	37	671	66
Nursing, midwifery and health visiting	1024	18	974	84	951	27
Scientific, therapeutic and technical	532	10	535	11	536	12
Total	3595	192	3,543	316	3466	284

5.3 Breakdown each year end of each gender by Directors, other Senior Managers and Employees

Below is a breakdown of the number of male and female directors and senior managers, calculated by using the average headcount for each month in the financial year.

	2022/2023		2021/2022		2020/2021		2019/2020		2018/2019	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Directors (Executive, Non-Executive and Associate Non-Executive Director)	9	7	8	8	8	8	8	8	8	8
Senior Managers (Band 8a and above)	58	230	57	210	57	191	54	168	53	160
Other Employees	808	3414	964	3673	913	3568	843	3459	813	3440

5.3.1 Gender Pay Gap

The Trust is committed to furthering equality, diversity and human rights and reducing inequalities in the workplace. Warrington and Halton Teaching Hospitals address equality and fair access to career pathways and progression in our Workforce Equality, Diversity and Inclusion Strategy 2022-2025.

Under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and with reference to the Cabinet Office website (<https://gender-pay-gap.service.gov.uk/>), WHH is required to report annually by 30th March on its Gender Pay Gap. A summary of the data for 2022/23 can be found in the below table:

	Female	Male	Pay Gap
Mean Hourly Rate	£17.67	£22.64	21.94%
Median Hourly Rate	£15.39	£16.99	9.38%
Mean Bonus Pay	£7594	£7347	+3.36%
Median Bonus Pay	£5122	£5122	+0%

A full report, including the analysis of the data, can be found here: <https://whh.nhs.uk/about-us/corporate-publications-and-statutory-information/equality-diversity-and-human-rights>

5.4 Sickness Absence Data

Supporting Attendance

The Trust has a clear and robust framework within which managers are able to address the issues of attendance and sickness absence with a consistent, supportive and fair approach through the Supporting Attendance policy. There is a strong focus on workforce health and wellbeing across the organisation, as set out within our People Strategy.

Initiatives such as health and wellbeing drop-in events have successfully been held, offering education, support and signposting to health and wellbeing services. In addition, the Trust has started to introduce health and wellbeing appraisals; these preventative measures support the workforce to remain healthy in the workplace.

For information in respect of sickness absence, please use the following link:

<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>

Staff Turnover

Improving staff turnover and retention is a fundamental part of the People Strategy and NHS People Plan. Since the pandemic, where many employees delayed retirement, the Trust has a significant increase in the number of individuals choosing to retire. The Trust supports these individuals to return to the workplace (retire and return), recognising their invaluable skills and experience. 50% of individuals who retire, return to the Trust in some capacity.

The Trust supports staff to achieve a work/life balance, by offering both flexible and agile working arrangements. Individuals and line managers are encouraged to reflect upon the flexibility of roles and are supported to do so through dedicated policies and toolkits.

The Trust measures both overall turnover and retention and of the permanent staff only. The below table outlines the annual permanent turnover and retention percentages for 2022/2023. For all other information in respect of staff turnover, please use the following link:

[NHS workforce statistics published by NHS Digital](#)

	2022/2023	2021/2022	2020/2021
Permanent Staff Turnover	13.8%	14.6%	10.2%
Permanent Staff Retention	85.6%	87.5%	91.8%



5.5 Staff policies and actions applied during the financial year

1. Adoption Leave Policy
2. Agile Working Policy
3. Annual Leave Policy
4. Annual Leave Policy for Consultant Medical and Dental Staff
5. Appraisal Policy
6. Apprenticeship Policy
7. Bank Agency Staffing Policy
8. Conflict of Interest Policy
9. Consultant and SAS Job Planning Policy
10. Disciplinary Policy
11. Employment Break Policy
12. Employee Subject Access Request Policy
13. Equality Diversity and Inclusion Policy
14. Fire Safety Policy
15. First Aid Policy
16. Flexible Working Policy
17. Health and Safety Policy
18. Health Clearance Policy
19. Induction Policy
20. Local Clinical Excellence Awards Policy
21. Lone Worker Policy
22. Job Planning Policy for Medical and Dental Staff
23. Maintaining High Professional Standards (MHPS) Procedures of Medical and Dental Staff Policy
24. Management of Needlestick, Sharps and Inoculation Injury, including Sharps Policy
25. Management of Personal Relationships at Work Policy
26. Maternity Policy
27. Medical Illustration Photography Policy
28. Mental Health and Wellbeing Policy
29. Multi-professional Clinical Supervision Policy
30. Non-Medical Staff Study Leave Funding Policy
31. On Call Policy
32. Organisational Change Policy
33. Overtime Policy
34. Paternity and Partner Leave Policy
35. Pay Progression Policy
36. Payment of Travel and Expenses Policy
37. Preceptorship Policy
38. Professional Clinical Registration Policy
39. Protection of Pay Policy
40. Recruitment and Selection Policy
41. Recovery of Employee Related Overpayments and Outstanding Debt Policy
42. Remediation Policy for Medical and Dental Staff
43. Removal Expenses Policy
44. Resolving Workplace Issues Policy
45. Resuscitation Policy
46. Retirement and Long Service Policy
47. Revalidation Policy
48. Secondment Policy
49. Shared Parental Leave Policy
50. Special Leave Policy
51. Staff Car Park Policy
52. Study and Professional Leave Policy for Non-Training Grade Medical Staff
53. Supporting Attendance Policy
54. Supporting Performance Improvements Policy
55. Strengthened Medical Appraisal Policy
56. Time off for TU Reps Policy
57. Training and Development Policy
58. Transfer of Patients and Clinicals Handover Policy (Adults)
59. Uniform and Workwear Policy
60. Freedom to Speak Up Policy
61. Work Experience Policy
62. Workplace Alcohol, Drug and Substance Misuse Policy

5.5.1 Equality, Diversity and Inclusion

The Trust is committed to equality, diversity and inclusion across our workforce. We aim to be a leading organisation, which is recognised locally, regionally and nationally, for promoting equality, diversity and inclusion.

As part of the specific duties outlined in the Public Sector Equality Duty, the Trust published the Workforce Equality, Diversity and Inclusion Strategy for 2022-2025 in April 2022. This includes a review of the organisation's strategic objectives and aligns a separate strategy for patients, service users and staff.

The strategy outlines the Trust's commitment to workforce equality, diversity and inclusion, ensuring WHH is the best place to work and details the steps we will take to be an inclusive employer creating a culture of belonging for all. The strategy is aligned to the NHS People Plan, and internal People Strategy 2022 to 2025, outlining the ambition for our workforce strategy to support the delivery of the NHS Long Term Plan.

The integrated 'People Promises' within the Workforce Equality, Diversity and Inclusion Strategy 2022–2025 are:

Looking After our WHH People:

1. We will address health inequalities at WHH.
2. We attract and retain people at WHH creating a positive impact on our communities.

Innovating the Way We Work:

3. Create an open, productive and learning environment that educates and addresses privilege and everyday bias.
4. Reach into WHH communities, understanding and drawing from the communities it serves, acting as an 'anchor institution'.

Growing our WHH Workforce for the Future:

5. Ensure that WHH talent management, recruitment and career pathways address underrepresentation and promote diversity.
6. Champion policies and practices that achieve tangible, measurable improvements to workforce equality, diversity and inclusion.

Belonging in WHH:

7. To understand, encourage and celebrate diversity, making WHH a place where we all feel we belong.
8. Develop and embed a 'restorative just culture' across WHH that helps to eliminate cultures that bring blame or fear.

The Trust continues to undertake a strategic review of equality, diversity and inclusion practice within the organisation which has resulted in a revised Equality Impact Assessment and 'due regard' toolkit. This has included the implementation of Equality Impact Assessment training at senior levels within the organisation to ensure cascading of information through operational teams. This approach will enable the organisation to demonstrate the importance of thinking of equality, diversity and inclusion at the outset of any policy, programme, project and as part of the and organisational change review process.

The development of ensuring opportunities to engage with our staff voice has continued with the investment in our Staff Networks. The organisation has four thriving Staff Networks in the following areas:

- MESN – Multi-Ethnic Staff Network
- PROGRESS – supporting the LGBTQIA+ workforce at WHH
- DAN – Disability Awareness Staff Network
- AFVN – Armed Forces and Military Veterans Community Staff Network

Our Staff Network members have had the opportunity to participate in the implementation of a reciprocal mentoring scheme where senior leaders across the organisation have the opportunity to mentor and be mentored by our Staff Network members to understand what it is like to be part of our WHH team.

Staff Network members have also had the opportunity to participate in a career development programme developed in partnership with the Staff Network and implemented as a result of the findings in both the statutory Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

As part of our organisation commitment to being recognised as a Trust which promotes and celebrates diversity the Trust is actively seeking to act as a pioneer in the equality, diversity and inclusion agenda. In 2022 the Trust achieved the Disability Confident Leader status which demonstrates our commitment to supporting people in work who have a disability. The Trust also ascertained the In-Trust Merseyside and Cheshire Navajo Charter Mark, focused on improving experiences for our LGBTQIA+ workforce and patients.

The Trust in 2022/23 made a commitment to strive to achieve the NHS North West Anti-Racist Organisation Framework Accreditation – highlighting that WHH is an inclusive organisation with zero tolerance to any form of discrimination, harassment and victimisation. To support the delivery of this an Anti-Racist Task and Finish Group was commenced reporting to the Workforce Equality, Diversity and Inclusion Sub-Committee to ensure progress on the delivery of the commitment.

To ensure a representation voice as part of the Equality Delivery System review process, the Trust has engaged with Staff Network members, Union Representatives, Community Partners and other internal stakeholders. This ensures that the views of a wide range of equality and diversity characteristics, and other socioeconomic factors are considered as part of our equality reporting and sustainability processes.

As part of the Trust's Public Sector Equality Duty requirements, the Trust has met all of its statutory reporting throughout 2022/23. All reports are published on the Trust website (available here: <https://whh.nhs.uk/about-us/corporate-publications-and-statutory-information/equality-diversityand-human-rights>). The outputs of these publications continue to direct our engagement with our patients, our workforce and our communities, and has been an integral part of the Trust's operational and strategic equality, diversity and inclusion agenda.

5.5.2 Actions taken in year – health & wellbeing

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

We have continued to communicate with our workforce through a variety of different methods, both physically and digitally. We make use of a variety of media platforms such as the monthly team brief, the emailed weekly update and daily safety briefing arising from the daily safety huddle.

The safety huddle outcomes are also used as part of our clinical areas daily face-to-face huddle and handover which has been cited as best practice by the Good Governance Institute. In addition, the Staff Engagement and Wellbeing Team visit all clinical and non-clinical areas across the organisation to deliver any key messages or information on campaigns that will be of interest to the workforce.

There is also an expectation that all team members who were unable to attend the monthly team brief sessions have this information provided to them as part of their team meetings. Team Brief continues to be an open invite to all our staff and is presented

by our Chief Executive virtually via Microsoft Teams. The Team Brief is focused on our Quality, People and Sustainability framework and is delivered during the day and early evening to facilitate our night and weekend staff to participate. As part of Team Brief, subject matter experts continue to provide information on upcoming changes to Trust services and offers, whilst also ensuring that there is an opportunity for questions to be asked.

Our social media profile continues to grow utilising this opportunity to communicate via Twitter, Facebook and Instagram ensuring a wide reach for our communications. Our Executive Directors and Senior Leadership Team continues to be a visible presence within the Trust engaging with staff and seeking opinions, experience and feedback.

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

The strong culture of partnership working with Staff Side colleagues and the Trust continues with the ongoing Joint Negotiating and Consultative Committee (JNCC) meetings providing a forum for communication and collaborative working. 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. There is also a bi-monthly Joint Local Negotiating Committee, which feeds into JNCC, relating to medical staff. In addition to the formal partnership working structures, there are a range of informal 'touch points' each month between the People Directorate and Staff Side colleagues.

Staff Side colleagues, and members of Staff Networks and other engagement groups are also members of other committees where their voices can support and influence changes across the Trust. This includes the Workforce Equality, Diversity and Inclusion Sub-Committee which reports to Strategic People Committee chaired by a Non-Executive Director.

Employee voice is heard through the Staff Survey and the national People Pulse survey. In addition to formal surveys, the development of Staff Networks provide another channel to promote collaborative working and ensure that the employee voice is heard and acted upon. Our Staff Engagement and Wellbeing Team continue to seek engagement from all areas of our workforce in bringing ideas to life to improve our patient care and staff experience. To ensure that there is equality of opportunity in our decision making, the Workforce Equality, Diversity and Inclusion Team ensure that diversity in groups is representative of our workforce profile and local population census.

Information on health and safety performance and Occupational Health:

Our Workplace Health and Wellbeing Team deliver our Occupational Health and Wellbeing Service and have responsibility for supporting staff health and wellbeing. The Occupational Health and Wellbeing Department is a Safe Effective Quality Occupational Health Service (SEQOSH) 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, and physiotherapy.

In addition to the Occupational Health and Wellbeing Team, the Trust has invested in a Mental Wellbeing Team which provides a Mental Wellbeing Service to all staff where they can feel safe within a confidential environment to explore any difficulties they may be experiencing. The team consists of a Senior Staff Counsellor and two additional Staff Counsellors who offer a range of holistic, therapeutic and self-care therapies at both of our sites.

In 2022/23 the Occupational Health and Wellbeing Team continued to provide a bespoke COVID-19 workforce response service which provided advice, information and support for all members of staff.

The team consists of Nurses, Physiotherapists, Administrators and external Doctor provisions offering a robust integrated Occupational Health and Wellbeing service, supporting Commissioning for Quality Innovation (CQUIN) targets and our People Strategy.

Key highlights of the year include:

Flu Campaign

1. The Trust achieved the vaccination rate of 76.4% of front-line staff
2. A total of 2930 vaccinations were administered
3. The CQUIN target for 2022/23 was achieved

Musculoskeletal (MSK)

The Physiotherapists have continued to provide a hybrid service during 2022/23 with both telephone advice and face-to-face appointments available for our workforce. The team continue to offer a fasttrack referral system for the workforce.



5.6 Trade Union Facility Time

The Trust's statistics relating to our Trade Union (Facility Time Publication Requirements) Regulations Data 2021-22 for the period ending 31st March 2022 (published in July 2022) are as follows:

Table 1 – Number of employees who were relevant union officials during the period 21-22

No. employees who were relevant union officials	Full time equivalent employee number
25	22.4

Table 2 – Percentage of time spent on facility time

Percentage	No. of individuals
0%	7
1 – 50%	16*
51 – 99%	0
100%	2

*Excluding the Chair and Deputy Chair, the 16 active representatives' capacity for trade union deployment in hours is estimated at 352 hours in total for the year.

Table 3 – Total cost of facility time

	£
Total cost of facility time	£56,108
Total pay bill (2021-22)	£238,416,000
% Total pay bill spent on facility time	0.02%

Table 4 – Paid trade union activities

	%
Paid TU activity time as a percentage of paid facility time	6.15 %

NOTE: 2022/23 Data not available until July, the Trust typically reports a year in arrears

5.7 Reporting high paid off-payroll arrangements

For all off-payroll engagements as of 31st March 2023 for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31st March 2023	0
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Of which...

Number that have existed for less than one year at time of reporting	0
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Number that have existed for between one and two years at time of reporting	0
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Number that have existed for between two and three years at time of reporting	0
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Number that have existed for between three and four years at time of reporting	0
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Number that have existed for four or more years at time of reporting	0
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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 1st April 2022 and 31st March 2023, for more than £245 per day and that last for longer than six months:

Number of new engagements, or those that reached six months in duration between 1st April 2022 and 31st March 2023.	0
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Of which...

Number assessed as within the scope of IR35	0
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Number assessed as NOT within the scope of IR35	0
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Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
--	---

Number of engagements reassessed for consistency/assurance purposes during the year	0
---	---

Number of engagements that saw a change to IR35 status following the consistency review	0
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For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2022 and 31st March 2023

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year	32*

*All directors and Bands 8d and 9 (all on payroll)





Additional Information

6.1 Disclosures set out in the NHS Foundation Trust Code of Governance

Information can also be found under the Accountability Report **page 49**

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

Principles and standards of clinical and corporate governance are set and overseen by standing committees of the Board.

The Trust has established policies and processes that reflect the principles of the NHS Foundation Trust Code of Governance. These include:

1. Standing Orders of the Board of Directors
2. Standing Orders of the Council of Governors
3. Scheme of Reservation and Delegation of Powers (SoRD)
4. Standing Financial Instructions (SFIs)
5. Established role of the Senior Independent Director (SID)
6. Agreed recruitment process for Non-Executive Directors
7. Induction programme for Non-Executive and Executive Directors
8. Regular private meetings between the Chair and the Non-Executive Directors
9. Robust performance appraisal process for all Non-Executive Directors, including the Chairman, developed and approved by the Council of Governors
10. Attendance records for Directors and Governors at key meetings
11. Induction programme and continuing training and development for Governors
12. Council of Governors process for raising concerns and resolving disagreements between the Council of Governors and Board of Directors
13. Established role of Lead Governors
14. Structure of Council of Governors subgroups
15. Patient, Public Participation and Involvement (PPP&I) strategy in place
16. Nomination and Remuneration Committee (NARC) of the Board of Directors
17. Nomination and Remuneration Committee of the Council of Governors (GNARC)
18. Publicly available Register of Interests for Directors, Governors and Senior staff
19. Fit and Proper Persons checks and declarations
20. Code of Conduct for Board of Directors
21. Code of Conduct for Council of Governors
22. Robust Audit Committee arrangements
23. Governor-led appointment process for External Auditor
24. Freedom to Speak Up Policy and counter fraud policy and plan
25. Going Concern statement.

Warrington and Halton Teaching 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. As at 31st March 2023 The Trust can evidence its compliance with all principles of the NHS Foundation Trust Code of Governance.

6.2 NHS England System Oversight Framework & Segmentation

In 2021/22, NHS England & Improvement launched the NHS System Oversight Framework (replacing the NHS Oversight Framework) with an emphasis on collaboration and performance as a system. The framework is built on five national themes in addition to

a local theme to be agreed by the system.

The five national themes are:



Quality of Care, Access & Outcomes



Finance & Use of Resources



Preventing Ill Health & Reducing Inequalities



Leadership



People

NHS England & Improvement have allocated Trusts and ICSs to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for a recovery support programme (segment 4).

(iii) Segmentation

On 31st March 2023, the Trust is assigned to segment 2. Current segmentation of NHS Trusts and Foundation Trusts is published on the NHS England website



6.3 Statement of Accounting Officer's responsibilities as the accounting officer of Warrington & Halton Teaching Hospitals NHS Foundation Trust

Statement of the Chief Executive's responsibilities as the accounting officer of Warrington & Halton Teaching Hospitals NHS Foundation Trust.

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

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

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

1. Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
2. Make judgements and estimates on a reasonable basis.
3. State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statement.

4. Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance. Confirm that 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.
5. Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 them 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.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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



Professor Simon Constable FRCP,
Chief Executive

29th June 2023

6.4 Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Warrington and Halton Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Warrington and Halton Teaching Hospitals NHS Foundation Trust for the year ended 31st March 2023 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

The Quality Assurance Committee oversees all aspects of risk relating to quality, including improvement, delivery, clinical risk management and governance, clinical audit and the regulatory standards relevant to quality and safety on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register.

The Finance and Sustainability Committee oversees financial and digital risks on behalf of the Trust and reports on any additional risk/controls/assurances which will be recorded on the appropriate risk register. The Strategic People Committee oversees workforce risk on behalf of the Trust and reports on any additional risk/controls/assurances which will be recorded on the appropriate risk register.

The Risk Review Group oversees the Corporate Risk Register and CBU risk registers on a rolling programme making recommendations to the appropriate Board Committees regarding new strategic risks, review of existing strategic risks and assurance review of the Corporate Risk Register and CBU risk registers.

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

Risk training

Staff are trained and equipped to manage risk in a way appropriate to their authority and duties. All new staff receive information as part of the local induction programme organised by line managers. Monthly risk assessment training is in place for all staff who are required to undertake risk assessments as part of their role.

All senior managers are required to complete Risk Management training.

Further education is provided with cyclical mandatory training undertaken by both clinical and nonclinical staff; the content for this programme is continually reviewed in light of any changes. There is a robust appraisal process which facilitates the identification of individual staff training needs. These are reviewed as part of the member of staff's annual performance and development appraisal. All relevant risk policies are available to staff via the Trust's document management system including:

1. Risk Management Strategy
2. Risk Assessment Policy
3. Incident Reporting & Investigation Policy (Including Serious Incident Framework & Duty of Candour)
4. Complaints & Concerns Policy

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

Lessons learned and good practice is shared throughout the Trust, for example via the Trust-wide Safety Huddle, daily Safety Briefings, Quality Assurance Committee, Patient Safety & Clinical Effectiveness Sub Committee, Complaints Quality Assurance Group and the Clinical Claims Group.

Furthermore, the Trust publishes the Learning to Improve Newsletters quarterly. The Clinical Business Units (CBUs) also have a robust governance process for feedback.

The Trust invested in external training for senior key leads throughout May and June 2022. This training was facilitated by Amber Wing.

The risk and control framework

During the Year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks, approved the Trust's Risk Appetite Statement and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and at Committee meetings bi-monthly. In year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board. Each strategic risk is allocated to a committee for focused oversight and scrutiny.

The Risk Management Strategy provides a framework for managing risk across the Trust. The Strategy describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the Trust. Local risk registers are monitored and maintained locally within the Clinical Business Units (CBU) which enables risk management decision-making to occur as near as practicable to the risk source.

For those risks that cannot be managed locally these are escalated to the Corporate Risk Register and Strategic Risk Register where required.

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

1. **8 or below** (low, and very low) are verified by the ward or department manager.
2. **9-12** (moderate) are verified by CBU Managers, Corporate Heads of Service, Lead Nurse, Matron
3. **≥15** (significant) are verified at Executive level. They are reviewed at the Risk Review Group which is chaired by the Chief Nurse & Deputy Chief Executive and attended by the Director of Integrated Governance & Quality, Chief Operating Officer, Medical Director, Trust Secretary and Head of Safety and Risk. CBU Managers, Lead Nurses and Heads of Service also attend on a rotational basis. This group will review the risk for inclusion onto the Board Assurance Framework. The recommendation will then be reviewed and ratified by the Trust Quality Assurance Committee.

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

There are corporate policies and procedures in place to support risk management, covering the management of incidents, risk assessment and consent and general risk management arrangements. Risk appetite levels will depend on circumstances; for example the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but a greater appetite for opportunity risks such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation. Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board.

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

The Trust has a Board Assurance Framework in place which is reviewed by the Board of Directors and includes: the identification of the key risks to the achievement of the Trust strategic objectives and the systems in place to manage/mitigate these risks; the control systems in place to manage the key risks; the identification of sources of internal and external assurances evidencing the management of risk; and evidence of compliance with equality, diversity and human rights legislation.

The Board Assurance Framework is reviewed by the Board of Directors at each of their meetings and the Audit Committee, and bi-monthly by the Board Committees, which provides additional challenge and scrutiny of the risks identified.

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

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

Incidents, complaints, claims, Coroners' Inquests, and patient feedback are routinely 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.

Throughout 2022/23 the COVID risk register continued to be monitored at the Risk Review Group. A full report of all COVID related risks was presented at the Risk Review Group in January 2023. The report provided assurance that the COVID risks had been robustly managed and detailed the mitigations around each risk. Due to the assurances within the report, it was agreed to close the COVID risk register, and all open risks were transferred for oversight to the appropriate risk register.

Learning and improvement from incidents, complaints and claims has continued to be a focus for the Trust to help to improve internal controls impacting patient experience and patient safety. Risk KPIs are reported through the Quality Assurance Committee, its sub-committees, CBU-level reports; and shared with the lead Commissioners as part of the Quality Contract. Lessons for learning are also disseminated to staff using a variety of methods including Trust Wide Safety Huddle, which convenes on each weekday, the subsequent Safety Briefings and regular safety alerts.

Learning is further supported by meetings that include the Complaint Quality Assurance Group chaired by the Chair of the Trust, the Clinical Claims Group, Policy Review Group and Mortality Review Group.

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

The table below details the top five risks identified at the end of 2022/23 and these continue to be risks to the strategic objectives pertinent to 2023/24. All risks are effectively managed through the risk governance arrangements.



Risk Description/Key Controls

Risk Description	Key Controls
<p>If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.</p>	<ul style="list-style-type: none"> • Trust Board approval of capital plan to build new purpose built acute Medical Ambulatory Care area (ED Plaza) • Integrated Discharge Team in place • Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day • Discharge Lounge/Patient Flow Team/Silver Command • ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing • Private Ambulance Transport to complement patient providers in and out of hours • FAU/Hub operational operating five days per week • Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. • Increase IMC provided by the system such as the opening of the additional bedded capacity • Increase IMC at home • Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place • Same Day Emergency Care Centre (SDEC) completed July 2022 • Upgrade to Minors resulting in oxygen points in all cubicles • Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients • ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised • Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly • Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings • Additional Senior Manager on call support a weekends • Senior Doctor at Triage Function • Ward A10 opened as winter escalation capacity funded by the ICB • Plans being progressed to procure and install a new CT scanner co-located in the main body of the ED department. This will support increases urgent care pathway efficiency in the ED. This is set to be operational in September 2023 • Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients • Plans to co-locate ED Minors in the SDEC building to enhance patient pathways. The capital project is now agreed and set to be operational in April 23 • Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter • Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E • Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside • Work plan to reduce super stranded and no criteria to reside in 2023/24 is being finalised by the System Sustainability Group

Risk Description	Key Controls
<p>If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the Trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.</p>	<ul style="list-style-type: none"> • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery • Reconfigured of ED to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance • Plans to create a co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Due to be operational by April 23 • Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted • Waiting lists are reviewed through the Performance Review Group Weekly • Workforce is continually reviewed to ensure that all wards and teams are staffed safely • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancellations as a result of urgent care pressures • Capacity identified and being utilised with appropriate independent sector providers • To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive Reservice programme of work • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a fifth theatre at CSTM, a daycase unit and increased CT and MR capacity • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward A5 on the Warrington site • Weekly theatre scheduling to ensure listing of patients in line with national guidance • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks • Continue to ensure urgent cancers are prioritised in line with national guidance • Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends. • Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients • Use of Insourcing via 18 Weeks (NHS approved contractors) commenced in January 2023 to support 78-week target. Following approval by Execs. There are further plans to expand Insourcing to Maxfax and Gynae by the end of Q4 2022/23 • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24

Risk Description	Key Controls
<p>If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.</p>	<ul style="list-style-type: none"> • 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG) • Progress against recruitment to fill Trust vacancies monitored by Associate Chief nurses and Deputy Chief Nurse at WRG, areas of concern escalated to Chief Nurse, Deputy Chief Executive and local actions plans in place with additional support from Executive Team • Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity • Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels • Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency request via agreed Agency Managed Service • Staff numbers and skill mix recorded daily on Gold Command report for transparency of clinical decision making • Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust • Workforce plan in place • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team
<p>If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton.</p>	<ul style="list-style-type: none"> • Core financial policies controls in place across the Trust • Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning • Weekly review at extended Executive team meeting • Workshop undertaken with Exec, CBU, Corporate to review 2022/23 cost pressures • Workshops undertaken 2022/2023 budget setting • Capital Plan 2022/23 approved by Trust Board on 30th March 2022 • Procurement/tender waiver training in place • Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M • TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m over three years) • Latest guidance from MIAA Counter Fraud Team circulated Counter Fraud campaign took place for national anti-fraud week in November 2022 • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance • Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced • Appointed GIRFT Finance Lead and three Clinical Leads • Financial strategy developed to support improvement in financial sustainability. 2022–2027 Financial Strategy approved by the Trust Board in May 2022 • ICS executive peer to peer review June 2022, and September 2022 • Undertaken a review of a number of mitigations to support delivery of the Trust's Control Total and engaged with system partners to seek support; therefore, forecasting delivery of the control total • Daily review of Non-Pay requests to reduce Non-Pay spend in the last quarter • Annual Planning timetable established for 2023/24 • CDC phase 2 application approved for £4.5m capital over three years • Capital & Revenue Plans being developed for 2023/24 • Contract negotiations underway with a move to part block part PbR contracts • Additional £2.4m funding to support additional capacity • Introduced system of escalation where there are risks to CIP delivery

Risk Description	Key Controls
<p>If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff.</p>	<ul style="list-style-type: none"> • New Supporting Attendance Policy implemented in February 2022 and reviewed post six months implementation, update policy to be implemented April 2023 • Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers • Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. These actions have all supported an increase in compliance with target being met September 2022 – December 2022 • Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management, • People Health and Wellbeing Group. The group have focused on understanding the Trust’s absence reasons and reducing the volume of absences recorded as ‘unknown’ • Supporting Attendance Month – roadshows, drop-in sessions, comms and events to showcase the Trust’s commitment to Supporting Attendance • Focused welcome back conversation recording and internal audit • Review of policy implementation in September 2022 internally with Trade Unions, staff and managers. Awaiting feedback from NHSE • Exit Interview process – collation and analysis of data captured enables themes to be identified and targeted action. This information is available on the Trust Workforce Information Dashboard • Rugby League Cares have been supporting WHH since July 2021 Grief and Menopause cafes • Social media accounts have been created to support recruitment attraction across a number of social media platforms • Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream • To support with the development of an Agile/Flexible Working Toolkit, views of the staff have been sought on the current agile working culture, barriers, opportunities and best practice. A dedicated area to supporting Agile/Flexible working is available on the extranet, and in April 2023, a summary of the survey will be provided to the Executive team, before further promotion of the various tools available for managers/employees • The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: <ul style="list-style-type: none"> – ECF process for non-clinical vacancies approval – ECF process for bank and agency temporary staffing pay spend approval – Medical Rate Escalations approved by Medical Director • A Resourcing Task and Finish group has been established to review any gaps identified through the Agency Controls best practice toolkit. This will support plans to work with agencies to ensure they are operating within controls and improve the use of the Trust’s bank rather than agency staff

CQC Registration and Assessment

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

The CQC inspected Warrington and Halton Teaching Hospitals NHS Foundation Trust from 29th March to 2nd May 2019 and the final report was received in July 2019. During the visit the CQC looked at the quality and safety of the care provided, based on whether the service is: Safe, Effective, Caring, Responsive and Well-led. Included within the remit of the inspection was the Well-Led Inspection and NHSI Use of Resources review. The Trust was rated as 'Good' overall with an 'Outstanding' rating for Caring in Critical Care. A robust and comprehensive action plan was developed, and this has recently been signed off by the 'Moving to Outstanding' Steering Group which reports on progress to the Quality Assurance Committee and the Trust Board. The Trust is currently enhancing the specific workstreams developed to drive improvement actions, whilst identifying training, development, infrastructure and capital investment needs.

The Foundation Trust Code of Governance

The Foundation Trust governance structure ensures that the Board has an overarching responsibility through its leadership and, to ensure and be assured that the organisation operates with openness, transparency, and candour particularly in relation to its patients, the wider community and its staff.

The Board holds itself to account including with a wide range of stakeholders. The Governors play a significant role in holding the Board, and in particular the Non-Executive Directors, to account in a challenging but constructive way within a unitary board. A Governor observes each Board Committee and provides feedback to the Council of Governors. The Council of Governors meets quarterly as well as a quarterly Governor Engagement Group and regular Governor Working Party meetings. The Board has developed a culture across the organisation which supports open dialogue and includes Non-Executive Directors and Executive Directors visiting wards and departments to personally listen to feedback from staff, patients, their carers and relatives when possible.

The Board of Directors have throughout the year reviewed the relationship and responsibilities of the Board committees and sub-committees to ensure appropriate delegation of authority and that the appropriate assurance and oversight is maintained on behalf of the Trust Board. All the committees, which comprise of the Quality Assurance Committee, the Finance and Sustainability Committee, the Strategic People Committee and the time limited Clinical Recovery Oversight Committee, have Non-Executive Director (NED) membership and Chairs. The Complaints Quality Assurance Group is also chaired by the Chair of the Trust. The Audit Committee is a significant statutory committee of the Board that is chaired by a Non-Executive Director.

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

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

The Trust is able to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation Trust condition 4(8)(b) through its Annual Governance Statement (this document), its Code of Governance self-assessment evidence and its Head of Internal Audit Opinion, which reported substantial assurance for the period 1st April 2022 to 31st March 2023.

People & Organisational Development

The Trust's People Strategy delivery plan has been mapped against the NHS People Plan, NHS People Promise and the Future of HR&OD NHS Report to produce a cohesive strategic workforce delivery plan. Operational delivery of the plan continues to be overseen by the Operational People Committee, chaired by the Chief People Officer. Strategic People Committee, which is a Sub-Committee of the Board, chaired by a Non-Executive Director, has strategic oversight of the plan, and provides assurance to Board.

Developing Workforce Safeguards support WHH to deliver high quality care through safe and efficient staffing. The National Quality Boards (NQB's) guidance in relation to safe staffing states that providers:

1. Must deploy sufficient suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively
2. Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
3. Must use an approach that reflects current legislation and guidance where it is available

The development of the WHH Annual Workforce Plan, which contributes to the Cheshire and Merseyside overall Workforce Plan, enables the identification of skill gaps and supports a system wide approach to addressing these gaps, enabling WHH to continue to deliver high quality care through safe and efficient staffing. Scrutiny and operational oversight on systems and processes to support safer staffing, is provided from within the Trust's current governance structure. Strategic People Committee and Trust Board receive regular updates on safe staffing, staff development and key work developments such as the systematic approach to skill mixes or the introduction of new roles to support personal and professional development that will nurture, grow, and develop sufficiently competent diverse teams with a shared purpose to care for patients.

In addition, formal audits are undertaken into staffing processes such as recruitment and payroll, which are reported to the Trust Audit Committee. The Safer Staffing Report is provided to Quality Assurance Committee and presented bi-monthly to Trust Board. This identified areas of acuity, safe nursing staffing numbers and any incidents associated with staffing are brought to the attention of the Committee and the Board for assurance.

Board oversight of staffing processes is also achieved via the workforce elements of the Integrated Performance Report, which include key operational indicators such as absence, turnover and training compliance.

Register of Interests

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

NHS Pension Scheme

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

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

Delivering a Net Zero Health Service

The foundation trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;

For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

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 Chief Finance Officer & Deputy Chief Executive chairs the monthly Finance Resource Group (FRG) which reviews financial performance of all CBUs and Corporate Areas and reports into the non-executive led Finance and Sustainability Committee (FSC).

Part of the remit of the FSC, which meets monthly, is to support the Trust Board in gaining assurances on the economy, efficiency and effectiveness of the use of resources. Standing items on the agenda include the monthly financial position report, pay report) and COVID-19 expenditure report to ensure regular review of any financial challenges and implementation of recovery measures. In addition in 2022/23 the Wednesday Executive meeting has been changed to a Finance meeting with the Care Groups and Corporate teams presenting their progress on CIP and GIRFT. This meeting is chaired by the Chief Executive.

The Executive Team reviews and monitors the operational performance of the Trust. The Trust has a Use of Resources Group, which is led by the Chief Finance Officer & Deputy Chief Executive. Use of Resources is a workstream supporting the Trust's programme of 'Moving to Outstanding' CQC rating.

The Chief Finance Officer & Deputy Chief Executive reports to the Quality Committee on the Cost Improvement Plan (CIP) Quality Impact Assessments to provide assurance that CIPs have not had a detrimental impact to the quality of services.

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 Scheme of Reservation and Delegation. In addition, there is a robust system for developing and routinely reviewing policies and procedures and staff are appropriately updated and guided or trained on their application.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by counter fraud. Reports are presented to the Audit Committee in each meeting. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the regulators.

Financial Governance

The Trust recorded an adjusted deficit of £7.9m which is £2.5m away from the £5.4m deficit plan.

This adjusted surplus is the value which NHSE/I monitors the Trust against and was achieved.

The annual capital programme was £25.6m and the actual spend for the year was £25.5m, delivering an underspend of £0.1m.

The cash balance at the end of the year was £34.9m which will be utilised to fund the remaining annual leave accrual, new EPCMS (Electronic Patient Care Management System) and capital creditors.

There were no failures in financial governance during the year. The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on a regular basis.

Capital has been monitored through the year via Capital Planning Group and Finance and Sustainability Committee, with particular focus on schemes over £0.5m.

Over the last 12 months the Trust has continued to have regular meetings with the ICS where the financial position, forecast and capital have been discussed, reviewed, and challenged.

Information Governance

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

The Trust's most recent Data Security and Protection Toolkit assessment was finalised by Mersey Internal Audit Agency (MIAA) in August 2022 as part of the Trust's annual audit programme. The Trust was the subject of a two-part Data Security and Protection Toolkit review conducted by MIAA from February to May 2022. Part one of the review concluded that the Trust's self-assessment deviated only minimally from the independent assessment. On that basis the assurance level awarded in relation to the veracity of the self-assessment was substantial assurance.

Part two of the review conducted by MIAA was comprised of an assessment against the National Data Guardian's 10 data security standards. The assurance level awarded across nine of the data security standards was substantial with one standard rated as moderate. Therefore, the overall assurance level across all 10 National Data Guardian standards was rated as moderate.

In the 2022/23 financial year the Trust reported ten data loss incidents via the NHS England Data Security and Protection Toolkit reporting tool which were escalated to the Information Commissioner's Office (ICO). After investigating the circumstances surrounding each of the ten reported incidents the ICO ruled that further action against the Trust was not necessary in relation to any of the incidents.

NHS Digital Reference	Date Reported	Detail	Information Commissioner's Office Decision
27656	08/04/22	Test documentation filed in the notes of incorrect patient resulting in a data subject's details being made available to the parent of another data subject.	ICO deemed no further action necessary
28074	19/05/22	A data subject's antenatal notes (patient-held notes) given to incorrect data subject to take home.	ICO deemed no further action necessary
28151	26/05/22	A member of the public was inadvertently copied into a sensitive email that they did not have a legitimate reason to see.	ICO deemed no further action necessary
28629	08/07/22	Access was made to clinical systems for non-business purposes by a staff member that accessed a relative's records.	ICO requested the outcome of the disciplinary action taken and this was provided. No action beyond this request was taken.
29740	10/10/22	Information provided to a data subject as part of a subject access request contained detail relating to a different data subject.	ICO deemed no further action necessary
30383	30/11/22	A staff member accessed the records of a family member for non-business purposes.	ICO deemed no further action necessary
30768	06/01/23	An email containing details relating to one data subject was sent to an incorrect data subject.	ICO deemed no further action necessary
30849	13/01/23	Foster parents address disclosed in error to the biological mother of a data subject.	ICO deemed no further action necessary
30916	19/01/23	Case notes supplied as part of an access to health records request contained the detail of an unrelated data subject.	ICO requested further information which was provided in March 2023. As of April 2023, the ICO have not finalised their decision.
31117	02/02/23	Two letters sent to the parents of two data subjects went to incorrect addresses.	ICO deemed no further action necessary

Under the Network and Information Systems (NIS) Regulations 2018 the Trust is required to have adequate data and cyber security measures in place to protect against the increasing cyber threat.

As an operator of essential services, we are required to report network and information systems incidents which have significantly affected the continuity of services. The Trust has recorded no such incidents in the 2022/23 financial year.

As required by the Data Protection Act 2018 the Trust conducts Data Protection Impact Assessments (DPIAs) on projects that involve new types of data processing. No high-risk data processing issues which would require escalation to the ICO were identified in the impact assessments completed during 2022/23 financial year.

The Trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its Information Governance and Records Sub-Committee.

The Information Governance and Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust board.

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

Data Quality and Governance

A Data Quality and Assurance Group is established as a sub-group of the Information Governance & Corporate Records Sub-Committee and is chaired by the Associate Director of Information. The membership of the group includes the following as core members: Information Governance; Digital Analytics; Workforce; Contracting & Performance; ePR; Clinical Coding; Finance; Clinical Audit; Referral to Treatment, with subject experts from operational teams co-opted as and when required.

The standard agenda includes the following items:

- SUS (Secondary User Service) Data Quality Report.
- Systems Data Quality corrections.
- NHS Digital Information Standards Notifications tracking.
- Data Security and Protection Toolkit update.
- Documents for Review/Approval.
- Data Quality Policy.
- Finance update including NHS England Compliance report for financial data quality.
- Coding update.
- Contracts/Model Hospital updates.
- Workforce update.
- ePR/(PAS) Patient Administration System update.
- RTT update.

The Trust Data Quality policy is available via the Trust's policy HUB for ease of access.

All staff including clinicians and administrative staff who collect and record data, both manually and on the Trust clinical information systems, are responsible for ensuring adherence to the relevant data standards and for ensuring good data quality.

In order to achieve this they must:

- Ensure the timely, accurate and complete recording of data in the appropriate Trust information systems or record.
- Ensure they have the appropriate level of knowledge and skills for using the information systems required to do their role.
- Undertake regular validation checks of data collection and input to confirm that the patient demographic data and Personally Identifiable Data for our patients is accurate and up to date.
- Update any inaccuracies and/or missing data in server user records.
- Address any data quality issues as soon as possible and escalate appropriately. Reporting any concerns to the appropriate Information Asset Owner (IAO) or Information Asset Administrator (IAA).
- Have an awareness of and comply with national legislation, Trust level and local procedures.
- Ensure that they meet the Trust's Data Quality Standards where agreed for their area.
- Monitor their own competencies and access training where necessary both for clinical information systems and record keeping/data quality.
- Ensure all data is process in a secure and confidential way to comply with General Data Protection Regulation standards.

Ensuring that data is accurate, valid, reliable, timely, relevant and complete will help the Trust and its partners to assess the quality of our data and take action to address potential weaknesses.

Internal Trust-wide Standard Operating Procedures (SOPs) are created, reviewed and maintained to ensure the consistency with data collection and adherence to standards. SOPs are used by clinical and non-clinical teams and are also available on the Trust's policy HUB for ease of access.

A dedicated Referral to Treatment (RTT) team supported by the operational teams validate all clinical specialties focussing on inpatients, outpatients, diagnostics and cancer as part of the RTT pathways with the latter two also validated by the relevant teams. The team also follow up on issues, e.g. tests not ordered or patients not added to waiting lists to ensure the patient pathway is progress in a timely manner and avoiding any further delays to treatment.

The Electronic Staff Record Programme ('ESR')

ESR received an ISAE 3402 Type II (service auditor report) for the year ended 31st March 2023. This had a qualified audit opinion. There were three control deficiencies highlighted by the report, two of which were not relevant to the Trust. The finding deemed relevant was as follows:

"The controls related to the authorisation and revocation of logical access did not operate effectively during the period 1st April 2022 to 31st March 2023 to achieve the control objective of "controls provide reasonable assurance that security configurations are created, implemented and maintained to prevent inappropriate access".

The Trust is satisfied that it has local compensating controls in place that sufficiently mitigate this control deficiency.

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 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, the Quality Assurance Committee and the Risk Review Group; and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

Audit Committee: The Audit Committee reviews the effectiveness of internal control through the delivery of the internal audit plan.

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

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

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

The Head of Internal Audit issued an overall opinion for 2022-23 of Substantial Assurance noting that there is a good system of internal control designed to meet the organisation's objectives. The HOIA confirmed continued compliance with the definition of internal audit (as set out in the Trust's Internal Audit Charter), code of ethics and professional standards. The HOIA also confirmed organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

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

The BAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The effectiveness of the system of internal control is maintained and reviewed by the Board of Directors via its Committees and individual management responsibilities at Director and senior manager level. Regular reports have been reviewed by the Committees of the Board and individuals in relation to all key risks.

Clinical governance and processes to ensure quality of patient care are overseen by the Quality Committee under the leadership of the Chief Nurse and Deputy Chief Executive. Minutes of this Committee were received by the Board of Directors together with ad hoc reports, as required, and an annual report summarises the most significant issues in this area.

The Chief Nurse and Deputy Chief Executive has delegated lead responsibility for risk management across the Trust. Individual Directors and senior managers are empowered to review and manage risks within their own areas of responsibility, linking closely with wider Trust processes. Significant support has been provided via training, advice, and guidance documentation to enable senior staff to effectively fulfil their functions.

An analysis of controls and assurance in relation to key organisational risks has been undertaken via the assurance framework.



Conclusion

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

A handwritten signature in black ink, appearing to read 'Simon Constable'.

Professor Simon Constable FRCP,
Chief Executive

29th June 2023



7 Annexes

7.1 Staff Exit Packages

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

The table below discloses the number and value of exit packages agreed in 2022/23.

2022/23

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000	Number	£000	Number	£000	Number	£000
<£10,000			22	79	22	79		
£10,00 – £25,000			1	13	1	13		
£25,001 – £50,000								
£50,001 – £100,000								
£100,001 – £150,000								
£150,001 – £200,000								
>£200,000								
Total			23	92	23	92		

The number and value of exit packages agreed in 2021/22 are listed in the table below for comparison.

2021/22

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000	Number	£000	Number	£000	Number	£000
<£10,000			13	46	13	46		
£10,00 – £25,000	1	11			1	11		
£25,001 – £50,000								
£50,001 – £100,000								
£100,001 – £150,000								
£150,001 – £200,000								
>£200,000								
Total	1	11	13	46	14	57	0	0

Exit packages: non-compulsory departure payments

	2022/23		2021/22	
	Agreements	Total Value of Agreements	Agreements	Total Value of Agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	23	92	13	46
Exit payments following Employment Tribunals or court orders			0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	23	92	13	46
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

*Includes any non-contractual severance payment made following judicial mediation, and £0 relating to non-contractual payments in lieu of notice.

The Remuneration Report provides details of exit payments payable to individuals named in that Report.



7.2 Staff Engagement

The organisation has a dedicated Staff Engagement and Wellbeing function based within the People Directorate who are responsible with ensuring that all members of the workforce feel valued, included, supported and developed irrespective of staff group or protected characteristic. This team is supported by subject matter experts in other areas, including Occupational Health, Equality, Diversity and Inclusion, Learning and Development, Apprenticeships and HR Business Partnering.

There are formal and informal mechanisms in place to support and facilitate effective staff engagement across the whole organisation. Formal mechanisms include the People Champion Network, our Trade Unions and also Staff Networks such as PROGRESS (supporting the LGBTQIA+ Community), MESN (Multi-Ethnic Staff Network), Disability Awareness Network and Armed Forces and Military Veterans Community Network. Informal mechanisms include monthly visibility of the Staff Engagement and Wellbeing Teams within clinical and non-clinical areas to disseminate information, share best practice and highlight opportunities for staff voices to be heard and to facilitate staff participation.

The Staff Engagement and Wellbeing function also lead on the National NHS Staff Survey annually and quarterly People Pulse Surveys. These mechanisms allow for our workforce to share their voice in a confidential space. The Team then work with Senior Leaders and Managers to develop robust action plans to address findings from surveys to improve the experience of all our workforce.

In addition, the Staff Engagement and Wellbeing Team support staff engagement through internal mechanisms such as the monthly You Made a Difference Award, which celebrates members of our workforce who have gone above and beyond in their work, making a difference to the lives of those around them. In November 2022 the Trust also held a WHH Recognition Event, celebrating our staff receiving long-service awards and the work of our WHH Volunteers. In March 2023 the Trust also recognised the impact of all our workforce and held our annual Thank You Awards at the Concorde Conference Centre in Manchester.

7.3 NHS Staff Survey

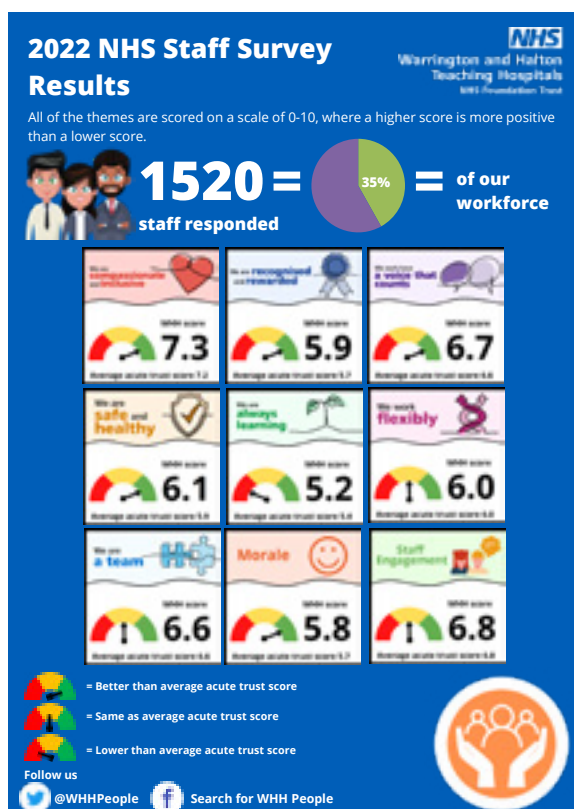
The NHS Staff Survey is a nationally mandated survey across all organisations to inform local improvement in staff experience and wellbeing. It is a national measure against the pledges set out in the NHS Constitution and provides useful intelligence to the Care Quality Commission and local commissioners.

In 2022 the organisation achieved a response rate of 35%, with 1520 respondents, a 5% decrease in comparison to the 2021 Staff Survey. Although a decrease this is reflective of the national trend in response rates in comparison to 2021.

We use the outcomes of our survey to direct future organisational change for example developing guidance and training for line managers to improve relationships between line managers and their staff.

The 2022 results highlight that we scored better than the Acute Trust average score in five out of the nine themes as illustrated in the below table:

Score	Theme
Better than Average Trust Score	1. We are compassionate and inclusive
	2. We are recognised and rewarded
	3. We each have a voice that counts
	4. We are safe and healthy
	5. Morale
Same as Average Trust Score	6. We work flexibly
	7. We are a team
	8. Staff engagement
Worse than Average Trust Score	9. We are always learning



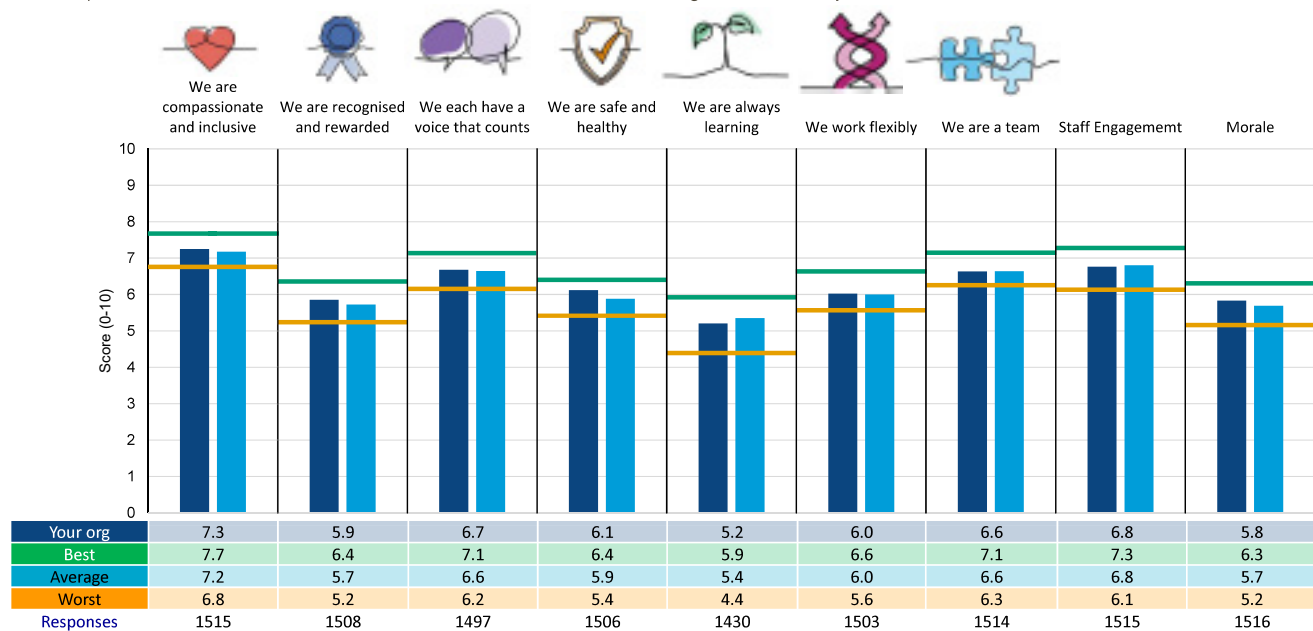
The NHS Staff Survey is conducted on an annual basis across all NHS organisations. The survey for 2022, similarly with recent years was aligned to the NHS People Plan and the People Promises. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The 2021 Staff Survey took place between September and November 2022 via Quality Health, who are an approved NHS Staff Survey provider.

The survey is sent out to all eligible members of the workforce with a blended approach of paper and online questionnaires. A communications plan was carried out in collaboration with the Staff Engagement and Wellbeing Team and the Communications Team to promote the campaign.

The results of the Staff Survey 2022 are communicated to staff via a variety of channels and through interactions with the People Directorate Teams.

People Promise Elements and Themes: Overview Survey Coordination Centre 

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



Warrington and Halton Teaching Hospitals NHS Foundation Trust Benchmark report

The thematic results from the 2022 Staff Survey including best and average scores. The results illustrate that the organisation has performed better than the average score in five areas and worse than the average score with comparable organisations in one area relating to learning and development.

Pertinent to note in comparison to the Staff Survey completed in 2021 are three areas which have shown statistical decline, they include:

- We are recognised and rewarded
- We each have a voice that counts
- Staff engagement

Although the above results demonstrate a statistically decline, the recognition and voice themes are still better than the Acute Trust national average and staff engagement remains the same as the Acute Trust national average.

The Staff Survey results provide the organisation with the opportunity to respond to staff feedback through robust assurance and priority setting with an organisational and local action plans developed to respond and address the findings of the Staff Survey for 2022.

The Staff Survey results have been shared in a variety of methods that are accessible and capture all staff by utilising some of our existing engagement approaches and communication channels.

7.4 Modern Slavery

Modern Slavery Act 2015 – Statutory Statement

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

A person commits an offence if:

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

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 regarding our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

The Trust has a non-pay budget of £85m (inclusive of drugs at £18m) of which over £60m per annum is spent on goods and services.

Our Supply Chain

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

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

The standard NHS Terms and Conditions of Contract which form the basis of all orders and contracts with supplier have a specific clause contained within them relating to modern slavery that determine that suppliers (and their sub-contractors) will:

- Comply with the Modern Slavery Act 2015 and implement due diligence policies for its sub-contractors.
- Respond promptly to all slavery and trafficking due diligence questionnaires.
- At the request of the Trust, prepare and deliver an annual slavery and trafficking report setting out steps to ensure slavery and trafficking is not taking place within its supply chain.
- Implement a system for all employees to ensure compliance with the Slavery Act.

The Trust's Procurement Team has contacted each of its top 250 suppliers to request confirmation that they are compliant with the Act. As part of this work Procurement also issued the Supplier Code of Conduct to all suppliers used across the organisation inclusive of pharmaceutical suppliers.

As part of the Trust's commitment to ensuring that we do not trade with organisations who do not meet the requirements of the Act, suppliers will be required to provide a copy of their annual Modern Slavery Action Statutory Statement detailing actions undertaken to ensure they meet and enforce the requirements of the Act. This will only apply to suppliers defined as a "commercial organisation" in accordance with the Act:

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

The Trust's Procurement team is committed to raising awareness with all suppliers by ensuring that all suppliers the Trust trades with are aware of our commitment to ensure compliance with the Act. As part of the Trust's ongoing procurement processes, when trading with new suppliers, and prior to establishing the supplier on Trust systems, the supplier will be requested to confirm in writing that they are compliant with the Act.

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

7.5 The Trust

The Trust employs around 5,000 staff comprising of 74 nationalities. Most of these staff are employed and paid under national pay arrangements established under Agenda for Change or Medical and Dental provisions. A small number of staff, which comprises the Trust Board and Very Senior Managers (VSM), are employed under local pay and terms and conditions of service which are established by the Remuneration Committee of the Board.

All staff are appointed subject to meeting the NHS Standards on Employment Checks which includes workplace references, health checks, DBS checks, immigration checks and identity checks. In addition, the Trust has developed a number of values and behaviours which are fully embedded into the organisation. The Trust expects its existing staff to comply with these standards and all future appointments will be expected to demonstrate these attributes as part of the appointment process.

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

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

The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers but to also comply with employment legislation. Every policy is impact assessed from an Equality, Diversity and Inclusion perspective ensuring that equality of opportunity is considered as well as ensuring no staff experience discrimination, harassment or victimisation.

The Trust does have specific policies in place to deal with the Safeguarding of Children and Adults at Risk but does not have a specific policy on the Modern Slavery Act as this is embedded into current Safeguarding policies. However, should the Trust become aware of any issue covered under the Modern Slavery Act, it would immediately report the matter to police following our policy principles.

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

The Trust employs a Head of Workforce Equality, Diversity and Inclusion and Lead Nurse for Safeguarding Children and Adults who take the lead on the Modern Slavery Act and where possible the Trust does support awareness raising events both locally and nationally on such matters, including events focused on hate crime, disability, LGBTQIA+, race, honour crime and forced marriages.





Annual Accounts 2022–23

8.1 Auditors Report

Independent auditor's report to the Council of Governors of Warrington and Halton Teaching Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Warrington and Halton Teaching Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2023, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to

continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2022/23 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS foundation trust annual reporting manual 2022/23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Accounting Officer's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the

form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2022/23, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit Committee, concerning the Trust's policies and procedures relating to:
 - the identification, evaluation and compliance with laws and regulations;
 - the detection and response to the risks of fraud; and
 - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
 - High risk or unusual journal entries as identified by our risk assessment
 - Key accounting estimates
 - Income recognition in respect of patient care income and other operating revenue, other than the block contract income element of patient care revenues and education & training income.
 - Expenditure recognition in respect of non-pay expenditure, the occurrence of capital expenditure and the existence of related capital creditor balances.
- Our audit procedures involved:
 - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
 - journal entry testing, with a focus on high risk or unusual journals;
 - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations;

- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item;
- testing a suitable sample of variable income and receivables to supporting evidence;
- agreeing, on a sample basis, expenditure to supporting evidence
- testing a sample of capital additions to ensure that the expenditure has been incurred in-year and that it was appropriate to capitalise;
- testing a sample of capital creditors to supporting evidence.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to land and building valuations.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
 - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
 - knowledge of the health sector and economy in which the Trust operates
 - understanding of the legal and regulatory requirements specific to the Trust including:
 - the provisions of the applicable legislation
 - NHS England's rules and related guidance
 - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
 - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
 - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of Warrington and Halton Teaching Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Georgia Jones

Georgia Jones, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Liverpool

Date: 30 June 2023

8.2 Forward to the Accounts

Trust name: Warrington and Halton Teaching Hospitals NHS Foundation Trust
This year: 2022/23
This year ended: 31 March 2023
This year beginning: 1 April 2022

Foreword to the accounts for the year 1 April 2022 to 31 March 2023

Warrington and Halton Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2023, have been prepared by Warrington & Halton Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of National Health Service Act 2006.



Simon Constable
Chief Executive
29 June 2023

8.3 Primary Financial Statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2023

	NOTE	2022/23 £000	2021/22 £000
Income from activities	3	316,327	306,611
Other operating income	3	30,725	25,992
Operating income	3	347,052	332,603
Operating expenses	4	(350,106)	(329,653)
OPERATING SURPLUS / (DEFICIT)		(3,054)	2,950
FINANCE INCOME / (EXPENSE)			
Finance income - interest receivable	7	894	35
Finance expense - interest payable	8	(101)	0
PDC dividends payable		(4,650)	(4,180)
NET FINANCE COSTS		(3,857)	(4,145)
Net losses on disposal of assets	9	(19)	(81)
DEFICIT FOR THE FINANCIAL YEAR		(6,930)	(1,276)
Other comprehensive income / (expense)			
Items that will not be reclassified to income and expenditure			
Net impairments on property, plant and equipment	10	(2,734)	3,968
Revaluation gains on property, plant and equipment		5,900	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		(3,764)	2,692
Allocation of losses for the period			
(a) Surplus / (Deficit) for the period attributable to:			
(ii) owners of the parent		(6,930)	(1,276)
TOTAL		(6,930)	(1,276)
(b) Total comprehensive income / (expense) for the period attributable to:			
(ii) owners of the parent		(3,764)	2,686
TOTAL		(3,764)	2,686

The notes on pages 5 to 38 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2023

	NOTE	31 March 2023 £000	31 March 2022 £000
NON-CURRENT ASSETS			
Intangible assets	11	2,470	3,198
Property, plant and equipment	12	177,949	158,287
Right of use assets	13	10,713	0
Trade and other receivables	15	1,136	1,229
Total non-current assets		192,268	162,714
CURRENT ASSETS			
Inventories	14	4,145	4,218
Trade and other receivables	15	18,802	12,534
Cash and cash equivalents	17	34,926	44,656
Total current assets		57,873	61,408
CURRENT LIABILITIES			
Trade and other payables	18	(47,453)	(40,597)
Borrowings	20	(2,283)	0
Provisions	21	(244)	(231)
Other liabilities	19	(5,113)	(5,102)
Total current liabilities		(55,093)	(45,930)
Total assets less current liabilities		195,048	178,192
NON-CURRENT LIABILITIES			
Borrowings	20	(8,327)	0
Provisions	21	(2,696)	(2,693)
Total non-current liabilities		(11,023)	(2,693)
TOTAL ASSETS EMPLOYED		184,025	175,499
TAXPAYERS' EQUITY			
Public dividend capital		214,577	202,287
Revaluation reserve		40,855	37,689
Income and expenditure reserve		(71,407)	(64,477)
TOTAL TAXPAYERS' EQUITY		184,025	175,499

The primary accounts on pages 1 to 4 and the notes on pages 5 to 38 were approved by the Audit Committee on 21 June 2023 on behalf of the Trust Board using the powers delegated to the Committee and signed on its behalf by Simon Constable, Chief Executive.



Signed: Date: 29 June 2023

Simon Constable
Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2023

	Total Taxpayers' Equity £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' equity as at 1 April 2022	175,499	202,287	37,689	(64,477)
Deficit for the year	(6,930)			(6,930)
Net impairments on property, plant and equipment	(2,734)		(2,734)	
Revaluation gains on property, plant and equipment	5,900		5,900	
Public Dividend Capital received	12,290	12,290		
Other reserve movements	0		0	0
Taxpayers' equity as at 31 March 2023	184,025	214,577	40,855	(71,407)
	Total Taxpayers' Equity £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' equity as at 1 April 2021	169,681	199,156	33,721	(63,196)
Deficit for the year	(1,276)			(1,276)
Net impairments on property, plant and equipment	3,968		3,968	
Public Dividend Capital received	3,132	3,132		
Other reserve movements	(6)	(1)		(5)
Taxpayers' equity as at 31 March 2022	175,499	202,287	37,689	(64,477)

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2023

	NOTE	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus / (deficit) from continuing operations		<u>(3,054)</u>	<u>2,950</u>
Non-cash income and expense			
Depreciation and amortisation	4	12,942	10,413
Impairments and reversals	4	(648)	2,494
Income recognised in respect of capital donations	3	(807)	(154)
(Increase) / decrease in trade and other receivables	15	(6,507)	(3,128)
(Increase) in inventories	14	73	(195)
Increase in trade and other payables	18	6,063	5,916
Increase / (decrease) in other liabilities	19	11	1,957
Increase in provisions	21	16	59
Other movements in operating cash flows		0	0
Net cash used in operations		<u>8,089</u>	<u>20,312</u>
Cash flows from investing activities			
Interest received	7	894	35
Purchase of intangible assets	11	(495)	(1,423)
Purchase of property, plant and equipment	12	(24,206)	(19,883)
Sales of property, plant and equipment		50	76
Receipt of cash donations to purchase capital assets	3	807	0
Net cash used in investing activities		<u>(22,950)</u>	<u>(21,195)</u>
Cash flows from financing activities			
Public Dividend Capital received		12,290	3,132
Public Dividend Capital repaid			0
Capital element of lease liability repayments		(2,740)	0
Other interest	8	(4)	0
Interest element of lease liability repayments	8	(97)	0
Public Dividend Capital paid		(4,318)	(5,530)
Net cash used in financing activities		<u>5,131</u>	<u>(2,398)</u>
Increase / (Decrease) in cash and cash equivalents		(9,730)	(3,281)
Cash and cash equivalents as at 1 April		44,656	47,937
Cash and cash equivalents as at 31 March	17	<u><u>34,926</u></u>	<u><u>44,656</u></u>

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Note 1.3 Key sources of judgement and estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements that management have made in the process of applying the Trust's accounting policies, together with the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Provisions

The Trust has the following categories of provisions:

- Pensions - relates to early retirement costs information is provided by NHS Business Service Authority.
- Legal - claims relates to third party legal claims advised by NHS Resolution.
- Other - employment tribunals.
- Clinical Pension - information is provided by NHSE.

The only category where the Trust applies a judgement and estimate is to the employment tribunal cases within other provisions. This is in respect of likelihood of outcome and any financial awards that may be made against the Trust.

Asset valuations and lives

The value and remaining useful lives of land and building assets are estimated by Cushman & Wakefield who provide professional valuation services. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the DHSC and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost based on the Modern Equivalent for specialised operational property (property rarely sold on the open market) and Current Value in Existing Use for non-specialised operational property.

A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years.

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.

Note 1.4 Income

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied.

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services, however this has not been operated locally. Where actual elective activity delivered differs from the agreed level set in the fixed payments no adjustment to income was made by local agreement."

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN). Delivery under this scheme is part of how care is provided to patients. As such CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under this scheme is included in fixed payments from commissioners based on assumed achievement of criteria. Where CQUIN criteria was not achieved, no adjustment to income was made by local agreement

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.1 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Income (continued)

Where income is received for a specific activity that is to be delivered in a future financial year that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

The main sources of other operating income are from the DHSC, Health Education England, NHS Trusts, NHS Foundation Trusts and Local Authorities.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 1.6 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as an intangible asset or an item of property, plant and equipment.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8 Property, plant and equipment

Note 1.8.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
 - it is probable that future economic benefits will flow to, or service potential will be provided to, the Trust;
 - it is expected to be used for more than one financial year;
 - the cost of the item can be measured reliably; and
 - the item has a cost of at least £5,000; or
-
- collectively, a number of items which have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
 - items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Note 1.8.1 Recognition (continued)

The whole of a site is designated as the property asset with the land, the separate buildings upon it and the external works being the main components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

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.

Note 1.8.2 Measurement

Valuation

All property, plant and equipment is initially measured at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the Trust's services or for administrative purposes are stated in the SoFP at their revalued amounts, being the current value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and where it would meet the location requirements of the service being provided an alternative site valuation can be used. The Trust has used alternative site valuation from 2017/18 onwards. The Trust commissioned Cushman & Wakefield to undertake a 'desk top' valuation as at 31 March 2023.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the SoFP date.

- Land and non specialised buildings - market value for existing use.
- Specialised buildings - depreciated replacement cost.
- Equipment - depreciated historical cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at current value. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Note 1.8 Property, plant and equipment (continued)

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-SoFP PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the SoCI as an item of 'other comprehensive income / expenses'.

Impairments

At the end of the financial year the Trust reviews whether there is any indication that any of its assets have suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with the GAM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses, and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve, where at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments, such as unforeseen obsolescence, are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains and classed as 'other operating income'.

Note 1.8 Property, plant and equipment (continued)

Note 1.8.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.4 Donated, government grant and other grant funded assets

Donated, government grant and other grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited in full to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.9 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

Note 1.9.1 The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

Note 1.9 Leases (continued)

Note 1.9.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.9.3 Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust is an intermediate lessor, classification of all continuing sublease arrangements has been reassessed with reference to the right of use asset.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line or other systematic basis.

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula, which is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Cash and cash equivalents

Cash is defined as cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. Interest earned on bank accounts is recorded as interest receivable in the periods to which it relates. Balances exclude monies held in bank accounts belonging to patients (Note 17).

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the SoFP is the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rates. Early retirement provisions and injury benefit provisions have both been discounted using the HM Treasury's pension discount rate of 1.70% (-1.30% in 2021/22) in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 21 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 NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of successful claims are charged to operating expenses as and when the liability arises.

Note 1.13 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 22, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Corporation tax

Warrington and Halton Teaching 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 2021/22).

Note 1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with requirements of HM Treasury's FReM (Note 17).

Note 1.17 Public Dividend Capital (PDC) and PDC dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital 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, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at:-

<https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the unaudited version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.18 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 expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Consolidation

The Trust is the corporate Trustee to Warrington & Halton Teaching Hospitals NHS Foundation Trust Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to effect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

The Trust has opted not to consolidate charitable funds with the main Trust Accounts in 2022/23 because they are immaterial. This will be reviewed each year for appropriateness.

Note 1.20 Financial assets and financial liabilities

Note 1.20.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. on receipt or delivery of the goods or services.

Note 1.20.2 Classification and measurement

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described in note 1.9.

Financial assets and liabilities are classified and subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the SoCI and a financing income or expense.

Note 1.20 Financial assets and financial liabilities (continued)

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

In determining the classification of financial assets the Trust has considered both the business model and associated cash flows for the collection of contractual income that are solely payments of principal and interest. Financial assets are measured at amortised cost. Contract receivables will initially be measured at their transaction price, as defined by IFRS 15 adjusted for any allowance for expected credit losses using a general approach.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the SoCI and reduce the net carrying value of the financial asset in the SoFP.

Note 1.20.3 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expired.

Note 1.21 Reserves (continued)

Note 1.21.2 Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are also recognised in operating expenses. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Note 1.21.3 Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

Note 1.23 Accounting standards and interpretations issued but not yet adopted

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM, therefore early adoption is not permitted."

Note 2. Operating segments

The Trust has considered segmental reporting, the Chief Executive and the Trust Board receive sufficient and appropriate high level information to enable the business to be managed effectively supporting the monitoring and management of the Trust's strategic aims. Sufficiently detailed information is used by middle and lower management to ensure effective management at an operational level. Neither of these are sufficiently discrete to profile operating segments, as defined by IFRS 8, that would enable a user of these financial statements to evaluate the nature and financial effects of the business activities that this Trust undertakes. Therefore, the Trust has decided that it has one operating segment for healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2022/23	Restated 2021/22
	£000	£000
Acute services		
Block contract / system envelope income (note 1)	273,627	275,595
High cost drugs income from commissioners (note 1)	14,124	12,301
Other NHS clinical income (note 1)	3,426	4,946
All services		
Private patient income	12	227
Elective recovery fund	8,017	4,507
Agenda for change pay award central funding (note 2)	7,777	0
Additional pension contribution central funding	8,337	8,117
Other non-protected clinical income	1,007	918
Total income from activities	316,327	306,611

note 1 - A reclassification of income has been made in the prior year. This relates to £48.088m moved from Other NHS clinical Services to Block contract / system envelope income (£48.002) and High cost drugs income from commissioners (£0.086m).

note 2 - In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.'

Note 3.2 Income from patient care activities (by source)	2022/23	2021/22
	£000	£000
Income from patient care activities received from:		
NHS England	32,051	21,636
Clinical Commissioning Groups (note 3)	65,289	282,881
Integrated Care Boards (note 3)	217,469	0
NHS Foundation Trusts	386	761
Department of Health and Social Care	5	1
NHS Other	224	317
Non NHS : private patients	12	227
Non NHS : overseas patients	90	9
Injury cost recovery scheme	801	779
Total income from activities	316,327	306,611

All income from activities relates, in its entirety, to continuing operations for 2022/23 and 2021/22.

note 3 - on 01/07/22 Clinical Commissioning Groups (CCGs) ceased to exist and were replaced by Integrated Care Boards (ICBs). Income in 2022/23 for CCGs is for April to June and ICBs is for July to March.

Note 3.3 Overseas visitors (relating to patients charged directly by the Trust)

	2022/23	2021/22
	£000	£000
Income recognised this year	90	9
Cash payments received in-year	51	37
Amounts added to provision for impairment of receivables	11	13
Amounts written off in-year	0	12

Note 3. Operating income (continued)

Note 3.4 Other operating income	2022/23	2021/22
	£000	£000
Research and development	1,022	585
Education and training	10,965	9,280
Non-patient care services to other bodies	4,951	1,664
Reimbursement and top up funding	778	1,963
Income in respect of staff costs where accounted on gross basis	1,813	2,337
Education and training - Notional income from apprenticeship fund	589	592
Donation of assets	0	54
Donated equipment from DHSC for COVID response (non-cash)	0	100
Cash donations / grants for the purchase of assets	807	0
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response (note 1)	626	1,032
Rental revenue from operating leases	236	224
Other (note 2)	8,938	8,161
Total other operating income	<u>30,725</u>	<u>25,992</u>

note 1 - relates to donated Personal Protective Equipment (PPE) for COVID. The same value is included in expenditure which is shown in note 4.1.

note 2 - all other operating income relates in its entirety to continuing operations for 2022/23 and 2021/22.

Analysis of other operating income 'other'	2022/23	2021/22
	£000	£000
Car parking	1,317	2,062
Catering	424	242
Pharmacy sales	60	56
Staff accommodation rentals	64	102
Non-clinical services recharged to other bodies	867	781
Clinical tests	2,078	1,694
Other (note 3)	4,128	3,224
Total other operating income 'other'	<u>8,938</u>	<u>8,161</u>

note 3 - other income for 2022/23 contains £0.5m for recruitment of international nurses, £0.5m for COVID related activities, £0.2m maternity & midwifery funding.

Note 3.5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of Trust failure. This information is provided in the table below.

	2022/23	2021/22
	£000	£000
Income from services designated as commissioner requested services	315,308	305,466
Income from services not designated as commissioner requested services	1,019	1,145
Total	<u>316,327</u>	<u>306,611</u>

Note 3.6 Fees and charges

HM Treasury requires disclosure of fees and charges in respect of charges to service users where income from that service exceeds £1m and is presented as the aggregate of such income. There haven't been any costs exceeding £1m in either 2022/23 or 2021/22 in respect of fees and charges.

Note 3.7 Additional information on revenue from contracts with customers recognised in the period

	2022/23	2021/22
	£000	£000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	4,547	1,305

Note 4. Operating expenditure

Note 4.1 Operating expenses	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	241	427
Purchase of healthcare from non-NHS and non-DHSC bodies	729	373
Staff and executive directors costs	251,740	234,923
Non-executive directors	138	126
Supplies and services (clinical; excluding drug costs)	24,235	20,250
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response (note 1)	626	1,032
Supplies and services (general)	3,572	3,734
Drug costs	20,243	18,321
Consultancy costs	294	656
Establishment	2,607	2,327
Premises (business rates)	1,230	1,135
Premises (other)	13,844	10,984
Transport (business travel only)	350	382
Transport (including patient travel)	1,118	854
Depreciation on property, plant and equipment and right of use assets	11,707	9,368
Amortisation on intangible assets	1,235	1,045
Net impairments	(648)	2,494
Movement in credit loss allowance: contract receivables/assets	(51)	216
Provisions arising / released in year	210	85
Change in provisions discount rate	(174)	38
Audit services (statutory audit)	144	107
Internal audit costs	109	94
Clinical negligence, liability to third parties and property expenses scheme premiums	9,275	9,189
Legal fees	266	198
Insurance	215	150
Research and development - staff costs	406	435
Research and development - non-staff	77	126
Education and training - staff costs	2,899	3,047
Education and training - non-staff	2,028	2,143
Education and training - notional expenditure funded from apprenticeship fund	589	592
Lease expenditure (note 2)	51	0
Operating lease expenditure (note 2)	0	3,918
Redundancy	0	11
Losses and special payments	742	602
Other expenditure	59	271
Total operating expenses	350,106	329,653

All operating expenses relate, in their entirety, to continuing operations for 2022/23 and 2021/22

note 1 - Relates to donated Personal Protective Equipment (PPE) for COVID. The same value is included in income which is shown in note 3.4.

note 2 - from 1 April 2022 International Financial Reporting Standard (IFRS) 16 was implemented. This has seen the cessation of operating leases. The majority of the expenditure is now classified on the Statement of Financial Position as a capital asset with a corresponding liability. Please see note 13.1 and 20. The balance of any lease expenditure which does not fall under the scope of IFRS16 is included in the new line above "lease expenditure"

Note 4.2 Limitation on auditor's liability

The external auditors' liability is limited to £1m. The scope of work for the external auditors is to provide a statutory audit of annual accounts and report and provide opinion on them to the Trust and the Trust's Council of Governors. This will be conducted in accordance with the Audit Code for NHS Foundation Trusts (the Audit Code) issued by Monitor in accordance with paragraph 24 of schedule 7 of the National Health Service Act 2006, schedule 10 of the National Health Service Act 2006 with due regard to the Comptroller and Auditor General's Code of Audit Practice (the Code) issued by the National Audit Office (NAO) in April 2015.

Note 5. Staff

Note 5.1 Employee expenses

	2022/23	2021/22
	Total	Total
	£000	£000
Salaries and wages	170,235	161,712
Social security costs	16,956	15,344
Apprenticeship levy	808	772
Pension costs (employer contributions to NHS Pensions)	18,994	18,429
Pension costs (employer contributions paid by NHSE on Provider's behalf (6.3%))	8,337	8,117
Pension costs (other)	106	88
Termination benefits	91	46
Temporary staff - external bank	25,771	21,829
Temporary staff - agency/contract staff	14,795	12,735
Total employee benefit expenses	256,093	239,072
Less costs capitalised as part of assets	(1,048)	(656)
Total per employee expenses in Note 4.1	255,045	238,416

Employee costs include staff costs of £1,048k (£656k in 2021/22) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses (Note 5.1). The employee expenses table above is for executive directors, staff costs and redundancy payments only. It excludes non-executive directors.

An accrual in respect of the cost of annual leave entitlement carried forward at the SoFP date of £2,216k has been provided for within the accounts (£4,784k as at 31 March 2022).

Note 5.2 Early retirements due to ill-health

4 members of staff retired early on ill-health grounds during the year at an additional cost of £397k (1 member of staff at a cost of £178k for the year ending 31 March 2022). The cost of ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

Note 6. Operating leases

This note discloses income generated in operating lease agreements where Warrington and Halton Teaching Hospital NHS Foundation Trust is the lessor.

Note 6.1 Operating lease income	2022/23	2021/22
	£000	£000
Lease receipts recognised as income in the year	236	224
Total	236	224

Future minimum lease receipts due:	2022/23	2021/22
	£000	£000
Not later than one year	236	221
Later than one year and not later than five years	944	882
Later than five years	9,603	9,236
Total	10,783	10,339

Note 7. Finance revenue

	2022/23	2021/22
	£000	£000
Interest on bank accounts	894	35
Total	894	35

Interest received for 2022/23 relates to the increase in the interest rate to 4.25%. The interest rate for 2021/22 was 0.64% and interest was earned from December 2021.

Note 8. Finance expenditure

Note 8.1 Finance expenditure

	2022/23	2021/22
	£000	£000
Interest on lease obligations	97	0
Interest on Late Payment of Debt	4	0
Total interest expense	101	0

Note 8.2 The Late Payment of Commercial Debts (Interest) Act 1998

The total paid within 2022/23 for late payment of commercial debt was £4k (£0k in 2021/22).

Note 9. Other - Net Gain / (Losses)

	2022/23	2021/22
	£000	£000
Gains on disposal of property, plant and equipment	49	68
Net Losses on disposal of property, plant and equipment	(68)	0
Loss recognised on return of donated COVID assets to DHSC	0	(149)
Total losses on disposal of assets	(19)	(81)

Note 10. Impairment of assets

	2022/23		
	Net Impairments £000	Impairments £000	Reversal of Impairments £000
Impairments and (reversals) charged to operating surplus / (deficit):			
Abandonment of assets in the course of construction	0	0	0
Total DEL	<u>0</u>	<u>0</u>	<u>0</u>
Change in market price	(648)	2,023	(2,671)
Total AME	<u>(648)</u>	<u>2,023</u>	<u>(2,671)</u>
Impairments charged to operating expenses	(648)	2,023	(2,671)
Impairments charged to the revaluation reserve	2,734	2,810	(76)
Total impairments due to change in market price	<u><u>2,086</u></u>	<u><u>4,833</u></u>	<u><u>(2,747)</u></u>
	2021/22		
	Net Impairments £000	Impairments £000	Reversal of Impairments £000
Impairments and (reversals) charged to operating surplus / (deficit):			
Abandonment of assets in the course of construction	1,252	1,252	0
Total DEL	<u>1,252</u>	<u>1,252</u>	<u>0</u>
Change in market price	1,242	1,621	(379)
Total AME	<u>1,242</u>	<u>1,621</u>	<u>(379)</u>
Impairments charged to operating expenses	2,494	2,873	(379)
Impairments charged to the revaluation reserve	(3,968)	1,176	(5,144)
Total impairments due to change in market price	<u><u>(1,474)</u></u>	<u><u>4,049</u></u>	<u><u>(5,523)</u></u>

A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years. Any increase in valuation which reverses a previous impairment has been credited to other operating income, to the extent of what has been charged there already relating to the asset. Any remaining balance has been credited to the revaluation reserve.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared that the valuation is not reported as being subject to 'material valuation uncertainty'. This is due to property markets functioning again despite COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

Note 11. Intangible assets

	Software licences £000
Cost as at 1 April 2022	7,743
Additions - purchased	495
Reclassifications	(659)
Disposals	(888)
Cost as at 31 March 2023	<u>6,691</u>
Accumulated amortisation as at 1 April 2022	4,545
Provided during the year	1,235
Reclassifications	(671)
Disposals	(888)
Accumulated amortisation as at 31 March 2023	<u>4,221</u>
Cost as at 1 April 2021	7,757
Additions - purchased	1,423
Impairments	
Reclassifications	198
Disposals	(1,635)
Cost as at 31 March 2022	<u>7,743</u>
Accumulated amortisation as at 1 April 2021	4,937
Provided during the year	1,045
Reclassifications	198
Disposals	(1,635)
Accumulated amortisation as at 31 March 2022	<u>4,545</u>
Net book value as at 31 March 2023	2,470
Net book value as at 31 March 2022	3,198

All intangible assets are owned assets.

	Minimum Life Years	Maximum Life Years
Software licences	2	15

Note 12. Property, plant and equipment

	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
Note 12.1 Property, plant and equipment 2022/23	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2022	179,170	18,375	110,054	1,022	6,014	31,313	101	11,228	1,063
Additions - purchased	24,492		5,585		14,945	2,125		1,593	244
Additions - assets purchased from cash donations	507				148	9			350
Impairments charged to operating expenses	0								
Impairments charged to revaluation reserve	(2,810)	(875)	(1,935)						
Reversal of impairments credited to operating expenses	0								
Reversal of impairments credited to the revaluation reserve	76		48	28					
Revaluations	2,254		2,313	(59)					
Reclassifications	659		5,009		(5,745)	265		666	464
Disposals	(4,861)					(2,535)		(2,279)	(47)
Cost or valuation as at 31 March 2023	199,487	17,500	121,074	991	15,362	31,177	101	11,208	2,074
Accumulated depreciation as at 1 April 2022	20,883	0	0	0	0	13,937	92	6,013	841
Provided during the year	9,070		4,235	59		3,106	4	1,571	95
Impairments charged to operating expenses	2,023	0	2,023						
Impairments charged to the revaluation reserve	0								
Reversal of impairments credited to operating expenses	(2,671)		(2,671)						
Reversal of impairments credited to the revaluation reserve	0								
Revaluations	(3,646)		(3,587)	(59)					
Reclassifications	671							671	
Disposals	(4,792)					(2,466)		(2,279)	(47)
Accumulated depreciation as at 31 March 2023	21,538	0	0	0	0	14,577	96	5,976	889
Net book value as at 31 March 2023	177,949	17,500	121,074	991	15,362	16,600	5	5,232	1,185

Note 12. Property, plant and equipment

	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
Note 12.1 Property, plant and equipment 2021/22	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2021	172,692	17,500	102,821	1,061	4,617	29,471	101	16,086	1,035
Additions - purchased	17,572	0	6,479	0	5,859	3,396	0	1,802	36
Additions - donation of physical assets (non-cash)	54	0	42	0	0	12	0	0	0
Additions - equipment donated from DHSC for COVID response (non-cash)	100					100			
Impairments charged to operating expenses	(1,252)	0	0	0	(1,252)	0	0	0	0
Impairments charged to revaluation reserve	(1,176)	0	(1,176)	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	5,144	875	4,247	22	0	0	0	0	0
Revaluations	(5,630)	0	(5,569)	(61)	0	0	0	0	0
Reclassifications	(198)	0	3,210	0	(3,210)	0	0	(198)	0
Disposals	(7,987)	0	0	0	0	(1,517)	0	(6,462)	(8)
Derecognition - COVID equipment returned to DHSC	(149)					(149)			
Cost or valuation as at 31 March 2022	179,170	18,375	110,054	1,022	6,014	31,313	101	11,228	1,063
Accumulated depreciation as at 1 April 2021	24,074	0	0	0	0	12,156	87	11,088	743
Provided during the year	9,368		4,327	61		3,284	5	1,585	106
Impairments charged to operating expenses	1,621	0	1,621	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	(379)	0	(379)	0	0	0	0	0	0
Revaluations	(5,630)	0	(5,569)	(61)	0	0	0	0	0
Reclassifications	(198)	0	0	0	0	0	0	(198)	0
Disposals	(7,973)	0	0	0	0	(1,503)	0	(6,462)	(8)
Accumulated depreciation as at 31 March 2022	20,883	0	0	0	0	13,937	92	6,013	841
Net book value as at 31 March 2022	158,287	18,375	110,054	1,022	6,014	17,376	9	5,215	222

	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
Note 12.3 Property, plant and equipment financing	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value as at 31 March 2023									
Owned	174,016	17,500	118,920	991	15,152	15,039	5	5,232	1,177
Donated / Granted	3,502	0	2,154	0	210	1,130	0	0	8
Donated equipment from DHSC and NHSE for COVID response	431					431		0	
Total net book value as at 31 March 2023	177,949	17,500	121,074	991	15,362	16,600	5	5,232	1,185
Net book value as at 31 March 2022									
Owned	154,228	18,375	107,895	1,022	6,014	15,491	9	5,215	207
Donated / Granted	3,541	0	2,159	0	0	1,367	0	0	15
Donated equipment from DHSC and NHSE for COVID response	518	0	0	0	0	518	0	0	0
Total net book value as at 31 March 2022	158,287	18,375	110,054	1,022	6,014	17,376	9	5,215	222

Note 12.4. Lives of non-current assets

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and/or have short useful lives, these are carried at depreciated historical cost as a proxy for current value.

The following table discloses the range of lives of various assets.

	Minimum Life Years	Maximum Life Years
Buildings excluding dwellings	5	119
Dwellings	20	60
Plant and machinery	5	15
Transport and equipment	7	10
Information technology	5	23
Furniture and fittings	5	15

Note 13 Leases

This note details information about leases for which the Trust is a lessee.

From 1st April 2022 the Trust has applied IFRS 16 to account for lease arrangements without restatement of comparatives. From this date leases are accounted for as capital assets with a corresponding lease creditor within borrowings (note 20).

Note 13.1 Right of use assets

	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
IFRS 16 implementation - adjustments for existing operating leases / subleases on 1 April 2022	4,023	7,434	11,457	193
Additions	565	149	714	289
Remeasurements of the lease liability	194	997	1,191	(193)
Disposals / derecognition	(1)	(11)	(12)	
Valuation/gross cost at 31 March 2023	4,781	8,569	13,350	289
Provided during the year	1,098	1,539	2,637	37
Accumulated depreciation at 31 March 2023	1,098	1,539	2,637	37
Net book value at 31 March 2023	3,683	7,030	10,713	252
Net book value of right of use assets leased from other NHS providers				10,461
Net book value of right of use assets leased from other DHSC group bodies				252

Note 13.2 Revaluations of right of use assets

The Trust measure right of use assets using the cost model. Therefore annual revaluations are not carried out.

Note 13.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 20.1.

	2022/23
	£000
Carrying value at 31 March 2022	
IFRS 16 implementation - adjustments for existing operating leases	11,457
Transfers by absorption	
Lease additions	714
Lease liability remeasurements	1,191
Interest charge arising in year	97
Termination of lease	(12)
Lease payments (cash outflows)	(2,837)
Other changes	
Carrying value at 31 March 2023	<u>10,610</u>

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 4.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

The Trust does not sublease any of its right of use assets.

Note 13.4 Maturity analysis of future lease payments at 31 March 2023

	Total	Of which
	31 March	leased
	2023	from
	£000	DHSC
		group
		bodies:
		31 March
		2023
		£000
Undiscounted future lease payments payable in:		
- not later than one year;	2,283	63
- later than one year and not later than five years;	7,322	251
- later than five years.	1,353	0
Total gross future lease payments	<u>10,958</u>	<u>314</u>
Finance charges allocated to future periods	(348)	(25)
Net lease liabilities at 31 March 2023	<u>10,610</u>	<u>289</u>
Of which:		
- Current	2,283	63
- Non-Current	8,327	226

Note 13.5 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	2021/22
	£000
Operating lease expense	
Minimum lease payments	3,918
Total	3,918
	31 March
	2022
	£000
Future minimum lease payments due:	
- not later than one year;	3,179
- later than one year and not later than five years;	8,260
- later than five years.	4,037
Total	15,476
Future minimum sublease payments to be received	0

Note 13.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.9.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April
	2022
	£000
Operating lease commitments under IAS 17 at 31 March 2022	15,476
Impact of discounting at the incremental borrowing rate	(1,123)
IAS 17 operating lease commitment discounted at incremental borrowing rate	14,353
Less:	
Irrecoverable VAT previously included in IAS 17 commitment	(2,896)
Total lease liabilities under IFRS 16 as at 1 April 2022	11,457

Note 14. Inventories

Note 14.1 Inventory movements 2022/23

	Total	Drugs	Consumables	Consumables donated from DHSC group bodies
	£000	£000	£000	£000
Carrying value at 1 April 2022	4,218	1,806	2,412	0
Additions	42,052	20,131	21,295	626
Inventories consumed (recognised in expenses)	(42,125)	(20,243)	(21,256)	(626)
Total as at 31 March 2023	4,145	1,694	2,451	0

Note 14.1 Inventory movements 2021/22

	Total	Drugs	Consumables	Consumables donated from DHSC group bodies
	£000	£000	£000	£000
Carrying value at 1 April 2021	4,023	1,430	2,593	0
Additions	41,632	18,698	21,902	1,032
Inventories consumed (recognised in expenses)	(41,437)	(18,322)	(22,083)	(1,032)
Total as at 31 March 2022	4,218	1,806	2,412	0

Note 15. Trade and other receivables

	2022/23	2021/22
	£000	£000
Current		
Contract receivables (IFRS 15): invoiced	4,975	4,442
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	11,627	6,174
Allowance for impaired contract receivables / assets	(1,624)	(1,609)
Prepayments	1,819	1,850
PDC dividend receivable	213	545
VAT receivable	694	160
Clinical pension tax provision reimbursement funding from NHSE	14	0
Other receivables	1,084	972
Total current trade and other receivables	18,802	12,534
Non current		
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	785	957
Allowance for impaired contract receivables / assets	(202)	(275)
Clinician pension tax provision reimbursement funding from NHSE	553	547
Total non current trade and other receivables	1,136	1,229
Total trade and other receivables	19,938	13,763

Note 16.1 Allowances for credit losses - 2022/23

	All receivables £000
Allowances as at 1 April 2022 - brought forward	1,884
New allowances arising	(51)
Utilisation of allowances (write offs)	(7)
Allowances as at 31 March 2023	<u><u>1,826</u></u>

Note 16.2 Allowances for credit losses - 2021/22

	All receivables £000
Allowances as at 1 April 2021 - brought forward	1,725
New allowances arising	216
Utilisation of allowances (write offs)	(57)
Allowances as at 31 March 2022	<u><u>1,884</u></u>

Note 17. Cash and cash equivalents

	2022/23 £000	2021/22 £000
As at 1 April	44,656	47,937
Net change in year	(9,730)	(3,281)
As at 31 March	<u><u>34,926</u></u>	<u><u>44,656</u></u>

Breakdown of cash and cash equivalents

Cash at commercial banks and in hand	15	15
Cash with the Government Banking Service	34,911	44,641
Cash and cash equivalents as at 31 March	<u><u>34,926</u></u>	<u><u>44,656</u></u>

Third party assets held by the Trust

35	26
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As at 31 March 2023 the Trust held £35k (£26k as at 31 March 2022) within the Trust bank accounts which related to monies held by the Trust on behalf of patients and for the staff lottery. This has been excluded from the cash at bank and in hand figure above.

Note 18. Trade and other payables

	2022/23 £000	2021/22 £000
Current		
Trade payables	9,567	7,932
Trade payables capital	7,935	7,142
Accruals	19,078	12,913
Annual leave accrual	2,216	4,784
Social security costs	2,344	2,284
Other taxes payable	2,526	2,071
Pension contributions payable	2,612	2,528
Other payables	1,175	943
Total trade and other payables	<u><u>47,453</u></u>	<u><u>40,597</u></u>

Note 19. Other liabilities

	2022/23 £000	2021/22 £000
Current		
Deferred income	5,113	5,102
Total other liabilities	<u><u>5,113</u></u>	<u><u>5,102</u></u>

Note 20. Borrowings

	31 March 2023 £000	31 March 2022 £000
Current		
Lease liabilities*	2,283	0
Total current borrowings	2,283	0
Non-current		
Lease liabilities*	8,327	0
Total non-current borrowings	8,327	0
Total borrowings	10,610	0

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 13.

Note 20.1 Reconciliation of liabilities arising from financing activities - 2022/23

	Lease Liability £000
Carrying value at 1 April 2022	
Cash movements:	
Financing cash flows - payments and receipts of principal	(2,740)
Financing cash flows - payments of interest	(97)
Non-cash movements:	
Impact of implementing IFRS 16 on 1 April 2022	11,457
Additions	714
Lease liability remeasurements	1,191
Application of effective interest rate	97
Termination of lease	(12)
Carrying value at 31 March 2023	10,610

Note 21. Provisions

	2022/23				
	Total	Legal	Other	Clinical Pension Tax Reimbursement	Pensions
Movements in provisions for liabilities and charges	£000	£000	£000	£000	£000
As at 1 April 2022	2,924	117	1,004	547	1,256
Change in the discount rate	(174)	0	0	0	(174)
Arising during the year	1,085	115	822	20	128
Utilised during the year	(263)	(142)	(5)	0	(116)
Reversed unused	(632)	22	(599)	0	(55)
As at 31 March 2023	2,940	112	1,222	567	1,039
Expected timing of cash flows:					
Within one year	244	112	0	14	118
Between one and five years	1,989	0	1,222	38	729
After five years	707	0	0	515	192
Total	2,940	112	1,222	567	1,039
	2021/22				
	Total	Legal	Other	Clinical Pension Tax Reimbursement	Pensions
Movements in provisions for liabilities and charges	£000	£000	£000	£000	£000
As at 1 April 2021	2,865	91	820	640	1,314
Change in the discount rate	38	0	0	0	38
Arising during the year	1,120	163	899	0	58
Utilised during the year	(155)	(41)	0	0	(114)
Reversed unused	(944)	(96)	(715)	(93)	(40)
As at 31 March 2022	2,924	117	1,004	547	1,256
Expected timing of cash flows:					
Within one year	231	117	0	0	114
Between one and five years	1,982	0	1,004	505	473
After five years	711	0	0	42	669
Total	2,924	117	1,004	547	1,256

The pensions provision relates to early retirement costs in line with the NHS Business Service Authority - Pensions Division. Legal claims relates to third party legal claims advised by NHS Resolution. These claims are generally expected to be settled within one year but may exceptionally take two years to settle.

Clinical negligence and employer liabilities

£142m is included in the provisions of NHS Resolution as at 31 March 2023 in respect of clinical negligence and employer liabilities of the Trust (£162m as at 31 March 2022).

Note 22. Contingent liabilities

	31 March 2023	31 March 2022
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(29)	(54)
Gross value of contingent liabilities	(29)	(54)
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	(29)	(54)

Note 23. Financial instruments

Note 23.1 Financial risk management

Liquidity risk

The Trust's net operating costs are incurred under annual service level agreements / contracts with commissioners which are financed from resources voted annually by Parliament. The Trust receives such income for the activity delivered in that year in accordance with national and locally agreed tariffs. Monthly payments are received from Commissioners based on the annual contract values, this arrangement reduces liquidity risk.

The Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form.

Interest rate risk

All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest and the Trust is not therefore exposed to significant interest rate risk.

Credit risk

The main source of income for the Trust is from Clinical Commissioning Groups from April to June 2022 and Integrated Care Systems from July to March 2023 in respect of healthcare services provided under contract and Service Level Agreements. The credit risk associated with such customers is negligible.

The Trust has minimal exposure to credit risk as all cash balances are held within the Government Banking Services (GBS) account which generates additional cash through an applied interest rate. The Trust does not hold cash in any other investment institution on a short or long term basis.

Before entering into new contracts with non NHS customers, checks are made regarding creditworthiness. The Trust also regularly reviews debtor balances and has a comprehensive system in place for pursuing past due debt. Non NHS customers represent a small proportion of income and the Trust is not exposed to significant credit risk in this regard. There are no amounts held as collateral against these balances.

The movement in the allowances for credit losses for contract receivables / assets during the year is disclosed in Note 16. Of those assets which require an allowance for credit losses none are impaired financial assets (none in 2021/22).

There are no financial assets that would otherwise be past due date or impaired whose terms have been renegotiated (none in 2021/22).

Currency risk

The Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

All financial assets and liabilities are held in sterling and are shown at book value, which is not significantly different from fair value.

Note 23. Financial instruments (continued)

Note 23.2 Carrying values of financial assets

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total £000
Carrying values of financial assets as at 31 March 2023				
Receivables (excluding non financial assets) - with DHSC group bodies	11,628			11,628
Receivables (excluding non financial assets) - with other bodies	5,580			5,580
Cash and cash equivalents at bank and in hand	34,926			34,926
Total as at 31 March 2023	52,134	0	0	52,134

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total £000
Carrying values of financial assets as at 31 March 2022				
Receivables (excluding non financial assets) - with DHSC group bodies	7,235			7,235
Receivables (excluding non financial assets) - with other bodies	2,999			2,999
Cash and cash equivalents at bank and in hand	44,656			44,656
Total as at 31 March 2022	54,890	0	0	54,890

Note 22.3 Carrying value of financial liabilities

	Held at amortised cost £000	Held at fair value through the I&E £000	Total £000
Carrying values of financial liabilities as at 31 March 2023			
Obligations under leases	10,610	0	10,610
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	3,132		3,132
Trade and other payables (excluding non financial liabilities) - with other bodies	37,308		37,308
Total as at 31 March 2023	51,050	0	51,050

	Held at amortised cost £000	Held at fair value through the I&E £000	Total £000
Carrying values of financial liabilities as at 31 March 2022			
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	1,832		1,832
Trade and other payables (excluding non financial liabilities) - with other bodies	32,604		32,604
IAS 37 provisions which are financial liabilities			0
Total as at 31 March 2022	34,436	0	34,436

Note 22.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 23. Financial instruments (continued)

Note 23.5 Maturity of financial liabilities

	31 March 2023 £000	31 March 2022 £000
Financial liabilities fall due in:		
One year or less	51,050	34,436
Total	51,050	34,436

Note 24. Contractual Capital Commitments

The Trust has contractual capital commitments of £1.3m as at 31 March 2023 (£4.6m as at 31 March 2022). This includes, catering upgrade £0.3m, pharmacy robot £ 0.2m, other equipment of £0.7m and buildings works of £0.1m

Note 25. Related party disclosures

Note 25.1 Related party transactions

	Revenue £000	Expenditure £000
Value of transactions with other related parties in 2022/23		
Value of transactions with other related parties: Charitable funds (where not consolidated)	0	0
Total value of transactions with related parties in 2022/23	0	0

	Revenue £000	Expenditure £000
Value of transactions with other related parties in 2021/22		
Value of transactions with other related parties: Charitable funds (where not consolidated)	19	0
Total value of transactions with related parties in 2021/22	19	0

Note 25.2 Related party balances

	Receivables £000	Payables £000
Value of balances with other related parties as at 31 March 2023		
Value of transactions with other related parties: Charitable funds (where not consolidated)	76	0
Total value of balances with other related parties as at 31 March 2023	76	0

	Receivables £000	Payables £000
Value of balances with other related parties as at 31 March 2022		
Value of transactions with other related parties: Charitable funds (where not consolidated)	279	0
Total value of balances with other related parties as at 31 March 2022	279	0

Note 25.3 Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they are part of the DHSC group of bodies such that the DHSC is the parent department, and they fall under the common control of HM Government and Parliament. The GAM interprets IAS 24 (Related Party Disclosures) such that no information needs to be given about transactions relating to DHSC group bodies.

In line with this, these related parties notes only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

Below is a list of the main entities within the public sector with which the Trust has had dealings with.

From 1 April to 30 June 2022:

NHS Warrington CCG
NHS Halton CCG
NHS Liverpool CCG
NHS England

From 1 July 2022:

Cheshire and Mersey ICS

Note 26. Events after the reporting period

There were no events after the reporting period that require disclosure.

Note 27. Losses and special payments

	2022/23	
	Number	£000
Losses		
Bad debts and claims abandoned	19	6
Stores losses and damage to property	24	187
Total losses	43	193
Special payments		
Ex-gratia payments	48	130
Total special payments	48	130
Total losses and special payments	91	323
Value of compensation payments received		27
	2021/22	
	Number	£000
Losses		
Cash losses	10	2
Fruitless payments		
Bad debts and claims abandoned	10	23
Stores losses and damage to property	26	131
Total losses	46	156
Special payments		
Ex-gratia payments	40	609
Total special payments	40	609
Total losses and special payments	86	765
Value of compensation payments received		12

There were no individual cases exceeding £0.3m in either 2022/23 or 2021/22



**Warrington and Halton
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