NHS

Warrington and Halton Hospitals
NHS Foundation Trust

Annual Report & Accounts

2010-11

Warrington and Halton Hospitals
NHS Foundation Trust

Annual Report & Accounts 2010-11

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

1. Chairman's introduction

Welcome to the 2010/2011 annual report for Warrington and Halton Hospitals NHS Foundation Trust.

This report is written at something of a turning point for the NHS. A new coalition Government is taking the NHS in a new direction. It is a direction that still has many twists and turns to take. However, it is clear that it means that the landscape will change for hospitals like ours.

We will have new commissioners in the form of GP consortia. There has already been some productive work with the newly emerging groups from across the patch. The old PCTs will also be disbanded. The first steps of these steps took place during the year.

There were some difficult times during the year as NHS Warrington took steps to address some of their significant financial challenges by stopping non-urgent referrals to our services. We disagreed with the reasoning behind this policy which came after several years where we have worked to increase access to services and reduce waiting times. This policy over the last four months of the year went against that. With pressure on the public sector finances nationally, we expect this approach to be the norm in the future.

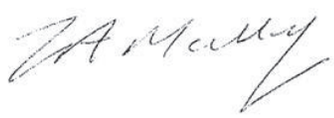
It was a year of internal change as well. After five years at the hospitals, chief executive Catherine Beardshaw left the trust to move to Aintree Hospitals. Director of nursing Kath Holbourn also retired during the year. I'd like to formally express my thanks to them for their key roles in helping the trust change so much over the last few years.

We have been able to secure two excellent new appointees to these roles. In November David Melia joined us from Salford Hospitals as director of nursing. Mel Pickup then joined us from the Walton Centre as chief executive in February. They have already started to make significant impact at the trust and bring a wealth of knowledge and new ideas to us.

As an NHS Foundation Trust my role as chairman spans the trust board and the Governors' Council. I firmly believe that as our experience grows as an NHS Foundation Trust our Governors are playing an important role. To help them to carry out this role it is important that the members communicate their views on what is important to them. This will enable the governors to have clear direction as to members' views when considering for instance, the trust's future strategies. Members are able to communicate through a number of ways; an example is by returning the surveys that appear in the members' magazine 'Your Hospitals'.

Despite all the change in the health sector at present, it is quite clear that quality and safety will be equal to financial management in the future. We redeveloped our vision this year with a clear and simple focus - high quality, safe healthcare. All of our staff, including our governors and our army of dedicated volunteers, have a role to play in delivering this vision. Over the last year we've made an impact. Our C-diff infection numbers dropped significantly once again, our governance arrangements around reporting of incidents has strengthened greatly

This annual report shows some of the work that is helping us to provide high quality, safe healthcare – it is an honest look at our successes and the challenges we have faced this year.



Allan Massey
Chairman

2. Background

Statutory information and history

Warrington and Halton Hospitals NHS Foundation Trust manages Warrington Hospital, Halton General Hospital and the Houghton Hall intermediate care facility in the North West of England.

The trust provides health care services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. It became an NHS Foundation Trust on 1 December 2008 and changed its name from North Cheshire Hospitals NHS Trust.

Board of Directors

During the period 1st April 2010 to March 31st 2011, the following were members of the trust's Board of Directors:

Name	Title	Notes
Allan Massey	Chairman	
Allan Mackie	Deputy Chair	
Rory Adam	Non Executive Director	
Clare Briegal	Non Executive Director	
Lynne Lobley	Non Executive Director	
Carol Withenshaw	Non Executive Director	
Catherine Beardshaw	Chief Executive	Left 31st January 2011
Mel Pickup	Chief Executive	Started 15th February 2011
Jonathan Stephens	Director of Finance and Deputy Chief Executive	
Kathryn Holbourn	Director of Nursing	Left 20th October 2010
David Melia	Director of Nursing	Started 22nd November 2010
Christopher Knights	Director of Strategy and Business Development	Non voting director
Gordon Ramsden	Medical Director	
Sheila Samuels	Director of Governance and Organisational Development	
Simon Wright	Chief Operating Officer	Non voting director

Gordon Ramsden retired from the trust on 11th May 2011. Phil Cantrell has taken over the role as interim medical director.

Principal activities of the trust

During the period 1st April 2010 to March 31st 2011, the trust's principle activity was the provision and delivery of health services as required to be provided in our Terms of Authorisation as an NHS Foundation Trust.

Our vision and objectives

Warrington and Halton Hospitals NHS Foundation Trust's vision is to provide High Quality, Safe Healthcare. To help deliver this vision there are four clear objectives:

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

Each objective has a range of measures underpinning them that help us measure our performance in achieving them.

Our sites and services

Warrington Hospital

Warrington Hospital is a major general hospital which is home to a wide range of NHS services. There are over 500 inpatient beds at the hospital. It focuses on emergency and urgent care and has all the back-up services required to treat patients with a range of complex medical and surgical conditions.

Warrington Hospital is home to the trust's accident and emergency department and maternity services. The hospital also provides specialist critical care, stroke, paediatric, cardiac and surgical units.

Services provided at Warrington Hospital include:
Accident and Emergency, surgical services, general medicine, children's services, intensive care, cardiac care, stroke care, cancer care, elderly care, obstetrics (maternity), gynaecology, orthopaedic, critical care, genito-urinary medicine and ophthalmology.

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

Halton General Hospital

Halton General Hospital in Runcorn provides a wide range of NHS services with a focus on planned specialist surgery. There are around 100 inpatient beds at the hospital. A range of care for medical and surgical conditions is provided from the hospital and it houses a mix of inpatient and outpatient services.

The hospital provides outpatient clinics in all trust specialties to ensure that people can access their initial appointment close to home. The hospital also has a minor injuries unit which provides a range of minor emergency care services for local people. An intermediate care 'step down' ward at the hospital is designed for patients who have had surgery or emergency medical care but who require some further support before going home.

Services provided at Halton General Hospital include:
General surgery, urology, minor injuries (not accident and emergency), endoscopy, intermediate rehabilitation, cancer care, renal dialysis, outpatient services and genito-urinary medicine.

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

Houghton Hall

Houghton Hall in Warrington was an intermediate care facility managed and run by the trust in partnership with the Community Services Unit of NHS Warrington and Warrington Borough Council Social Services. It provides 39 beds in total.

35 of the beds were used for 'step down' care for patients who had completed their acute care at Warrington Hospital following illness or surgery but who require high quality therapy and rehabilitation before going back home or to community care. Four beds were used for step up care – providing a facility for local GPs to send patients from the community who needed some support to help manage their condition and preventing them from needing a longer acute hospital stay.

Houghton Hall closed in March 2011 as part of a reconfiguration of intermediate care led by NHS Warrington.

3. Directors' report and business review

3.1 End of year position

As a Foundation Trust it is increasingly important that the organisation's finances are secure and that it develops robust long-term financial plans that are achievable and support future development.

During 2010-2011 the trust had an operating income of £198,893,000 and achieved a surplus of £965,000 which is 0.5% of turnover and reflects the savings that the trust had to make in the financial year. In 2009-2010 a surplus of £4.01million was achieved.

Copies of the full accounts of the trust are available on the following websites:

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

3.2 Patient care report

Our Quality Report on page 22 provides full information on the care received by our patients over the course of the year. The Quality Report also includes information on our clinical and patient care performance including surveying, complaints handling and key quality improvements.

We have seen some significant achievements across the trust in the last year which are outlined in full in the Quality Report including:

- a reduction in the number of hospital acquired Clostridium difficile cases by 44%
- a reduction in the number of cardiac arrests of 23%
- a reduction of our HSMR (mortality rates) to 90.2 against the national standard of 100 (where a lower score is better)
- compliance with a range of improvement packages to maintain safety and clinical effectiveness
- patient feedback giving a high rating for being treated with dignity
- 97% of patients rating their care as "good" to "excellent"

A summary of activity undertaken over the year compared to prior year is provided in the table below.

Table: **Hospital activity (spells, attendances, other)**

	2009-2010 activity	2010-2011 activity	% change
Elective inpatients and Day Cases	35,418	**32,796**	-7.4
Emergency inpatients	44,022	**44,120**	+0.22
Outpatients (including ward attenders and outpatient procedures)	308,204	**298,509**	-3.15
Accident and Emergency	97,252	**100,269**	+ 3.10
Total	484,896	**480,694**	-0.87

Overall hospital activity dropped slightly over the year compared to the previous year. This was in part due to the postponement of non-urgent elective referrals by NHS Warrington (our lead Primary Care Trust).

In December 2010, NHS Warrington made a decision to ask GPs in Warrington to stop non-urgent referrals to hospital services and the increase in the range of surgical procedures which fell under the definition of procedures of limited clinical value. Outpatient referrals have since grown back to levels experienced prior to this action being taken.

There was a small rise in emergency inpatient activity and a significant rise in Accident and Emergency numbers over the year.

Some of the key developments and topics around patient care in the year included:

In focus - **Making improvements around overall infection control**

Reducing Clostridium difficile cases by 44 percent

The trust has made increasing progress in reducing the incidence of cases of the healthcare associated infection Clostridium difficile (C-diff). The trust had 65 cases in 2010-2011 which was a 44 percent reduction from the 114 cases in 2009-2010.

However, the trust did not meet its target of no more than four cases of hospital acquired Methicillin Resistant Staphylococcus aurelius (MRSA) bacteraemia. In total there were five hospital acquired bacteraemia over the year, an increase of one case compared to 2009-2010.
Whilst disappointing to see a rise of any nature, given the small number of overall cases over the course of the year, this remains in line with the expected number of cases of hospital acquired MRSA for a trust of this size.

In focus - **Improving surgical services**

Moving more routine surgery to Halton General Hospital

In November 2010 the trust moved more of its routine surgery from Warrington Hospital to Halton General Hospital. The aim of this move was to ensure our patients get the best possible surgical services as part of the commitment to making Halton General a surgical centre of excellence.

By moving more routine short stay procedures to Halton it has meant that operations are protected from the day to day emergency pressures at Warrington Hospital. A greater range of procedures are now carried out at Halton General for patients from across the areas that the hospitals serve.

Emergency surgery is still carried out at Warrington Hospital for the local population – as well as surgical cases where patients might need complex post operative care such as critical care or high dependency care because of the nature of their surgery or any underlying conditions they have. Children's surgery also remains at Warrington due to the Children's Ward being based there.

The changes have seen other elective surgery in specialities like general surgery, urology, ENT (ear, nose and throat), oral surgery and pain management being undertaken at Halton. This was one of a number of change programmes put in place in the trust during the year, designed to lead to more efficient working that would contribute to better patient flow in the hospitals and also to the trust's cost improvement plan.

In focus - **Improving our medical care services**

Stroke audit puts the trust as one of the best performers

The latest national audit of stroke care published by the Royal College of Physicians in August 2010 revealed that the stroke unit at Warrington Hospital is ranked as one of the top performers in the country.

The report placed Warrington and Halton Hospitals NHS Foundation Trust in the top quartile of hospitals and represents an improvement over recent years.

The audit - the Stroke Sentinel Audit 2010 - showed that 90% of patients with stroke received their care in a specialist acute stroke unit (up from 83% previously). The trust was also one of only 28% of hospitals that from April 2010 could arrange 24/7 access to clot-busting thrombolysis treatment. The trust was also one of only 44% of hospitals nationally that had a specialist early supported discharge team and one of only 55% of units nationally who could offer patients access to specialist community rehabilitation.

It highlighted the considerable investment and improvement in the quality of the care that the hospitals provide around stroke for the local population.

In focus - **Improving our emergency care services**

Developing the Urgent Care Centre

The trust took the decision to invest in developing a new Urgent Care Centre (UCC) for patients referred directly by GPs for surgical and medical assessment. The aim was to ensure that these patients can be directly referred to a fully equipped centre at the hospital without the need to go to accident and emergency for their assessment.

The UCC opened in October 2010 and comprises of two eight-bedded bays, cubicles for patient assessment and a full range of clinical facilities and patient services. The trust's thrombosis clinic is also now run from the Urgent Care Centre.

The UCC has a dedicated nursing team with full administrative and portering services support. On-call medical teams are based within the unit to provide immediate assessment and intervention to patients with the aim of avoiding unnecessary hospital admission and speeding up their assessment.

In focus - **Managing emergency demand on services**

Winter pressures and H1N1 Swine Flu

The winter period and spell of cold weather through December 2010 and January 2011 led to a number of pressures for the hospitals. This was worsened by the return of the H1N1 swine flu virus which led to hospitals across the North West putting their critical care escalation plans in place in January 2011. Whilst the majority of routine surgery was cancelled across the region, the move of non-urgent elective work to Halton General meant that we were able to continue to provide a number of routine procedures which many other trusts were unable to do.

The day of December 9th 2010 fully tested our hospital emergency services when we had our busiest day on record in accident and emergency. Black ice caused several severe road traffic accidents on the motorway network around Warrington and the gridlock meant that Warrington Hospital became the focus for treating many of the serious injuries from the accidents as other local hospitals were not easily accessible. By lunchtime, 53 ambulances had already 'blue-lighted' patients to the department. On a normal day staff would expect that number of emergency ambulance arrivals in a 24 hour period.

The ice on pavements that day also meant a massive rise in the usual number of slips and falls leading to fractured bones. Between 9am and 10am alone 35 walk in patients arrived at the department, three times the usual number. In total around 114 cases involving limb injuries and slips and falls were treated at Warrington A&E and the Halton General minor injuries unit, with many resulting in fractures. With the usual emergency work on top, in total the A&E department treated 329 patients on the day, compared to a typical day when around 200-220 people use the service.

Whilst this was a day of unprecedented pressures, the hospitals were able to treat patients in a timely manner due to the professionalism of the emergency care staff and flexibility of the team to run extra fracture clinic services. Close working with the ambulance service and local GPs, alongside the extra capacity delivered by the development of the Urgent Care Centre and move of more elective surgery to Halton General Hospital, also helped the trust to rearrange services and manage patient flow on a record day.

3.3 Financial Summary

Warrington and Halton Hospitals NHS Foundation Trust was established on the 1 December 2008, and therefore the financial results reported for 1 April 2010 to the 31 March 2011 represent the second complete financial year.

Summary: **Actual Income and Expenditure results compared with plan**

Narrative	Planned £000	Actual £000	Variance £000
Operating Income	197,662	**198,893**	1,231
Operating Expenses	(193,053)	**(194,276)**	(1,223)
Finance Costs	(4,009)	**(3,652)**	(357)
Surplus	600	**965**	365

The additional surplus is as a result of additional operating income partially reduced by additional operating expenses and finance costs and the surplus generated will allow the trust to invest in clinical services and capital schemes. Based on these financial results the trust has assessed its Financial Risk Rating as 3 which is good performance and in accordance with the planned rating at the start of the financial year. A risk rating of 1 represents highest financial risk and a risk rating of 5 represents lowest financial risk.

Operating Income

The total operating income generated in the year was £198.9m with the majority of income received from Primary Care Trusts for health care services provided to patients.

An analysis of income is provided in the tables below.

Sources of Income	2009/10 £000	2010/11 £000
Primary Care Trusts	176,670	180,043
Education and Training	6,579	6,955
Other Clinical Income	1,865	2,158
Other Non Clinical Income	9,424	9,737
Total	**194,538**	**198,893**

Analysis by Primary Care Trust	2009/10 £000	2010/11 £000
Warrington PCT	101,925	106,243
Halton & St Helens PCT	58,656	62,277
Western Cheshire PCT	3,841	3,657
Ashton, Leigh & Wigan PCT	3,582	3,503
Central & Eastern Cheshire PCT	3,344	3,571
Other PCTs	5,322	792
Total	**176,670**	**180,043**

Operating Expenses

The total operating expenses incurred in the year were £194.2m with the majority of expenses incurred on salaries and wages.

An analysis of operating expenses is provided in the table below.

Operating Expenses	2009/10 £000	2010/11 £000
Salaries and Wages	135,609	139,359
Drugs	8,420	9,116
Clinical Supplies and Services	15,712	16,402
General Supplies and Services	2,911	2,859
Establishment Expenses	2,196	2,316
Depreciation	6,430	5,555
Premises	7,881	8,166
Clinical Negligence	3,512	4,258
Fixed Asset Impairment	126	166
Other	3,887	6,079
Total	**186,684**	**194,276**

The year on year increase in expenses reflects the

- cost increases associated with inflationary and incremental pay costs to staff
- inflationary increases necessary to deliver patient care
- increase in the VAT rate introduced on 1st January 2011
- the increase in the clinical negligence insurance premiums

Finance Costs

The total finance costs incurred in the year were £3.7m with the majority incurred on Public Dividend Capital payments.

An analysis of finance costs is provided in the table below.

Finance Costs	2009/10 £000	2010/11 £000
Public Dividend Capital payments	3,622	3,567
Finance Income (Interest receivable)	(24)	(57)
Finance Expenses (Interest payable)	246	142
Total	**3,844**	**3,652**

Capital Investment

During the year the trust completed £3.1m of capital investments which has significantly improved services for both patients and staff.

A summary of the capital investment undertaken in the year is provided in the following table although a number of schemes will only be completed in 2011-2012.

Capital Investment Scheme	Investment Benefits	Value £m
Site Repairs & Maintenance	General improvements to buildings, services and public areas.	0.9
Health and Safety Improvements	Improvements to buildings services and public areas resulting improved patient safety.	0.9
Service Developments	Improved facilities for patients.	0.7
Information technology	Hardware and software additions improving clinical and corporate data and services.	0.4
Purchases of medical equipment	Modern equipment resulting in improved services to patients.	0.2
Total		**3.1**

Prudential Borrowing Limit and compliance with the Prudential Borrowing Code

As an NHS Foundation Trust, Warrington and Halton Hospitals is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

a) The maximum cumulative amount of long term borrowing. This is set by reference to the four ratio tests set out in Monitor's prudential Borrowing Code. A copy of this code is available on the Monitor website www.monitor-nhsft.gov.uk

b) The amount of any working capital facility approved by Monitor.

The trust had a prudential borrowing limit of £31.9m and a working capital facility of £15.0m for the financial year. As at 31st March 2011, following principal and interest repayments during the year, the trust has a remaining principal balance of £2.3m on the capital loan. A further £0.9m is due for repayment in 2011/12.

The NHS Foundation Trust working capital facility of £15m has not been utilised during the year.

Performance against Monitor's Compliance Framework

As part of the ongoing regulation the trust carries out a self assessment against the financial risk rating metrics developed by Monitor. These metrics which are set out below assess the financial risks to the trust based on its historical financial performance.

There are five measurements which are weighted to provide a combined overall score of between 1 and 5 with a rating of 1 being the highest risk and 5 being the lowest risk. This self assessment is carried out monthly by the trust and reported and verified by Monitor on a quarterly basis.

The metrics based on the annual accounts are detailed in the table below and for the year the rating is 3 which is in accordance with the planned rating and indicates there are no regulatory concerns at this time.

Risk Rating Metrics as at 31st March 2011

Financial Criteria	Metric	Rating
Underlying Performance	EBITDA margin %	5.2%
Achievement of Plan	EBITDA % of plan achieved	93.1%
Financial Efficiency	Return on assets	4.0%
	I&E surplus margin	0.5%
Liquidity	Liquid Ratio (days)	24.8
Overall Rating		**3**

Related Party Transactions

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

Disclosure to Auditors

The Board of Directors would confirm that at the date of the approval of this report that

> *So far as the directors are aware there is no relevant audit information of which the auditors are unaware and further that each director has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.*

Going Concern

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

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

Appointment of Auditors

The existing auditor (Audit Commission) was approved as the auditor of the accounts for 2008/09 and 2009/10 at a meeting of the Governor's Council on 11 December 2008. The Governors' Council at a meeting on the 13 May 2010 also approved the extension by one year of the Audit Commission's contract to undertake the external audit for the 2010/11 financial year.

Private Patient Cap

The proportion of private patient income to the total patient related income is within the limit set out in the Terms of Authorisation.

3.4 Principal risks and uncertainties during the year

The trust continues to face risks to achieving its strategic objectives and developments and has established and maintained a comprehensive Assurance Framework and supporting Corporate Risk Register to identify, understand and manage risk. The Assurance Framework and Corporate Risk Register are subject to regular review and appraisal to ensure risks and reduction of risk are managed proactively.

The table below sets out a number of governance risks that the Board of Directors considers to be of particular significance. Systems and controls have been established to manage the risks, which are monitored by the Board on a regular basis.

Financial Criteria
Risk of failure to achieve agreed thresholds of all mandatory operational performance and clinical targets as defined in the Monitor Compliance Framework and Governance rating assessment
Risk of failure to comply with Care Quality Commission National core healthcare standards and maintain registration
Risk of failure to develop Robust business continuity and plans
Risk of failure to achieve the minimum requirements for NHSLA Standards within Maternity Services and wider Trust
Risk of failure to comply with Health & Safety Legislation
Risk of failure to comply with Terms of Authorisation
Risk of failure to engage and involve staff in the design and delivery of our services
Risk of failure to develop a Workforce Planning Strategy which supports delivery of core objectives
Risk of failure to implement an effective Equality & Diversity Strategy
Risk of failure to develop an effective and engaged Governors Council
Risk of failure to maintain good reputation with the public and service users, including partners and stakeholders
Risk of failure to develop an integrated Estates Strategy to meet service priorities and Trust patient environment quality standards
Risk of failure to develop a fit for purpose clinical and business information systems to support delivery of high quality patient care
Risk of failure to develop an effective Quality and safety strategy
Risk of failure to develop an effective and engaged public membership
Risk of failure to develop and maintain partnerships that support the Trust's business strategy
Risk of failure to achieve financial plan targets and maintain a minimum risk rating of 3
Risk of failure to secure designated vascular centre status

3.5 Future trends and factors likely to affect the trust

The Board of Directors has responsibility to implement robust assurance, governance and performance management arrangements to deliver its corporate objectives, which it does through a number of assurance and management committees and a rigorous and regular analysis of risk.

As part of the annual planning requirements the trust must develop a three year strategic plan (referred to as the annual plan) covering the period up to 2013-2014.

These medium-term plans contain a number of assumptions including levels of income and expenditure inflation and forecasts of the financial impact of changes in clinical activity on income and costs. This plan is reviewed periodically at board-level in the trust and revised, as required, to reflect updated information.

Looking ahead to 2011-2012, the trust is looking to build on the good results achieved during 2010-2011. This includes sustaining strong financial performance and investing in front line services to ensure the delivery of continued improvements both in clinical quality and patient and staff experience. In addition, the trust will further develop its working with the Governors' Council and continue to grow the public membership. In support of the objective, the trust is planning a £0.9m million surplus for the 2011-2012 financial year before restructuring costs.

The level of surplus planned for 2011-2012 recognises the reduced level of funding the trust will receive next year following reductions made to the national tariffs and the need to provide for increases in expenditure such as pay awards and price inflation for the goods and services we buy. The trust will not receive an inflationary increase in 2011-2012 to the income it receives for the provision of health care services and therefore these cost increases will need to be financed from internally generated savings.

Cost improvement plans and referral trends

In addition, the financial plans for 2011-2012 include revenue investments which recognise and address the main service pressures experienced delivering the growth in activity during 2010-2011. In total, the cost increases and income reductions for the coming financial year are forecast to be in the region of 6.5% in total, requiring the trust to deliver cost savings of circa £13m.

The trust has identified a range of potential cost savings and efficiencies that can be achieved by doing things differently across the hospitals. Whilst understanding that the most significant cost to the trust is salaries and wages, the trust is aiming to avoid having to make any forced cuts to staffing as part of these cost savings.

Initiatives in place include better use of staff rostering at the hospitals so we can reduce spend on agency staff, more productive use of our clinics and operating theatre slots and a wide range of general efficiency work across our departments. The trust has been planning in advance and has put a wide range of change programmes in place through 2010-2011 to help us prepare for the financial challenges ahead in 2011-2012.

In addition to the challenge of delivering cost savings, the trust also faces challenges over the coming year in relation to its contract position with its main commissioning body, NHS Warrington (the Primary Care Trust PCT) and the challenging financial position facing the local health economy.

Financial difficulties at NHS Warrington towards the end of 2010-2011 meant that the PCT needed to take action to reduce overall demand for health care services across all of its providers in order to contain the cost of services within the resources it receives. This led to the postponement of non-urgent referrals to our services.

In the interest of partnership working, the trust is working with NHS Warrington to deliver new models of care which will reduce the reliance on expensive hospital admission and redirect care to be undertaken more locally and economically in the community.

Capital investment programme

Despite the financial pressures on the organisation, the capital programme for 2011-2012 has been increased to £14million. This includes investment in a number of services that form part of the trust's annual plan and include the development of a musculoskeletal centre of excellence, investment in our vascular services and a range of essential works across the hospitals. £9m of this is planned to be supported by external borrowing.

Other major service changes

Significant service developments planned for 2011-2012 include the aforementioned development of a musculoskeletal centre of excellence at the trust which will improve our orthopaedic facilities and provide additional capacity to meet increasing demand for these services.

Investment is also being made in vascular services so that the trust is in a position to be named as a vascular centre as part of the North West review of vascular services which has been taking place at the end of 2010-2011 and into 2011-2012.

In line with the commissioning intentions of NHS Warrington, a focus is being carried out on providing more outpatient services in the community. This will involve partnership working with NHS Warrington, GPs and the newly formed commissioning consortia to explore other community based options for outpatient care.

The focus for the next 12 months is one of consolidation, but with significant investment in key strategic services that will benefit the long term development of the trust.

3.6 Regulatory Ratings

Care Quality Commission Ratings

Prior to achieving Foundation Trust status, the organisation in 2007-2008 was rated 'good' for quality of services and 'fair' for use of resource /financial performance in the annual healthcheck carried out by then Healthcare Commission. In the 2008-2009 ratings the trust was rated 'good' for both quality of service and 'excellent' for its use of resources / financial performance.

The trust declared compliance with all 44 health care standards. Standards for Better Health is a set of standards that the National Health Service in England must meet. The standards were set out by the Department of Health. NHS Trusts must declare their level of compliance with these standards annually as part of the Annual Health Check.

The Care Quality Commission has now published a set of standards which superseded those previously used in the Annual Health Check. The trust must demonstrate ongoing compliance with these as part of its registration requirements.

Care Quality Commission visits and action plans

The Care Quality Commission has not taken enforcement action against Warrington and Halton NHS Foundation Trust during 2010-2011.

Warrington and Halton NHS Foundation Trust has participated in a special inspection by the Care Quality Commission during April 2010 – March 2011. An unannounced response inspection was made in August 2010 following an incident within the Emergency Medical Unit (EMU) earlier in 2010.

Following the incident (which was reported via the Strategic Executive Information System (STEIS)) an action plan was developed to improve practice and services.

The action plan included issues to address:

- Safe standards of practice within EMU
- Provision of services for GP admissions to the trust
- Competencies required for nursing teams in the provision of care within an acute assessment setting

The action plan is now complete. The visit from the CQC did not result in any restrictions to the provision of services/ practices within the trust.

Monitor Ratings

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

Monitor requires each foundation trust board to submit an annual plan and quarterly and ad hoc reports. Performance is monitored against these plans to identify where potential and actual problems might arise. Monitor publishes quarterly and annual reports on these submissions and assigns each foundation trust with an annual and quarterly risk rating. These risk ratings are designed to indicate the risk of a failure to comply with the terms of authorisation. There are two ratings – a **Governance Rating** and a **Financial Risk Rating**.

The **Governance rating** describes the effectiveness of an NHS foundation trust's leadership. Monitor use performance measures such as whether foundation trusts are meeting national targets and standards, such as a reduction in MRSA rates, as an indication of this, together with a range of other governance measures. Monitor consider these areas when assessing the annual and quarterly governance risk ratings which they publish for each trust:

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

Financial risk ratings are allocated using a scorecard which compares key financial information across all foundation trusts. A rating of 5 reflects the lowest level of financial risk and a rating of 1 the greatest.

When assessing financial risk, Monitor assign quarterly and annual risk ratings using a system which looks at four criteria:

1. Achievement of plan;
2. Underlying performance;
3. Financial efficiency; and
4. Liquidity.

The risk rating is forward-looking and is intended to reflect the likelihood of an actual or potential financial breach of the foundation trust's terms of authorisation. Monitor also assigns a rating for **mandatory services**. Mandatory services are the services which each NHS Foundation Trust must provide as detailed in their terms of authorisation.

There are specific processes which must be followed if an NHS Foundation Trust wishes to request a change in these services or to dispose of assets required to provide these services.

Warrington and Halton Hospitals NHS Foundation Trust performance against Monitor risk ratings 2009-2010 and 2010-2011

	Trust Annual Plan 2009/2010 target	Quarter 1 2009/2010	Quarter 2 2009/2010	Quarter 3 2009/2010	Quarter 4 2009/2010
Financial Risk Rating	4	3	4	4	4
Governance Risk Rating	Green	Green	Green	Green	Green
Mandatory Services	Green	Green	Green	Green	Green

	Trust Annual Plan 2010/2011 target	Quarter 1 2010/2011	Quarter 2 2010/2011	Quarter 3 2010/2011	Quarter 4 2010/2011
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Green	Amber Green	Amber Green	Amber Green
Mandatory Services	Green	Green	Green	Green	Green

3.7 Our Staff

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

One of our corporate objectives is to be employer of choice for the healthcare services that we deliver. The trust prides itself on its ability to attract the highest calibre of staff and aims to provide an environment that encourages staff to continuously develop and update their skills. Staff can access a range of benefits, including access to onsite occupational health and counselling services and a range of training and education opportunities. The trust is proud that its efforts to be a good employer are recognised by the staff and a range of external bodies and is an Improving Working Lives Practice Plus employer.

Over the last year, the trust has paid particular attention to the Boorman Report – the national report on NHS staff health and wellbeing which was published in 2009 - and has developed an action plan to meet the recommendations of that report.

The trust works closely with trade union staff representatives and unions through its Joint Negotiating and Consultative Committee. The group meets every two months as a forum for consultation and negotiation on a range of issues which are of common interest to managers and employees. Full minutes of each meeting are available through either trade union representatives or the human resources department. The bi-monthly meetings are supplemented by further sub-committee meetings on specific topic items and ad-hoc meetings to discuss developments and areas of concern.

Staff in post at year end

	31st March 2010	31st March 2011
Total Staff in Post	4,102	4,117
Whole Time Equivalents	3,292	3,297

Sickness absence

	31st March 2010	31st March 2011
Cumulative figure	5.14 percent	5.35 percent

Thanking our staff

In January 2011 the trust held its third annual staff awards event – the Thank You Awards. Nominations were received from staff, patients and Foundation Trust members with over 100 nominations in total – more than treble the number of nominations from the first year of the event in 2009. Over 350 staff were able to attend the event and share best practice and celebrate their achievements.

In focus - **patient nominations amongst our award winners**

The trust's annual staff awards scheme – the Thank You awards - took place at the end of January. There were over 100 nominations this year for the awards which give patients and visitors the chance to nominate staff who have cared for them. Many of the nominations this year came from Foundation Trust members and several of the winners were staff nominated in this way. The winners included nurses, domestic staff and entire teams from across the hospitals. The patient nominated winners were:

Tony Connolly
Rheumatology Nurse Specialist
Excellence in Patient Care

Tony is a nurse specialist in rheumatology and was nominated by two of his patients at Halton hospital. Mr Scott said that Tony is 'everything you expect of a senior nurse and more. He listens to what you say, uses his great knowledge to remedy your problems and has a good sense of humor to keep you happy while he treats you.' These words were backed up by Mrs Redman who wanted to nominate Tony for being a sympathetic ear who 'listens to what you have to say no matter how insignificant it may seem.'

Sally Cooper
Ward Manager Urgent Care Centre
Excellence in Leadership

The new Urgent Care Centre at Warrington Hospital was developed at the end of 2010 and it provides an improved service and environment for a group of patients needing assessment and monitoring after being referred by their GPs. Sister Sally Cooper has shown outstanding leadership throughout the project, leading on the change initiatives and fully involving her team with the end result of an excellent new facility for local patients.

The Warrington Hospital Catering Team
Team of the Year

The catering staff provide over 1500 meals a day to our patients and are true unsung heroes of the trust. The team have made major improvements to the excellent service that they provide. This has included providing improved meals for patients from ethnic and faith backgrounds to ensure their specialist needs are met, providing soft meals and gluten free menu choices, improving the range of meals for our long term patients and gaining positive feedback from patients on other menu changes.

The other winners nominated by staff were:

Susan Lapersonne
Domestic Assistant
Excellence in Supporting Patient Care (Non Clinical) Award

Wendy Turner
Assistant Matron, Scheduled Care Division
Excellence in Respect, Dignity and Improving Quality of Working Lives Award

Andrea Critchley
Theatre Support Assistant
Excellence in Innovation and Improvement Award

Kate Warbrick
Divisional Manager, Unscheduled Care
Excellence in Partnership Working Award

Denise Ellis
Ward Manager, Ward A1
The Employee of the Year

Communications with our staff

Communication with staff is vital and is provided in the form of a quarterly newsletter 'Link Up' which provides detailed features and information on key developments. This is complemented by a weekly email bulletin called 'The Week' and a monthly team brief system, led by the Chief Executive, which works by cascading information to managers for dissemination across the hospital teams.

A review took place of internal communications in the trust in November 2010 led by the associate director communications. The results showed that whilst there was satisfaction with the main communications methods in place, some staff did not regularly access information as they could not get access to a computer regularly. This was particularly mentioned by nursing staff. One development in response to this was the publication of a new bulletin called 'Nursing Matters' which bought together all the information that nursing staff require and is created in hard copy for direct distribution to nursing staff on the wards.

The survey also gave information on topics that staff felt they needed to know more about. One of these topics was information from divisions other than those that a staff member works in. To address this, a divisional round up section was introduced to the team briefing.

Mandatory training

We are pleased to have improved the attendance at key mandatory training and the number of staff who are undertaking an annual appraisal. There is still room for improvement in these areas and we will major on this during the coming year.

	2009/10	2010/11
Mandatory Training		
Health & Safety	82%	88%
Fire Safety	55%	61%
Manual Handling	80%	70%
Non medical staff appraisal	67%	83%

The NHS Staff Survey 2010

The NHS Staff Survey is an annual survey of NHS staff that allows NHS Trusts to look at a range of measures of staff satisfaction. The Care Quality Commission publish the report and there are 38 key areas/themes (hereafter labelled Key Findings) which indicate how the trust is performing in relation to the four staff pledges. Most key findings are reported as percentages but some questions operate on a points scale between one and five.

In the 2010 survey, the trust showed improvement in 14 of the 36 areas of the survey areas overall.

Three of these areas were classed as significant by the Care Quality Commission. These were the [low] percentage of staff working extra hours, quality of job design and staff recommendation of the trust as a place to work or receive treatment. In these first two areas the trust was performing at national average in 2009 but now is amongst the top 20 percent, indicating a significant improvement over the last 12 months.

Although the third of these areas sees the trust still ranked below the national average, it is hoped with continued improvement over the next 12 months, this may change by the results of the 2011 survey. The percentage of staff agreeing that their role makes a difference to patients has increased this year and this lifts the trust out of the bottom 20 percent in this area.

When compared against similar NHS organisations, the trust scored particularly well on the percentage of staff feeling valued by their work colleagues, support from immediate managers, and percentage of staff suffering work-related stress in the last 12 months. The low percentage of staff feeling pressure to attend work when feeling ill was also favourable by comparison.

Other areas amongst the top 20 percent of NHS Acute Trusts included the percentage of staff stating hand wash facilities were always available, staff job satisfaction, and the percentage of staff appraised with personal development plans in the past year.

Whilst the percentage of staff returning the survey this year fell by 1%, the trust decided to extend the survey to all staff rather than a sample. This meant that although only 43% returned the survey (in comparison to 44% in 2009) there were 1,560 actual questionnaires returned, giving a far greater number of staff views than previously.

Responses to these 38 key findings have been compared with those of the other Acute Trusts. Of the 38 key findings the trust was in the top 20% for 15 areas, the middle 60% for 21 areas and the worst 20% for 2 areas.
Overall the trust compared favourably compared against similar trusts, however there are still areas where the trust recognises a need to continually improve the results and work will be targeted in order to achieve this over the coming 12 months. In order to address this, the trust has developed six key actions which will be taken forward and implemented during 2010.

These actions focus on enabling the trust to make improvements in those areas that it ranks in the bottom 20 percent of NHS Trusts. These areas are percentage of staff receiving health and safety training in last 12 months and percentage reporting errors, near misses or incidents witnessed in the last month. The former of these areas had already been recognised within the trust's own performance management systems and continue to be addressed. The trust's reporting of untoward incidents has also been reviewed and actions taken to encourage and improve reporting.

Improvement will be achieved through greater communication, simplified commitments regarding the actions we will take to address staff concerns and a programme of consultation with staff to gain a greater insight into their concerns.

Staff survey report overall response rates

	2009		2010		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Response rate	44%	55%	43%	54%	Decrease by 1%

Staff survey - Trust performance, top four ranking scores

	2009		2010		Trust Improvement /Deterioration in Year
Top 4 Ranking Scores	Trust	Comparison to other Trusts	Trust	National Average	
High percentage of staff feeling valued by their work colleagues	77%	Above average	82%	76%	Improvement of 5%
High support from immediate managers	3.77 (1 representing low support job and 5 high support)	Top 20%	3.76	3.61	Slight deterioration
Low percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	19%	Top 20%	21%	26%	Deterioration of 2%
Low percentage of staff suffering work-related stress in last 12 months	26%	Above average	24%	28%	Improvement of 2%

Staff survey - Trust performance, bottom four ranking scores

	2009		2010		Trust Improvement /Deterioration
Bottom 4 Ranking Scores	Trust	Comparison to other Trusts	Trust	National Average	
Percentage of staff who witnessed errors, near misses or incidents in the last month and reported them	98%	Top 20%	90%	95%	Deterioration of 8%
Percentage of staff receiving health and safety training in the last 12 months	78%	Average	72%	80%	Deterioration of 6%
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or members of the public in the last 12 months	N/A	N/A	16%	15%	N/A
Percentage of staff agreeing that their roles make a difference to patients	88%	Bottom 20%	89%	90%	Improvement of 1%

In view of the findings above, the trust's Strategic Workforce Committee will be giving consideration to a range of proposed actions to address hot spot areas and those areas which give indications on the impact of patient care and which may influence the Care Quality Commission assessment of the trust.

It is anticipated that these proposed actions may be used to inform the ongoing development of actions plans for sustained improvement.

3.8 Stakeholder relations

The trust cannot deliver its services in isolation, and is an active participant in quality and safety work undertaken across the health economy both with lead commissioners and neighbouring provider units. Through its Safeguarding work with both Adult and Children, strong relationships have been developed with other partner agencies such as the Police; Social Care; Youth Offending Services/ Probation and the Voluntary sector.

Over the year, the trust has unfortunately seen the attendance of its Partner Governors decrease at formal Governors' council meetings. This has been for a number of factors including the changes in Primary Care which has led to changing personnel and roles at the two NHS Primary Care Trusts in our area that are represented on the Governors' Council. This is something that the trust will seek to address in 2011-2012.

Work has also begun around developing new relationships with the newly emerging GP Consortia following the publication of the Health White Paper in 2010. Positive progress has been made in this area.

Our two local LINks organisations in Warrington and Halton provide external scrutiny by undertaking visits with formal reports which identify both areas of good practice as well as areas for improvement. Their involvement in larger pieces of work such as improving discharge and in membership of the Patient Experience and Patient Communication groups has been particularly valuable. The trust has worked closely with these groups and forged strong and open relationships.

The trust has close links with both Local Authorities Overview and Scrutiny Committees. Warrington has a system of Emissary members, whereby three members of the Health Overview and Scrutiny Committee have a specific liaison function with the trust and meet with the trust regularly to learn about key issues. This has been an excellent opportunity for the trust to work more closely with elected members, and gain feedback on services from their constituents' viewpoint.

We also enjoy a positive relationship with our local Members of Parliament all of whom have had meetings within the trust and spent time in the hospitals looking at our services in more detail over the last 12 months.

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

Stakeholder relations in action

A good example of our partnership work in action across the area we serve has been during the North West review of Vascular Services in early 2011. The review is looking at the future configuration of vascular services and reducing the number of vascular centres in the region. The trust wants to ensure that Warrington and Halton retains its status as a vascular centre in the future and is invested in for the benefit of local patients. As part of the consultation process around this work, and our ongoing positive relationship with our stakeholders, the trust was able to secure written support for its proposals from local MPs, both local authorities and the GP Consortia representatives. This was in addition to some 1,500 consultation responses from patients, Foundation Trust Members and staff.

3.9 Sustainability and climate change

One of the trust's four key objectives is to ensure that we provide sustainable healthcare services for the community that we serve. One aspect of sustainability is about enabling all people to satisfy their basic needs and enjoy a better quality life without compromising the quality of life for future generations.

The trust appreciates that, as the largest single organisation in the UK, the NHS is responsible for major consumption of resources emitting around 18 million tonnes of CO2 every year. It is therefore incumbent on all NHS organisations to lead, both by example and in practice, in making sustainability a strategic priority.

The 2010-2011 financial year has seen the trust continue to develop and introduce measures and initiatives that will enable the organisation to continue to make steady progress on the sustainability and carbon management agenda into the future. It saw the first full year benefit of our new natural gas/gas oil fired low pressure hot water (LPHW) boilers. Three of these boilers are now located within the Warrington Hospital boiler house, providing heating and hot water throughout large parts of the hospital.

The overall sustainability strategy of the Trust

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

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

The governance processes in place to support management and reporting of sustainability performance

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

Sustainability performance summary

The figures in the table below are based upon the trust's Carbon Footprint data for each year as determined under the trust's Carbon Management Plan using the Green House Gas Protocol methodology. Previously used forecasted figures (based upon on CRC emissions) have been superseded by figures this methodology (as per sustainability reporting guidance).

	2009-2010		2010-2011	
	Total usage	**Cost (£k)**	**Total usage**	**Cost (£k)**
Water	105,177 m3	348,400	105,770 m3	348,900
Electricity	6,688 tCO2	1,067,540	6,677 tCO2	977,270
Gas	5,428 tCO2	689,180	4,864 tCO2	678,790

Future priorities and targets around sustainability

The trust successfully completed the Phase 5 NHS Carbon Management Programme during the financial year 2010-11. The programme is operated by the Carbon Trust. The trust's Carbon Management Plan (CMP) developed under the programme contains the following Low Carbon Vision:

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

The Carbon Management Plan also sets the following ambitious carbon reduction target for the trust:

''Warrington and Halton Hospitals NHS Foundation Trust will reduce its measured (Level 2+) baseline carbon footprint emissions (2009/10) by a minimum of 30% by the end of March 2015."

The trust has identified, developed and is reviewing the potential implementation of a large number of carbon saving schemes in order to achieve the above target. The trust has developed and has started to implement a Sustainable Procurement Policy.

The trust's Sustainable Development Group actively uses the NHS Good Corporate Citizenship Assessment Test and is on plan to achieve the NHS Good Corporate Citizenship target scores set for 2012.

The trust is a full participant in the CRC – Energy Efficiency Scheme operated by the Environment Agency. Under the CRC Scheme arrangements the trust has a mandatory obligation to monitor and report all relevant carbon emissions to the Environment Agency on an annual basis.

The trust will also have a mandatory obligation to purchase sufficient annual Carbon Allowances to cover all relevant CRC Scheme carbon emissions each year.
The trust will also have a separate obligation to report annually across seventeen criteria areas included within the NHS Sustainability Reporting Framework.

3.10 Meeting the Foundation Trust Code of Governance

The Trust Board continues to seek to comply with the NHS Foundation Trust Code of Governance and has established processes to enable it to comply with the code provisions.

The Trust Board has reviewed compliance against all provisions within the NHS Foundation Trust Code of Governance.

There are two areas of the Code of Governance where the trust is declaring non or partial compliance:

- **In relation to Code Provision C.2.2** - The Trust Board declares partial-compliance.
  The Non executive Directors in post when the Trust achieved Foundation Trust status retained their terms and conditions and are subject to reappointment after four years. Non Executive Directors post achieving Foundation Trust are subject to reappointment after three years.

- **In relation to Code Provision E.2.2** - The Trust Board declares partial-compliance.
  The Remuneration Committee has general oversight of the Trust's pay policies but only determines the reward package for Directors and staff not covered by Agenda for Change. Senior Manager remuneration is covered by the NHS Agenda for Change pay structure.

We will continue to test and carefully monitor its compliance with all aspects of the Code of Governance.

The Annual Report, and the financial statements held in this report, were approved by the Board of Directors on 1st June 2011 and were signed on its behalf by:

Mel Pickup
Chief Executive
1st June 2011

4. **Our quality report**

Part 1: Statement on quality from Chief Executive

Warrington and Halton Hospitals NHS Foundation Trust is committed to provide high quality care and clinical excellence that puts patients at the centre of everything we do.

Our trust objectives, by which we deliver all of our services, are to:

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

In order to ensure that we meet these objectives, the trust has, over the past year, developed a set of quality metrics that enables us to demonstrate how we are performing and, most importantly, how we can strive to be the best. These metrics are part of a Quality Dashboard that is produced monthly and discussed across the different forums of the trust. Importantly, the transparency of this approach means that we can identify the impact any changes to practice have made to patients' safety, experience or the clinical effectiveness of the care we provide.

By ensuring that clinicians are at the forefront of developing these initiatives, we can maintain our commitment to develop services as well as ensuring accountability from the people who provide care. To this effect, the trust has continued to develop the process taken by the Leading Improvement in Patient Safety programme (LIPS) which was commenced in September 2009. LIPS has been the method in which they majority of patient safety improvements have been implemented.
Our participation with the North West Advancing Quality Programme has demonstrated our excellent performance in ensuring that patients get the right treatment at the right time.

During 2010, the Foundation Trust Governors established a Quality Committee of the Governors' Council. Led and chaired by a Governor, this group provides scrutiny to the whole process and is able to challenge the performance of the trust on its performance of the Quality Dashboard. This approach of a 'critical friend' has provided a valued additional tier of monitoring.

The trust has a robust performance management framework and engages in contract performance meetings with our commissioners.

The Board of Directors ensure that it too is provided with satisfactory evidence of the trust's performance. Quality is a standing item on the Board agenda – receiving the Quality Dashboards and other quality specific papers to embed the issues of safety, experience and quality at the heart of their discussions.

In order to ensure that colleagues can test the information that is being provided to them; Safety and Quality Walkabouts are scheduled into the monthly calendar. The Board are able to visit services first hand, talk to staff and patients to see that the information they receive is indeed, being practised and understood.

The senior nursing team perform a similar function in their Clinical Walkabouts that provide confidence that clinical standards are being maintained across the Trust.

2011/12 will see the introduction of Governor visits to our wards and departments, providing another perspective on the services we provide.

We have seen some significant achievements across the trust in the last year which are outlined in more detail in this report:

- a reduction in the number of hospital acquired Clostridium difficile cases by 44%
- a reduction in the number of cardiac arrests of 23%
- a reduction of our HSMR (mortality rates) to 90.2 against the national standard of 100 (where a lower score is better)
- compliance with a range of improvement packages to maintain safety and clinical effectiveness
- patient feedback giving a high rating for being treated with dignity
- 97% of patients rating their care as "good" to "excellent".

However, we know that we need to continue this improvement work and look at ways in which we can provide better care to patients (particularly in relation to falls and the development of pressure ulcers). The improvement of patient care will remain our top priority. As too will the further development of the structures and processes within the trust for ensuring effective monitoring.

In conclusion, this Quality Account will demonstrate that we have made positive strides in improving the care and services we deliver and that our determination remains strong to further that improvement.

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

Mel Pickup
Chief Executive
1st June 2011

Part 2: Priorities for improvement

The trust has developed a suite of performance markers within the Quality Dashboard to provide assurance of its progress in developing patient safety, patient quality and clinical effectiveness.

This Dashboard is reviewed and discussed at:

- The Quality Improvement Committee (a sub-committee of the Board, established in 2010-2011)
- Nursing and Midwifery Advisory Council (the trust's senior nursing committee)
- Governors' Council Quality Committee (established 2010-2011)
- Meetings of the Board of Directors.

In addition to the presentation of the Dashboard, the improvement initiatives are also discussed and presented at various trust committees to gain assurance on the processes taken and to ensure that the projects goals meet the overall trust objectives.

Our improvement priorities for 2011/12 will include:

- Achievement of the infection control standards set for the trust (no more that 4 MRSA blood stream infections and no more than 54 clostridium difficile cases to be acquired within the trust)
- A reduction in the number of falls within the trust which result in moderate to severe harm by 10%
- A reduction in hospital acquired pressure ulcers (grade 3 and 4) to no more than 29 within the year.

The approach for achieving these priorities will include:

- Developing Quality Improvement project teams to develop 'change packages' to address the specific issues
- Continued involvement with the Advancing Quality and LIPS programmes
- Develop measurements that are discussed with local teams in order to fully engage them with the projects
- Senior colleagues to 'adopt' a ward in order to demonstrate organisational commitment to achieving the targets
- Uphold a no compromise attitude to issues/practices which do not provide safe and effective care
- Receive more immediate feedback from patients regarding the care that they receive.

Targets for other safety, experience and effectiveness projects are contained within the main body of the Quality Account.

Statements of assurance from the Board

During 2010-2011 the Warrington and Halton Hospitals NHS Foundation Trust provided and/or sub-contracted seven NHS services as defined by the Care Quality Commission. These are:

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

The trust has reviewed all the data available to them on the quality of care in all seven of these NHS services. The income generated by these services makes up 100% of the total income generated from the provision of NHS services by the trust in 2010-2011.

Audit and Research

During 2010-2011 107 national clinical audits and four national confidential enquiries covered NHS services that the trust provides. The trust participated in 86% of national clinical audits and 75% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

National Audits

The national clinical audits and national confidential enquiries that Warrington and Halton NHS Foundation Trust was eligible to participate in during 2010-2011 are as follows:

- NDA: National Diabetes Audit
- ICNARC CMPD: Adult Critical Care
- ICNACNCAA: Cardiac Arrest
- National Elective Surgery PROMs: Four Operations
- National Vascular Database: Peripheral Vascular Surgery
- CEMACH: Perinatal Mortality
- NLCA: Lung Cancer
- MINAP (including ambulance care): Acute Myocardial Infarction (AMI) & other Acute Coronary Syndromes (ACS)
- Heart Failure Audit
- NHFD: Hip Fracture
- TARN: Severe Trauma
- National Childhood Epilepsy Audit (Epilepsy 12)
- National Audit of Heavy Menstrual Bleeding
- SINAP: Acute Stroke
- National Sentinal Stoke Audit
- National Audit of Dementia
- National Falls & Bone Health Audit
- National Clinical Audit of Management of Familiar Hypercholesterolemia
- National Comparative Audit of Blood Transfusion: O Negative Blood Use
- National Comparative Audit of Blood Transfusion: Platelets
- British Thoracic Society: Paediatric Asthma
- College of Emergency Medicine: Paediatric Fever
- College of Emergency Medicine: Vital Signs in Majors
- College of Emergency Medicine: Renal Colic
- National Inflammatory Bowel Disease: Ulcerative Colitis & Crohn's Disease
- SINAP: Acute Stroke

National Confidential Enquires

NCEPOD (National Confidential Enquiry into Patient Outcome and Death) aims to review medical clinical practice and to make recommendations to improve the quality of the delivery of care. This is done by undertaking confidential surveys covering many different aspects of medical care and making recommendations for clinicians and management to implement.

- Parenteral Nutrition
- Surgery in the Elderly
- Cardiac Arrest Procedures
- Peri-Operative Care

A full list of all audits and national confidential enquiries in which the trust participated during 2010-2011 is included in Appendix 1 of this report.

The national confidential enquiries that the trust participated in, and for which data collection was completed during 2010-2011, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- Parenteral Nutrition – 100%
- Surgery in the Elderly – 100%
- Cardiac Arrest Procedures – 100%
- Peri-Operative Care – 0% - did not complete data within the required time period.

The reports of national clinical audits were reviewed by the provider (trust) in 2010-2011 and the trust intends to take actions to improve the quality of healthcare provided. Appendix 1 of this report gives examples of actions taken of both national and local audits.

Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Warrington & Halton Hospitals NHS Foundation Trust in 2010-2011 who were recruited to participate in research approved by a Research Ethics Committee was 1,859. This includes National Institute for Health Research (NIHR) portfolio studies as well as non portfolio studies.

The White Paper *Equity and Excellence: Liberating the NHS* (DH July 2010) says: "Research is even more important when resources are under pressure - it identifies new ways of preventing, diagnosing and treating disease. It is essential if we are to increase the quality and productivity of the NHS, and to support growth in the economy."

Participation in clinical research demonstrates the trusts' commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are up to date with the latest treatment possibilities ensuring active participation in research to promote successful patient outcomes.

In 2010-2011 the trust was involved in conducting 90 clinical research studies (55% increase on 2009-2010) mainly in Cancer, Stroke, Paediatrics, Reproductive Health, Rheumatology, Critical Care, Cardiovascular, Diabetes, Musculoskeletal, Ophthalmology, Oral and Gastrointestinal.

The Research and Development department is working closely with the Cheshire & Merseyside Comprehensive Local Research Network, Topic Specific Networks and other health providers to increase NIHR clinical research activity and participation in research. Doubling the number of participants taking part in clinical trials and other well designed research studies over the next 3 years is a major priority for the trust. Measures will be put in place to assess actual total recruitment against targets. This will ensure that 80% of studies achieve 100% predicted recruitment at planned close of recruitment.

The trust has also adopted the Comprehensive Local Research Network (C&MCLRN) Research Management and Governance operational procedures and systems, including National Institute for Health Research Coordinated System for gaining NHS Permissions.

The trust will ensure that all NIHR portfolio research activities are conducted to the highest standards and undertaken within the framework of research governance, strict legislation and recognised good clinical practice.

Most of the research carried out is funded by the NIHR. For 2010-2011 the trust received £421,082. We fund eight research nurses to support principal Investigators with recruitment and assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

The Research & Development Strategy for 2010-2013 will set out a number of key objectives over the next three years for the delivery of high quality research.

Information on the use of the CQUIN framework

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

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

The locally agreed goals, which should be stretching and realistic, are discussed between co-ordinating commissioners and providers and included as part of contracts.

A proportion of trust income in 2010-2011 was conditional upon achieving quality improvement and innovation goals agreed between the trust and any person or body we entered into a contract, agreement or arrangement with for the provision of NHS services, through the CQUIN payment framework.

Further details of the agreed goals for 2010-2011 and for the following 12 month period are available online at the Monitor website - **www.monitornhsft.gov.uk**

Monetary total for the amount of income in 2010-2011, conditional upon achieving quality improvement and innovation goals, was £2,569,699, with a monetary total for the associated payment in 2010/11 of £2,545,969 received.

For purposes of clarity, a description of the national, regional and local CQUIN is illustrated on the following page with the identified targets and achievement status.

The Commissioning for Quality and Innovation (CQUIN)

		Targets	Achieved	
National	VTE	Baseline Reported	Baseline Reported 35.02%	
		90% Achieved in (Nov, Dec, Jan)	Nov = 94.41, Dec = 95.33 Jan = 96.16	Target fully achieved
	Patient Experience	70.9 (max) (09/10 performance 62.9%)	66.9	Trust improved performance by 4% from 62.9 % in 9/10.
Regional	AQ AMI	95% (cumulative)	99.43 cumulative to Dec 10	Latest position available is to December 2010. On target
	AQ Hip & Knee	93.25% (cumulative)	96.60 cumulative to Dec 10	Latest position available is to December 2010. On target
	AQ Heart Failure	76.42% (cumulative)	90.26 cumulative to Dec 10	Latest position available is to December 2010. On target
	AQ Pneumonia	85.11% (cumulative)	86.03 cumulative to Dec 10	Latest position available is to December 2010. On target
	AQ - PEMS	10%	21.8%	
		Pilot new system	Pilot implemented	Target fully achieved
	AQ - Stroke	Composite 90% Oct	89.34% cumulative to October to Dec 10	As at December the trust were marginally below target for the composite indicator but on target for the care bundle target
		Care Bundle 50% Oct	56.25%	
	TARN	Accreditation Clinical 97% Accreditation Demographics 97% Completeness 97%	Level 3 on target	Based on the December 2010 position the Trust are on target to achieve the Level 3 requirements
Local	CRAB	System/Baseline	Baseline reported	Achieved
		Trajectories	Trajectories reported	
	COPD	Complete TOR	Reported and agreed	Target requirements fully achieved
		Completion of Audit	Audit Complete and agreed	
	Medicine Management	1 Statins = 60% Q2, 3, 4	Fully achieved	Fully achieved
		2 Proton Pump Inhibitors =70% Q2, 3, 4	Fully achieved	Fully achieved
		3 ACE Inhibitors = 60% Q2, 3, 4	Fully achieved	Fully achieved
		4 Black Light = 0% Q1 - 4	Fully achieved	Fully achieved
		5 Clopidogrel = Q4 90% GP Notified	Fully achieved	Fully achieved
		6 Atorvastatin = Q4 90% GP Notified	Fully achieved	Fully achieved
		7 Anti TNF = 100% audited	Fully achieved	Fully achieved

Information relating to registration with the Care Quality Commission and periodic/ special reviews

Warrington and Halton NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered for the following regulated activity:

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

Warrington and Halton Hospitals NHS Foundation Trust have no conditions on its registration.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2010-2011.

The trust has participated in a special inspection by the Care Quality Commission during April 2010 – March 2011. An unannounced response inspection was made in August 2010 following an incident within the Emergency Medical Unit (EMU) earlier in 2010.

Following the incident (which was reported via the Strategic Executive Information System (STEIS)) an action plan was developed to improve practice and services.

The action plan included issues to address:

- Safe standards of practice within EMU
- Provision of services for patients admitted to hospital by their General Practitioner
- Competencies required for nursing teams in the provision of care within an acute assessment setting.

The action plan is now complete. The visit from the CQC did not result in any restrictions to the provision of services/ practices within the trust.

Information on the quality of data

Warrington and Halton NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS Number was: 99.73% for admitted patient care; 99.85% for outpatient care; and 98.89% for accident and emergency care.
- Which included the patient's valid General Practitioner Registration Code was: 99.57% for admitted patient care; 99.79% for outpatient care; and 99.09% for accident and emergency care.

Information Governance (against the Information Governance Toolkit level 2)

The trust's Information Governance Assessment Report overall score for 2010/11 was 40% and was graded: Not Satisfactory .

We will be taking the following actions to improve data quality:

- Setting up a new Information Governance and Corporate Record Sub-Committee (chaired by the Director of Organisational Development and Governance and attended by Executive Directors) where we address issues relating to:
  - o Data Quality
  - o SUS Dashboards
  - o Information Governance
  - o Data items
- Putting in place a plan of action to achieve compliance with level 2 of the Information Governance Toolkit during 2011/12.

The trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Part 3: Patient Safety, Clinical effectiveness & Patient Experience

In April 2010, the former Director of Nursing proposed that a 'dashboard' be presented to the trust board (and the wider committee groups) to provide assurance on:

- patient safety
- clinical effectiveness
- patient experience

It was proposed that this information should be collated from, whenever possible, sources which could be benchmarked with other organisations in order to indicate the trust's performance in relation to others. As such, Dr Foster and CRAB (Copeland Risk Adjusted Barometer) are used wherever relevant. Developments in practice have come from our participation with the LIPS programme.

Other sources of data collection come from in-house sources (audit, survey, incident reporting, complaints and observation).

The overall purpose of this information is to inform the organisation of its effectiveness and performance and to lead it in a direction of improvement by indicating specific issues/areas that need to be developed.

3.1 Patient safety

3.1.2 Infection Control

"We said that in 2010/11 we would have no more than 4 MRSA bloodstream infections and 116 cases of Clostridium difficile acquired within the hospital.

We had 5 cases of MRSA bloodstream infections and 65 cases of Clostridium difficile acquired within the hospital in the year.

Our plan for 2011/12 is to have no more than 4 cases MRSA bloodstream infections and 54 cases of Clostridium difficile acquired within the hospital"

Reducing healthcare associated infections remains a national priority for the NHS and for the trust in the delivery of its services.

Over the last twelve months the trust has maintained the low incidence of MRSA bloodstream infections and significantly reduced cases of Clostridium difficile. The following table provide an overview of these hospital acquired infections over the last three years.

Healthcare Associated Infections	Hospital Acquired Cases		
	2008/2009	2009/2010	2010/2011
MRSA bloodstream infection	8	4	5
Clostridium difficile	116	114	65

The targets set for reduction in 2010/11 were for the trust to have no more than four cases of MRSA bloodstream infections and so it was disappointing that there was one more hospital acquired case than had been anticipated.

MRSA screening remains in place for all elective (planned) and non-elective (emergency) patients and there is monitoring of the safe management of in-dwelling intravenous devices.

However, greater success is demonstrated in that the trust had 65 cases of Clostridium difficile in 2010/11 against a target of no more than 116. This is a considerable achievement and is testament to the seriousness that the trust places against infection prevention and control.

This success is a result in the strengthened practices the clinical staff employ whilst caring for patients; specifically in the prescription and monitoring of antibiotics (changes to the antibiotic formulary) and the introduction of new antibiotics with a lower reported association with Clostridium difficile.

The trust has antimicrobial ward rounds and has revitalised the 'Antimicrobial Steering Group' making it a much more effective forum.

Audit of appropriate antibiotic prescribing (84% compliance demonstrated) is carried out each quarter with the additional provision of additional audits of antibiotic prescribing where an increase in cases of Clostridium difficile have been identified.

Clostridium difficile training is provided to enable staff to identify and manage patients who develop symptoms to ensure they are isolated and tested immediately and prescribing training for junior doctors is also provided.

The trust is able to demonstrate compliance of good hand hygiene via weekly audits. Average monthly scores are reported to be between 94 – 98%.

The hospital environment has been reported as good by the PEAT (Patient Environment Action Teams) when inspections were carried out in February 2011. This team includes members of the local LINk organisations.

Infection Control Targets 2011-2012

The national MRSA and Clostridium difficile objectives have been set. The trust's targets for the next financial year are that we will have no more than:

- 4 cases of hospital acquired MRSA bacteraemia
- 54 cases of hospital acquired Clostridium difficile.

Future plans to control infection

The trust is committed to reducing infection risks. Additional activity is being undertaken to ensure the incidence of MRSA bloodstream infections remain low. This will include a re-launch of ANTT (aseptic non-touch technique). This is a nationally recognised approach for accessing intravenous devices to give fluid therapy and drugs.

In January 2011 the trust began reporting cases of meticillin-sensitive bloodstream infections. Hospital acquired cases will be investigated to identify how care improvements can be made.

The trust will continue the work on antibiotic prescribing. A target of 90% prescribing compliance has been set. A reformatted prescription chart is being introduced which will prompt medical staff to monitor the method of giving antibiotics and the length of time antibiotics are prescribed.

The trust will participate in the regional initiative to provide patients with an information card that they can use to inform medical personnel they have had a Clostridium difficile infection and that advice should be sought before prescribing antibiotics. In addition we are aiming to provide timely discharge information to GPs when healthcare associated infections have been identified.

3.1.3 Pressure Ulcers

"We said that in 2010/11 we would have no more than 35 grade 3 & 4 hospital acquired pressure ulcers.

We had 41 cases of grade 3 & 4 hospital acquired pressure ulcers.

Our plan for 2011/12 is to have no more than 29 grade 3 & 4 hospital acquired pressure ulcers"

Reducing the incidence of hospital acquired pressure ulcers (grade 3 and 4) was identified as an important challenge for the trust. During 2010/11, the organisation set itself a target of reduction of 10% of the previous year's total of 39.

Disappointingly, this was not achieved and at the end of March 2011, the trust reported that in the year 2010/11 there had been 38 grade 3 pressure ulcers and 3 grade 4 pressure ulcers acquired in the hospital.

This will remain a significant priority for the trust and is the focus of improvement activity. A package of measures to reduce the incidence of hospital acquired pressure ulcers to 29 (or less) has been introduced.

3.1.4 Venous Thromboprophylaxis (VTE)

"We said that in 2010/11 we would achieve a compliance rate of 90% or more for patients being assessed for VTE

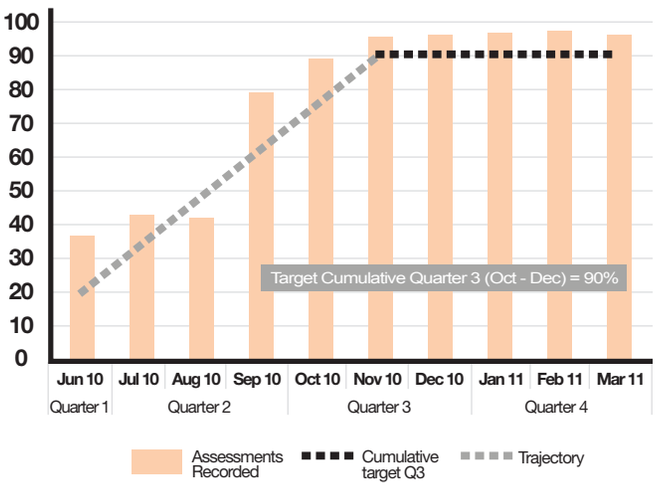
We achieved a compliance rate of 95.51%.

Our aim for 2011/12 is to continue to maintain the compliance rate of over 90%"

In 2010 we set out to improve the assessment, prescribing and administration of treatments to prevent patients from developing deep vein thrombosis. This serious issue was taken up as a national priority and incorporated it as part of the CQUIN targets. We were charged with a compliance target of 90% of patients being assessed by November 2010.

We are pleased to be able to report that we achieved that target and that the result for March 2011 was a compliance rating of 95.51%.

Venous Thromboprophylaxis (VTE)
% of patients being assessed



3.1.5 Falls

"We said that in 2010-2011 we would have no more than 50 incidents of a fall which caused moderate to severe harm.

We had 55 incidents of these falls within the year.

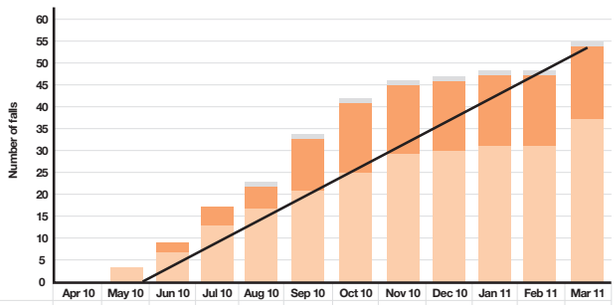
In 2011-2012 we will plan to achieve a target of having no more than 50 of these incidents"

In the period of 2010-2011, the trust set a trajectory to reduce the number of falls that caused moderate, major or severe harm to patients by 10% from the previous year's total number of 54 cases.

At the end of 2010-2011 the trust reported 55 cases of falls that caused this level of harm. The trust is disappointed that it did not achieve its target and has set about developing a series of measures to improve on this standard. The target to reduce this by 10% remains an objective for 2011-2012. This includes:

- A revised risk assessment process
- Increased training provision for staff in the care and management of patients who are identified as being at risk of falling
- A development of local quality improvement processes aimed at identifying a package of change to practice that will be rolled out across the whole of the trust.

Cumulative moderate, major and catastrophic falls 2010-2011



	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Catastrophic	0	0	0	0	1	1	1	1	1	1	1	1
Major	0	0	2	4	5	12	16	16	16	16	16	17
Moderate	0	3	7	13	17	21	25	29	30	31	31	37

Falls: Threshold is 55 total in the year

3.1.6 Clinical Effectiveness

Hospital Standardised Mortality Review (HSMR)

The HSMR scoring system works by taking a hospital's crude mortality rate (actual deaths) and adjusting it for a wide variety of factors such as population size, age profile, level of poverty, range of treatments and operations provided etc.

By taking these facts into account for each hospital, it is possible to calculate two scores – the mortality rate that which would be expected for NHS hospitals of a particular type and the observed rate for an individual hospital within that group. HSMR is an important indicator in alerting Trust's to potential issues that would adversely affect the quality of care provided.

Nationally the expected HSMR score for a trust such as Warrington and Halton NHS Foundation Trust is set at a score of 100. This figure does not represent deaths – it is just a baseline number used to compare performance. A number below 100 indicates that a hospital has less than the expected number of deaths.

This is a positive result for the trust and demonstrates that the improvement work implemented by our staff is having a positive effect on patient's outcomes.

	Warrington and Halton Hospitals NHS Foundation Trust HSMR score
February 2010	92.5
February 2011 (latest results)	90.2

Reducing harm to critically ill patients

"We said that in 2010-2011 we would have a compliance rate of at least 90% for bundles of care to prevent ventilator acquired pneumonia and urinary catheter infection

We achieved a compliance of 95% for ventilator acquired pneumonia prevention and 100% for urinary catheter infection prevention.

Our plan for 2011-2012 is to maintain this high level of compliance"

In last year's Quality Accounts we set out our intention to reduce harm to critically ill patients in relation to:

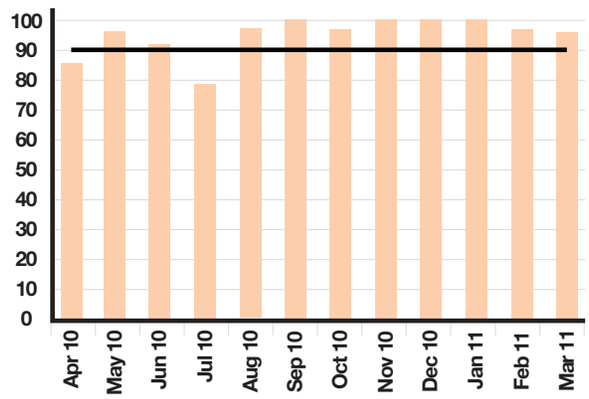
- Reducing ventilator acquired pneumonia (VAP)
- Reducing urinary associated catheter infections
- Reducing blood stream infections (as part of the 'Matching Michigan' study).

To achieve these goals, we introduced care bundles (packages of 'best practice'). Compliance against the implementation of these bundles is audited and we are able to demonstrate a reduction in the associated infections.

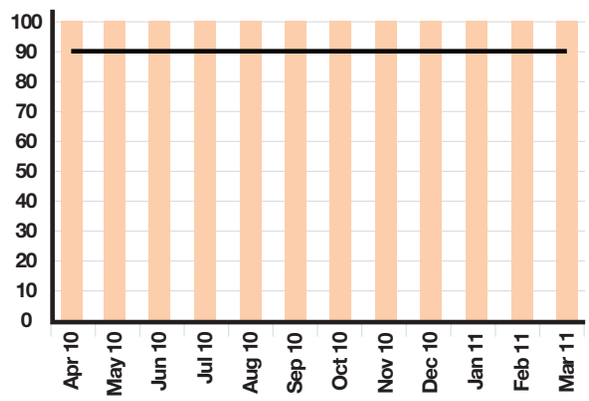
We set a trajectory of compliance of 90% for compliance against the implementation of care bundles for VAP and the insertion of urinary catheters.

Our successful achievement for these is demonstrated in the following graphs:

% of Ventilator or Bundles completed



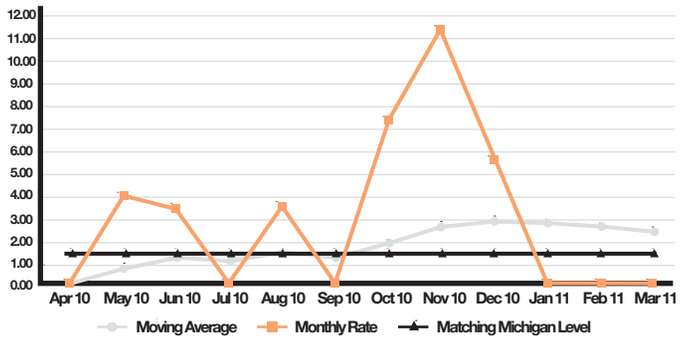
% of care bundles completed for urinary catheter insertion



——— = target

The graph below (courtesy of the Matching Michigan National Study) demonstrates our line infection rate per 1000 catheter days. This highlights a cluster of 8 infections over a 3 month period in October to December 2010 which significantly reduced our compliance with 'Matching Michigan'.

However, no further infections were reported in January 2011 – March 2011 which is beginning to affect our moving target positively.



Improving the care of the deteriorating patient

"Our aim for 2010-2011 was to reduce cardiac arrests by 5%

We achieved a reduction of 23%

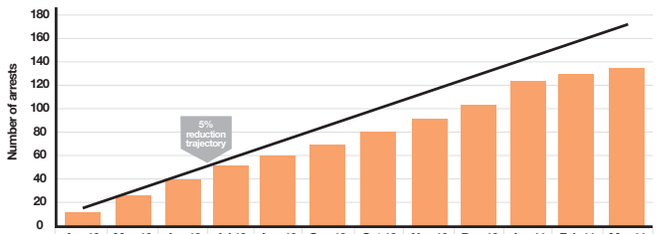
Our plan for 2011-2012 is to reduce this further by another 5%"

This aims to reduce the number of cardiac arrests of hospital patients other than those in the accident and emergency department, theatre department and the critical care areas.

In 2010-2011, we established our baseline for cardiac arrest and set a 5% reduction trajectory. As a result of the actions the trust has taken (improving the Modified Early Warning Score system and improved training of our staff) the trust has reduced the number of cardiac arrests by 23%.

The trust aims to build on this success and look at further ways of reducing cardiac arrests.

Total cardiac arrests (cumulative)



	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Arrests	11	25	40	51	60	69	80	91	106	122	127	136
Trajectory	14	28	42	56	70	84	98	112	126	140	154	168

Ensuring Safer Surgery

"Our aim for 2010-2011 was to achieve a 90% compliance in completing the 'safer surgery checklist'

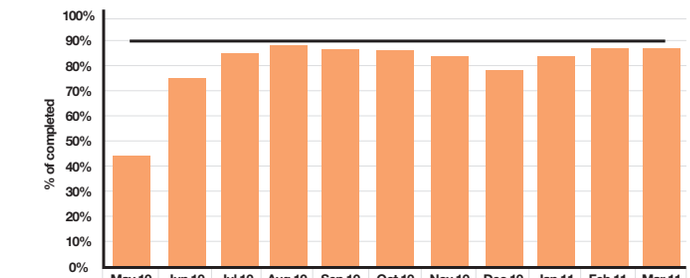
We achieved a compliance rate of 87%

Our plan for 2011-2012 is to achieve and maintain a compliance rate of 90%"

Last year's Quality Account stated the trust's intentions to adopt the principals of the 'Safer Surgery Checklist' (The goal of which is to improve the safety of surgical care around the world by ensuring adherence to proven standards of care. This is derived from a World Health Organisation initiative that has been shown to improve compliance with standards and decreased complications from surgery).

A baseline audit of compliance in May 2010 demonstrated a compliance of 43%. This has now increased to 87% at the end of March 2011, which is slightly below our target of 90%.

% of Safer Surgery Checklists completed



	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
% complete	43%	75%	85%	89%	86%	86%	82%	79%	82%	87%	87%

——— = target

The trust aims to achieve this target of 90% compliance in 2011/12 by providing further education to colleagues. There will then follow the important step change to ensure 100% compliance. This remains one of the trust's key objectives for the coming year.

Advancing Quality (AQ)

Advancing Quality aims to save lives and promote better quality patient care. It is based on a series of quality standards when treating patients for five common conditions/procedures (and a measure of patient experience):

- Acute myocardial infarction (heart attacks)
- Pneumonia
- Heart failure
- Hip and knee replacements
- Stroke

Pathway	Target	2009/10	2010/11
Acute myocardial infarction	95% (cumulative)	99.43 cumulative to Dec 2010	Latest position available is to December 2010. On target
Hip and knee replacements	93.25% (cumulative)	96.60% cumulative to Dec 2010	Latest position available is to December 2010. On target
Heart failure	76.42% (cumulative)	90.26% cumulative to Dec 2010	Latest position available is to December 2010. On target
Pneumonia	85.11% (cumulative)	86.03% cumulative to Dec 2010	Latest position available is to December 2010. On target
Stroke	Composite 90% Oct Care Bundle 50% Oct	89.34% cumulative to October to Dec 10. 56.25%	As at December the trust were marginally below target for the composite indicator but on target for the care bundle target
Patient Experience Measures (PEMS)	10% Pilot new system	21.8% Pilot implemented	Target fully achieved

NB – AQ data is produced some months after the end of each quarter and so information is only available for quarters 1 – 3 in 2010/11

3.2 Patient Experience

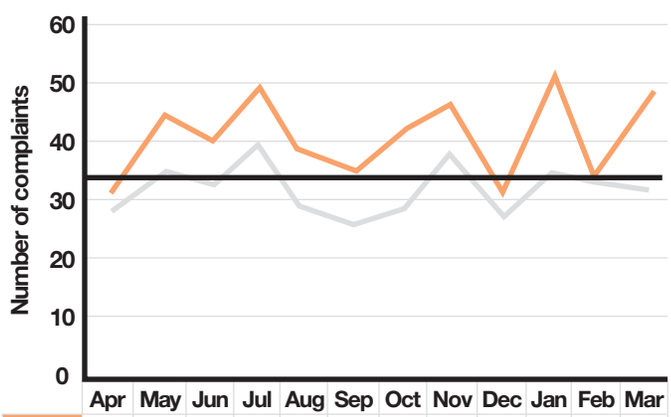
3.2.1 Complaints

The complaints process is an important source of data and feedback for the trust in its plan to improve the patient experience. The priority for the forthcoming year is to build on the progress made during 2010-2011. The patient relations team continues to provide support and guidance for Divisions when dealing with complaints and the patient relations manager attends regular meetings with key members of staff to discuss the handling of individual complaints.

All complaints are investigated in accordance with trust policy and wherever appropriate, action is taken to achieve service improvements.

In line with Care Quality Commission guidance we have encouraged more patients to make comments about their experience of services. This is an area in which we have improved our score as demonstrated in the National inpatient Survey around awareness of how to raise concerns. This has led to a rise in complaints this year which is part of a national trend in the NHS.

Complaints received



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	31	44	40	49	39	36	42	46	31	51	34	48
2009/10	28	34	32	39	29	26	28	38	27	33	33	32

Average no. of complaints received each month based on 2008/2009 and 2009/2010 data

	2009/2010	2010/2011
Total formal complaints received	379	491

Formal complaints - top five subjects 2010-11

	2010/2011
All aspects of clinical treatment	267
Appointments, delay/cancellation (outpatient)	59
Communication/information to patients (written and oral)	36
Patients property and expenses	20
Admissions, discharge and transfer arrangements	10

As a result of learning lessons about our services from feedback identified within complaints, the Trust has taken steps to ensure that patients have a much improved experience. Some of the actions taken have been the reinforcement of our current practice (for example, compliance with discharge planning pathways, infection control practice and the safe storage of patients' property) whilst other actions have required us to implement new approaches to how we provide care (for example, producing new patient information, providing additional training to our staff and changing some of the facilities/ ward environments).

3.2.2 PALS

The Patient Advice & Liaison Service (PALS) is an informal but valuable way of gaining patient feedback. PALS plays a significant and important role in the patient and public experience within the trust in dealing with concerns at the first level to help resolve issues before these escalate into formal complaints.

PALS contacts have increased in numbers in the past 2 years

	2009/2010	2010/2011
Total PALS contacts	920	1,253
Number of PALS contacts escalated to formal complaints	15	42

PALS contacts (by top five subjects 2010-11)

	2010/2011
Waiting times for an appointment	70
Support & advice	64
Communication problems with family	57
Waiting times for an operation	52
Staff attitude	48

3.2.3 Compliments

Although no figures for compliments received have been recorded in previous years it should be noted that from May 2010 (when compliment records began) to April 2011 the trust received 460 formal complaints, but received 2,125 compliments in the same period. These numbers do not reflect the many cards and letters sent direct to the wards and departments which are not forwarded for inclusion in the Divisional reports.

3.2.4 National Inpatient Survey 2010

The National Inpatient Survey 2010 has demonstrated that the improvement work the trust has implemented over the past year has had a significant effect on patient experience.

In the majority of issues that the survey addressed (admission to hospital, the ward patients stayed on, cleanliness, food, care and treatment provided, involvement in decisions, being treated with dignity and respect and discharge from hospital) the trust has made improvements in its scores.

This is a good result for the trust and it means that patients feel that they are receiving a much more improved experience at the time they spend under our care.

Overall, patients said that:

- They were treated with dignity and respect whilst in hospital (99% rated this as always or sometimes)
- They felt that the doctors and nurses worked well - excellently together (97%)
- They would rate the care they received as “good” to “excellent” (97%).

There are issues that we need to continue to improve upon and these will be the focus of our work over the next 12 months. These include:

- Responding to patients when they have used their call bell
- Improved ways of communication with patients about their care
- Reducing the delay in the process of discharge from hospital.

Evidence of achievement against these priorities will be demonstrated in the next National Patient Survey.

3.2.5 Training & Appraisal

	Target	Year End Results
Mandatory Training Health & Safety	85%	88%
Fire Safety	85%	61%
Manual Handling	85%	70%
Fire Safety - Over 100 additional refresher sessions have been agreed with the training department, and these are being organised.		
Staff Appraisal Non-medical	85%	83%
Medical & Dental Consultants	85%	59%
Medical & Dental (career grades)	85%	37%
Medical & Dental – consultants and career grades (excluding junior doctors)	85%	52%
Each division and professional group are now being performance monitored on a monthly basis to identify improvements they have made to compliance with training requirements. Divisions have been reminded of the need to make further progress and Clinical Leads will be giving this matter greater priority.		

An overview of performance in 2010/11 against the key national priorities from the Department of Health's Operating Framework

Level One - National Targets		Target	Weighting	Apr 10	May 10	Jun 10	QTR 1	Jul 10	Aug 10	Sep 10	QTR 2	Oct 10	Nov 10	Dec 10	QTR 3	Jan 11	Feb 11	Mar 11	QTR 4
Clostridium Difficile	Hospital Acquired (Target 116 per Year)	116	1	7	5	4	16	7	4	7	18	3	7	5	15	8	3	5	16
	Total (? Per Year)			8	8	7	23	9	7	9	25	5	10	7	22	10	5	7	22
MRSA Bacteraemia - (Hospital Acquired Target)		6	1	0	0	0	0	1	0	2	3	0	1	0	1	0	1	0	1
All Cancers: 31 - day wait for second or subsequent treatment	Surgery	94%	1	97.00%	100.00%	100.00%	99.00%	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	98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (From 01 Jan 2011)	94%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All Cancers: 62 - day wait for First treatment	From Urgent GP Referral To Treatment (Open Exeter Position)	85%	1	93.24%	76.67%	83.58%	85.07%	79.45%	83.87%	95.00%	86.18%	95.00%	81.00%	83.00%	85.29%	85.00%	86.96%	96.30%	89.57%
	From Consultant Screening Service Referral	90%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Level Two - Minimum Standards		Target	Weighting	Apr 10	May 10	Jun 10	QTR 1	Jul 10	Aug 10	Sep 10	QTR 2	Oct 10	Nov 10	Dec 10	QTR 3	Jan 11	Feb 11	Mar 11	QTR 4
All Cancers: 31-Day Wait From Diagnosis To First Treatment		96%	0.5	98.00%	97.00%	100.00%	97.00%	100.00%	92.90%	98.00%	97.00%	95.90%	100.00%	100.00%	98.40%	96.7%	100.00%	100.00%	98.37%
Cancer: Two Week Wait From Referral To Date First Seen	All Cancers	93%	0.5	98.00%	98.00%	96.00%	98.00%	97.40%	97.80%	96.00%	97.00%	95.70%	97.40%	94.80%	96.80%	98.64%	97.27%	96.80%	97.50%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	93%		97.00%	95.00%	97.0%	96.00%	95.07%	97.80%	96.0%	96.00%	97.50%	95.90%	93.90%	95.80%	96.69%	96.58%	97.40%	97.30%
Screening of all elective patients for MRSA		100%	0.5	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
% A&E and MIU throughput within 4 hours (hospital only)		95%	0.5	98.00%	98.55%	98.06%	98.21%	97.11%	96.77%	95.99%	96.63%	96.40%	95.98%	94.94%	95.77%	94.19%	95.05%	94.12%	94.42%
% A&E and MIU throughput within 4 hours (including 25% walk in with 308 added back in per week) = BASIS FOR COMPLIANCE ASSESSMENT		95%		98.55%	98.88%	98.48%	98.64%	97.89%	97.51%	96.91%	97.45%	97.39%	96.92%	96.22%	96.85%	95.50%	96.27%	95.43%	95.71%
% of patients thrombolysed within 60 minutes	Percentage	68%	0.5	100.00%	75.00%	From 1st June 2010 all eligible patients for Thrombolysis will be transferred to LHCH for Primary PCI and therefore these patients will not be thrombolysed and the collection of door and call to needle times will be obsolete. LHCH will be responsible for collecting data on call to balloon time with the target being 150minutes. If the patient self presents at Warrington Hospital is brought here by ambulance for further assessment or suffers an ST elevation MI as an in patient the times needed by LHCH will be documented on the transfer forms which are sent with the patient.													
	Number of patients eligible to be thrombolised			0	4														

All Acute and Mental Health Foundation Trusts	Target	Weighting	Apr 10	May 10	Jun 10	QTR 1	Jul 10	Aug 10	Sep 10	QTR 2	Oct 10	Nov 10	Dec 10	QTR 3	Jan 11	Feb 11	Mar 11	QTR 4	YTD
Self -Certification against compliance with requirements regarding access to healthcare for people with learning disability (Annual target)	N/A	0.5																	
Moderate CQC concerns regarding the safety of healthcare provision	N/A	1.0	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Major CQC concerns regarding the safety of healthcare provision	N/A	2.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) (or as subsequently amended with the CQC's agreement)	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	
Registration conditions imposed by Care Quality Commission	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	
Restrictive registration conditions imposed by Care Quality Commission	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	

Overall Governance Risk Rating Total Points 0 - 0.9 (Green, 1 - 1.9, Amber-Green, 2 - 2.9, Amber-Red, 3 or above Red)	0.0	0.0	0.0	0.0	0.0	0.5	1.0	1.0	1.5	2.0	2.0	1.0	1.0	1.0	1.0	1.0

Part 4: Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees

4.1 Statement from the Halton LINk:

"Members welcomed the trust's commitment to share the report widely and to seek the views of the Halton LINk and they appreciated the opportunity to be able to give feedback. Halton LINk is pleased to note the improvement shown in the quality of care within the report, especially with respect to infection control, mortality rates and some clinical outcomes. However, the statistics regarding falls and pressure ulcers are disappointing, although it is good to see that action plans have been put in place to address these issues. Additionally, the training and appraisal rates for staff, especially consultants are disappointing and it is hoped this will improve in the future.

"The Halton LINk would have liked to have had more detailed information about discharge processes and to have actual figures as well as percentages wherever possible. The lay-out and presentation of the information is clear and helpful for patients and the public and the Halton LINk appreciates the explanation for future plans for each section.

"Halton LINk members have been keen to have been involved with the trust throughout the year through groups such as the Patient Experience Group and the Patient Communication Group and the PEAT inspections. They are particularly pleased that a Halton LINk representative, as well as a Warrington LINk representative, is now sitting on the Governors' Council. It would be useful if there could be a mid-term consultation with the LINk regarding Quality Accounts and we would appreciate this next year."

4.2 Statement from the Halton Overview and Scrutiny Committee/Health Policy Performance Board:

"Positive improvements noted in the quality of care provided within the trust; this is evidenced within the document, in relation to MRSA, C Difficile rates and the overall HSMR. Although the target for the number of MRSA infections, pressure ulcers and falls were not achieved- the overall direction of improvement is evidenced.

"The report evidences a number of improvement action plans, which are being implemented- with a proactive approach to addressing issues raised. The National patient survey demonstrated excellent outcomes, however areas for improvement have been identified and plans in place to improve further. Partnership working with the trust and local authorities is good, and demonstrating improved outcomes for patients and carers- in particular on hospital discharges, intermediate care and the dignity agenda-this could be reflected in the report.

"It is good to see further improvements in quality of patient care recognised as a priority within the trust; including a reduction in the number of falls and pressure ulcers."

4.3 Statement from Warrington LINk

"The LINk agrees with the main priorities set out in the Quality Accounts, but would like to see more work and improvements in working with Vulnerable Adults. The LINk would encourage the trust to continue its work round the assessment and monitoring of Vulnerable Adults, including feeding and nutrition.

"Warrington and Halton Hospitals NHS Foundation Trust has an effective open working relationship with the Warrington LINk. A LINk member is a Governor of the Trust representing the LINk. LINk members sit on the following groups:

- Patient Experience Group
- Blood Transfusion Committee
- Patient Communications Group
- PEAT Inspection
- Governors' Committees
- Staff and Patient Care Committee
- Governor Council Meetings
- Governors Only Meetings

"LINk members also attend other meetings as and when required, such as Quality Accounts and training. The LINk manager and the LINk 'health champion' for Acute Care are invited to attend bi monthly meetings with staff and Halton LINk to discuss LINk work, comments that have been received and best practice.

"The LINk has an effective working relationship with many staff within the Trust. Any comments that are received regarding the Trust are sent monthly and a full response is always provided by the Trust, in a timely fashion.

"Over the past year the LINk have conducted visits to B14, EMU wards, A6 and the new short stay/ discharge lounge at Warrington Hospital. The visits are always arranged effectively with the quality matron and all staff have been helpful. Recommendations from the visits are always responded to. The two main outcomes this year have been the successful Business Cases for 24 hour Thrombolysis and the improvements of the bathing facilities on B14, both of which the LINk highlighted and recommended. The LINk has also been involved in the PEAT visits, with a member attending the visits at both Warrington and Halton Hospital and through these have highlighted the need for improvements in bathing facilities in both Daresbury Wing and the Children's Ward.

"Through comments and issues raised with the LINk, a piece of work regarding the Psychiatric Liaison Services (PLS) in Warrington A&E was undertaken. This work is ongoing, below are the recommendations from the report. The Trust is working with LINk to improve the service. There is a commitment by the Trust to secure funding and to improve the service.

"The funding for the service needs to be secured as soon as possible, with the possibility of joint funding

- Mental Health training to be given to all A&E staff, including reception staff. Contact details for some basic Mental Health training, provided by NHS Warrington, has been passed to the Mental Health Liaison Nurse.
- More awareness of the service and especially awareness of the use of the on call Psychologist Consultant after midnight to all staff
- More information available at A&E i.e. coping with stress etc
- To ensure that appropriate, up to date information is given to all patients that are discharged
- Improved communication between Warrington and Halton Hospitals NHS Foundation Trust staff and the staff who work in the Mental Health Liaison Team
- If there is to be a relocation of the service , we would strongly recommend that consultation with staff and service users takes place
- If the service is not relocated, the appropriateness of the current assessment room should be considered, again with consultation with staff

"The Trust has now put an action plan in place, which addresses all the recommendations and continues to work with the LINk to improve the service. "

4.4 Statement from the trust's Governors' Council

Governors have reviewed carefully all sections of the draft Quality Accounts for 2010/2011 in their role as having responsibility for holding the Trust Board to account on behalf of the members, patients and the public. They commented to the Trust on the presentation and suggested ways in which the text may be made clearly understandable for patients and the public. Overall governors consider the Trust's Quality Accounts to be helpful in explaining the Trust's achievements, improvements and its priorities for the future and they recommend reading it. Governors considered their comments related to four main questions.

Do the priorities reflect those of the local population?

We believe this to be the case as evidenced by the largely positive results of the inpatient survey. Governors note that the patient experience has improved, although it is acknowledged that there are still issues to be addressed, such as timely response to the call bell, better communication with patients and reducing delays in the discharge processes. Also the report that complaints and concerns are taken seriously with action plans arising from them is welcomed as are the many compliments received. It is good that the priorities are not only outlined

at the beginning, but also in every section. The governors noted that even though all the targets for infection control were not achieved, there has been much improvement in this area. However there was disappointment that falls are still a problem, as is the incidence of pressure ulcers. It was appreciated that these issues are a high priority for improvement, with which, governors believe, patients would concur.

Are there any important issues missed in the Quality Accounts?

Governors feel the accounts are comprehensive, but suggest that some further attention could be paid to the known aspirations of patients and the development of interaction with members, patients and the public.
Has the Trust demonstrated that it has involved patients and the public in the production of the Quality Accounts?
This has been done to some extent and is developing. Governors which include elected public and staff governors and appointed partner governors, through their Quality Committee, established in November 2010, have been involved in discussing quality information arising in monthly quality statistics for part of the year. LINk Governor representatives from both Halton and Warrington, who represent the public, have contributed to these discussions. LINk and patient representatives have sat on the Trust's Patient Experience and Communication Committees. Next year it is planned to develop this involvement by establishing a formal time table for regular consultation with the Governor's Quality Committee, who represent members, patients and the public.

Is the Quality Account clearly presented for patients and the public?

As stated above, Governors believe the format and section headings, where each topic shows what targets were set, to what extent they have been achieved and what plans there are for improvement is clear and understandable. The definition of acronyms is useful as is the arrangement of the appendices separated from the main text. It is hoped that patients and the public find this easy to read.

4.5 Statement from Warrington Health Consortium

"The overall content of the account was good however while the inpatient survey highlighted that the 'Patient Experience' has improved there are still a number of issues which appear unresolved,

- Poor communication between patients and staff appears to delay the patients discharge resulting in longer inappropriate stays in acute beds.
- Infection control targets not being met although there appear improvements in place to address these concerns.
- Falls – while there is a robust plan in place to monitor the numbers it appears that this is still an area where further work is necessary.
- Pressure Ulcers – the importance of ensuring patients skin integrity should be an essential component of the nursing process for all patients on admission.
- Poor response to call bells. This can be extremely distressing particularly for elderly and frail patients.

"A welcome aspect of the report is around the area of complaints and concerns which are clearly being taken seriously with a strong focus on the implementation of action plans to ensure that patient care and safety is improved upon quickly. However, a breakdown of the most common areas for complaint and the response of the trust to these areas would have enhanced the account.

"A further area which could have been included and in light of recent damming reports was a stronger focus on elderly care provision might have proved advantageous for assurance purposes.

"The inclusion of the low training and lack of staff appraisals was a further area of concern which raises the issue of 'safe' practice amongst the practitioners who are responsible for the delivery of patient care which the trust are ultimately responsible for.
"In conclusion while the report is concise there appeared a lack of attention to detail in the ensuring that the patient's needs are at the very centre of care delivery. While there have been improvements in reporting and the inclusion of elected public and staff as partner governors there doesn't appear to be a strong focus on improving the interface between the trust and the public."

John Wharton, Quality Lead
Warrington Health Consortium

4.6 Statement from Warrington Health and Well Being Overview and Scrutiny Committee

"The following comments are provided on behalf of Warrington Borough Council's Health and Well-Being Overview and Scrutiny Committee (OSC). Due to the nature of the request and the timescales involved, which unfortunately did not coincide with the Committee's scheduled meetings, it has not been possible to submit the Quality Accounts 2010-2011 to a formal meeting of the Health and Well-Being Overview and Scrutiny Committee. However, the draft Accounts have been considered by the newly elected Chair of the Committee for 2011-2012 and the previous Chair for 2010-2011.

"The Quality Accounts provide a useful précis of the Trust's objectives for the delivery of key services, its performance in relation to targets for 2010-2011 and

improvement priorities for 2011-2012. We note the on-going strengthening of performance management structures and development of robust procedures to test the quality of information gathered. It is pleasing to see the significant achievements highlighted in the report and an acknowledgement of where the Trust needs to do better, including the steps being taken to achieve those improvements. It is somewhat disappointing to see an increase in the number of complaints received by the Trust in 2010/11, but we feel that the Trust is well placed to learn from patients' feedback. The high number of formal compliments received is a real positive and the value of informal feedback through the sentiments expressed in cards and letters should not be underestimated.

"The Trust has worked constructively with the OSC during 2010-2011. It has provided information which has led to the development of recommendations about hospital discharges. It has also actively participated in a joint report drafted by Warrington LINk and the Warrington Mental Health Forum on the A&E Mental Health Liaison Service, which was subsequently endorsed by the OSC. The Committee has also received regular updates from Warrington LINk about site visits to facilities operated by the Trust, which demonstrates the Trust's willingness to engage with interested groups. In November 2010, the Committee noted the good relationship that had been established between the Trust and Warrington LINk. The Trust has also raised with the Committee the potential impact of a review of Vascular Services in Cheshire and Merseyside, which is being led by Knowsley PCT. The Committee will maintain a watching brief in relation to these developments and will consider carefully any views expressed by the Trust.

"The Committee will continue to develop its relationship with the Trust to ensure accountability to the public for the services provided to Warrington residents. We look forward to working closely with the Trust about key issues in 2011/12 and to monitoring progress on its identified improvement priorities."

Cllr Tony Higgins
Chair Health and Well-Being OSC (2011-2012)

Cllr Wendy Johnson
Chair Health and Well-Being OSC (2010-2011)

Part 5: Statement of Directors' responsibilities in respect of the quality report

The directors' are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-2011
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2010 to June 2011
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 03/06/2011
- Feedback from governors dated 03/06/2011
- Feedback from Halton LINk dated 03/06/2011
- Feedback from Warrington LINk dated 02/06/2011

- Feedback from Halton Overview and Scrutiny Committee/Health Policy Performance Board 02/06/2011
- Feedback from the Warrington Health and Well Being Overview and Scrutiny Committee dated 06/06/2011
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2011 (CLIPS Report);
- The [latest] national patient survey (2010)
- The [latest] national staff survey (2010)
- The Head of Internal Audit's annual opinion over the trust's control environment dated April 2011.
- CQC quality and risk profiles dated March 2011.

In preparing the Quality Account, directors' are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- The proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality account is robust and reliable, confirms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at: www.monitornhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Allan Massey
Chairman
1st June 2011

Mel Pickup
Chief Executive
1st June 2011

Part 6: Independent Assurance Report

to the Governors' Council of Warrington and Halton Hospitals NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Governors' Council of Warrington and Halton Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Warrington and Halton Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to May 2011;
- papers relating to Quality reported to the Board over the period April 2010 to May 2011;
- feedback from the Commissioners dated 6 June 2010;
- feedback from the Lead Governor dated 2 June 2011;
- feedback from LINKS dated 2 and 3 June 2011;
- the Trust's annual complaints report;
- the 2010 national patient survey;
- the 2010 national staff survey;
- the draft Head of Internal Audit's annual opinion over the trust's control environment March 2011; and
- Care Quality Commission quality and risk profiles dated September 2010, October 2010, November 2010, December 2010, February 2011 and March 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Governors' Council of Warrington and Halton Hospitals NHS Foundation Trust as a body, to assist the Governors' Council in reporting Warrington and Halton Hospitals' NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Governors' Council to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Governors' Council as a body and Warrington and Halton Hospitals NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents listed previously.

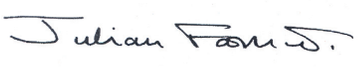
A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.



Julian Farmer FCA
Officer of the Audit Commission
3rd Floor Millennium House
60 Victoria Street
Liverpool
L1 6LD

23rd June 2011

Quality report appendix

a) Details of clinical audits and national confidential enquiries participated in by the trust 2010-2011

The national clinical audits and national confidential enquiries that the trust participated in during 2010-2011 are shown on the following page.

Topic	National
Advancing Quality Results	National
Fracture neck of femur - CEM	CEM Standards
Urinary Retention Audit - CEM	CEM Standards
Obstetric Haemorrhage	CEMACH
Obesity in pregnancy	College
Colposcopy	National
Acute GI Bleed in ACS Patients	National
Ambulatory Oxygen service	National
Inpatient Diabetes care audit in Acute Medical Ward	National
Lung cancer in patients under 50 NLCA	National
BSR guidelines for the commencement & follow up of Biological Therapy in Ankylosing spondylitis Nov 2009	National
Cataract Surgery and complications	National
Caesarean section wound audit 2009	National
AQ Results 2008 - 2009	National
Matching Michigan	National
Massive Blood Transfusion	National
Management of massive blood loss for 2009	National
Pneumothorax Audit	National
Compliance in 2 week referral for suspected head and neck cancer	National
Cutaneous Squamous cell Carcinoma reports - compliance with National minimum dataset	National
AQ Standards for Pneumonia	National
Surgical Check list	National
Audiology Audit	National
Diabetic Retinopathy	National
Vaginal delivery swab count	National
Cardiac Arrest Audit	National
Out of Hospital Cardiac Arrests presenting to the Emergency Department	National
Perioperative Management of Diabetes	National
National Heavy Menstrual Bleeding Audit	National
Peri-operative Normothermia	National
Glaucoma Surgery Audit	National
AQ Results 1st / 2nd Year	National
GP compliance of rapid Access Neck Lump Clinic	National
Chest pain management mapping the journey	National/Local
Audit of sedation practice A&E department	National/Local
Audit of Use of Beriplex / FFTP in Reversal of Anti-Coagulation with Warfarin	National/Local
Peri-operative Anaesthetic morbidity review	NCEPOD
Adherence to the recommendations of the 2004 NCEPOD report	NCEPOD
Anaesthetic & OPD staffing Audit	NHSLA/CNST
Consultant Obstetrician Staffing Audit	NHSLA/CNST
Documentation Audit x6	NHSLA/CNST
Health records	NHSLA/CNST
CNST	NHSLA/CNST
Doctor's handover	NHSLA/CNST
Thromboprophylaxis implementation of National VTE assessment form	NICE
Laparoscopic vs. open repairs of groin hernias	NICE
Bladder care in Obstetrics	NICE
Warrington Hospital use of Exanatide Management of Type 2 Diabetes vs. NICE Standards	NICE
Exanatide in management of type 2 diabetes vs. NICE standards	NICE
CPAP Audit 2007 – 2009	NICE

Topic	National
Foetal Blood sampling	NICE
Novasure Audit	NICE
Shoulder Dystocia	NICE
TVT The procedure	NICE
Rivaroxban for TVT prophylaxis	NICE
Severely ill pregnant women	NICE
NICE treatment of Ankylosing Spondylitis with Anti TNF	NICE
Treatment of Menorrhagia with TAH	NICE
Electronic Foetal Monitoring	NICE
NICE Ankylosing Spondylitis	NICE
NICE Guidance on Biologics in RA	NICE
Primip C Section	NICE
Head Injury Audit	NICE
Rheumatoid Arthritis Care & NICE Guidance	NICE
Outcomes of Forminal Epidural steroid Injections (FESI)	NICE
1st Metatarsal Osteotomy	NICE
Timing of antibiotic administration BTS Guidelines	National
Re-Admissions	Regional
Audit of use of Immunohistochemistry in Pleural biopsies	Royal College
Re-Audit of Quality of reporting and lymph mode yield in colorectal surgery	Royal College
Cytological Accuracy of Thyroid FNAs	Royal College
External Cephalic Version	Royal College
Vital Signs National Audit 2010 – 2011	CEM Standards
Quality Review	NHSLA/CNST
Nursing Majors / Minors Documentation	NHSLA/CNST
ENP Documentation Audit	NHSLA/CNST
Documentation Audits - Receptionist - Halton	NHSLA/CNST
Epididymo Orchitis	National
COPD	National
Safeguarding Audit	National
VBAC Audit	National
Tonsillectomy & adenoidectomy - do we make a difference	National
Thromboprophylaxis	National
GI Bleeds	National
TARN Audit	National
Perineal Trauma	National/Local
Cardiac Arrest	NCEPOD
Elective and Emergency Surgery	NCEPOD
Operative Vaginal Delivery	NHSLA/CNST
Neonatal Resuscitation	NHSLA/CNST
Maternal Screening	NHSLA/CNST
Use of Infliximab in IBD patients	NICE
Foetal blood Sampling	NICE
Temperature monitoring in Maternity	NICE
Middle Ear Effusion Audit	NICE
NICE Guidelines on Surgical Treatment of OME	NICE
Fever in Children Audit	NICE
Tonsillectomy - Re-Audit	National - re-audit
Current practice of duodenal biopsy	Royal College
Amniocentesis	Royal College
Renal Colic	Royal College
Telephoning Critically Abnormal Results	Royal College

b) Examples of actions taken following completion of national clinical audits 2010-2011

Examples of actions taken following completion of clinical audit:

Audit	Actions
Renal Colic	Renal Colic Pathway to be approved
	Complete full data collection for CEM Audit
	Present findings to surgical meeting
Caesarean Sections	Additional fields on Operative Summary
	Weekly reports taken from Meditech
	Discussed at monthly Incident Report Meetings
	Operative delivery summary to be completed by all doctors
	Alerts on Meditech
	Incident forms must be completed for both red and amber non-compliance
Vital Signs	Trust-wide letter regarding which EWS are being used
	Feedback results to all staff and complement those who have done well
	Carry out internal audit
	Re-audit
Upper GI Bleed	Introduce GI bleed pathway
	Liaise with IT to improve data capture
	Re-audit
AQ results	AMI - to continue
	Pneumonia - Record smoking advice - Record blood culture time - Give antibiotics stat - Refer to new antibiotic guidelines - Refer all eligible patients - Future electronic orders to incorporate time of venous blood sampling
	Heart failure - Review old Echo / request Echo - Refer all eligible patients - Local HF booklet (in approval process)
	PEMS - Limited start on A1/A2/A3/CCU/A7/A8/A9/ Daresbury - Agree responsibilities with nursing management

c) Examples of actions taken following completion of local clinical audits 2010-2011

The reports of local clinical audits were reviewed by the provider (trust) in 2010-2011 and Warrington and Halton Hospitals NHS Foundation Trust intends to take actions to improve the quality of healthcare provided (examples for illustrative purposes).

Children's Health Audit Recommendations	
Documentation	**Actions**
	All pages to be labelled with patient name and DOB/Unit number by whoever starts the page
	Doctors to have access and training on how to print patient labels from Meditech
	All signatures to be identified by printing name underneath
Eczema Annual report	**Actions**
	Improving knowledge of education staff in schools with children with eczema. To attend some schools that are having problems with children with eczema
	To continue to improve dermatology knowledge
	Continue to support The National Eczema Society, by being a volunteer. Supporting National Eczema week with display boards in COPD and the ward.
	To increase community staff awareness of eczema nurse led clinic.
	To be involved with and provide mentorship for new student nurses.
	To continue nurse led clinics
	The trust does not directly provide dermatology services but when it is a secondary condition we ensure that the correct care and treatment is prescribed.
Medical reports for children for whom there are safeguarding concerns	**Recommendations**
	Improve the content of our Medical reports
	Produce a template / checklist that is locally agreed
	Encourage discussion between trainees & consultants re
	Interpretation & opinion
	Reduce the time taken to issue the report, local target of 48 hours
	Compare our findings with audit of medical reports produced by Community colleagues
	Re-audit after changes implemented.

Emergency Medicine	
Sedation Practice	**Recommendations**
	Continue to use sedation log to facilitate audit (electronic)
	Continue to use pathway to improve documentation
	"Fast track" patients likely to need sedation
	Standardise post procedural observation
	Training in giving sedation: - Other procedures e.g. chest drain - Other agents e.g. propofol - Nursing expectations (simulation)

Surgery	
Quality of reporting & Lymph node yield in Colorectal Resection specimens	**Recommendations**
	Target - To achieve a 100% compliance in completing the dataset
	Use of the new dataset will help us target both the aims of completing a proforma and reporting the core data items
	If LN harvest <12 - individual pathologist to return to the specimen (where relevant) for more LN
	Re-audit in 1 year
	Present the data in a surgical audit meeting

ENT	
SLT voice caseload	**Actions**
	Adjust SLT leaflet (sent out with opt-in letter) to include voice deterioration with stress / anxiety
	Increasing requirement to obtain patient feedback
	Warrington will start to collect feedback Halton will update current feedback form used
	Consider adjusting opt-in process
	Telephone contact prior to d/c if patients do not opt-in
	Copy of d/c letter to patient
	ENT giving SLT leaflet with contact details at the point of referral
	ENT- ensure patients understand the specific reason for referral e.g. post surgery nodules (reason = prevention) MDT /stress (reason = improve voice use) reflux (reason = support lifestyle change/vocal hygiene)
	Clearer CNA / DNA protocols to be considered
	Taking into consideration most optimal timing of intervention

5. Foundation Trust Membership

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

Members play a key role the hospitals. Public and Staff Governors are elected from, and by, the membership so that the hospitals have ownership by the local community. This section gives more detail of our membership and work to involve our members and grow our membership this year.

Eligibility, constituencies and boundaries for membership

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

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

Halton

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

Warrington

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

Surrounding areas

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

Eligibility for membership is explained in detail on the Foundation Trust section of the Warrington and Halton Hospitals NHS Foundation Trust website and in the trust's Constitution. Membership is available to any individual aged 12 years and above who lives in the constituency areas above. The constitution states that there is a requirement for a minimum of 65 members in each of our constituencies which the trust has met since authorisation as an NHS Foundation Trust.

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

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

The **staff constituency** is divided into five classes:

- Medical
- Nursing and Midwifery
- Support
- Clinical Scientist or Allied Health Professional
- Estates, Administrative and Managerial.

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

Membership Size and Movements 1st April 2010 to 31st March 2011

Our total membership at 31st March 2011 was 13,700. This was in line with our predicted total membership of as revised in the trust's membership strategy which was developed in the year.

The membership size and movement in year and our predicted membership figures for 2011-2012 breaks down as follows:

Foundation Trust membership size and movement

Public constituency	Last year (2010/11)	Next year (estimated) (2011/12)
At year start (April 1)	8,426	9,621
New members	1,813	2,079
Members leaving	618	500
At year end (March 31)	**9,621**	**11,200**
Staff constituency	**Last year** (2010/11)	**Next year** (estimated) (2011/12)
At year start (April 1)	4,212	3,879
New members	425	500
Members leaving	758	500
At year end (March 31)	**3,879**	**3,879**
Patient constituency (out of area members)	**Last year** (2010/11)	**Next year** (estimated) (2011/12)
At year start (April 1)	157	200
New members	51	51
Members leaving	8	8
At year end (March 31)	**200**	**243**

Analysis of current membership

Public constituency	Number of members	Eligible membership
Age (years)**:**		
0-16	70	21,679
17-21	279	39,877
22 +	9,264	261,135
Not stated on form	8	
Ethnicity:		
White	9271	316,874
Mixed	46	1,974
Asian or Asian British	144	1,921
Black or Black British	20	527
Other	24	1,395
Not stated on form	116	
Socio-economic groupings17:		
ABC1	5967	157,803
C2	178	50,100
D	2260	63,811
E	1216	50,977
Gender analysis		
Male	3807	156,332
Female	5814	166,359
Patient constituency (out of area members)	**Number of members**	**Eligible membership**
Age (years)**:**		
0-16	1	Na
17-21	2	Na
22 +	197	Na

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

The trust recruited 1813 new Public Members over the course of the year. 2010-2011 was the trust's second full year as an NHS Foundation Trust and our focus was on sustainable recruitment at a low cost to the trust.

Our main recruitment focus was on the hospital sites themselves with the most successful recruitment method being a discharge survey combined with membership form that was given to patients on their discharge from the trust.

Outside of the hospital environment, the trust ran a range of recruitment events in local shopping centres, at local major events and at GP practices. The trust also worked together with Warrington Carers Centre to send membership information to all people with caring responsibilities in Warrington.

Changes in membership numbers over last twelve months

Alongside the recruitment of new members there were changes to the membership figures. The numbers of public members leaving the membership was as expected this year. This was mainly due to 'gone away' members who either moved from the area or who could not be located at their original address following our audits before mailings (where we run checks on the database) and returned mailings of our regular hospital newsletter.

There were also a number of deceased members who have been removed from the membership as part of the regular audits that we have carried out to ensure our membership list is up to date and accurate during the year. This also removes any duplicate members. We have a system of double checking our data through both our database providers (Capita) and the mail house we use for mailshots to ensure as far as we possibly can that we do not mail to members who have passed away.

The number of staff members leaving was higher than expected. The reason for this is that there were a number of doctors in training across the Mersey Deanery area who were employed by the trust on what is known as MADEL (Medical and Dental Education Levy) contracts where Warrington and Halton Hospitals acted as host employer for HR and other purposes. Responsibility as host employer for these staff transferred to another trust during 2010-2011 so they were excluded from our staff numbers. We would now expect the staff membership to remain stable and reflective of general turnover of staff in the future.

Involving our members

During the year the trust has worked to establish a number of ways in which Members can become involved in the hospitals and ways to ensure they are communicated with on a regular basis. These methods were largely developed through the Trust's Communications and Membership Committee (CAMC).

A new membership strategy called 'Active Community Engagement' was developed by the CAMC in 2010 and was adopted formally at our Annual Members Meeting in September 2010. It sets out a range of activities to further develop the membership at the hospitals and to support engagement between members and their Governors. Many of the ideas in this strategy will be fully delivered in 2011-2012 and key areas of work include:

Recruitment

- A continued focus on sustainable recruitment, led through the discharge survey work and other in hospital recruitment.

- A greater membership push with schools and colleges to attract more 12-16 and 17-21 year old members to join the trust. This will build on a model for working with schools and colleges which has been piloted with Lymm High School and has led to a number of recruitment and educational activities taking place.

- Further recruitment and events staged with community groups and societies (sports and rotary clubs for example) to help balance the number of 'working well' members.

Communications

- Continuation of the quarterly Your Hospitals magazine that is sent directly to every Public Member by post and contains membership information, articles on key health topics from our clinical staff and general hospital news. A new editorial panel was formed with to develop the content for each issue and has been meeting regularly.

- Direct letters from each Public Governor to their constituents introducing themselves and providing their contact details have continued. Each Governor is able to send a letter each year to their constituents.

- The continuation of our members' events – now called Your Health - where our clinicians present topics of interest to members in the form of lectures and talks. We staged six events in 2010-2011 ranging from an open day in the pathology laboratories (which attracted 150 members) through to smaller events promoting stroke services (attracting a full house of 26 members).

Involvement

- Developing our first membership survey which was sent to members in April 2011 and seeks further information on the types of interaction members want with their Governors and events that members want the trust to run in the future.

- Developing volunteering opportunities for the membership. This overall work programme is being led by the director of nursing at the trust. However, the first element of this work has been the establishment of readers' panels to help improve our patient information. Members were asked to volunteer and we have over 150 readers now registered. They receive information from us and comment on it before patient information is published.

How to contact your Governors

Governors for the trust can be contacted through our Membership Office. We have a physical Membership Office in the main entrance area at Warrington Hospital. The office provides Governors a place to hold meetings and the opportunity for members to access the Internet and a range of membership and health related information.

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

The contact details for the Membership Office are:

Warrington and Halton Hospitals NHS Foundation Trust
Membership Office
Warrington Hospital
Lovely Lane
Warrington WA5 1QG

Telephone - 01925 664222

Email - foundation@whh.nhs.uk

6. The Governors' Council

As an NHS Foundation Trust, our Governors' Council helps shape and endorse the future strategy of the organisation, and provide a critical link between the hospital and the local people it serves within Warrington, Halton and other local areas.

Staff and Public Governors are elected by the Foundation Trust Membership and give up their time voluntarily and make a major contribution to the way the hospital relates to its patients and the wider community. The Governors hold the hospital to account to the local population and, crucially, ensure that local people input into decisions and plans for the hospitals.

The nominated Lead Governor is Janet Walker, Public Governor representing South Mersey. The Lead Governor is the nominated contact for Monitor should an issue arise when Monitor have a need to contact the Governors directly or where the Governors have need to contact Monitor.

Structure and members of the Governors Council

Our Governors Council is made up of the following representatives:

- **16 Public Governors** - elected by the Public Members and representing the local community
- **5 Staff Governors** - elected by the hospital Staff Members
- **9 Partner Governors** - nominated by organisations we work closely with in Warrington and Halton.

Public Governors

Public Governors are elected by the Public Members to represent them. In order to make sure the Public Governors represent the areas we serve we have based the split of governors proportionately by the number of residents from each area.

We have further broken down Warrington and Halton areas based on the electoral wards that people live in. This means that when we run the elections for Public Governors, Members vote for a Governor to represent the area they are resident in. We have grouped together the electoral wards in Warrington, Widnes and Runcorn and outside the area.

Full biographies and details on the tenure of office for each Governor are available on the trust website www.warringtonandhaltonhospitals.nhs.uk

Halton area Public Governors

- **Daresbury, Windmill Hill, Norton North, Castlefields** – Position vacant at 31st March 2011
- **Beechwood, Mersey, Heath, Grange** – Doreen Shotton
- **Norton South, Halton Brook, Halton Lea** – David Trowbridge
- **Appleton, Farnworth, Hough Green, Halton View, Birchfield** – Geoffrey Swift (replaced Ron Doran 1st December 2010 following election)
- **Broadheath, Ditton, Hale, Kingsway, Riverside** – Ann Gibbons (replaced George Skarratts 1st December 2010 following election)

Warrington area Public Governors

- **Lymm, Grappenhall and Thelwall** – Peter Cotton
- **Appleton, Stockton Heath, Hatton, Stretton and Walton** – Helen Reay (replaced David Knowles 1st December 2010 following election)
- **Culcheth, Glazebury and Croft, Poulton North** – Anne Haddow (replaced Taha Tayih Al-Naimi 1st December 2010 following election)

- **Penketh and Cuerdley, Great Sankey North, Great Sankey South** – Lydia Carson
- **Latchford East, Latchford West, Poulton South** – Pamela Heesom
- **Bewsey and Whitecross, Fairfield and Howley** – Jean Ann Pownall
- **Poplars and Hulme, Orford** – Donald Miller
- **Birchwood, Rixton and Woolston** – David Ellis (replaced Julia Ellis 1st December 2010 following election)
- **Burtonwood and Winwick, Whittle House, Westbrook** – Chris Kenyon

Surrounding area public governors

- **North Mersey** – Joe Davies (replaced Marjorie Conroy 1st December 2010 after being elected unopposed)
- **South Mersey** – Janet Walker

Staff Governors

Staff Governors represent our staff on the Governors Council and will bring their knowledge and skills from working in the organisation. There are five Staff Governors representing the main staff groups at the hospitals. Staff at the hospitals automatically become Staff Members of the Foundation Trust - although they can choose to opt out if they wish to.

- **Medical** – Position vacant as at 31st March 2011 (Dr Janice Fazackerley stood down at election 1st December 2010)
- **Nursing and Midwifery** – Albert Lamb (elected unopposed 1st December 2010)
- **Support** – Position vacant as at 31st March 2011 (Lorna Carson stood down at election 1st December 2010)
- **Clinical Scientist or Allied Health Professionals** – Carol Over (replaced Jeff Green 1st December 2010)
- **Estates, admin and managerial** - Andrée Jane Birch

Partner Governors

Our Partner Governors are nominated by key local organisations that we work with. They bring their knowledge and experience to the Governors Council and help us to work in partnership with the community.

- **Warrington Borough Council** - Councillor Roy Smith
- **Halton Borough Council** - Councillor Kath Loftus (Councillor Stefan Nelson until 14th September 2010)
- **Warrington Primary Care Trust** - Chrissie Cooke (director of patient safety, quality and governance) (vacant from 15th February 2011)
- **Halton & St Helens Primary Care Trust** - Fiona Johnstone (director of health strategy) (vacant from 16th September 2010)
- **Warrington PBC (practice based commissioning consortium)** - Dr Brendon O'Colemain (vacant from 3rd September 2009)
- **Halton PBC/Widnes PBC** - Dr Cliff Richards (chair of Runcorn PBC Consortium) (vacant from 3rd March 2011)
- **Commercial sector** - Colin Daniels (Chamber of Commerce & Industry)
- **Mental Health** - Barrie Moore (Mental Health Forum)
- **LINKS representative** – Brian Miller (Halton LINks) and Anne Turner (Warrington LINKs)*

**This post rotated on an annual basis between Warrington LINks and Halton LINks. However it has been decided that in order to gain views from both LINKs groups that there will be two representatives in future, one from each LINKs group. They will have one joint vote between them when voting is necessary.*

Governor elections in year

Our first Governors were elected following the nominations and elections which took place amongst our Staff Members and Public Members in the summer of 2008. To ensure continuity in the future, half of the Public and Staff Governors had two year terms of office and half had three year term of office (selected based on their share of their respective votes/if they were elected uncontested in the initial elections).

In November 2010 we saw the first of our initial group of Governors who had been appointed in 2008 come up for election.

This led to several of our previous Governors standing down at election or not being re-elected. The Governors' Council expressed its thanks to those Governors for their valuable contribution to our initial period as an NHS Foundation Trust.

Our elections are carried out by Electoral Reform Services and the returning officer was Tom Colling. The close of polls for the elections was 26th November 2011 and the reports from the contested elections by constituency are shown on the following page:

- One Public Governor seat (North Mersey) was uncontested with only one candidate standing.
- One Public Governor seat (Daresbury, Windmill Hill, Norton North, Castlefields) had no candidate standing and remains vacant as at 31st March 2011.

Four of our Staff Governor positions also came up for election.

- Two were filled uncontested (Nursing and Midwifery and Clinical Scientist or Allied Health Professionals)
- Two seats (Medical and Support Staff) had no candidates.

Reports from the contested elections by constituency

Date of Election	Constituencies Involved	No of Members in Constituency	No of Seats Contested	Number of Contestants	Election Turnout %
26/11/10	Public - Beechwood, Mersey, Heath, Grange	569	1	3	16%
26/11/10	Public - Appleton, Farnworth, Hough Green, Halton View, Birchwood	396	1	2	18.2%
26/11/10	Public - Broadheath, Ditton, Hale, Kingsway, Riverside	372	1	4	17.5%
26/11/10	Public - Appleton, Stockton Heath, Hatton, Stretton, Walton	529	1	4	29.7%
26/11/10	Public - Culceth, Glazebury and Croft, Poulton North	525	1	2	20.8%
26/11/10	Public - Birchwood, Rixton and Woolston	569	1	4	21.6%
26/11/10	Public - South Mersey	477	1	2	19.1%

Work is underway in the early part of 2011-2012 to work with the current Staff Governors to encourage staff to understand the role of the Staff Governor before running elections for these two vacant seats.

Governors' Council meetings and attendance

When the trust was authorised the constitution outlined that Governors' Council would meet at least four times a year including the Annual Members Meeting. However, after reviewing the meeting structure in 2010 the Governors' Council meets formally six times a year (excluding the Annual Members Meeting) to better facilitate business. Minutes from the Governors Council meetings are available on the Trust website www.warringtonandhaltonhospitals.nhs.uk
Between April 1st 2010 and March 31st 2011 the Governors' Council met formally and in public on:

3th May 2010, 15th July 2010, 14th September 2010, 23rd November 2010, 20th January 2011 and 24th March 2011.

The following tables show the attendance at each formal public Governors Council meeting by Governor and also by attending Executive and Non Executive Directors.

Public Governors' attendance at Public Governors' Council meetings

Name/Constituency	13th May	15th July	14th Sept	23rd Nov	20th Jan	24th Mar
Daresbury, Windmill Hill, Norton North, Castlefields - Position vacant at 31st March 2010						
Beechwood, Mersey, Heath, Grange - Doreen Shotton	●	●	●	●	●	●
Norton South, Halton Brook, Halton Lea - David Trowbridge	●	●	●	●	●	●
Appleton, Farnworth, Hough Green, Halton View, Birchfield - Geoffrey Swift (Ron Doran until 30th November 2010)						●
Broadheath, Ditton, Hale, Kingsway, Riverside - Ann Gibbons (George Skarratts until 30th November 2010)				●	●	
Lymm, Grappenhall and Thelwall - Peter Cotton	●		●	●	●	●
Appleton, Stockton Heath, Hatton, Stretton and Walton - Helen Reay (David Knowles until 30th November 2010)		●	●	●	●	●
Culcheth, Glazebury and Croft, Poulton North - Anne Haddow (Taha Tayih Al-Naimi until 30th November 2010)	●	●	●			
Penketh and Cuerdley, Great Sankey North, Great Sankey South - Lydia Carson	●	●	●	●	●	●
Latchford East, Latchford West, Poulton South - Pamela Heesom	●	●		●	●	
Bewsey and Whitecross, Fairfield and Howley - Jean Ann Pownall	●	●		●	●	●
Poplars and Hulme, Orford - Donald Miller	●					●
Birchwood, Rixton and Woolston - David Ellis (Julia Ellis until 30th November 2010)		●	●	●	●	●
Burtonwood and Winwick, Whittle House, Westbrook - Chris Kenyon	●	●	●	●	●	●
North Mersey - Joe F Davies (Marjorie Conroy until 30th November 2010)	●	●		●	●	●
South Mersey - Janet Walker	●	●	●	●	●	●

Staff Governors' attendance at Public Governors' Council meetings

Name/Constituency	13th May	15th July	14th Sept	23rd Nov	20th Jan	24th Mar
Medical - Dr Janice Fazackerley (vacant from 1st December 2010)	●	●	●	●		
Nursing and Midwifery - Albert Lamb (vacant until 30th November 2010)					●	●
Support - Lorna Carson (vacant from 1st December 2010)						
Clinical Scientist or Allied Health Professionals - Carol Over (Jeff Green until 30th November 2010)	●					
Estates, admin and managerial - Jane Birch	●		●		●	●

Partner Governors' attendance at Public Governors' Council meetings

Name/Organisation represented	13th May	15th July	14th Sept	23rd Nov	20th Jan	24th Mar
Warrington Borough Council - Councillor Roy Smith	●	●	●	●		●
Halton Borough Council - Councillor Kath Loftus (Cllr Stefan Nelson until 14 September 2010)			●			
Warrington Primary Care Trust - Chrissie Cooke (vacant from 15th February 2011)	●	●	●			
Halton & St Helens Primary Care Trust - Fiona Johnstone (vacant from 16th September 2010)						
Warrington PBC (practice based commissioning consortium) (vacant from 3rd September 2009)						
Halton PBC/Widnes PBC - Dr Cliff Richards (chair of Runcorn PBC Consortium) (vacant from 3rd March 2011)						
Commercial sector - Colin Daniels (Chamber of Commerce & Industry)						
Mental Health - Barrie Moore (Mental Health Forum)	●	●	●	●		
LINKS representative - Anne Turner (Warrington LINKs)					●	●
LINKS representative - Brian Miller (Halton LINks)	●	●	●	●	●	●

Governors' committees and work programme

The formal public Governors Council meetings are a small part of the Governors' overall work in the trust. Governors have been involved in a range of work, using their experience and expertise to represent the views of members and focus on issues of interest.

Governor committee structure

A committee structure has also been put in place with five formal Governor led committees, each chaired by a Governor and with membership made up of Governors:

- **Staff and Patient Care Committee** - Recommending objectives and strategy for the trust in the development and improvement of the patient and workforce experience
- **Communications and Membership Committee** - Recommending objectives and strategy for the trust in the development of communication and engagement with members
- **Compliance with Authorisation Committee** - Reviewing the monthly Finance and Corporate performance reports and the annual report and accounts
- **Quality Committee** – Receiving and reviewing monthly quality dashboards and reviewing the annual quality report and accounts.
- **Nominations and Remuneration Committee** – The role of this committee is outlined in more detail in the remuneration report on page 58.

Other meetings and involvement

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

Two Governors (from the public or staff constituencies) observe each board meeting so that they can understand the issues raised at the Trust Board and report back to the other Governors. This is on a rotational basis so that each public and staff Governor has the opportunity to attend at least one board meeting each year.

A full list of Governor attendance at Governor Committee meetings is available on the trust internet site **www.warringtonandhaltonhospitals.nhs.uk** in the Foundation Trust section.

7. The Trust Board of Directors

Composition of the board

Executive Directors

Catherine Beardshaw
Chief Executive
(left 31st January 2011)

Catherine Beardshaw was appointed as chief executive in July 2006. Catherine started her NHS career as a radiographer in Sheffield in the 1970s and held a range of clinical posts, moving to her first superintendent radiographer post in 1984 at the Royal Hallamshire Hospital. In 1992 Catherine moved to Leeds General Infirmary as radiology services manager and then made a career change into general management with a range of management posts across the now Leeds Teaching Hospitals NHS Trust. This culminated in a director of operations post at the hospitals which she held from 2002 to her appointment at North Cheshire Hospitals. During this time, Catherine performance managed a wide range of services with an expenditure budget of some £190 million and over 5,000 staff.

Mel Pickup
Chief Executive
(joined 15th February 2011)

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

Jonathan Stephens
Director of Finance and Deputy Chief Executive

Jonathan Stephens joined the trust as director of finance in March 2008 and is deputy chief executive of the trust. Jonathan is a qualified accountant and was previously director of finance at Tameside Hospital NHS Foundation Trust. He has over 18 years experience in NHS finance with experience of community and primary care health provision, specialist teaching hospital services and the Strategic Health Authority. At Tameside Hospital he led the trust through to foundation trust status and delivered Department of Health and Treasury approval, and the subsequent commercial contract sign off, of the hospital's major PFI capital development.

Kathryn Holbourn
Director of Nursing
(left 20th October 2010)

Kath Holbourn was appointed as director of nursing to the trust in May 2002. Kath trained as a nurse at Manchester Royal Infirmary and qualified in 1977. She held several clinical roles there with her main specialty interests being A&E and general intensive care. Having completed an MSc in clinical nursing, she then worked at Bolton Health Authority advising on clinical standards and service developments across both primary and secondary care. She then returned to secondary care in St Helens & Knowsley, initially responsible for clinical developments for a year before becoming their director of nursing in 1988. Following a ten year career there with a varying portfolio including mental health, Kath moved to Mid Cheshire Hospitals as nurse director.

David Melia
Director of Nursing

(joined 22nd November 2010)

David Melia was appointed as director of nursing to the trust in November 2010. David has clinical experience in learning disabilities nursing, general medicine, general surgery and spent 17 years working with neurosciences in which he became responsible for nursing development and professional leadership. David's focus within his role at Warrington and Halton Hospitals will be to further develop the clinical leadership role of nurses across the trust, ensure nursing involvement within clinical developments, improving patient safety and enhancing the patient experience.

Chris Knights
Director of Strategy and Business Development

Chris Knights was appointed as director of business development in July 2007. The role includes responsibility for information management and technology, service modernisation, commissioning, business planning and project director of the trust's foundation trust application. Chris started his NHS career as a graduate management trainee at Halton General Hospital in 1993. He took up his first substantive role in 1995 at the Royal Liverpool Hospital as a business manager in the urology directorate. His career then developed through a range of general management posts at Stockport Acute Services NHS Trust and University Hospitals Aintree NHS Trust before his first board role at St Helens and Knowsley Hospitals NHS Trust in 2003.

Gordon Ramsden
Medical Director

Gordon Ramsden became medical director of the trust in August 2007 and is also a consultant in obstetrics and gynaecology at the hospitals. Gordon qualified from Manchester Medical School in1979 and worked as registrar at Warrington in 1986. In 1990 became lecturer at the University of Liverpool in obstetrics and gynaecology. He became a consultant at Warrington Hospital in 1993. Gordon was regional programme director for obstetrics and gynaecology services for five years before taking on the clinical directorship in women's health in 2004. In 2006 Gordon became director of medical education and helped to reorganise the trust's education centres. Gordon retired from the trust in May 2011.

Sheila Samuels
Director of Governance and Organisational Development

Sheila Samuels was appointed as director of human resources at the trust in June 2004. Sheila has over 30 years of working in the public sector, six years of which have been as a board level director in the NHS. Sheila started her public sector career in local government in 1976 working in the areas of policy development and in a support and advisory capacity to council members and leadership. In 1990 she moved into Human Resource Management. Her first position with NHS was as director of human resources in Mersey Regional Ambulance Service before taking up her role at the trust.

Simon Wright
Chief Operating Officer

Simon Wright was appointed as director of operations in June 2007. Simon started his management career working for nine years in the independent sector within health care leading on tendering and national negotiations on staff pay and conditions. On joining the NHS in November 1997 as general manager at the Walton Centre for Neurology and Neurosurgery NHS Trust he supported the hospital relocation onto the Fazakerly site. He moved to Salford Royal Hospitals Trust in May 2001, overseeing the integration of Greater Manchester Neurosciences from three sites into the one integrated service. The role expanded to pick up all surgical and most specialist services becoming an Associate Director. Before leaving Salford, Simon supported the successful achievement of foundation status for the trust.

Non-executive directors

Allan Massey
Chairman

Allan Massey was appointed chairman of North Cheshire Hospitals in December 2004. Allan started his career in 1965 in a civil engineering company in Warrington before working in a variety of private sector accountancy roles, culminating in works accounting manager for a major manufacturing company. In 1982 Allan moved to the public sector and worked in local government with Warrington Borough Council as treasury manager - managing a portfolio of over £500 million. He became a local councillor in 1997 at Halton Borough Council with executive board portfolios for social care and health, education and lifelong learning and business efficiency. Allan was appointed deputy chair of Halton NHS Primary Care Trust in 2002 before joining North Cheshire Hospitals as chairman. The Chairman has no other significant commitments and is not the Chairman of another NHS Foundation Trust.

Allan Mackie
Deputy Chair

Allan Mackie joined the trust as a non executive director in March 2005. Entering production management in the brewing industry in 1970, he held senior leadership positions in operations management with major national and regional companies with responsibility for the delivery of continuous improvement of business performance. In 1998 he became operations director of a company active in the fields of business change, transformation and technical management in the food and agriculture sectors in Russia and Eastern Europe and was responsible for the execution of strategic business plans and the delivery of modern business practices. Allan is a director and trustee of United Utilities Trust Fund.

Rory Adam

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

Clare Briegal

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

Lynne Lobley

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

Carol Withenshaw
Senior Independent Director

Carol Withenshaw was appointed as non executive director with the trust in 2007. Carol started her career at Greenall Whitley Brewery PLC from 1969, becoming group training manager in 1984. In 1988 she moved to the Fresenius Healthcare Group and worked in a range of senior management roles before becoming operations director. Carol then became managing director of Fresenius' Calea UK subsidiary and was responsible for developing and launching the new business which provides specialist support services to the NHS for patients and health care professionals in community and hospital settings.

Trust Board meetings and attendance

The Trust Board met 12 times during the year in total (12 monthly meetings (with the exception of December) and one extraordinary meeting to sign off the annual report and accounts). Attendance was as follows:

	28 Apr	26 May	2 Jun	30 Jun	28 Jul	25 Aug	29 Sep	27 Oct	24 Nov	26 Jan	23 Feb	30 Mar
Allan Massey (Chairman)	●	●	●	●	●	●	●	●	●	●	●	●
Catherine Beardshaw (Chief Executive) Until 31st January 2010	●		●	●	●	●	●	●	●			
Mel Pickup (Chief Executive) From 15th February 2011											●	●
Kath Holbourn (Director of Nursing) Until 20th October 2010	●	●		●	●	●	●	●	●			
David Melia (Director of Nursing) From 22nd November 2010										●	●	
Sheila Samuels (Director of Governance and Organisational Development)		●	●	●	●	●	●	●	●		●	●
Jonathan Stephens (Director of Finance/Deputy Chief Executive)	●	●		●		●	●	●	●	●		●
Gordon Ramsden (Medical Director)	●	●		●	●			●	●		●	●
Simon Wright (Chief Operating Officer – non voting director)	●			●		●	●		●		●	●
Chris Knights (Director of Strategy and Business Development – non voting director)	●	●		●	●	●	●	●	●	●	●	●
Carol Withenshaw (Non Executive Director)		●		●		●	●	●	●		●	●
Rory Adam (Non Executive Director)	●	●	●		●	●		●	●	●	●	●
Clare Briegal (Non Executive Director)	●	●	●	●	●		●	●	●	●	●	●
Allan Mackie (Non Executive Director)	●	●	●	●	●	●	●	●	●	●	●	●
Lynne Lobley (Non Executive Director)	●	●	●	●	●	●	●	●	●	●	●	●

How the Board operates

The Board of Directors comprises the chairman, chief executive, senior independent director, four independent Non-Executive Directors, five voting Executive Directors and two non-voting executive directors. The Board meets monthly in private and a summary of the minutes is published on the public website.

The Directors have collective responsibility for setting strategic direction and providing leadership and governance. The Scheme of Delegation which is included in the trust's standing orders, sets out the decisions which are the responsibility of the Board of Directors and those which have been delegated to a sub-committee of the Board.

The trust has regular Executive Team meetings chaired by the Chief Executive. Its remit is to consider the operational management of the day to day business of the trust.

As set out in the constitution, the Governors Council consists of 16 public elected governors, five staff governors and nine appointed partner governors

The Governors Council meets in public six times a year.

The statutory duties of the governors are to:

- Set the terms and conditions of Non-Executive Directors
- Approve the appointment of future Chief Executives
- Appoint or remove the trust's external auditor
- Consider the annual accounts, annual report and auditor's report
- Be consulted by the Board of Directors on the forward plans for the trust

The Board of Directors and the Governors Council meet regularly and enjoy a strong and developing working relationship. Mr Allan Massey chairs both and acts as a link between the two. Each is kept advised of the other's progress through a number of systems, including informal updates via the chairman, ad hoc briefings and exchange of meeting minutes and attendance of the Board of Directors at the Governors' Council and by individual directors at Governors' Council committee meetings.

Balance, Completeness and Appropriateness

There is a clear separation of the roles of the chairman and the chief executive. The chairman has responsibility for the running the board, setting the agenda for the trust and for ensuring that all directors are fully informed of matters relevant to their roles. The chief executive has responsibility for implementing the strategies agreed by the board and for managing the day to day business of the trust.

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance.

The board considers that the Non-Executive Directors bring a wide range of business, commercial and financial knowledge required for the successful direction of the trust.

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

All directors are subject to an annual review of their performance and contribution to the management and leadership of the trust.

At the present time the board is satisfied as to its balance, completeness and appropriateness, but will keep these matters under review.

Evaluation of board of directors and committees

During early 2010, the trust appointed its internal auditors to assist the board to evaluate performance of both the trust board and supporting committees. This consisted of self-assessment processes and evaluation of results. The results from this work were positive and showed the strengths of the board and committee structure. Where limited weaknesses were identified, an action plan was developed to address them and reviewed in August 2010.

An example of actions includes ensuring all directors fully understand the role and function of committees that they do not participate in. The trust is committed to continual improvement and development and will review and evaluate performance annually.

Understanding the views of the Governors and Members

The board has had a number of board to Governors meetings to discuss issues with the Governors and asked them to contribute their views to the strategic development of the trust. At each of the board meetings, there is a standing item for the chairman to share any views or issues raised by Governors or members through Governors at the Governors' Council meetings.

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

Two of the staff and public Governors observe each board meeting so that they can understand the issues raised at the trust board and report back to the other Governors. This is on a rotational basis so that each public and staff Governor has the opportunity to attend at least one board meeting each year.

Register of interests

An updated Register of Interests of our Trust Board is available on our internet site **www.warringtonandhaltonhospitals.nhs.uk** in the about us/corporate and Trust Board section.

The Audit Committee

The Audit Committee is chaired by Rory Adam, Non-Executive Director. The other Non-Executive Directors Lynne Lobley, Allan Mackie, Carol Withenshaw and Clare Briegal are also members.

The committee has met 5 times within the full 12 months to March 31st 2011.

Attendance at Audit Committee by meeting

	21st Apr	2nd Jun	14th Jul	10th Nov	27th Jan
Rory Adam (Non Executive Director)	●	●	●	●	●
Carol Withenshaw (Non Executive Director)	●		●		
Clare Briegal (Non Executive Director)	●	●	●	●	●
Allan Mackie (Non Executive Director)	●	●	●	●	●
Lynne Lobley (Non Executive Director)	●	●	●		●

The role of the audit Committee which is accountable to the Board is set out in the terms of reference with the following key areas:

- Maintenance of an effective system of integrated governance, risk management and internal control across the organisation's activities that supports the achievement of the organisational objectives
- Ensure there is an effective internal audit function that provides appropriate independent assurance
- Review the work and findings of external audit and the implications and management responses to their work
- Ensure the organisation has robust systems of financial control and reporting.

Approved by Rory Adam,
Chairman of the Audit Committee.

Details of the Trust Remuneration and Nomination Committees can be found in the Remuneration Report on page 58.

8. Remuneration Report

The Board Remuneration Committee

The trust board Remuneration Committee meets annually, or as required to make decisions regarding remuneration and conditions of service for executive directors including our Chief Executive.

Agreements for these staff reflect the provisions of national arrangements. Pay arrangements are also determined for senior managers and staff not covered by national pay review bodies.

The Remuneration Committee has general oversight of the trust's pay policies, but only determines the reward package for directors and staff not covered by Agenda for Change. The vast majority of staff remuneration, including to include the first layer of management below board level, is covered by the NHS Agenda for Change pay structure.

Remuneration and conditions of service include provisions for other benefits as well as arrangements for termination of employment. It considers all ex gratia payments and redundancy payments over £50k. There are no special termination arrangements for senior managers, and no such awards have been made to past senior managers this year.

The trust does not apply performance conditions linked to remuneration. Executive directors participate in annual performance development reviews and appraisals. Individual objectives are linked to the corporate objectives.

The committee comprises the trust's:

- Chairman
- Chief executive (except for matters concerning their employment and conditions)
- All non-executive directors.

During the 2010-2011 the committee met twice on 28th April 2010 (apologies were received from Carol Withenshaw, non executive director) and on the 25th of August 2010 (apologies were received from Clare Briegal, non-executive director).

The trust board Remuneration Committee will review its role in succession planning of Executive Directors in 2011-2012 in line with the NHS Foundation Trust Code of Governance.

The Governors' Council Nomination and Remuneration Committee

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

The committee comprises the Trust's:

- Chair (or deputy chair when the appointment of the chair or his or her remuneration and allowances/other terms and conditions of office are being discussed)
- One Partner Governor (Colin Daniels)
- One Staff Governor (Janice Fazackerley vacant from 1st December 2010 until the appointment of Jane Birch to the committee from 24th March 2011)
- Two Public Governors (Doreen Shotton and David Knowles vacant from 1st December 2010 until the appointment of David Trowbridge to the committee from 24th March 2011).

During 2010-2011, the committee met twice.

Attendance was as follows:

	6th Jul	2nd Nov
Allan Massey (Chairman)	●	
Colin Daniels		●
Janice Fazackerley	●	●
Doreen Shotton	●	●
David Knowles	●	

Appointment process adopted for Non Executive Directors

It was agreed at the Governors Council meeting on 15th January 2009 to engage the Appointments Commission to act as the Governors Council recruitment advisors for the appointment of Non Executive Directors. A decision in regard to the position of Chairman will be made in due course and will follow best practice. The process followed in relation to Non Executive Director appointment is as explained below;

- The Appointments Commission work closely with the Governors Council Nomination and Remuneration Committee together with the Chairman, Executive Director of Organisational Development and Governance and the Board Secretary. The Appointments Commission to attend the Trust at all key stages including briefing, shortlisting and interviews for the Non Executive Director.

- The Governors Council Nomination and Remuneration Committee to agree the basis on which candidates are to be assessed based on feedback from the Board of the skills required on the Board. Candidates to be assessed on the basis of the qualities and expertise criteria set out in the advertisement and candidate information pack, the competence demonstrated at interview and the eligibility stated in the candidate information pack.

- Initial Assessment and Shortlisting - The pre-assessment exercise to be managed by the Appointments Commission. The applications are to be assessed against the criteria in the candidate information pack and the advertisement and divided into 3 groups (A, B and C). Group A to consist of candidates who present the strongest evidence against the criteria with Groups B and C demonstrating less evidence of how they met the qualities/expertise required. A breakdown of all 3 groups to be provided to the Governors Council Nomination and Remuneration Committee.

- The Governors Council Nomination and Remuneration Committee to review the stronger applications from Group A at a shortlisting meeting and agreed a final shortlist of 5 candidates to attend a formal interview. References to be sought for the shortlisted candidates

- Interviews to be conducted by the Governors Council Nomination and Remuneration Committee supported by the Chairman of the Board and set questions posed to all candidates to explore the qualities, expertise and competencies outlined in the candidate information pack as requirements for the post.

- The Governors Council Nomination and Remuneration Committee to assess all candidates against the criteria and fully discussed by the Committee at the conclusion of the interviews. Assessment documentation to be completed for all candidates and decision made to propose a candidate for appointment to the position.

- The Governors Council Nomination and Remuneration Committee to make a recommendation to the Governors Council for ratification of the preferred candidate.

Contractual arrangements for non-executive directors

Name	Contract Commencement date	Contract expiry date	Notice period
Allan Massey	01/12/2004	30/11/2012	Three months
Lynne Lobley	01/12/2009	1/12/2012	Three months
Carol Withenshaw	01/07/2006	30/06/2014	Three months
Allan Mackie	01/03/2005	28/02/2013	Three months
Rory Adam	01/12/2007	30/11/2011	Three months
Clare Briegal	01/11/2008	30/11/2012	Three months

Executive directors – our executive directors are not employed under fixed term contractual arrangements and are required to give three months notice under the terms of their employment.

Both the employee and employer contribute to the NHS pension scheme and Note 1.5 of the annual accounts provides an explanation of how pension liabilities are treated in the accounts.

Directors Remuneration - Year ended 31st March 2011 (and comparison year ended 31st March 2010)

Salaries and allowances

Name and title	1 April 2010 to 31 March 2011			1 April 2009 to 31 March 2010		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (rounded to the nearest £)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (rounded to the nearest £)
	£000	£000	£	£000	£000	£
Catherine Beardshaw Chief Executive Leaver 31.01.11	120 - 125		nil	145 - 150		nil
Mel Pickup Chief Executive Starter 15.02.11	15 - 20		nil			
Gordon Ramsden Medical Director	55 - 60	120 - 125	nil	95 - 100	80 - 85	nil
Sheila Samuels Director of Organisational Development and Governance	100 - 105		nil	95 - 100		nil
Jonathan Stephens Director of Finance	110 - 115			110 - 115		
Kath Holbourn Director of Nursing Leaver 20.10.10	50 - 55		nil	95 - 100		nil
David Melia Director of Nursing Starter 22.11.10	30 - 35		nil			
Simon Wright Chief Operating Officer	105 - 110		nil	95 - 100		nil
Chris Knights Director of Strategy and Business Development	95 - 100		nil	95 - 100		nil
Allan Massey Chairman	40 - 45		nil	40 - 45		nil
Allan Mackie Non Executive Director	10 - 15		nil	10 - 15		nil
Rory Adam Non Executive Director	10 - 15		nil	10 - 15		nil
Carol Withenshaw Non Executive Director	10 - 15		nil	10 - 15		nil
Lynn Lobley Non Executive Director Starter 01.12.09	10 - 15		nil	0 - 5		nil
Clare Briegal Non Executive Director	10 - 15		nil	10 - 15		nil
Maureen Banner Non Executive Director Leaver 30.11.09				5 - 10		nil

Pension Entitlements Year ended 31st March 2011

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Catherine Beardshaw Chief Executive	0 - 2.5	2.5 - 5	65 - 70	195 - 200	1,371	1,450	-79	nil
Mel Pickup Chief Executive	n/a	n/a	40 - 45	125 - 130	534	n/a	n/a	nil
Chris Knights Director of Strategy and Business Development	0 - 2.5	2.5-5	20 - 25	65 - 70	289	320	-31	nil
Gordon Ramsden Medical Director	2.5 - 5	7.5 - 10	65 - 70	205 - 210	1,370	1,426	-56	nil
Jonathan Stephens Director of Finance	0 - 2.5	2.5 - 5	40 - 45	120 - 125	562	628	-66	nil
Kath Holbourn Director of Nursing	0 - 2.5	0-2.5	40 - 45	125 - 130	n/a	917	n/a	nil
David Melia Director of Nursing	n/a	n/a	25 - 30	80 - 85	384	n/a	n/a	nil
Sheila Samuels Director of Organisational Development and Governance	0 - 2.5	10 - 12.5	40 - 45	120 - 125	688	697	-9	nil
Simon Wright Chief Operating Officer	2.5 - 5	7.5 - 10	15 - 20	50 - 55	238	228	10	nil

As Non Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non Executive Directors

Explanation of cash equivalent transfer values

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

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

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

Explanation of real increase in cash equivalent transfer values

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

Remuneration report signed by:

Mel Pickup
Chief Executive
1st June 2011

9. Accounting Officer's Responsibilities

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

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Warrington and Halton Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Warrington and Halton Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS foundation trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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

Mel Pickup
Chief Executive
1st June 2011

10. Statement on internal control

1. Scope of Responsibility

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

2. The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Warrington and Halton Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Warrington and Halton Hospitals NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to Handle Risk

Leadership & Accountability

The executive lead for risk management is the Director of Organisational Development and Governance. A supporting system for managing risk has been devolved to the Associate Director of Governance, bringing together all aspects of the risk management process and Governance systems. Further support is provided to the trust's risk management systems through designated risk and clinical governance leads within Divisions.

The current Risk Management Strategy provides a framework for managing risk across the organisation in line with best practice and Department of Health guidance. The strategy 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 organisation.

The role of the Board and the committees, together with individual responsibilities of the Chief Executive, Executive Directors, managers and all staff are set out within the strategy, and in particular the role of the Governance Committee, which is the mechanism for managing and monitoring risks across the Trust and reporting through to the Board. Board committees covering Quality and Workforce and the Audit Committee support this role along with the sub committees of Clinical Governance, Infection Control and Safety and Risk.

Training

Risk management training is provided through a number of sources. The trust's corporate induction programme ensures all new staff (including Consultant appointments) are provided with details of the trust's risk management systems and processes. This is also supported by a local induction programme. Risk management training is provided to all levels of staff within the organisation based upon the requirements of the position held.

The comprehensive mandatory training covers a wide variety of risk management processes including, Health and Safety, Manual Handling, Resuscitation and Blood Transfusion. An E-learning system has been developed by key individuals across the organisation to support the continued delivery of the Trust's mandatory requirements.

Root Cause Analysis training has been undertaken led by the Associate Director of Governance within the framework of the National Patient Safety Agency. The training is

underpinned by Levels of Investigation. For Serious Incidents (Level Two Investigation) the lead investigating Officers are outside of the area where the incident has occurred.

Control Mechanisms including 'Learning Lessons'

Learning and Improvement from incidents, complaints, claims and Coroners Inquests has been the focus for the trust. Monthly meetings have been established with key post holders who work closely together, sharing best practice and learning lessons collectively rather than on an individual Divisional basis. The Complaints, Litigation, Incidents and Patient Services (CLIPS) quarterly report has been completely revised. This revamped and more comprehensive report and approach has been well received by our commissioners as a demonstration of how we identify and learn from issues identified by staff, patients and relatives.

We are continually reinforcing the need for issues to be raised within the organisation and expect a higher level of reporting in future as this represents an open and learning culture. Our aim is to ensure that whilst there may be an increasing level of reported incidents, there will an increasingly lower level of claims and complaints and incidents which result in harm. A bi-monthly newsletter called 'Risky Business' has also been developed and is circulated to all staff.

The trust has an integrated IT Risk Management System called Datix that links all key risk elements (including incident reporting, complaints and claims management) which, in turn, inform the Trust's Risk Register.

The Trust Board routinely considers specific risk issues and receives minutes from Board Sub-Committees including the Audit and Governance Committees. The Clinical Governance, Safety and Risk sub committees and Governance Committee, on behalf of the Trust Board, routinely receives information on Serious Untoward Incidents (SUI's) including lessons learned and examples of good practice.

The trust actively encourages networking and has strong links with relevant central bodies, e.g. Care Quality Commission, National Patient Safety Agency (NPSA), National Health Service Litigation Authority (NHSLA), Health and Safety Executive (HSE).

The Information Governance and Corporate Records Group has been agreed as a sub-committee to the Governance Committee. This will support the Information Governance and NHS Records agenda by providing the Governance Committee with the assurance that effective Information Governance and Records best practices are in place and monitored within the organisation

The trust undertakes Equality Impact Assessments on each new policy which is introduced within the trust and this requirement is laid down within the Trust Policy on the production of new policies and procedures.

4. The risk and control framework

The risk management framework is set out in the Risk Management Strategy. The key elements of the strategy include delegated roles and responsibilities in respect of the various elements of the risk management process and a strong focus on the training and support given to staff within the organisation to enable them to fulfil their responsibilities.

There is a robust system in place of risk identification, monitoring and reporting throughout the organisation's divisions and committees. The trust's strategic risk register is based upon the principle risks of the organisation and is populated by all services/departments via local risk registers, which are monitored and maintained within Divisions. This enables risk management decision-making to occur as near as practicable to the risk source and for those risks that cannot be dealt with locally to be escalated to the appropriate level.

The Safety and Risk Sub Committee maintains and monitors the Corporate Risk register on a monthly basis. The Governance Committee has an overarching role to ensure that significant issues are brought to the attention of the Trust Board.

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

The trust has a number of corporate policies and procedures in place to support risk management, covering the management of adverse incidents, safety alerts, and consent and general risk management arrangements. The trust encourages stakeholder and partner organisations' participation and has developed an active Patient Experience Group. Partners and Governors' are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management. Input from both Warrington LINks and Halton LINks, along with the emissary members of Warrington Overview and Scrutiny Committee has been a welcome addition in providing patient and public involvement on a range of issues.

There is a Board approved Assurance Framework in place which is reviewed by the Governance Committee and the Trust Board, and includes the following:

- the strategic objectives of the Trust covering the main activities of the organization,
- the identification of the key deliverables and the key risks to the achievement of the 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,
- evidence of compliance with equality diversity and human rights legislation.

The framework links to the Care Quality Commission regulated activities and the statutory registration requirements and the trust has a system in place to monitor continued compliance against the CQC essential standards and to address any concerns against the level of compliance which are raised by the Care Quality Commission.

The framework also links with the corporate risk register providing a holistic review of strategically significant risks relating to the organisation's business and where gaps in control or assurance and evidence of risk management are identified action is taken to rectify them.

The Assurance Framework led to the unconditional registration for the provision of Health Care services with the Care Quality Commission for 2010/11. This demonstrates clear mechanisms for identifying gaps in control and assurance, and enabled these to be managed in year.

As part of the process of continual review and development, the existing Board Assurance Framework will be further strengthened to reflect the future requirement required to support on-going registration with the Care Quality Commission and any changes to Monitor's, the Independent Regulator of NHS Foundation Trusts, Compliance Framework.

The trust has established robust systems to identify, monitor, and implement actions in respect of working towards the achievement of all of its targets including the Care Quality Commission Regulated Activities within the essential standards for Quality and Safety.

Risks to information are managed and controlled through the use of the Information Governance Toolkit.

Information Governance

The trust uses the Information Governance Toolkit in conjunction with its Information Governance and Corporate Records Group to identify areas of weakness in relation to the management of its information. Any areas of weakness in control and or risk management identified or highlighted from internal audit review are then targeted with action plans to ensure that we continue to strive to be information governance assured.

In addition to the Information Governance self-assessment the trust is working towards certification to ISO 27001, the international information security standard.

During the financial year there was one incident involving loss of personal data which was reported to the Information Commissioners Office.

Summary of Serious Untoward Incidents Involving Personal Data as Reported to the Information Commissioner's Office in the 2010/11 financial year

Date of Incident (month & year)	Nature of Incident	Nature of data involved	Number of People Potentially Affected	Notification Steps
Nov 2010	Loss of Inadequately Protected Electronic Storage Device due to theft of lap top	Name, Address, Dates of Birth, Diagnostic Charts	110	NHS Northwest and the Information Commissioner's Office.

Following this incident security was reviewed within the area where the theft occurred and further changes were made to the organisations procurement process for IT related products and data encryption controls enhanced for mobile devices.

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 and Diversity and Human Rights

The trust ensures that its obligations under the equality and diversity and human rights legislation are complied with via the production of its equality diversity scheme and associated action plan. This is managed through the Equality and Diversity Sub Committee which reports to the Quality Improvement Board. Any risks which arise are highlighted within the Assurance Framework. The trust has approved a revised Single Equality Scheme which incorporates the General Duty requirements under the Equality Act 2010, and this will be further reviewed during 2011 once the consultation on the Specific Duty requirements has completed and have been published.

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

5. Review of Economy, Efficiency and Effectiveness of the Use of Resources

The foundation trust's financial plan, which was submitted to Monitor, Independent Regulator of Foundation Trusts, included a planned surplus of £0.6million for the period from 1 April 2010 to March 31st 2011. This plan included a savings target of £9.4million (described within the organisation as the cost improvement programme target) which has been delivered in the year. The actual surplus delivered by the trust for the year ended 31 March 2011 is £0.9million, which is in line with the plans submitted to Monitor at the start of the financial year and as forecast in the trust's annual plan for 2010/11.

The resources of the foundation trust are managed within the framework set by the Standing Financial Instructions and various guidance documents that are produced within the foundation trust which have a particular emphasis on budgetary control and ensuring that service developments are implemented with appropriate financial controls.

The Board of Directors receives a comprehensive finance report on a monthly basis incorporating all relevant financial information including future projections to allow them to discharge their duties effectively.

The foundation trust also provides financial information to Monitor, the independent Regulator of Foundation Trusts on a quarterly basis inclusive of financial tables and a commentary.

The financial results and performance against the relevant Governance rating metrics is reported to the Governors Council and is discussed in detail on a quarterly basis at the Governors Compliance with Authorisation Sub-Committee.

The resource and financial governance arrangements are further supported by both internal and external audit to secure economic, efficient and effective use of the resources the Foundation Trust has at its disposal.

Clinical Divisions and other corporate functions are explicitly made responsible for the delivery of financial and other performance targets through a system of Performance Targets which are agreed as part of the annual business planning cycle and monitored through a series of meetings led by the Chief Operating Officer and the Director of Finance.

6. 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, and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the Head of Internal Audit Opinion of Significant Assurance in relation to internal control and comments made by the external auditors in their management letter and other reports.

I have also received independent auditor assurance provided on behalf of NHS Shared Business Services Ltd clients confirming the robustness and effectiveness of controls associated with the shared financial services provided to the trust.

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

There have been no significant gaps in control to report in this statement.

7. Annual Quality Report

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

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

- The trust has two strategic objectives focussing on quality and safety and patient experience, these being: 1) Ensure all patients are safe in our care and 2) Give our patients the best possible experience.
- The Board has appointed the Director of Nursing to lead, and advise it, on all matters relating to the preparation of the trust's annual Quality Account for 2010/11.
- In May 2010, the Board established a Quality Improvement Committee which provides ongoing assurance and drives the delivery of the trust's quality improvement strategy and performance targets described in the annual Quality Report & Accounts.

- The trust has continued to implement the Leading Improvement in Patient Safety initiative, run by the NHS Institute, which has resulted in improvements to the quality and safety of care provided.
- The Trust Board continue to gain assurance from the clinical nursing care indicators which demonstrate an improvement in the nursing care on the wards, the indicators have been expanded to cover maternity and emergency areas of the hospital and will be measured quarterly from 2011/12.
- The trust has engaged Governors, PCT Commissioners and LINks in the preparation of the Quality Accounts of this Trust.
- The trust has a monthly patient experience group with membership including patient representatives, Governors, both Warrington and Halton LINKs and PCT representation as well as trust staff. All real time and retrospective patient experience feedback is reviewed in this meeting and ensures patient experience is integral to planning and review of services and informs where improvements are targeted. The trust also continues to work with a range of Community Groups, as well as self-help groups, in specific areas.
- The quality accounts will be shared with the patient experience group in draft format who last year gave a valuable perspective on content; language and presentation.

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

- The trust meets monthly with the PCT to specifically discuss performance against quality performance measures contained within the Contract for Healthcare services. The trust has received confirmation from the Lead Commissioner that they will provide a corroborative statement on the Quality Report & Accounts.
- The Annual Internal Audit programme agreed by the Audit Committee includes a review of elements of the systems, processes and performance metrics which are included in or support the preparation of the annual Quality Account.
- 2010/11 plan for the Quality Account has ensured close working and involvement with the governors through the various stages.

Mel Pickup
Chief Executive
1st June 2011

11. Financial Statements

Foreword to the accounts for the period 1st April 2010 to 31st March 2011

These accounts for the period ended 31st March 2011 have been prepared by the Warrington and Halton Hospitals NHS Foundation Trust under a direction issued by Monitor in accordance with Schedule 7, sections 24 and 25 of the National Health Services Act 2006.

Mel Pickup
Chief Executive
1st June 2011

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

I have audited the financial statements of Warrington and Halton Hospitals NHS Foundation Trust for the period ended 31 March 2011 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 89
- the table of pension benefits of senior managers and related narrative notes on page 90 and 91.

This report is made solely to the Governors' Council of Warrington and Halton Hospitals NHS Foundation Trust in accordance with paragraph 24(5)of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Governors' Council those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Warrington and Halton Hospitals NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

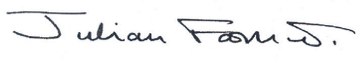
- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Statement on Internal Control on which I report to you if, in my opinion the Statement on Internal Control does not reflect compliance with Monitor's requirements.

Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide external assurance over the Trust's annual quality report. I am satisfied that this work does not have a material effect on the financial statements.



Julian Farmer FCA
Officer of the Audit Commission
3rd Floor Millennium House
60 Victoria Street
Liverpool
L1 6LD

6th June 2011

NB: References in this auditor's report to pages 89 and 90 and 91 refer to the audit carried out on the initial draft of the Annual Report and refer to the tables and narrative on pages 60 and 61 in this final edition of the Annual Report.

Statement of Comprehensive Income for the Year Ended 31st March 2011

	NOTE	2010/11 £000	2009/10 £000
Operating Income from continuing operations	2	198,893	194,538
Operating Expenses of continuing operations	3	(194,276)	(186,684)
OPERATING SURPLUS/(DEFICIT)		**4,617**	**7,854**
FINANCE COSTS			
Finance income	6	57	24
Finance expense - financial liabilities	7	(142)	(246)
Finance expense - unwinding of discount on provisions		0	0
PDC Dividends payable		(3,567)	(3,622)
NET FINANCE COSTS		**(3,652)**	**(3,844)**
Corporation tax expense		0	0
Surplus/(deficit) from continuing operations		**965**	**4,010**
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations		0	0
SURPLUS/(DEFICIT) FOR THE YEAR		**965**	**4,010**
Other comprehensive income			
Impairments	22	0	(8,240)
Revaluations		0	0
Receipt of donated assets		0	0
Asset disposals		0	0
Share of comprehensive income from associates and joint ventures		0	0
Movements arising from classifying non current assets as Assets Held for Sale		0	0
Fair Value gains/(losses) on available-for-sale financial investments		0	0
Recycling gains/(losses) on available-for-sale financial investments		0	0
Other recognised gains and losses		0	0
Actuarial gains/(losses) on defined benefit pension schemes		0	0
Other reserve movements		(161)	(147)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE PERIOD		**804**	**(4,377)**
Prior period adjustments		0	0
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**804**	**(4,377)**
Note: Allocation of Profits/(Losses) for the period:			
(a) Surplus/(Deficit) for the period attributable to :			
(i) minority interest, and		0	0
(ii) owners of the parent		965	4,010
TOTAL		**965**	**4,010**
(b) total comprehensive income/(expense) for the period attributable to:			
(i) minority interest, and		0	0
(ii) owners of the parent		804	(4,377)
TOTAL		**804**	**(4,377)**

The notes on pages 74 to 91 form part of these accounts.

Statement of Financial Position as at 31st March 2011

	NOTE	31/3/2011 £000	31/3/2011 £000
Intangible assets	9	184	109
Property, plant and equipment	10	114,170	116,855
Investment property		0	0
Investments in associates (and joined controlled operations)		0	0
Other Investments		0	0
Trade and other receivables	13	1,266	1,231
Other financial assets		0	0
Tax receivable		0	0
Other assets		0	0
Total non-current assets		**115,620**	**118,195**
Current assets			
Inventories	12	2,517	2,604
Trade and other receivables	13	6,293	6,624
Other financial assets		0	0
Tax receivable		0	0
Non-current assets for sale and assets in disposal groups		0	0
Cash and cash equivalents	15	12,182	9,671
Total current assets		**20,992**	**18,899**
Current liabilities			
Trade and other payables	16	(12,873)	(12,390)
Borrowings	17	(900)	(900)
Other financial liabilities		0	0
Provisions	20	(847)	(1,590)
Tax payable	16	(2,722)	(3,434)
Other liabilities	19	(3,139)	(2,595)
Liabilities in disposal groups		0	0
Total current liabilities		**(20,481)**	**(20,909)**
Total assets less current liabilities		**116,131**	**116,185**
Non-current liabilities			
Trade and other payables	16	0	0
Borrowings	17	(1,350)	(2,250)
Other financial liabilities		0	0
Provisions	20	(1,416)	(1,314)
Tax payable	16	0	0
Other liabilities	19	(994)	(1,054)
Total non-current liabilities		**(3,760)**	**(4,618)**
Total assets employed		**112,371**	**111,567**
Financed by (taxpayers' equity)			
Minority interest		0	0
Public dividend capital		75,950	75,950
Revaluation reserve	22	27,187	28,009
Donated asset reserve		1,078	1,239
Available for sale investments reserve		0	0
Other reserves		0	0
Merger reserve		0	0
Income and expenditure reserve		8,156	6,369
Total taxpayers' equity		**112,371**	**111,567**

The primary financial statements on pages 68 to 73 and the notes on pages 74 to 91 were approved by the Board of Directors on 1st June 2011 and signed on its behalf by Mel Pickup, Chief Executive.

Signed:  (Chief Executive) **Date:** 1st June 2011

Statement of Changes in Taxpayers' Equity

	Total	Minoroty interest	Public dividend capital (PDC)	Revaluation reseve	Donated asset reserve	Other reserves	Income & expenditure reserve
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1st April 2010	111,567	0	75,950	28,009	1,239	0	6,369
Surplus/(deficit) for the year/(period)	965	0	0	0	0	0	965
Impairments	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0
Receipt of donated assets	0	0	0	0	0	0	0
Asset disposals	0	0	0	0	0	0	0
Share of comprehensive income from associate and joint ventures	0	0	0	0	0	0	0
Movements arising from classifying non current assets as assets held for sale	0	0	0	0	0	0	0
Fair value gains/(losses) on available-for-sale financial investment	0	0	0	0	0	0	0
Recycling gains/(losses) on available-for-sale financial investment	0	0	0	0	0	0	0
Other recognised gains and losses	0	0	0	0	0	0	0
Actuarial gains/(losses) on defined benefit pension schemes	0	0	0	0	0	0	0
Public Dividend Capital received	0	0	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0	0	0
Public Dividend Capital written off	0	0	0	0	0	0	0
Other reserve movements	(161)	0	0	(822)	(161)	0	822
Taxpayers' Equity at 31st March 2011	**112,371**	**0**	**75,950**	**27,187**	**1,078**	**0**	**8,156**

	Total	Minoroty interest	Public dividend capital (PDC)	Revaluation reseve	Donated asset reserve	Other reserves	Income & expenditure reserve
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1st April 2009	115,944	0	75,950	37,066	1,386	0	1,542
Surplus/(deficit) for the year/(period)	4,010	0	0	0	0	0	4,010
Impairments	(8,240)	0	0	(8,240)	0	0	0
Revaluations	0	0	0	0	0	0	0
Receipt of donated assets	0	0	0	0	0	0	0
Asset disposals	0	0	0	0	0	0	0
Share of comprehensive income from associate and joint ventures	0	0	0	0	0	0	0
Movements arising from classifying non current assets as assets held for sale	0	0	0	0	0	0	0
Fair value gains/(losses) on available-for-sale financial investment	0	0	0	0	0	0	0
Recycling gains/(losses) on available-for-sale financial investment	0	0	0	0	0	0	0
Other recognised gains and losses	0	0	0	0	0	0	0
Actuarial gains/(losses) on defined benefit pension schemes	0	0	0	0	0	0	0
Public Dividend Capital received	0	0	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0	0	0
Public Dividend Capital written off	0	0	0	0	0	0	0
Other reserve movements	(147)	0	0	(817)	(147)	0	817
Taxpayers' Equity at 31st March 2009	**111,567**	**0**	**75,950**	**28,009**	**1,239**	**0**	**6,369**

Statement of Cash Flows for the Year Ended 31st March 2011

	2010/11 £000	2009/10 £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	**4,617**	**7,854**
Operating surplus/(deficit) from discontinued operations	**0**	0
Operating surplus/(deficit)	**4,617**	**7,854**
Non-cash income and expense		
Depreciation and amortisation	5,577	6,430
Impairments	144	1,183
Reversals of impairments	0	(1,057)
Transfer from donated asset reserve	(161)	(147)
Amortisation of government grants	0	0
Amortisation of PFI credit	0	0
(Increase)/Decrease in Trade and Other Receivables	296	1,791
(Increase)/Decrease in Other Assets	0	0
(Increase)/Decrease in Inventories	87	(201)
Increase/(Decrease) in Trade and Other Payables	483	(2,634)
Increase/(Decrease) in Other Liabilities	484	425
Increase/(Decrease) in Provisions	(641)	1,164
Tax (paid)/received	(712)	166
Movements in operating cash flow of discontinued operations	0	0
Other movements in operating cash flows	(120)	109
Net cash generated from/(used in) operations	**10,054**	**15,083**
Cash flows from investing activities		
Interest received	57	24
Purchase of financial assets	0	0
Sales of financial assets	0	0
Purchase of intangible assets	(97)	(109)
Sales of intangible assets	0	0
Purchase of Property, Plant and Equipment	(3,014)	(5,766)
Sales of Property, Plant and Equipment	0	0
Cash flows attributable to investing activities of discontinued operations	0	0
Cash from acquisitions of business units and subsidiaries	0	0
Cash from disposals of business units and subsidiaries	0	0
Net cash generated from/(used in) investing activities	**(3,054)**	**(5,851)**
Cash flows from financing activities		
Public dividend capital received	0	0
Public dividend capital repaid	0	0
Loans received	0	0
Loans repaid	(900)	(2,332)
Capital element of finance lease rental payments	0	0
Capital element of Private Finance Initiative Obligations	0	0
Interest paid	(136)	(246)
PDC Dividend paid	(3,453)	(3,731)
Cash flows attributable to financing activities of discontinued operations	0	0
Cash flows from/(used in) other financing activities	0	0
Net cash generated from/(used in) financing activities	**(4,489)**	**(6,309)**
Increase/(decrease) in cash and cash equivalents	2,511	2,923
Cash and cash equivalents at 1st April	**9,671**	**6,748**
Cash and cash equivalents at 31st March	**12,182**	**9,671**

Notes to the Accounts

1. Accounting policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

The Directors have a reasonable expectation that the NHS Foundation Trust will continue in operational existence for the foreseeable future and have therefore continued to adopt the going concern basis in preparing these accounts.

1.1 Accounting convention

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

1.2 Key sources of judgement and estimation uncertainty

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

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

Provisions

Pension provisions relating to former employees, including directors, have been calculated using the life expectancy estimates from the Government's actuarial tables.

Other legal claims provisions relate to employer and public liability claims and expected costs are advised by the NHS Litigation Authority.

Provision for impairment of receivables

A provision for impairment of receivables has been made for amounts which are uncertain to be received from NHS and Non NHS organisations. The provision includes 9.6% of accrued Injury Cost Recovery (ICR) income to reflect the average value of claims withdrawn as advised to the Department of Health by the Compensation Recovery Unit.

Provision for staff and associate specialist (SAS) doctors

A new pay contract was issued for SAS Doctors in April 2008. Doctors in post at the time had the opportunity to transfer onto the new pay contract and the majority of doctors in post are now being paid under the new contract terms and conditions. 8 doctors who have not yet transferred could potentially transfer to the new contact, at which point back pay will be due to these doctors. A provision for this has been included in the annual accounts which has been estimated based on Doctors in post as at 31st March 2008. Additional guidance on the calculation has been sought using Employee Contract Terms and Conditions.

Asset valuations and lives

The value and remaining useful lives of land and building assets are estimated by the District Valuers of the HM Revenue & Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. No building indices have been applied as research into building costs implies the fair value of the buildings has not increased.

The last asset valuation was undertaken in 2009 as at the prospective valuation date of 1st April 2010 and was applied on 31st March 2010.

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

Software licences are depreciated over the shorter of the term of the licence and the useful economic life.

Employee benefits

Annual leave entitlement not taken is accrued for at the year end. Accruals are calculated using a sample of Trust employees with each member of staff in the sample assumed to be on the mid point of their salary band.

1.3 Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:

a. the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;

b. if a termination, the former activities have ceased permanently;

c. the sale or termination has a material effect on the nature and focus of the Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS Foundation Trust's continuing operations; and

d. the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as continuing.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is from commissioners for healthcare services. Income relating to patient care spells that are partially completed at the year end are immaterial and therefore excluded from the accounts.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the ICR Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Other operating income is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of this income is from Strategic Health Authorities, Primary Care Trusts, NHS Trusts, NHS Foundation Trusts and Borough Councils.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional cost is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 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 the consideration payable. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as an intangible asset or an item of property, plant and equipment.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Measurement

Intangible assets are initially recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point this it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains, losses and impairments are treated in the same manner as for property, plant and equipment.

Economic life of intangible assets

	Minimum life years	Maximum life years
Software	5	5

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- a number of items which collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is initially measured at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Professional valuations are carried out by the District Valuers of the HM Revenue & Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date.

Fair values are determined as follows:

Land and non specialised buildings
– market value for existing use.

Specialised buildings
– depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de- recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.9 Depreciation

Items of property, plant and equipment are depreciated on a straight-line basis over their estimated useful lives to a residual value. No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction are not depreciated until the asset is brought into operational use.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Estimated useful lifes

	Minimum life years	Maximum life years
Buildings excluding dwellings	16	46
Dwellings	27	43
Plant & Machinery	5	15
Information Technology	5	8
Furniture and Fittings	7	10

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments

At each reporting period end, the Trust checks whether there is any indication that any of its tangible assets have suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.10 Donated assets

Donated non-current assets are capitalised at their current value receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the Statement of Comprehensive Income. Similarly, any impairment on donated assets charged to the Statement of Comprehensive Income is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value is transferred from the donated asset reserve to the Income and Expenditure Reserve.

1.11 Government grants

Government grants are grants from Government bodies other than income from Primary Care Trusts, NHS Trusts or NHS Foundation Trusts, for the provision of services. Grants from the Department of Health, are accounted for as Government grants, as are grants from the Big Lottery Fund. Where the 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 the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.12 Leases

Leases are classified as finance leases when substantially all risks and rewards of ownership are transferred to the lessee. The Trust does not hold any finance leases. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rents are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased buildings are assessed as to whether they are operating or finance leases.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.14 Cash and cash equivalents

Cash, bank and overdraft balances are recorded at the current value. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, Finance Income (interest receivable) and Finance Expense (interest payable) in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate. Balances exclude monies held in bank accounts belonging to patients (Note 15 Third Party Assets).

1.15 Liquid resources

Deposits and other investments that are readily convertible into known amounts of cash, at or close to, their carrying amounts, are treated as liquid resources in the Statement of Cash Flow. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase. In accordance with the Trust's Treasury Management Policy, the maximum investment period is 3 months.

1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provision and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

1.17 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 21 but is not recognised in the Trust's accounts.

1.18 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and, in return, receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.19 Commercial insurance

The Trust has arranged additional commercial insurance cover, as detailed below, to supplement the schemes in 1.18:

Property Damage and Business Interruption
Group Personal Accident
Engineering Insurance
Directors & Officers Liability
Motor Vehicle Insurance

1.20 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation tax

The introduction of Corporation Tax for NHS Foundation Trusts has been deferred. However during the period under review, the Trust did not have any trading accounts and therefore would have no Corporation Tax Liability.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31st March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenses in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.23 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. Details of third party assets are given in Note 15 to the accounts.

1.24 Public dividend capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in a NHS Foundation Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for (i) donated assets (ii) cash balances held with Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the unaudited version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.25 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, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.26 Subsidiaries

The Trust does not have any subsidiaries nor does it consider Charitable Funds to be a subsidiary.

1.27 Financial assets & financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure', Loans and Receivables or Available for Sale Financial Assets.

Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial Liabilities'.

Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. The Trust does not hold any financial assets or financial liabilities at 'fair value through income and expenditure'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market and are included in current assets.

The Trust's loans and receivables comprise: Cash at bank and in hand, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

The Trust does not hold any available-for-sale financial assets.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the Statement of Comprehensive Income.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from any of quoted market prices, independent appraisals or discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of the impaired receivables provision account.

1.28 Accounting standards and amendments issued but not yet adopted in the Annual Reporting Manual

IFRS 7 Financial Instruments and Disclosures - Transfers of financial assets (amendment). Effective date 2012/13 but not yet adopted by the European Union (EU). This amendment will not have an impact on the Trust.

IFRS 9 Financial Instruments. Effective date uncertain. The new requirement is likely to have some impact on how the Trust discloses its Financial Instruments.

IAS12 Income Taxes (amendment). Effective date 2012/13 but not adopted by the EU. This amendment will not have an impact on the Trust.

IAS24 Related Party Disclosures (revision). Effective date 2012/13. The revised standard will apply to the Trust but is not expected to have a significant impact on the Trust's Financial Statements.

Annual Improvements 2010. Effective date 2011/12. The International Accounting Standards Board (IASB) has adopted the annual improvement process to deal with non urgent but necessary amendments to Financial Reporting Standards. At the time of submission the Trust is not aware of the full impact of these changes.

IFRIC14 Prepayments of a minimum funding requirement (amendment). Effective date 2011/12. This revised standard will not have an impact on the Trust.

IFRIC19 Extinguishing financial liabilities with Equity Instruments. Effective date 2011/12. This revised standard will not have an impact on the Trust.

IFRS - International Financial Reporting Standards
IFRIC - International Financial Reporting Interpretations Committee
IAS - International Accounting Standard

2. Operating Income

2.1 Income from activities

	2010/11 £000	2009/10 £000
Mandatory Income		
Elective income	34,591	35,789
Non elective income	69,116	72,093
Outpatient income	31,888	29,480
A & E income	8,681	8,014
Other NHS clinical income	35,767	31,294
Non Mandatory Income		
Private patient income	119	62
Other non-protected clinical income*	2,039	1,803
Total Income from Activities	**182,201**	**178,535**

*Other non-protected clinical income relates to the income received from the Compensation Recovery Unit.

2.2 Private patient income

	2010/11 £000	2009/11 £000	2002/03 £000
Private patient income	119	62	269
Total patient related income	182,201	178,535	129,162
Proportion (as percentage)	0.07%	0.03%	0.21%

To comply with the NHS Foundation Trust's Terms of Authorisation as a Foundation Trust and section 44 of the 2006 Act, the NHS Foundation Trust must ensure that the income received from treating private patients during the year does not exceed a cap of 0.21% of the total income from activities earned whilst the body was an NHS Trust in 2002/03. The Trust is therefore compliant with its obligation in this respect.

2.3 Operating lease income

The Trust received £221k during the year in respect of rental income (£52k in 2009/10).

2.4 Operating income by type

	2010/11 £000	2009/10 £000
Primary Care Trusts	179,405	176,001
Department of Health - other	0	0
NHS Other	638	669
Non NHS: Private patients	119	62
NHS injury scheme	2,039	1,803
Non NHS: Other	0	0
Total	**182,201**	**178,535**

Other operating income

	2010/11 £000	2009/10 £000
Education and training	6,955	6,579
Transfers from the donated asset reserve in respect of depreciation, impairment and disposal of donated assets	161	147
Non-patient care services to other bodies	2,999	2,864
Other	6,577	6,413
Total	**16,692**	**16,003**

Other operating income of £6.6m (£6.4m in 2009/10) includes: staff recharges £2.3m (£2.7m in 2009/10) , IT funding £1m (£1m in 2009/10), clinical tests £0.6m (£0.5m in 2009/10), catering £0.4m (£0.3m in 2009/10), estate recharges £0.03m (£0.2m in 2009/10) and other misc income of £2.2m (£1.7m in 2009/10).

Total income

	2010/11 £000	2009/10 £000
Total Income from Activities	182,201	178,535
Total Other Operating Income	16,692	16,003
Total	**198,893**	**194,538**

2.5 Operating segments

The Trust has only one operating segment - Provision of Healthcare and has reported all activities as such.

3. Operating expenses

	2010/11 Total £000	2009/10 Total £000
Services from other NHS Bodies	98	108
Purchase of healthcare from non NHS bodies	150	302
Employee Expenses - Executive directors	884	929
Employee Expenses - Non-executive directors	118	118
Employee Expenses - Staff	138,357	134,562
Drug costs	9,116	8,420
Supplies and services - clinical (excluding drug costs)	16,402	15,712
Supplies and services - general	2,859	2,911
Establishment	2,316	2,196
Transport	1,556	1,527
Premises	8,166	7,881
Increase / (decrease) in bad debt provision	248	25
Depreciation on Property Plant and Equipment	5,555	6,430
Amortisation of Intangible Assets	22	0
Impairments of Property Plant and Equipment	144	1,183
Reversal of impairments - Property Plant and Equipment	0	(1,057)
Audit Fees - Statutory Audit	93	64
Clinical negligence	4,258	3,512
Legal fees	150	237
Consultancy Costs	1,783	350
Training Courses and Conferences	799	563
Patient travel	20	21
Redundancy	162	0
Insurance	123	98
Losses, ex gratia & special payments	17	7
Other	880	585
TOTAL	**194,276**	**186,684**

4. Employee expenses

4.1 Employee expenses

2010/11	Total £000	Permanently Employed £000	Agency Contract Staff £000
Salaries and Wages	105,565	105,565	
Social Security Costs	8,056	8,056	0
Pension costs - Employer contributions to NHS Pensions	12,304	12,304	0
Termination benefits	162	162	0
Agency Contract Staff	13,392	0	13,392
Total	**139,479**	**126,087**	**13,392**

2009/10	Total £000	Permanently Employed £000	Agency Contract Staff £000
Salaries and Wages	104,953	104,953	0
Social Security Costs	7,385	7,385	0
Pension costs - Employer contributions to NHS Pensions	10,838	10,838	0
Termination benefits	0	0	0
Agency Contract Staff	12,315	0	12,315
Total	**135,491**	**123,176**	**12,315**

4.2 Average number of persons employed

2010/11	Total Number	Permanently Employed Number	Other Number
Medical and Dental	360	360	0
Administration and Estates	727	727	0
Healthcare Assistants and other support staff	710	710	0
Nursing, Midwifery and health visiting staff	1,068	1,068	0
Scientific, therapeutic and technical staff	501	501	0
Bank and Agency Staff	154	0	154
Other	0	0	0
Total	**3,520**	**3,366**	**154**

2009/10	Total Number	Permanently Employed Number	Other Number
Medical and Dental	336	336	0
Administration and Estates	713	713	0
Healthcare Assistants and other support staff	668	668	0
Nursing, Midwifery and health visiting staff	1,060	1,060	0
Scientific, therapeutic and technical staff	481	481	0
Bank and Agency Staff	164	0	164
Other	0	0	0
Total	**3,422**	**3,258**	**164**

4.3 Employee benefits

An accrual in respect of annual leave entitlement carried forward at the balance sheet date of £601k has been provided for within the accounts. (£539k as at 31st March 2010). No other employee benefits were made during the period.

4.4 Early retirements due to ill-health

Five members of staff retired early on ill health grounds during the year at an additional cost of £235,351 (6 members of staff at a cost of £193,155 for the period ending 31st March 2010). These retirements represent 1.50 per 1,000 active scheme members. The cost of ill health retirements are borne by the NHS Business Services Authority - Pensions Division.

4.5 Directors remuneration and other benefits

	2010/11 £000	2009/10 £000
Directors Remuneration	794	851
Employer Contributions to NHS Pension Scheme	106	102
No of directors to whom benefits are currently accruing under the NHS Pension Scheme	7	7

4.6 Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
£10,001 - £25,000	1	0	1
£25,001 - £50,000	1	0	1
£100,001 - £150,000	1	0	1
Total number of exit packages by type	3	0	3
Total resource cost	£202,000	0	£202,000

The Trust faces significant challenges over the forthcoming years to respond to the well publicised reductions in NHS allocations. To assist in facilitating the necessary change and efficiencies, a time-limited Mutually Agreed Resignation Scheme (MARS) has been introduced. The scheme offers a financial package to a member of staff to leave their employment on voluntary terms.

The Scheme was opened to applicants between 17th March 2011 and 30th April 2011. At the time of submitting the Annual Accounts the Trust had not approved any applications under this scheme.

5.1 Operating leases

	2010/11 £000	2009/10 £000
Minimum lease payments	293	258
Contingent rents	0	0
Less sublease payments received	0	0
Total	**293**	**258**

5.2 Arrangements containing an operating lease

	2010/11 £000	2009/10 £000
Future minimum lease payments due:		
- not later than one year	206	154
- later than one year and not later than five years	755	386
- later than five years	2,061	1,794
Total	**3,022**	**2,334**

5.3 The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments made under this legislation.

Better Payment Practice Code - measure of compliance

2010/11	Number	£000
Total Non-NHS trade invoices paid in the period	61,890	47,059
Total Non NHS trade invoices paid within target	50,182	38,925
Percentage of non-NHS trade invoices paid within agreed payment terms	**81%**	**83%**
Total NHS trade invoices paid in the period	2,824	17,352
Total NHS trade invoices paid within target	1,669	9,080
Percentage of NHS trade invoices paid within agreed payment terms	**59%**	**52%**

2009/10	Number	£000
Total Non-NHS trade invoices paid in the period	66,740	50,276
Total Non NHS trade invoices paid within target	56,171	43,202
Percentage of non-NHS trade invoices paid within agreed payment terms	**84%**	**86%**
Total NHS trade invoices paid in the period	3,556	21,600
Total NHS trade invoices paid within target	1,951	14,211
Percentage of NHS trade invoices paid within agreed payment terms	**55%**	**66%**

As a NHS Foundation Trust there is no statutory requirement to achieve a target of 95% of invoices paid within 30 days. The Trust however considers this to be good practice and monitors its progress against the 95% target.

6. Finance income (interest receivable)

During the year, the Trust received £31k from cash deposited in accounts held with GBS (£23k in 2009/10). Additional interest was received during the year of £24k as a result of the Trust investing £4m in a Barclays Business Premium account in accordance with its current Treasury Management Policy (£1k in 2009/10 in respect of £1m invested) and £2k from debtors in respect of amounts recovered through external debt recovery (nil in 2009/10).

7. Finance expense (interest payable)

The Trust incurred finance expenses during the period on the following loans as detailed below;

	2010/11 £000	2009/10 £000
Working Capital Loan	0	60
Capital Loan	142	186
Total	**142**	**246**

8. Impairment of Assets

The Trust has impaired a number of assets with a net book value as at 31st March 2011 of £144k. The financial impact of these impairments charges operating expenses with £144k and a transfer from the donated asset reserve to other income of £37k, giving a net effect of £107k.

9. Intangible assets

9.1 Intangible assets 2010/11

	Total	Software licences (purchased)	Licences & trademarks (purchased)	Patents (purchased)	Information technology (internally generated)	Development expenditure (internally generated)	Other (purchased)	Other (internally generated)	Goodwill	Intangible Assets Under Construction
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1st April 2010	**109**	**109**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to revaluation reserve										
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation surplus	0	0	0	0	0	0	0	0	0	0
Additions - purchased	97	97	0	0	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Gross cost at 31st March 2011	**206**	**206**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation at 1st April 2010	0	0	0	0	0	0	0	0	0	0
Provided during the year	22	22	0	0	0	0	0	0	0	0
Impairments recognised in the income and expenditure account	0	0	0	0	0	0	0	0	0	0
Reversal of impairments recognised in the income and expenditure account	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation surplus	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Amortisation at 31st March 2011	**22**	**22**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

9.2 Intangible assets 2009/10

	Total	Software licences (purchased)	Licences & trademarks (purchased)	Patents (purchased)	Information technology (internally generated)	Development expenditure (internally generated)	Other (purchased)	Other (internally generated)	Goodwill	Intangible Assets Under Construction
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1st April 2009	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to revaluation reserve		0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation surplus	0	0	0	0	0	0	0	0	0	0
Additions - purchased	109	109	0	0	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Gross cost at 31st March 2010	**109**	**109**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation at 1st April 2009	0	0	0	0	0	0	0	0	0	0
Provided during the year	0	0	0	0	0	0	0	0	0	0
Impairments recognised in the income and expenditure account	0	0	0	0	0	0	0	0	0	0
Reversal of impairments recognised in the income and expenditure account	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation surplus	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Amortisation at 31st March 2009	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

9.3 Intangible assets financing

	Total	Software licences (purchased)	Licences & trademarks (purchased)	Patents (purchased)	Information technology (internally generated)	Development expenditure (internally generated)	Other (purchased)	Other (internally generated)	Goodwill	Intangible Assets Under Construction
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value										
NBV - Purchased at 31st March 2011	184	184	0	0	0	0	0	0	0	0
NBV - Donated at 31st March 2011	0	0	0	0	0	0	0	0	0	0
NBV total at 31st March 2011	**184**	**184**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value										
NBV - Purchased at 31st March 2010	109	109	0	0	0	0	0	0	0	0
NBV - Donated at 31st March 2010	0	0	0	0	0	0	0	0	0	0
NBV total at 31st March 2010	**109**	**109**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

10. Property, plant and equipment

10.1 Property, plant and equipment 2010/11

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1st April 2010	**139,307**	**19,181**	**88,444**	**1,183**	**0**	**22,529**	**0**	**7,208**	**762**
Additions - purchased	3,014	0	2,124	0	0	588	0	302	0
Additions - donated	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	(3)	0	0	2	0	(2)	3
Revaluation surpluses	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Cost or valuation at 31st March 2011	**142,321**	**19,181**	**90,565**	**1,183**	**0**	**23,119**	**0**	**7,508**	**765**
Depreciation at 1st April 2010	22,452	0	7,115	74	0	11,871	0	2,916	476
Provided during the year	5,555	0	3,056	42	0	1,590	0	819	48
Impairments recognised in operating expenses	144	0	0	0	0	144	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Other revaluations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Depreciation at 31st March 2011	**28,151**	**0**	**10,171**	**116**	**0**	**13,605**	**0**	**3,735**	**524**

10.2 Property, plant and equipment 2009/10

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1st April 2009	**141,781**	**23,669**	**87,368**	**1,140**	**0**	**21,453**	**0**	**6,624**	**1,527**
Additions - purchased	5,766	0	4,026	0	0	1,223	0	506	11
Additions - donated	0	0	0	0	0	0	0	0	0
Impairments	(13,474)	(4,488)	(8,986)	0	0	0	0	0	0
Reclassifications	0	0	845	0	0	(147)	0	78	(776)
Other revaluations	5,234	0	5,191	43	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Cost or valuation at 31st March 2010	**139,307**	**19,181**	**88,444**	**1,183**	**0**	**22,529**	**0**	**7,208**	**762**
Depreciation at 1st April 2009	15,896	0	3,295	37	0	10,126	0	2,081	357
Provided during the year	6,430	0	3,694	37	0	1,745	0	835	119
Impairments	1,183	0	1,183	0	0	0	0	0	0
Reversal of impairments	(1,057)	0	(1,057)	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Other revaluations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Depreciation at 31st March 2010	**22,452**	**0**	**7,115**	**74**	**0**	**11,871**	**0**	**2,916**	**476**

10.3 Property, plant and equipment financing

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value 31st March 2011									
Owned	113,092	15,303	83,428	1,024	0	9,324	0	3,773	240
Donated	1,078	3,878	(3,034)	43	0	190	0	0	1
Total NBV at 31st March 2011	**114,170**	**19,181**	**80,394**	**1,067**	**0**	**9,514**	**0**	**3,773**	**241**
Net book value 31st March 2010									
Owned	115,616	19,181	80,413	1,109	0	10,341	0	4,292	280
Donated	1,239	0	916	0	0	317	0	0	6
Total NBV at 31st March 2010	**116,855**	**19,181**	**81,329**	**1,109**	**0**	**10,658**	**0**	**4,292**	**286**

11. Analysis of property, plant and equipment

11.1 Analysis of property, plant and equipment as at 31st March 2010

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000
NBV - Protected assets at 31st March 2010	99,653	19,181	79,363	1,109					
NBV - Unprotected assets at 31st March 2010	17,202	0	1,966	0	0	10,658	0	4,292	286
Total at 31st March 2010	**116,855**	**19,181**	**81,329**	**1,109**	**0**	**10,658**	**0**	**4,292**	**286**

11.2 Analysis of property, plant and equipment as at 31st March 2010

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000
NBV - Protected assets at 31st March 2011	98,740	19,181	78,492	1,067					
NBV - Unprotected assets at 31st March 2011	15,430	0	1,902	0	0	9,514	0	3,773	241
Total at 31st March 2011	**114,170**	**19,181**	**80,394**	**1,067**	**0**	**9,514**	**0**	**3,773**	**241**

12. Inventories

12.1 Inventories

	2010/11 £000	2009/10 £000
Materials	2,517	2,604
Total	**2,517**	**2,604**

Inventories consists of drugs, medical supplies and other consumable items.

12.2 Inventories recognised in expenses

The total expenditure on items classed as inventories recognised in expenses during the year was £26m (£24m in 2009/10) which includes £12k relating to the write down of stock items (Nil in 2009/10). The value of inventories purchased but not used as at 31st March 2011 was £2.5m as per table 12.1.

13. Trade and other receivables

	2010/11 £000	2009/10 £000
Current		
NHS receivables	1,013	3,165
Provision for impairment of receivables	(363)	(158)
Prepayments	1,401	1,166
Accrued income	2,118	96
PDC receivable	0	109
Other receivables	2,124	2,246
Sub Total	**6,293**	**6,624**
Non-current		
NHS receivables	0	0
Provision for impaired receivables	(134)	(104)
Other receivables	1,400	1,335
Sub Total	1,266	1,231
Total	**7,559**	**7,855**

Accrued income in respect of NHS organisations has been recorded in the current year as “Accrued income”. In 2009/10 NHS Accrued Income was recorded under NHS Receivables.

14. Receivables

14.1 Provision for impairment of receivables

	2010/11 £000	2009/10 £000
At 1st April	262	243
Increase in provision	248	25
Amounts utilised	(13)	(6)
Unused amounts reversed	0	0
At 31st March	**497**	**262**

14.2 Analysis of impaired receivables

	2010/11 £000	2009/10 £000
Ageing of impaired receivables		
Up to three months	0	0
In three to six months	0	0
Over six months	497	262
Total	**497**	**262**
Ageing of non-impaired receivables past their due date		
Up to three months	1,224	361
In three to six months	0	336
Over six months	176	555
Total	**1,400**	**1,252**

15. Cash and cash equivalents

	2010/11 £000	2009/10 £000
At 1st April	**9,671**	**6,748**
Net change in year	2,511	2,923
At 31st March	**12,182**	**9,671**
Broken down into:		
Cash at commercial banks and in hand	508	1,033
Cash with the Government Banking Service	11,674	8,638
Other current investments	0	0
Cash and cash equivalents as at 31st March 2011	**12,182**	**9,671**

Third party assets held by the Trust	**19**	**14**

At the end of the financial year the Trust held £19k within Trust bank accounts which related to patient monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts. Balances held in bank accounts £760k (£706k in 2009/10), managed by the Trust on behalf of its Charitable Funds, are excluded from cash at bank and in hand figure reported in the accounts.

16. Trade and other payables

	2010/11 £000	2009/10 £000
Current		
NHS payables	970	4,051
Trade payables capital	721	874
Other trade payables	4,853	1,920
Taxes payable	2,722	3,434
Other payables	35	145
Accruals	6,289	5,400
PDC payable	5	0
Total	**15,595**	**15,824**

Accruals in respect of NHS Organisations have been recordered in the current year as accruals. In 2009/10 these were recorded under NHS Payables.

17. Borrowings

	2010/11 £000	2009/10 £000
Current		
Other Loans	900	900
Total	**900**	**900**

	2010/11 £000	2009/10 £000
Non Current		
Other Loans	1,350	2,250
Total	**1,350**	**2,250**

18. Prudential borrowing limit

	2010/11 £000	2009/10 £000
Total long term borrowing limit set by Monitor	31,900	20,500
Working capital facility agreed by Monitor	15,000	15,000
Total prudential borrowing limit	**46,900**	**35,500**

NHS Foundation Trusts are able to borrow from commercial or public sources within limits set by Monitor through the Prudential Borrowing Code (PBC) and as specified in their Terms of Authorisation.

The Trust is required to comply and remain within a prudential borrowing limit which is made up of two elements:

> The maximum cumulative amount of long term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and can therefore impact on the long term borrowing limit.

> The amount of any working capital facility approved by Monitor.

The Trust has a prudential borrowing limit of £46.9m (£35.5m in 2009/10) including the working capital facility of £15m (£31.9m net limit). The Trust has £2.25m of outstanding borrowing against the net limit of £31.9m after having made loan repayments during the year of £0.9m.

The Trust has not utilised the working capital facility of £15m.

Financial Ratio	2010/11 Actual Ratios	2010/11 Approved PBL Ratios	2009/10 Actual Ratios	2009/10 Approved PBL Ratios
Minimum dividend cover	3	> 1 times	4	> 1 times
Minimum interest cover	73	> 3 times	59	> 3 times
Minimum debt service cover	10	> 2 times	15	> 2 times
Maximum debt service to revenue	0.52%	< 2.5%	0.56%	< 2.5%

19. Other liabilities

	2010/11 £000	2009/10 £000
Current		
Deferred income	1,541	671
Deferred government grant	65	85
Net pension scheme liability	1,533	1,839
Total Other Current Liabilities	**3,139**	**2,595**
Non Current		
Deferred income	0	0
Deferred government grant	994	1,054
Net pension scheme liability	0	0
Total Other Non Current Liabilities	**994**	**1,054**

20. Provisions for liabilities and charges

	2010/11 Total £000	Legal £000	Other £000	Pensions £000
At 1st April 2010	2,904	215	1,312	1,377
Change in the discount rate	193	0	0	193
Arising during the period	607	190	417	0
Utilised during the period	(1,026)	(74)	(830)	(122)
Reversed unused	(415)	(88)	(327)	0
As at 31st March 2011	**2,263**	**243**	**572**	**1,448**
Expected timing of cash flows:				
Within one year	847	151	572	124
Between one and five years	540	92	0	448
After five years	876	0	0	876
Subtotal > 1 year	1,416	92	0	1,324
Total	**2,263**	**243**	**572**	**1,448**

	2009/10 Total £000	Legal £000	Other £000	Pensions £000
At 1st April 2010	1,740	121	229	1,390
Change in the discount rate	0	0	0	0
Arising during the period	1,602	181	1,312	109
Utilised during the period	(313)	(38)	(153)	(122)
Reversed unused	(125)	(49)	(76)	0
As at 31st March 2011	**2,904**	**215**	**1,312**	**1,377**
Expected timing of cash flows:				
Within one year	1,590	157	1,312	121
Between one and five years	542	58	0	484
After five years	772	0	0	772
Subtotal > 1 year	1,314	58	0	1,256
Total	**2,904**	**215**	**1,312**	**1,377**

The amounts and timings of the above provisions are subject to significant uncertainty.

Pensions provision relates to early retirement costs in line with the NHS Business Service Authority - Pensions Division. Legal claims relates to employers and public liability claims advised by the NHS Litigation Authority. Others relates to estimated outstanding settlements.

21. Clinical negligence liabilities

£29,674k is included in the provisions of the NHS Litigation Authority as at 31st March 2011 in respect of clinical and employers liabilities of the Trust (£31,362k as at 31st March 2010).

22. Revaluation reserve

22.1 Revaluation reserve 2010/11

	Total Revaluation Reserve £000	Revaluation Reserve Intangibles £000	Revaluation Reserve Property, plant & equipment £000
Revaluation reserve at 1st April 2010	28,009	0	28,009
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	0
Other reserve movements	(822)	0	(822)
Revaluation reserve at 31st March 2011	**27,187**	**0**	**27,187**

22.2 Revaluation reserve 2009/10

	Total Revaluation Reserve £000	Revaluation Reserve Intangibles £000	Revaluation Reserve Property, plant & equipment £000
Revaluation reserve at 1st April 2009	37,066	0	37,066
Revaluation gains/(losses) and impairment losses property, plant and equipment	(8,240)	0	(8,240)
Other reserve movements	(817)	0	(817)
Revaluation reserve at 31st March 2010	**28,009**	**0**	**28,009**

The Trust has transferred £822k from the Revaluation Reserve to the Income and Expenditure reserve in respect of excess depreciation charges over historic cost. This transfer avoids the Revaluation Reserve remaining in perpetuity after an asset has become fully depreciated.

23. Related party disclosures

Warrington and Halton Hospitals NHS Foundation Trust is a public interest body authorised by Monitor, the Independent Regulator for NHS Foundation Trusts. During the financial year under review none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Warrington and Halton Hospitals NHS Foundation Trust. The Trust has received £197k in payments from Charitable Funds for which the Trust acts as Corporate Trustee. During the year Warrington and Halton Hospitals NHS Foundation Trust had a number of material transactions with other NHS entities which are listed below.

Related Party	2010/11 Income £000	2010/11 Expenditure £000	2009/10 Income £000	2009/10 Expenditure £000
Ashton, Leigh and Wigan PCT	3,503	2	3,570	0
Central & Eastern Cheshire PCT	3,571	0	3,372	0
Halton & St Helens PCT	62,277	91	60,384	61
Knowsley PCT	688	0	872	0
Liverpool PCT	941	138	687	147
National Blood Authority	0	1,117	0	1,338
NHS Business Services Authority	28	20,341	2	21,277
NHS Litigation Authority	0	4,258	0	3,518
NHS Purchasing & Supply Chain	0	4,678	0	4,096
North West Ambulance Service NHS Trust	38	1,211	3	1,267
North West Strategic Health Authority	6,627	57	6,744	7
Royal Liverpool and Broadgreen University Hospitals NHS Trust	694	1,120	627	1,925
Salford PCT	813	0	973	1
St Helens and Knowsley Hospitals NHS Trust	211	3,691	27	441
Warrington PCT	106,243	302	103,016	254
Western Cheshire PCT	3,657	28	3,794	301

Related Party	2010/11 Receivables £000	2010/11 Payables £000	2009/10 Receivables £000	2009/10 Payables £000
Ashton, Leigh and Wigan PCT	2	116	0	0
Central & Eastern Cheshire PCT	45	0	16	0
Halton & St Helens PCT	772	46	623	17
Knowsley PCT	0	81	0	34
Liverpool PCT	14	54	0	104
National Blood Authority	0	24	0	49
NHS Business Services Authority	0	1,533	20	1,861
NHS Litigation Authority	0	0	0	2
NHS Purchasing & Supply Chain	54	586	0	369
North West Ambulance Service NHS Trust	1	16	3	113
North West Strategic Health Authority	0	3	57	0
Royal Liverpool and Broadgreen University Hospitals NHS Trust	57	115	110	370
Salford PCT	0	192	0	41
St Helens and Knowsley Hospitals NHS Trust	109	247	42	11
Warrington PCT	1,033	83	11	1,878
Western Cheshire PCT	0	47	32	109

24. Contractual capital commitments

The Trust has contractual capital commitments of £239k as at the 31st March 2011(£210k as at 31st March 2010).

25. Financial instruments

Liquidity risk

The Trust's net operating costs are incurred under service level agreements/contracts with Primary Care Trusts which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

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 Primary Care Trusts in respect of healthcare services provided under agreements. Non NHS customers represent a small proportion of income, the majority of which relate to other public sector bodies which are considered low risk. The Trust is not, therefore exposed to significant credit risk.

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 also equates to fair value.

26. Financial assets & liabilities

26.1 Financial assets by category

	2010/11		2009/10	
	Loans and receivables	Assets at fair value through I & E	Loans and receivables	Assets at fair value through I & E
	£000	£000	£000	£000
Assets as per statement of financial position				
Trade and other receivables excluding non financial assets	3,501	0	4,443	0
Cash and cash equivalents at bank and in hand	12,182	0	9,671	0
Total Financial Assets	**15,683**	**0**	**14,114**	**0**

26.2 Financial liabilities by category

	2010/11		2009/10	
	Other financial liabilities	Liabilities at fair value through I & E	Other financial liabilities	Liabilities at fair value through I & E
	£000	£000	£000	£000
Liabilities as per statement of financial position				
Borrowings excluding Private Finance Initiative contracts	2,250	0	3,150	0
Trade and other payables excluding non financial assets	12,848	0	12,365	0
Provisions under contract	2,020	0	2,689	0
Total Financial Liabilities	**17,118**	**0**	**18,204**	**0**

27. Losses and special payments

There were 102 cases of losses and special payments totalling £133k (66 cases, £74k in 2009/10) paid during the year. During the year the Trust recovered £17k from the NHS Litigation Authority in respect of Public and Employers Liability payments made above the excess limit (£34k in 2009/10) giving net payments of £116k (£39k in 2009/10).

There were no cases exceeding £100k in either the current year or prior year.

28. Auditors liability

The Audit Commission is currently the Trust's Auditors and there is no limit on the Auditors Liability.

Warrington and Halton Hospitals
NHS Foundation Trust

Warrington Hospital

Lovely Lane, Warrington WA5 1QG
Tel: 01925 635911

Halton General Hospital

Hospital Way, Runcorn WA7 2DA
Tel: 01928 714567

Email: enquiries@whh.nhs.uk