5 Boroughs Partnership NHS
NHS Foundation Trust

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NHS Foundation Trust

Annual Report and Accounts
1 April 2016 to 31 March 2017

5 Boroughs Partnership NHS Foundation Trust

(From 1 April 2017, now known as North West Boroughs Healthcare NHS Foundation Trust)

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

Contents

Welcome from the Chairman and Chief Executive

Welcome to 5 Boroughs Partnership NHS Foundation Trust's Annual Report and Accounts for 2016/17.

This report covers the financial year of 2016/17 and sets out how we deliver high-quality mental health, learning disability and community services to service users and patients across the boroughs we serve.

It celebrates our key successes and acknowledges where our performance has not met targets set, why and how we plan to address this.

In July, the Care Quality Commission reinspected those areas which received a 'Requires Improvement' rating in 2015/16. As a result of the reinspection, we are delighted that our overall rating has been revised to 'Good'. Read more on page 8.

This year, we have built on the borough structure set up during 2015/16. Leadership teams have established themselves which has enabled us to align ourselves to the boroughs we serve, strengthen relationships and work closely on transforming and integrating services across the health system to focus on whole person care for the benefit of patients.

A big focus during the year has been on growing our Trust, the services we deliver and the footprint in which we deliver them. We are proud to have won a number of new contracts both within and outside of our existing boroughs.

This has seen around 500 staff join the Trust from other organisations up until 1 April 2017, with more due to join in summer 2017. More detail about these new contracts is available within the Performance Report, starting on page 7.

This growth and success has led to us make the decision to formally change our name from 1 April 2017 to North West Boroughs Healthcare NHS Foundation Trust. Details about this can be found within the Performance Report. For the purpose of this report, which predominantly looks back at the last 12 months, our Trust will be referred to as 5 Boroughs Partnership NHS Foundation Trust.

In March, our new mental health hospital – Atherleigh Park – opened in Leigh and has received positive feedback from patients, carers, staff, visitors and local residents. Full details are within the Quality Report, starting on page 99.

During 2016/17, we appointed our Vice Chair Helen Bellairs to succeed our current Chairman Bernard Pilkington when he retires on 16 May 2017.

We continue to listen to and work with our patients, service users, carers, governors and clinicians to drive service improvement and to shape services to meet need and improve patient experience.

In the Annual Report and Accounts, you will see we have met our quality regulatory ratings and our Trust is currently in a good financial position with good financial management.

Bernard Pilkington, **Chairman** Simon Barber, **Chief Executive**

Performance Report

1. Performance overview

1.1. Purpose

The performance overview aims to provide a short summary with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

1.2. Chief Executive's statement

2016/17 has been a successful year for our Trust. Our focus on growth has resulted in us winning and mobilising a number of new contracts and services both within and outside of our existing boroughs.

These include:

- 0-19 children's community services in St Helens
- Wigan child and adolescent mental health services single point of access and tier 2
- Greater Manchester criminal justice liaison and diversion service – in partnership with Care and Custody and Cheshire and Greater Manchester Community Rehabilitation Company
- 0-19 children's community services in Sefton
- Adults' community nursing and therapy services in St Helens – in partnership with St Helens and Knowsley Teaching Hospitals NHS Trust and St Helens Rota
- Perinatal mental health services across Cheshire and Merseyside in partnership with Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust
- Young people's community eating disorder services across Halton, Knowsley, St Helens, Warrington, Wigan and Bolton
- Adults' community services in South Sefton – in partnership with Mersey Care NHS Foundation Trust

As a result of this, in January, our Trust Board made the decision to change the Trust's name to reflect the extended geography and to recognise the new boroughs we now deliver services in.

A three-week consultation saw more than 1,000 responses from service users, carers, staff, stakeholders and public, with 61 per cent voting for North West Boroughs Healthcare NHS Foundation Trust.

At our meeting on 27 March, Trust Board approved a recommendation to accept the majority vote and change the name effective from 1 April 2017. Our Council of Governors also ratified this decision and our constitution has been updated accordingly.

The timing of the change coincides with directions from NHS Identity to update our Trust logo to comply with changes to national NHS branding guidance. As a result, we are able to combine the statutory changes required with updates to our new name branding.

Full details about the change, including responses to key themes raised as part of the consultation are available on our website: www.5boroughspartnership.nhs.uk/name-change

I'm extremely proud of our new £40 million mental health hospital in Leigh – Atherleigh Park – which opened to patients in March, offering a purpose-built environment which promotes enhanced privacy, dignity and respect and facilitates new ways of working and improved patient care with a focus on holistic care.

This has been the largest capital project ever undertaken by the Trust. The development has been an excellent example of working in partnership with service users, carers, local residents, councillors, and staff, alongside professional architects and building contractors. Find out more about Atherleigh Park in the Quality Report starting on page 99.

During the year, the Trust was subject to a follow-up inspection by the Care Quality Commission following the outcome of our first comprehensive inspection during 2015. The follow-up inspection took place in July, with the results published in November.

I am delighted that our overall Trust rating was adjusted from 'Requires Improvement' to 'Good'. All of our 13 core services are now rated as 'Good', and we are also rated as 'Good' across all five domains the Care Quality Commission inspects – safe, effective, caring, responsive and well-led. In addition, we are rated as 'Outstanding' for the caring domain within community health services.

The full report is available on our website at: www.5boroughspartnership.nhs.uk/cqc-reports

We are beginning to see some positive effects from our clinical transformation projects, resulting in improvements in patient care and efficient working. It will be exciting to see the impact these have in the future as more transformation projects are completed.

We have achieved our financial goals in times of significant hardship and pressure across the NHS, delivering a retained deficit of £60,000, in line with the control total set by NHS Improvement.

Finally, I am pleased to report that we have achieved all our 2016/17 quality priorities, as outlined in detail within the Quality Report starting on page 99.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2017

1.3. History, purpose and activities

Formed in 2002, 5 Boroughs Partnership NHS Trust achieved foundation trust status on 1 March 2010 to become 5 Boroughs Partnership NHS Foundation Trust.

In April 2011, as a result of the government's Transforming Community Services Programme, we acquired community health services in Knowsley. These are delivered by multidisciplinary integrated health and social care teams.

We are an award-winning NHS provider of specialist mental health and learning disability community and inpatient services based in the North West of England. We also deliver physical community health services across Knowsley, St Helens and some in Halton.

During 2016/17, we had a turnover of approximately £155 million and served a population of around one million people across the boroughs of Halton, Knowsley, St Helens, Warrington and Wigan. These figures will increase as we expand our footprint from 1 April 2017.

We have defined our overall purpose as this:

"We will take a lead in improving the wellbeing of our communities in order to make a positive difference throughout people's lives."

1.4. Risks and issues

The key issues and risks which could affect the Trust in delivering our objectives are covered in detail within the Annual Governance Statement, starting on page 74.

Risks are effectively managed through a robust risk management process. All risks scored 12 and above with limited or fair controls are escalated to the Trust Board through Board Assurance Framework reports which are discussed at alternate Trust Board meetings.

At the end of March 2017, there are 13 open risks identified which may impact on the achievement of the high-level objectives. These include 12 from the 2016/17 high-level objectives and one from the 2015/16 high-level objectives.

1.5. Going concern disclosure

After making enquiries, the Trust Board has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing the accounts.

2. Performance analysis

2.1. Performance measures

As part of the Trust's quality and performance cycle, a monthly Quality and Performance Report is produced to inform the Trust Board of things we are proud of and anything we are concerned about; in particular, whenever key performance measures have triggered pre-defined tolerances at Trust or borough level. These measures include national targets and locally-agreed priorities in addition to a number of internally-agreed targets to quality assure our services.

Detailed definitions of all the Trust's indicators and tolerances can be found in a separate document on our website at: www.5boroughspartnership.nhs.uk/trustboardpapers2016-2017

Each measure falls within one of the following six questions:

- Are we delivering our services safely?
- Do we have sufficient, highly motivated and skilled staff?
- Are we delivering to our patients and service users?
- Are we financially viable?
- Are we delivering on our strategy?
- Do our stakeholders support what we do?

The detail behind each measure is scrutinised by the Trust's various committees and during performance meetings held within the quality and performance cycle. Where a measure falls outside of tolerance, narrative will explain what tolerance has been triggered, details of any corrective action required or taken and will make reference, where relevant, to previous or future Trust Board agenda items.

The monthly Quality and Performance Reports are delivered in the public part of every Trust Board meeting and circulated to all board members in the two months of the year when there is not a board meeting. They can be found within Trust Board papers on our website using the link above.

Our performance during 2016/17 against the six key questions is detailed below.

Are we delivering our services safely?

- All the key measures are within tolerance.
- During the year, complaints to the Trust reduced from an average of 18 a month to 12.
- Self-harm actual has reduced from an average of 132 a month to 75 and inpatient incidents have reduced from around 412 a month to 325.

Do we have sufficient, highly motivated and skilled staff?

- This year, the level of staff experiencing an annual review remains at 84 per cent for the second consecutive year, based on figures reported at the end of June 2015 and June 2016. The rate still falls below the Trust target of 90 per cent.
- Compliance with core and statutory training has reduced this year. At the end of March 2017, the figures stood at 82 per cent and 80 per cent respectively – which are down on last year's figures of 89 per cent and 85 per cent. This, however, is not an entirely unexpected picture given the additional in-year training requirements related to two significant Trust-wide projects – implementation of the clinical information system, RiO, and becoming smokefree. During 2017/18, we will see improved reporting of performance below compliance, allowing us to provide targeted training delivered locally to meet the needs of the team.
- Specialist training rose one per cent this year to 87 per cent.
- Staff turnover has remained fairly static at around 13.5 per cent, and attendance has been around the Trust target of 95 per cent during the year, rising slightly towards the end of the year to 94.5 per cent.
- The Trust has continued to monitor agency usage and, in the last three months of the year, has reduced the total number of agency cap breaches by 65 per cent, dropping from more than 1,000 breaches in December to just over 400 in March 2017.

Are we delivering to our patients and service users?

- Looking at the Single Oversight Framework, the Trust has achieved all targets, with the exception of delayed transfers of care, recording of accommodation and employment status.
- The target for delayed transfers is 7.5 per cent. During the year, a significant amount of work was undertaken to develop a standard operating procedure so that recording has improved significantly. All boroughs now have weekly planning and monitoring arrangements with clinical commissioning groups and local authority colleagues to make sure this was maintained within the Trust target.

- Recording of settled accommodation is at 84.5 per cent and employment status at 83.1 per cent, against a target of 85 per cent. Management actions are in place to ensure both measures are on target.
- Our Improving Access to Psychological Therapies services have all achieved and exceed the waiting times, prevalence and recovery targets. The recovery rate at the end of the year was 57.5 per cent against a target of 50 per cent.

Are we financially viable?

- The Trust has been operating at a very challenging time for the NHS and, despite this, has achieved its target level of retained deficit of £60,000, in line with the control total set by NHS Improvement.
- We have delivered in full our £5.4 million cost improvement plan and have invested to transform the efficiency of the organisation in the future by incurring exceptional costs relating to redundancy costs and investments in informatics, such as new clinical systems.
- The Trust has spent £13.8 million of capital during the year against a plan of £14.8 million. The shortfall in spend is largely due to the cost of our major capital project, Atherleigh Park – a new mental health hospital in Leigh – being lower, and the timing of the expenditure on the information management platform, which will be completed during 2017/18.
- The Trust ends the year with a positive cash balance of £4.9 million.

Are we delivering our strategy?

- The Trust set itself 15 high level objectives for 2016/17 and all these have been achieved as outlined in this section.

Do our stakeholders support what we do?

- In 2016/17, the Trust has been well supported by its Council of Governors. Governors have contributed to strategy sessions determined our quality priorities, regularly attended their own meetings and been present at Trust Board meetings.
- 2016/17 has been the most successful year for the Trust in relation to business development, demonstrating strong relationships and support from our commissioners. During the year, more than £27 million of new recurrent funding has been secured, including £1.6 million of recurrent contribution. The new growth achieved by the Trust has expanded the geography into which the organisation provides services.
- This year has also seen the Trust bidding and winning new services in partnership with statutory (NHS) and third sector partners. These partnerships have enhanced care pathways, supported new service developments and contributed to delivering the Trust's overall purpose to deliver whole person care services.

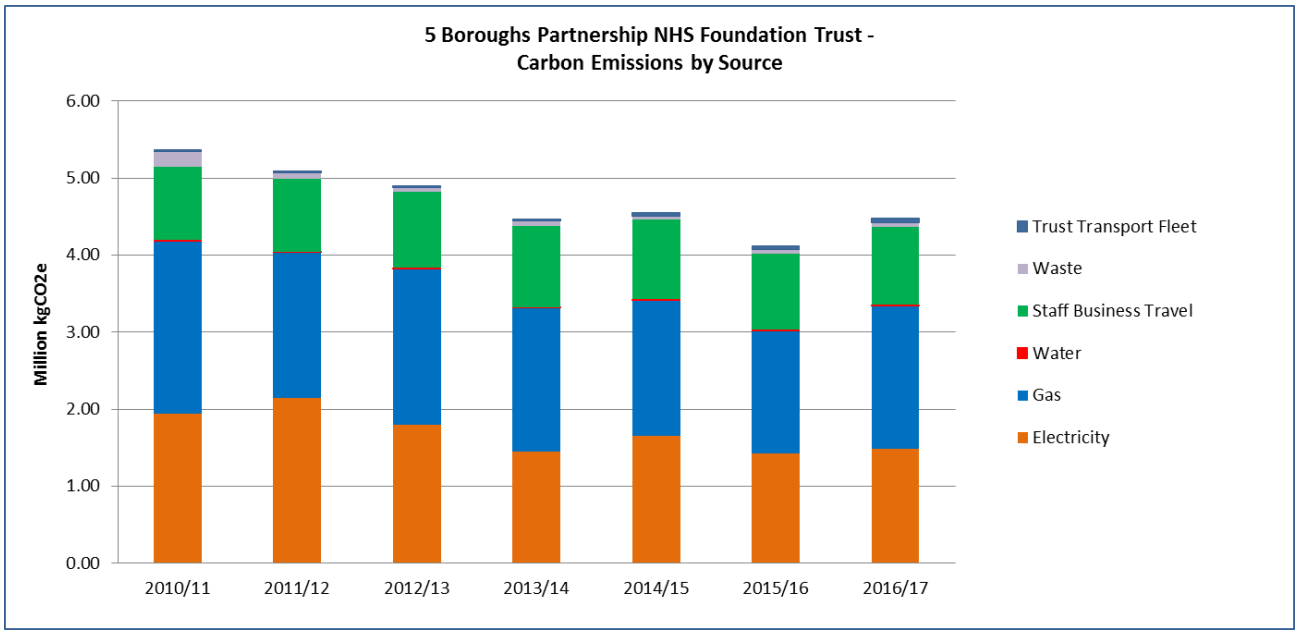
2.2. Environment and sustainability report

The Trust continues to measure and monitor its environmental impact and take actions to improve its performance.

The sustainability group meets every quarter to progress actions on all areas of the Trust Sustainable Development Management Plan, including carbon, energy, business travel, transport, waste, natural capital and social value.

Carbon emissions equivalent (C02e) is a measure of carbon and other emissions. It is a useful proxy measure of the Trust's environmental performance. The graph below shows

Trust emissions from 2010 to 2017. The emissions in 2016/17 are 4.5million kg of C02e. This represents a reduction of 26.62 per cent since 2010 and an increase of 8.6 per cent on the previous year. While emissions from transport, waste, business travel, water and electricity have remained consistent, there has been an increase in emissions from gas. This increase is due to the development of a new hospital, Atherleigh Park, in Leigh. The hospital became fully operational in March 2017, but the gas-fuelled combined heat and power plant was commissioned in May 2016 and this accounts for the increase.



The projects delivered this year will continue to deliver future carbon savings. However, combined with the growth in Trust activity, in terms of additional estate, new services coming on board and an increase in staff numbers, it is expected there will be an increase in overall emissions over the next two years. Future reports may normalise carbon emissions per m² or per staff member to better monitor progress.

The Sustainable Development Management Plan includes an action to expand the scope of the 2017/18 carbon profile to include procurement which is known to be the largest source of carbon emissions, contributing 72 per cent to the NHS, public health and social care carbon footprint nationally.

Energy

A new gas heating system was installed at Hollins Park Hospital in December 2016. It has two main energy saving features. The first sees six new energy efficient boilers replace the old inefficient ones. The second is a new zoning system. The building has been divided into 14 distinct zones. Based on the occupancy times and function, each zone has been pre-set to meet the needs of that area and, importantly, to turn the heating off when it is unoccupied; for example, overnight or at weekends in office areas. It is estimated this feature will save the equivalent of heating the entire building for five weeks a year.

In addition to being efficient, the new system also improves patient experience in that each patient bedroom now has individual temperature control. The temperature can be altered by the ward staff to create a comfortable environment to suit each patient.

Travel

Work continues to reduce the number of single occupancy car journeys generated by the Trust and reduce the associated carbon emissions and air pollution.

With support from the Merseytravel Employers' Network, the extension of cycle infrastructure has continued this year. Travel surveys identified needs for cycle storage and shower facilities at four sites. As a result, new cycle storage was installed at the Dudley Wallis Centre, Willis House and Peasley Cross. New shower and changing facilities were built in Knowsley Resource and Recovery Centre.

Staff travel promotions included a visit by Dr Bike to Hollins Park in August to repair staff bicycles, and a competition with Merseytravel in which two members of staff won free bus travel for a month.

Cycle to Work is a salary sacrifice scheme which allows staff to purchase bicycles and cycling equipment and make the repayments through 12 monthly instalments. Because the repayments are deducted from gross salary, there is a significant tax saving. Cycle to work is available to staff all year. During 2016/17, 20 bicycles were purchased through the scheme.

To encourage more staff to cycle and support staff to get back into cycling, the Trust launched 'borrow a bike' in March 2017. The Trust has four bicycles available for staff to borrow for a period of between one week and one month. The project was funded by the regional growth fund.

The Trust signed up to liftshare.com this year and now has its own online car sharing network to help staff find a buddy to share their journey to work with.

The Trust's network of electrical vehicle charging points has expanded again this year, now having eight charge points in total. There are four at Hollins Park and four new points went live in February 2017 at Atherleigh Park. There are plans to extend the network further in the coming year in to a third borough, making them accessible to more staff across the Trust footprint.

Nine members of staff who drive as part of their job for the Trust completed fuel efficiency driver training this year. The training was funded by St Helens Council and delivered by Professional Driver Training Ltd. It involved one-to-one training in Trust vehicles where staff learned driving skills to reduce the amount of fuel used, reduce wear and tear on the vehicle and promote safer driving. The training is expected to deliver annual savings of 2,500kgCO2 and £1,300 in fuel costs.

Waste

The Trust continues to deliver high levels of recycling and energy recovery levels. During 2016/17, the Trust had a total recycling and recovery figure of 83.24 per cent. The rates varied between 66 per cent at the poorest performing site and 93.18 per cent at the best performing site. An action has been added to the Sustainable Development Management Plan action plan to investigate those poorer performing sites and work with staff and the waste contractor to bring the average to above 85 per cent for 2017/18.

This year, the Trust has become involved in a new reuse project in partnership with two local charities Warrington Disability Partnership and St Mark Universal Copts Care. Mobility and independent living equipment, including zimmer frames, crutches and

wheelchairs, which had been condemned to waste is now being repaired and refurbished and donated to hospitals facing crisis in Egypt and Syria. This innovative project provides a vital resource to hospitals and patients in need, while also preventing equipment going to waste and reducing Trust waste management costs. The project is currently being piloted at Knowsley's Centre for Independent Living.

Atherleigh Park

Atherleigh Park is a new purpose-built mental health hospital in Leigh, Wigan. It opened in March 2017 and has number of sustainability features, many of which are firsts for the Trust, to improve the environmental performance of the site.

This hospital signifies a real shift in energy management for the Trust. For the first time, the Trust is generating its own renewable energy, with 156 solar panels on the roof generating electricity. Another first for the Trust is the installation of a gas-fuelled combined heat and power plant. This is a highly efficient method of producing heat and electricity.

There are also several heat exchanges and heat recovery units throughout the building for efficient temperature control. The heating system is centrally controlled by a building management system and has optimisation features which enable it to self-learn and automatically adjust to respond to external temperatures and occupancy times.

There is secure and covered parking for up to 24 bicycles and six motorbikes. And there are showers and changing facilities available in the building for staff who cycle to work. There are also four electrical vehicle charging points in the car park for staff and visitors to use.

Another first for the Trust are the anaerobic digestion units located on site for the disposal of food waste. Anaerobic digestion is like composting but in an oxygen-free container. It's a biological process in which naturally occurring microorganisms break down organic waste.

When we build on land, the water can no longer soak in to the ground naturally which can cause high volumes of water to flow over-ground risking saturation of soil nearby or flooding. At Atherleigh Park, the impact of building on the land has been offset by installing a system of water tanks under the car park providing a temporary store and controlled release of water back into the water course. This helps to prevent saturation and is a valuable tool to prevent flooding further downstream.

2.3. Social, community and human rights

The Trust operates a suite of policies which recognise the human rights issues of employees, patients, carers and the public. These include:

- Equality and Diversity Policy
- Supporting Advocacy Policy and Procedure
- Supporting Trans Service Users Policy and Procedure
- Breastfeeding Policy
- Dress Code Policy
- Gender Reassignment Policy
- Maternity Policy
- Paternity Leave Policy
- Respect at Work Policy

Enshrined within the Equality Act 2010 are the nine protected characteristic groups the Trust must ensure do not experience direct or indirect discrimination, by any act or omission of the Trust.

Since the development of the Public Sector Equality Duty in 2011, public bodies are required to have due regard to reduce discrimination, advance equality of opportunity and foster good relations between different people when carrying out activities.

A range of activity has been undertaken to ensure the Trust can evidence its compliance. This includes:

Equality Delivery System (EDS) 2

Work during 2016/17 has concentred on Outcome 2.4 *'People's complaints about services are handled respectfully and efficiently'*. The Trust hosted an external consultation event on 28 March 2017 to consult with community groups as to the grading of our EDS 2 evidence. The full EDS 2 report about Trust compliance will be published at the end of June 2017.

Workforce Race Equality Standard (WRES)

The Trust completed the NHS Workforce Race Equality Standard and action plan for 2016/17. These can be viewed at: www.5boroughspartnership.nhs.uk/workforce-race-equality-standard

Publication of Trust demographic data

Trust demographic data was published in relation to patients and service users, staff and Foundation Trust members. This can be viewed at: www.5boroughspartnership.nhs.uk/demographic-data

2.4. Important events since the end of the financial year

There have been no events since the end of the financial year with a material effect on the Trust.

2.5. Overseas operations

The Trust is not engaged in any overseas operations.

Accountability Report

The Chief Executive, as the accounting officer, has approved the contents of the following accountability report, which includes:

- Directors' Report
- Remuneration Report
- Staff Report
- NHS Foundation Trust Code of Governance Disclosures
- Single Oversight Framework
- Statement of Accounting Officer's Responsibilities
- Annual Governance Statement

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2017

Directors' Report

1. Our Trust Board

Our Trust Board has responsibility for strategic development, approving policy and monitoring performance. This includes ensuring the delivery of effective financial stewardship, high standards of clinical and corporate governance and promoting effective relations with the local community we serve.

The Board collectively considers that it is appropriately composed with a balanced spread of expertise to fulfil its function and the terms of licence. The Chairman and non-executive directors meet the independence criteria laid down in the NHS Foundation Trust Code of Governance.

Our Executive Leadership Team provides organisational leadership and takes appropriate action to ensure we deliver our strategic and operational objectives. It maintains arrangements for effective governance throughout the organisation; monitors performance in the delivery of planned results; and ensures corrective action is taken when necessary.

There were 10 Trust Board meetings held during 2016/17 (there was no meeting in August or December).

Names and roles of those who made up our Trust Board during 2016/17 are below.

Name	Title
Simon Barber	Chief Executive
Gail Briers	Chief Nurse and Executive Director of Operational Clinical Services
Tracy Hill	Director of Strategy and Organisational Effectiveness
Dr Louise Sell	Medical Director
Sam Proffitt	Chief Finance Officer
Bernard Pilkington	Chairman
Helen Bellairs	Non-Executive Director and Vice Chair
Derek Taylor	Non-Executive Director and Senior Independent Director (until 31 August 2016)
Philippa Tubb	Non-Executive Director
Alison Tumilty	Non-Executive Director
Brian Marshall	Non-Executive Director
Richard Sear	Non-Executive Director (from 1 September 2016)

1.1. Declarations of interest

A register of interests for Trust Board members is available on our website at: www.5boroughspartnership.nhs.uk/trust-board-members-register-of-interests

1.2. HM Treasury cost allocation and charging guidance

The Trust has complied with the HM cost allocation and charging policy in setting its prices.

1.3. Political donations

The Trust has not made any political donations during 2016/17.

1.4. Better Payment Practice Code

Under the Better Payment Practice Code, the Trust aims to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust is also an approved signatory to the Prompt Payment Code.

The table below shows our level of compliance.

	2016/17		2015/16	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	30,557	39,804	28,491	44,534
Total non-NHS trade invoices paid within target	29,545	38,724	27,505	43,334
Percentage of non-NHS trade invoices paid within target	97%	97%	97%	97%
Total NHS trade invoices paid in the year	990	13,768	1,031	14,115
Total NHS trade invoices paid within target	951	13,525	1,003	13,805
Percentage of NHS trade invoices paid within target	96%	98%	97%	98%
Total invoices paid in the year	31,547	53,572	29,522	58,649
Total invoices paid within target	30,496	52,249	28,508	57,139
Percentage of invoices paid within target	97%	98%	97%	97%

During the reporting year, there were no claims for interest made against the Trust under the Late Payment of Commercial Debts (Interest) Act 1998. There were also no claims during 2015/16.

2. Quality governance

The Trust Board is confident and assured that it will continue to comply fully with Monitor's Quality Governance Framework and new guidance from NHS Improvement and Care Quality Commission on the Use of Resources and Well-Led Framework.

The Chief Executive is responsible for ensuring a sound system of internal control and a robust assurance framework is in place. The organisational management structure illustrates the Trust's commitment to effective governance, including the risk management processes.

During 2016/17, the following audits evaluated the Trust's compliance to Monitor and NHS Improvement requirements:

- Trust policy processes
- Clinical Audit
- Safeguarding
- Corporate Governance
- Risk management and Board Assurance Framework

All were conducted by the Trust's internal auditors, KPMG, and achieved 'significant assurance with minor areas for improvement'.

Full details of the Trust's systems of internal control are included within the Annual Governance Statement starting on page 74.

This year, we have produced our eighth annual Quality Report. Our Quality Report is published alongside our Annual Report, which we will continue to produce each year and make available as a public statement of our commitment to improving quality and safety in the Trust. The Annual Governance Statement provides details of the arrangements in place for quality governance.

2.1. Quality governance – patient care

The Trust has had foundation trust status since March 2010, and works closely with the five clinical commissioning groups and five local authorities within the footprint we serve. Similarly, the Trust is engaged in dialogue and developments as part of sustainability and transformation planning footprints.

The Trust is part of two sustainability and transformation planning footprints – Greater Manchester (Wigan) and Cheshire and Merseyside (Warrington, Halton, St Helens and Knowsley).

The Wigan element of our service delivery forms part of Greater Manchester Health and Social Care Partnership. Although a small part of our overall organisational footprint, the Trust is represented on the strategic forums to ensure influence and connectivity with our local plans. Our Chief Executive is a member of the Greater Manchester Provider Federation Board and the Greater Manchester Health and Social Care Partnership Board. He also chairs the Children's and Young People Mental Health Strategic Health Group. In addition, our Chief Finance Officer is a member of the Greater Manchester Provider Directors of Finance Group, and our Director of Strategy and Organisational Effectiveness is a member of the Greater Manchester Strategy Group.

Planning across Greater Manchester is more advanced, having developed an approach for the region in relation to the NHS Planning Guidance 2016-21.The 37 health and care systems across Greater Manchester have come together to set out their aims in a five-year strategic plan which underpins the NHS England Forward View.

Wigan represents one of 10 localities within Greater Manchester and has developed its own locality plan in the context of the Greater Manchester five-year strategic plan. The Trust has been fully engaged with this work and, in particular, has supported the development of the mental health priorities identified within the plans.

It was agreed at a meeting of Cheshire and Merseyside organisations in January 2016 that Cheshire would join together with the Liverpool City Region footprint to form a single 'place'. The local delivery footprints within this area are West Cheshire, East Cheshire, Vale Royal, Wirral, North Mersey and Mid-Mersey (named the Alliance Local Delivery System). The Trust is engaged in North and Alliance. The mental health elements of this plan reflect the priorities outlined in the Mental Health Taskforce and are summarised as:

- Improving the health of the people of Cheshire and Merseyside
- Improving the quality of services by the key interventions of access and integration
- Improving productivity and closing the financial gap

The mental health trusts within this area are working closely with commissioners to ensure the mental health chapter of the plan reflects the Mental Health Taskforce recommendations.

The Trust ensures it delivers best practice to all boroughs and offers equality for service users. The Trust has now fully embedded its borough structure as a result of the Future Fit Transformation Programme undertaken in 2015. Each borough is led by a senior team compromising an assistant director, assistant clinical director(s), associate medical director and lead psychologist. In boroughs where we deliver physical health and mental health plus learning disability services or secure services, we have placed two assistant clinical directors to reflect the range of clinical diversity. The provision of dedicated clinical leadership has enabled the quality and safety agenda to be fully supported in each borough with a standardised governance structure.

Organisation-wide quality and safety methodology is incorporated within the Trust's Quality Strategy and Improvement Plan. Training in service improvement methodology has been delivered Trust-wide and a range of tools made available on the Trust intranet.

Available publically on our website at: www.5boroughspartnership.nhs.uk/quality-strategy-and-improvement-plan, the quality strategy demonstrates how the Trust identifies and makes continuous improvements to the quality of care we provide. It outlines the key drivers to identifying our quality improvement work and how we engage with our staff, patients, their families and stakeholders in identifying what is important to them. Acknowledging that this is a three-year strategy, the Trust is taking the opportunity to review and update the Quality Strategy in 2017 to ensure there is a culture of continuous focus on quality embedded in all work streams.

Through the Quality Committee, the Quality and Safety Committee and the Clinical Leadership Group, all aspects of quality and safety are considered and assurance sought. Service user and carer representatives are an integral part of our clinical governance and have recognised membership of the Quality Committee which is a sub-committee of the Trust Board.

Performance against key health targets

Acknowledging the success of last year's approach to CQUINs being led by the assistant clinical directors, this has been continued through 2016/17, again realising the vast majority of contract income secured through delivery against the national and local quality targets.

The commissioners have appreciated the presence of the lead clinicians at contract quality meetings and have valued the first-hand experience of the impact the initiatives have had within services. This has been a much more valuable experience for all involved and has led to rich discussions which have informed the negotiations for the coming year.

National and local commissioning priorities

The Trust attends three meetings with commissioners where quality and safety are discussed. Warrington Clinical Quality and Contract Review Meeting meets monthly; Wigan Quality, Safety and Safeguarding Group meet bimonthly; and the remaining three commissioners attend a joint Contract Quality and Performance Group which meets monthly. These groups provide the opportunity for the Trust to provide assurance and enter into constructive dialogue with our collaborating clinical commissioning groups on core issues of the quality and safety of service delivery.

The groups ensure the contract is aligned to the achievement of national and local quality standards and targets; that robust systems for contract monitoring of clinical quality performance indicators are in place; identify new developments, opportunities and threats relating to quality for consideration within the contracting process; and agree Clinical Quality Performance Indicators, CQUINs and Service Development and Improvement Plans for future contract years.

The Trust has robust quality governance arrangements in place which support our quality initiatives. The executive lead for quality is the Chief Nurse and Executive Director of Operational Clinical Services. The Trust has a Quality Committee chaired by a non-executive director which has delegated powers from the Trust Board to provide leadership and assurance on the effectiveness of the Trust's arrangements for quality, ensuring there is a consistent approach, specifically in the areas of safety (patient health and safety), effectiveness, and patient experience.

Quality goals 2015/2016 – 2018/2019

The Trust has established a set of quality objectives which outline the Trust's quality goals, and are the focus of the Trust's Quality Strategy 2015-2018. They use the domains of safety, effectiveness and experience, and each have a number of objectives which make up each goal.

- **Safety:** Our goal is to improve safety and reduce harm to patients.
- **Effectiveness:** Our goal is to demonstrate success in our outcomes.
- **Experience:** Our aim is to ensure that people using our services have the best possible experience.

All quality initiatives undertaken by the Trust fit within the objectives of each of the three goals above; these include the Trust's established quality 'big dots' and quality priorities as defined below.

Quality Big Dots 2013/14 – 2017/18

The Trust has established three 'Quality Big Dots' – long-term aspirational quality goals – which cover a five-year period. These Quality Big Dots were established by the Trust Board, Senior Leadership Team and Council of Governors, supported by AQuA (Advancing Quality Alliance). The following Quality Big Dots are supported by programmes of work:

- We will demonstrate a year-on-year improvement in the collaborative participation with, and engagement of, service users. This will result in improved collaboration and engagement of service users with a long-term condition, thus achieving the Quality Big Dot.

- We will implement our suicide reduction strategy with the aim to reduce service user suicide to zero in five years. This will be achieved by the implementation of a Suicide Reduction Strategy that will be informed by a suicide audit, which we completed at the end of 2013/14.

- We will aim to reduce avoidable harm to service users and staff by 20 per cent year-on-year. This will be achieved by an initial scoping of the harm that the Trust will focus on and the development of a five-year trajectory.

Sign up to Safety

The Trust adopted the Sign Up to Safety campaign with aims to reduce avoidable harm by 50 per cent by 2018. The Patient Safety Improvement Plan builds on and brings together all the quality and safety work in the organisation. The work streams identified are prevention and management of violence and aggression, self-harm, suicide, falls and physical health.

To date, this has resulted in:

- 27.5 per cent reduction in restraint across the wards involved
- Implementation on three female wards of an evidence-based self-injury pathway
- The start of a review of the Trust's Suicide Strategy
- The implementation of suicide prevention groups in each borough
- A fluctuating pattern of falls, but overall reduction in falls and harm from falls
- A comprehensive review and education awareness-raising programme regarding the modified early warning score
- A sepsis task and finish group working on all staff recognition of sepsis
- Procurement of clinicalskills.net licence to further standardise physical healthcare practice in all settings

The Trust is about to enter into the last year of the current Sign up to Safety pledges and a refreshed work plan has been developed. The aims of the Sign up to Safety steering group are to fully understand and adopt the successes made in each area and continue to use those approaches as we continuously drive improvement in patient safety.

Quality priorities

To demonstrate the Trust's continual commitment to quality improvement, each year we engage with our five local Healthwatch groups, five local authorities, and five clinical commissioning groups, as well as our service users and carers and the Council of Governors to establish the Trust's quality priorities. These quality priorities demonstrate improvements in the domains of safety, experience and effectiveness, and will be monitored throughout the year.

The Trust achieved the 2016/17 quality priorities. Progress against each is briefly described below.

Safety: Lesson Learned Strategy

It has never been more important for organisations to ensure a culture wherein lessons are learned and embedded to prevent recurrence. Over the past year, the Lessons Learned Strategy has been implemented, which has included:

- Revising Trust policies and procedures.
- Creating a robust system to record and track lessons learned themes from different sources and using this to develop themed reporting, examining patterns and trends to identify areas of focus, and reviewing outcomes to determine the impact from actions.
- A suite of lessons learned communications has been developed and cascaded for discussions at team level.

The Lessons Learned Strategy has seen a reduction of recurring themes, which will be further reviewed and evaluated.

Effectiveness: End of Life Care Strategy
The strategy outlines the Trust's approach to ensuring we meet the needs of patients approaching the end of life, based on best practice and innovation. Achievement of this quality priority includes:

- Development of robust governance arrangements, including the evaluation of the care provided by regular clinical audits. Outcomes from the audits show good results, with the Trust exceeding its expected targets.
- Improvements to the care provided to patients, by providing high quality training to staff; this has included the verification of expected death by nurses and administration of subcutaneous fluids.
- The above improvements have been supported by the implementation of the electronic patient record system.

Our End of Life Care service received an 'outstanding' rating from the Care Quality Commission following an inspection in July 2016.

Experience: Living Life Well Strategy
The strategy is an important element of our programme of cultural change. It supports and is supported by our culture of care and our Trust values in relation to our patients and service users, our colleagues and ourselves. Achievement of this quality priority is demonstrated by the six teams which incorporated the principles of Living Life Well into their everyday work and how they use them as a service improvement tool. These teams are:

- Later Life and Memory Service, St Helens
- Integrated Wellness Service, Knowsley
- Cavendish Unit, Wigan
- Improving Access to Psychological Therapies Team, Halton
- Learning Disabilities Team, Knowsley
- Chesterton Unit, Warrington

The Trust now has a number of people – staff, service users and carer representatives – versed and experienced in Living Life Well. This was recognised in 2016 at the Staff Recognition Awards where the Living Life Well support team won the award for improving patient experience.

Living Life Well is now accepted as the cultural framework on which all service improvement, development or change is based.

Full details and achievements of all three quality priorities are included in part two of the Quality Report, starting on page 99.

Responding to external reports
External reports are monitored and reviewed by the Quality Committee which has delegated authority from the Trust Board. Where recommendations are made following external reports, the Trust benchmarks against the reports and develops action plans for any areas where deficits are identified. These action plans are reported to the Quality Committee until assurance has been received that all actions have been completed. External reports specific to the Trust are managed and monitored through the same process.

Progress towards locally-agreed targets and key quality improvements

The borough leadership teams have engaged in leadership development activity and have been key participants in drafting the Trust's strategic objectives. These objectives, alongside our clinical strategies, will make sure services are designed around and developed to meet the needs of the population.

In each borough, the Trust has been actively involved in the Crisis Care Concordat and has supported and collaborated on specific initiatives.

Clinical transformation programme

During 2016/17, we have launched a series of projects aimed at transforming and improving the clinical services we provide to better meet the needs of our patients and service users.

The overall clinical transformation portfolio is divided into three programmes focusing on integrating care pathways, improving the mental fitness of the local population, and managing the journey.

Each of these programmes has a number of individual projects underneath it – some focus on reviewing and transforming individual services, while others are about identifying opportunities to make changes across the organisation.

This is our chance to make a real difference to people's lives by stepping back and thinking differently about what we do, why we do things the way we do and how we can improve.

We're aiming to:

- Improve the mental and physical health of the local population, building resilience and creating independence.
- Provide assessment when and where it's needed.
- Prevent crisis through timely intervention.
- Improve the flow within the patient journey, across inpatient and community services, to meet clinical need.
- Improve outcomes for service users through the coordinated delivery of whole person care, based on the principles of Living Life Well.
- Integrate mental and physical health care to support the delivery of whole person care.
- Deliver care models which are high quality, effective, robust and sustainable.

New and revised services

2016/17 has been a successful year for our Trust. Our focus on growth has resulted in us winning and mobilising a number of new contracts and services both within and outside of our existing boroughs.

These include:

- 0-19 children's community services in St Helens
- Wigan child and adolescent mental health services single point of access and tier 2
- Greater Manchester criminal justice liaison and diversion service – in partnership with Care and Custody and Cheshire and Greater Manchester Community Rehabilitation Company
- 0-19 children's community services in Sefton

- Adults' community nursing and therapy services in St Helens – in partnership with St Helens and Knowsley Teaching Hospitals NHS Trust and St Helens Rota
- Perinatal mental health services across Cheshire and Merseyside in partnership with Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust
- Young people's community eating disorder services across Halton, Knowsley, St Helens, Warrington, Wigan and Bolton
- Adults' community services in South Sefton – in partnership with Mersey Care NHS Foundation Trust

In addition, there has also been a range of new investment from our existing commissioners to support new access targets in our early intervention in psychosis services, as well as a number of other pathway and service enhancements.

Service improvements

The Trust has a culture of continuous service improvement and takes every opportunity to identify areas for improvement and any action required.

This year we have continued to deliver the Living Life Well Strategy supporting delivery of services in accordance with our Culture of Care. Living Life Well is a cultural framework based on 12 key principles of person-centred, needs-led engagement which is strengths-based, promoting social inclusion, engaging carers, and using shared goals and language. During the year, involvement of service users in articulating the 12 key principles has seen these translated into service user goals and aspirations. Latterly, work has begun to articulate the 12 key principles into a framework for staff. It is envisioned these will support maximising potential conversations during annual and interim performance review and supervision meetings.

A number of services have engaged in promoting shared decision making with service users, including transition arrangements from child and young people based services into adult services, and from secondary care into primary care.

The Living Life Well approach and shared decision making align to our Culture of Care – compassion, competence, communication, courage, commitment, and care. This was the Trust's response to a number of national inquiries, including the Francis Report, Winterbourne View and the Berwick Report, and forms the Trust's engagement in the Chief Nurse's 6Cs.

Care Quality Commission

The Trust is expected to maintain its registration with the Care Quality Commission to undertake the regulated activities it provides. The Trust's registration status is registered with no conditions attached to registration.

The Trust is routinely inspected by the Care Quality Commission as part of its programme of Mental Health Act commission inspections. The Trust had a comprehensive assessment in July 2015; the overall outcome was the Trust 'Requires Improvement'. During 2016/17, the Trust was reinspected by the Care Quality Commission. The Trust received one Requirement Notice in relation to a breach of Regulation 10(2) (a); this related to wards for older people with mental health problems where staff left door observation windows to patients' bedrooms open as a default position. Actions have been taken to address the issue and continual monitoring of compliance has been implemented. An action plan has been provided to the Care Quality Commission.

The Trust is now rated as 'Good' for all five domains of safe, effective, caring, responsive and well-led. An area of note was the increased rating from 'Requires Improvement' in the July 2015 inspection to 'Outstanding' in July 2016 for End of Life Care.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2016/17.

The Trust will continue to assess itself monthly against the fundamental standards of care, Care Quality Commission intelligent monitoring, and internal assessments of compliance. As at March 2017, all fundamental standards were rated as 'green'. Assurances will be provided by the clinical quality assurance cycle, which incorporates the following areas:

- Internal quality reviews – a programme of unannounced inspections of teams undertaken by staff, service user and carer volunteers against the standards of quality and safety and Trust policy.
- Trust Board safety walkabouts – visits undertaken by executive and non-executive directors. A total of 38 have taken place up to the end of March 2017. Following each visit, the executives feed back their findings and recommendations to the Trust Board. Following safety walkabouts, local managers are encouraged to act on any issues identified.
- Continuous clinical improvement – a review of outcomes from the above elements which identifies areas for improvement. These are either carried out at a local level within teams, or on a Trust-wide basis to inform the quality agenda for the Trust.

Patient, service user and carer feedback

The Friends and Family Test is used across all Trust services. The test consists of two sections:

- A single question asking patients whether they would recommend the NHS service they have received to their friends and family if they needed similar care or treatment.
- An open question designed to ascertain reasons for this decision.

Results are included within monthly updates to services, and frontline staff use this real-time information to identify service improvements.

A monthly update on Friends and Family Test activity, including numbers and improvements from feedback is provided to Trust Board.

A Patient Experience Report brings together complaints, concerns, Patient Opinion feedback, and Friends and Family Test results, alongside feedback from service user and carer forums and Healthwatch colleagues. The report analyses the intelligence provided and is utilised to identify themes which are then presented to the Lessons Learned Forum to develop areas for action.

Service user and carer forums are held across the Trust footprint, enabling our patients, service users and carers to discuss issues relating to our services with members of our senior management team. Our 'Take it to the Top' question and answer sessions are led by the Chief Executive and Chairman.

A patient story is presented for discussion at the start of each Trust Board meeting. Patient stories have been a long-standing feature of the Trust Board agenda and set the tone for the meeting, reminding us our core business is about patient care.

Stories highlight examples of good patient experience and also where we could have done better, which provides us an opportunity to learn lessons and make improvements. They are presented in a variety of formats, sometimes with the patient or service user present, although patients can choose to be anonymous if they wish.

A total of 10 patient stories have been presented to Trust Board during the reporting year, covering all five boroughs and various services.

Patient, service user and carer information

In order to improve patient, service user and carer information, the Trust has embedded the Accessible Information Standard requirements into the clinical information system, RiO. This makes sure patients' preferred communication methods are known, recorded and used in any interaction with the patient.

A single point of access approach has been developed and rolled out for translation and interpretation services, which are provided by Capita. A link to Capita is embedded within the RiO system to facilitate speedy referral for translation and interpretation needs.

Complaints handling

We are committed to doing everything possible to resolve concerns and complaints raised with us. The Complaints Team and Patient Advice and Liaison Service have streamlined their processes and work together to ensure concerns and complaint issues are captured and resolved at the earliest opportunity and that the complainant's views are sought at all stages as part of the resolution process. All complaints we receive are dealt with through our Complaints and Concerns Policy and in line with current NHS complaint regulations.

We continue to maximise the use of Datix – an electronic system for patient safety and risk management – allowing operational services to directly capture compliments and complaints.

For the period 1 April 2016 to 31 March 2017, we received 2,072 compliments, 180 complaints and 480 concerns.

We closed 186 complaints during the reporting period – some of which were received during the previous year, and were closed in the current one.

Four complaints were referred to the Parliamentary and Health Service Ombudsman during the reporting period. Of these, two were not upheld, one was upheld with actions for the Trust and one is currently open and under investigation.

A further four Parliamentary and Health Service Ombudsman complaints, which had been referred before to 1 April 2016, were closed during the reporting period. Of these, two were not upheld and two were upheld with actions for the Trust.

2.2. Quality governance – stakeholder relations

We take our duty to involve our stakeholders seriously and have robust mechanisms and channels in place to engage with patients, service users, carers, partner organisations and local charity and voluntary organisations, as outlined below.

Local partnership working

We work with our partners – commissioners, other healthcare providers and third sector organisations – across our footprint to enhance services and improve patient care. Some examples of this are outlined below.

Halton

Halton has been selected as one of 10 areas across the country that NHS England will support as part of its Healthy New Towns programme.

Healthy New Towns aims to help shape the way areas develop, so as to test creative solutions for the health and care challenges of the 21st century, including obesity, dementia and community cohesion.

Halton was chosen as it has great potential as a thriving community hub, with new opportunities for social and community activities, healthy retail provision and integrated housing, health and social care provision.

This programme will include development of a health and wellbeing campus, incorporating leisure and wellbeing services co-located with mental health, acute care, GPs and therapies. It will also support the development of a plan focused on providing additional housing, developing commercial opportunities and maximizing the use of NHS land.

In addition to our Trust, the programme includes Halton Borough Council, Warrington and Halton Hospitals NHS Foundation Trust, Halton Clinical Commissioning Group and Bridgewater Community Healthcare NHS Foundation Trust.

Halton and Warrington child and adolescent mental health services have run a three-month pilot of a baby and infant bonding support service. The pilot was jointly commissioned by Warrington and Halton Clinical Commissioning Groups. Throughout the pilot, the child and adolescent mental health service practitioners have worked very closely with personnel from Bridgewater and met with the midwives and health visitors frequently, which has undoubtedly contributed to the success of the pilot.

During the pilot, nine mums have been supported along with their partners, all of whom have shown marked improvement in their outcome measures.

We have developed a business case and are currently negotiating with commissioners to develop a substantive service.

Knowsley and Halton Clinical Commissioning Groups jointly commission the admiral nurse service. Admiral nurses work under the guidance of Dementia UK to offer a national model of support to families and carers of individuals with dementia. They are currently taking part in a national genes project, where data is collected to measure and analyse the outcomes of the service.

The service has been running for just over 12 months in Halton and has been very well received. The team has developed strong relationships with carers' centres and plays an active part in the Dementia Action Alliance in the borough.

The Trust is working closely with Warrington and Halton Hospitals NHS Foundation Trust, Halton Borough Council and Halton Clinical Commissioning Group in shaping the development of the Halton Health Campus. The project is in its infancy; however, the end

goal is that, as part of the healthy town initiative, the current site for Halton Hospital will become a health campus which will include mental health facilities. The vision is that the campus will have a badge-less workforce and shared facilities for all.

Knowsley

During 2016/17, Knowsley borough has been successful in retaining the Integrated Wellness Service, Weight Management Services and Universal 0-19 Children's Services following tendering from Knowsley Council. In addition, in collaboration with Knowsley Clinical Commissioning Group, we redesigned our Mental Health Care Home Liaison Service to create an Integrated Health Care Home Liaison Service with both mental and physical health nursing staff coming together to provide this service. Finally, the borough was successful in its bid to host the new mid-Mersey children's eating disorder service. This service was mobilised during the winter period and launched 1 February 2017.

The Knowsley borough began reporting on the Cheshire and Merseyside Emergency Management System in January. The borough reports the operational situations within the walk-in centres, intermediate care, district nursing and mental health inpatient beds on a daily basis. This assists the health economy in responding to increasing escalation by trying to divert resources from one part of the system to another.

Knowsley's street triage mental health scheme welcomed the clinical commissioning group's director of commissioning to its service in February. The director spent some time with the staff and service users during a late shift. Since this meeting, the director has reviewed the service provision and released funds to enhance this service.

Over the last year, Knowsley's Health and Wellbeing Strategy Board has been developing proposals for how community healthcare would be delivered within the borough. The board's vision is that care services will be commissioned and provided in the most appropriate place, tailored to the people who need them and available when they need them.

The locality model of care will build on the vision and design principles agreed and outlined in the Health and Social Care Transformation Programme Report and Knowsley Clinical Commissioning Group's Operational Plan for 2016/17 and it is anticipated that the development of an integrated community model based on four localities will ensure patient-centred care is provided and coordinated to meet the needs of individuals, families and local communities within the locality.

The Trust has been working with Knowsley Clinical Commissioning Group to operationalise this strategy. We have developed a robust model which will see core services moved into the four localities. In addition, the borough has reviewed the locations of its current services and has developed a hub and spoke model for all borough-based services. This will result in speciality borough services being located together to provide better communication and reduce duplication. The borough launched the plan to staff in March 2017 and has begun consultation with staff to progress this development.

St Helens

We welcomed the 0-19 children's service into the organisation in September 2016 which broadens the profile of services delivered in this borough and opens up opportunities for collaborative and integrated working across mental and physical health for the families of St Helens.

The Trust formally entered into a consortium with St Helens and Knowsley Teaching Hospitals NHS Trust and St Helens Rota (GP out-of-hours provider), working together in successfully bidding for the community nursing services in the borough with a view to bringing partners in the system closer together to wrap more seamlessly around patients and their pathways. This will further enhance our opportunities to provide whole person care in St Helens.

We are actively engaged and valuable members of the People's Board in St Helens (previously Health and Wellbeing Board) and have worked with partners in this group to create St Helens Cares (the accountable care management system) which will be a key feature in next year's strategy and development for the borough and our services.

Warrington

In line with the five year forward plan and Future in Mind, Warrington and Halton Clinical Commissioning Groups are collaborating on the development of a thrive model for child and adolescent mental health service design.

The model is a nationally-endorsed conceptual framework to reconfigure child and adolescent mental health service provision without tiers. Working in partnership with key stakeholders, local authority and third sector providers, services will be designed based on need rather than severity. Children, young people and their families and carers should be able to receive timely access to evidence-based intervention through a skilled practitioner in a timely manner.

Over the last year, a number of joint consultation and engagement events have taken place across Warrington and Halton with partners across the wider children's workforce. A model for the new service has now been formed and agreed with all partners, local authority and schools. This model is now out for consultation with young people and their parents and carers before final sign off is agreed.

Child and adolescent mental health services across Warrington and Halton are working in partnership with Kooth, an organisation providing online and face-to-face counselling to young people aged 11 years and over. The partnership supports young people in accessing alternative forms of therapy, along with online support and information.

This is a collaborative agreement between both services to provide greater access for young people.

Alongside all statutory providers within the borough, we are an active partner in progressing the drive towards an accountable care organisation for Warrington.

Wigan

In Wigan, we supported our partners Wrightington, Wigan and Leigh NHS Foundation Trust to achieve the national target of 95 per cent of accident and emergency patients being seen within four hours by providing a hospital liaison service.

We continue to work with Compassion in Action – a charity based in Leigh – to deliver Haven House which offers 24-hour mental health wellbeing support, and, if necessary, short-stay alternatives to hospital admission to people in the Wigan borough.

Compassion in Action is also running the patient, staff and public café at our new hospital, Atherleigh Park.

We also actively participate in Healthier Wigan (integrated care organisation), which brings together partners from across the borough to join up services for the benefit of patients.

Specialist / trust-wide services

The Trust has extended its criminal justice provision to provide specialist mental health interventions across the Greater Manchester footprint, delivering support, advice and care, primarily within court and custody settings. This went live on 27 February 2017. The criminal justice liaison service has also enhanced its commissioned service from NHS England to provide a seven-day service to St Helens custody suite.

£3.3 million funding has been awarded to the Cheshire and Merseyside Sustainability and Transformation Plan (STP) footprint to develop community perinatal mental health services.

The money will be used to develop a Specialist Perinatal Community Mental Health Service which will be delivered through three local teams across the region. The local teams, provided by our Trust, Cheshire and Wirral Partnership NHS Foundation Trust, and Mersey Care NHS Foundation Trust, will support women with serious mental health problems during pregnancy and in the first year after birth. They will greatly improve access to evidence-based treatments, as well as training for other frontline staff caring for local women to ensure consistent, high-quality care across the region.

Overview and scrutiny committees

As part of the Trust's ongoing consultation in relation to quality accounts, an annual programme of consultation exists. This includes each of the five local overview and scrutiny committees and, for 2016/17, included a quality priority update event in January 2017. This event indicated the start of consultation with regard to priorities for 2017/18. Consultation continued throughout January and February 2017.

In order to support their ability to formally comment on quality accounts, all overview and scrutiny committees are also offered an opportunity to meet and hear from senior Trust staff in the lead-up to the publication date (May 2017).

During 2016/17, we worked with Halton Clinical Commissioning Group and the borough's overview and scrutiny committee to carry out formal public consultation on proposals to reconfigure the location of older people's inpatient beds across our footprint which resulted in the closure of Grange Ward at the Brooker Centre in Runcorn.

Public and patient involvement

Our Involvement Scheme provides structured support to patients, service users, carers and volunteers involved in Trust business. Involvement Scheme members are supported through the application process, induction, independent welfare benefits and tax checks and are offered payments, personal development training and practical assistance.

Highlights of involvement this year include:

- Leading guided tours for visitors during the Atherleigh Park open day and supporting staff to welcome and help orientate inpatients transferred to Atherleigh Park from Leigh Infirmary.
- Involvement of trained service users and carers in Lessons Learned Forums.
- Successful implementation of a transition plan regarding service user and carer representation on the Quality Committee, ensuring any new volunteer is fully supported by the retiring one.

- Supporting ward staff to provide activities.
- Supporting community staff to provide activities, including obtaining donation of equipment support from a private sector construction company to enable a gardening project to proceed.
- Reviewing and updating the Trust's health and social care self-help directory.
- Working in partnership with Liverpool University to train and support 18 mental health service users to mentor trainee psychologists.
- Working in partnership with a number of NHS trusts and education organisations to train and support eight service users from the Trust to be mentors for associate nurses.
- Work placements for two mental health services users with the Trust's catering contractors.
- Service users working alongside staff in the Criminal Justice Team to design and deliver training for Trust staff and external partners.
- Service users and carers embedded within the Transformation Team as part of a number of service reviews.
- Volunteers being trained and supported to review Cheshire and Wirral Partnership's Crisis Resolution and Home Treatment Teams.

In the last 12 months, we have reviewed the procedures for volunteering in the Trust, including carrying out a data cleanse as part of the implementation of an enhanced IT system. There are now 131 currently active volunteers registered with the Involvement Scheme who carried out more than 10,000 hours of work across 51 separate work programmes. This year, 55 volunteers have done more than 100 hours.

Volunteers continue to actively participate in the production of Trust newsletter 'Reflect'. Volunteers sit on the editorial panel so their ideas shape the content.

The Trust operates a robust engagement process to develop quality priorities for the annual Quality Account. In January 2017, an event was held, attended by service users and carers, local Healthwatch representatives, clinical commissioning group colleagues, and representatives from local authority overview and scrutiny committees.

At this event, an update on progress against the quality priorities for 2016/17 was presented, along with an opportunity to gather feedback from attendees as to the areas for focus for quality priorities for 2017/18. This consultation continued through January to allow those who had not been able to attend to contribute.

As in previous years, the Trust also attends update events coordinated by partners to support their understanding of the Quality Account and support them to meet their obligations with regards to commentary against year-end Trust position.

Children and young people's involvement

Each borough has its own participation group for young people – SHOUT – engaging young people in working alongside trust staff to improve our child and adolescent mental health services. These meet regularly throughout the year.

Our Chairman and Chief Executive, welcomed 84 people to a Christmas-themed celebration of SHOUT's achievements in December 2016 at the DW stadium in Wigan.

Awards were presented in 10 categories including:

- Contribution to Service – individuals who have contributed their time to the Trust
- Innovator of the Year – an individual young person or group who has designed or created a piece of artwork to be used within our child and adolescent mental health services
- Inspiration of the Year – a member of Trust staff who has contributed to young people's participation and shown a commitment to improving services
- Volunteer of the Year – celebrates the volunteering efforts of a young person to SHOUT

The Trust has also supported a parent and carer group to create a leaflet – 'Getting the most out of an appointment with child and adolescent mental health services' – which is now shared with parents and carers of young people newly referred to the service; and a video – 'what I know now, that I wish I'd known when I first came to child and adolescent mental health services' – which has been shared widely and is available on the Trust website.

Third sector involvement

We work closely with a wide variety of third sector organisations including Healthwatch in Halton, Knowsley, St Helens, Warrington and Wigan.

This year, we shared information about how we meet the needs of our diverse communities with 52 voluntary and community organisations. We gave all these groups the opportunity to comment on the Trust's evidence and engaged directly with 15 individuals representing a variety of community support groups and networks to performance assess our work.

In addition, we have worked on projects with local third sector organisations to improve care for service users across the full diversity of our local community. This includes:

- Carers' centres in Halton, Knowsley, St Helens, Warrington and Wigan; members of local carers' groups are involved in the implementation of our activities relating to carers.
- Wigan Alzheimer's Society and St Helens Age UK invite our staff and volunteers to join them at their dementia cafes and support service users and carers to critique services.
- Supporting Knowsley Healthwatch and Halton Healthwatch to develop confidential internet-based feedback systems enabling local residents to share their experience of Trust services directly with frontline and corporate teams.
- Worked in partnership with Compassion in Action, a charity based in Leigh, to provide a front of house cafeteria within Atherleigh Park, staffed by people with lived experience of using mental health services.

We have also developed a system to enable local community, voluntary and statutory groups to share information directly with Foundation Trust members and members of the Involvement Scheme. In the last year, we have forwarded more than 100 emails concerning a wide range of community activities, national surveys and health promotion materials.

In July 2016, we were a corporate sponsor of the North West Disability Awareness Day which attracted 250-plus exhibitors (including in excess of 100 third sector support groups) and more than 28,000 visitors. During the week prior to Disability Awareness Day, we hosted one of the supporting events – Ignite Your Life – which focused on mental health

and wellbeing. The event was supported by more than 30 of our closest third sector partner organisations.

3. Income disclosures

The Trust has met Section 43(2) of the NHS Act 2006 which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Information about the impact other income received has had on the Trust's provision of goods and services for the purposes of the health service in England, as required by Section 43(3A) of the NHS Act 2006, can be found in the Notes to the Annual Accounts, starting on page 194.

4. Disclosure to auditors

For each individual who is a director at the time the report is approved, so far as the director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware. Each director has taken all the steps they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish the NHS Foundation Trust's auditor is aware of that information.

Remuneration Report

1. Annual remuneration statement

This statement has reference to senior managers employed by the Trust. Senior managers are defined as: the Chairman, the Chief Executive, non-executive directors and executive directors.

For the year 2016/17, the Remuneration Committee determined that a consolidated one per cent cost-of-living rise should be awarded to senior managers who were compliant with core and statutory training. This was in line with national general pay awards for other staffing groups.

For the third year, performance-related pay formed part of the remuneration package specifically for executive directors. The Trust Board continues to acknowledge that the future success of the Trust, its capabilities to achieve its business strategy and to deliver safe and quality care, is contingent on attracting and retaining the highest talent in the most senior roles.

Bernard Pilkington, **Chair of Remuneration Committee**

2. Senior managers' remuneration policy

Table 1 on page 38 shows the following components of the remuneration policy for senior managers.

Salary: This is annual basic pay.

Other remuneration: This payment is in respect of duties outlined with the executive director role.

Performance-related bonuses: Up to 15 per cent of basic salary may be awarded as a performance-related payment. In order for any payment to be made, the Trust must achieve its Targeted Financial Control Total for the year and not have any unresolved issues relating to Care Quality Commission inspections. Achievement of these two objectives will result in participants receiving a proportion of their target bonus. In the event the Trust fails to deliver on its Targeted Financial Control Total or has any unresolved Care Quality Commission issues at 31 March 2017, no performance-related payment will be made.

The balance of any further performance-related payment will be contingent on the successful delivery of previously agreed personal objectives as part of the annual performance and development review process for 2016/17. This process is completed by the Chairman for the Chief Executive, and the Chief Executive for all executive directors. These objectives directly relate to successful achievement of the Trust business strategy and high-level objectives for 2016/17. The unsuccessful delivery of personal objectives will result in a proportional or no further payment being made. All payments are subject to Remuneration Committee approval and there are no provisions for the recovery of the sums paid to senior managers.

As noted above, performance-related pay is offered as part of the remuneration package to attract and retain high performing individuals to our senior roles.

Taxable benefits: Additional tax benefits.

Pension-related benefits: This shows the annual increase in pension entitlement determined in accordance with the HM Revenue and Customs method.

Excepting two post holders, all managers employed by the Trust below executive director level are covered by the nationally agreed and negotiated NHS Agenda for Change pay system and the associated terms and conditions of employment. These post holders are employed on a personal contract which contains a flexible pay element governed by the Remuneration Committee. All other terms and conditions are consistent with Agenda for Change.

2.1. Senior managers paid more than £142,500

During this period, one senior manager was paid more than £142,500. The Remuneration Committee satisfied itself, following consideration of market value, that this level of remuneration is reasonable.

2.2. Non-executive directors

The Chairman and non-executive directors' remuneration is determined by the Nominations and Remuneration Committee of the Council of Governors. In determining pay levels, the committee takes into account market data provided by the NHS Providers.

2.3. Service contract obligations

The Trust has no service contract obligations to report.

2.4. Policy on payment for loss of office

Notice periods for senior managers' contracts are determined by the Remuneration Committee as part of the process of recruitment. Currently, the Chief Executive and all executive directors are on six months' notice. In the eventuality of a senior manager's loss of office, the Chief Executive (for executive directors) or the Chairman (for the Chief Executive) may alter, postpone or disallow any individual payment they deem appropriate. These actions must be supported by the Remuneration Committee.

2.5. Statement of consideration of employment conditions elsewhere in the Trust

The Trust did not make any changes to senior manager remuneration and so therefore did not engage in consultation with employees.

3. Annual report on remuneration

3.1. Service contracts

For the Chief Executive and executive directors who have served during the year, the date of their service contract, the unexpired term, and details of the notice period is disclosed below.

Details of the Chairman and non-executive directors' service contracts are included within the NHS Foundation Trust Code of Governance Disclosures, starting on page 53.

Executive director	Date appointed to Trust Board	Tenure	Notice period
Simon Barber, Chief Executive	1 December 2007	Permanent	6 months

Gail Briers, Chief Nurse and Executive Director of Operational Clinical Services	20 June 2011	Permanent	6 months
Tracy Hill, Director of Strategy and Organisational Effectiveness	1 July 2011	Permanent	6 months
Sam Proffitt, Chief Finance Officer	4 September 2013	Permanent	6 months
Dr Louise Sell, Medical Director	1 October 2011	Permanent	6 months

3.2. Remuneration Committee

During 2016/17, the Remuneration Committee comprised the Chairman, Bernard Pilkington, and three designated non-executive directors – Brian Marshall, Derek Taylor and Helen Bellairs. The committee met twice during the period 1 April 2016 to 31 March 2017 and was quorate. Full details of attendance are included within the NHS Foundation Trust Code of Governance Disclosures, starting on page 53.

The committee is supported by the Director of Strategy and Organisational Effectiveness, who is able to provide market movement and benchmark data to the committee. In addition, the committee receives independent data about executive salaries and employment benefits. The Chief Executive also attends the committee in an advisory capacity except when discussing his own remuneration or other terms of service.

3.3. Expenses

During 2016/17, 12 executive and non-executive directors claimed a total of £10,549 in expenses. In the previous reporting year, 14 directors claimed a total of £14,023 in expenses.

Details relating to expenses claimed by governors during 2016/17 are included in the NHS Foundation Trust Code of Governance Disclosures, starting on page 53.

Details of senior managers' salaries and allowances and senior managers' pension benefits can be found in the tables on the following pages.

3.4. Fair pay multiple

The fair pay multiple disclosures below have been subject to audit.

The highest paid director's total remuneration during 2016/17 was in the banding £205,000 to £210,000, which is the same as 2015/16.

The median total remuneration for Trust staff during 2016/17 was £26,302, compared with £25,967 in 2015/16. The median calculation is based on the full-time equivalent staff of the Trust at the reporting end date on an annualised basis.

The ratio between the mid-point of the banded remuneration of the highest paid director and the median remuneration of the Trust's staff was 7.9 in 2016/17, which is the same as in 2015/16. The median calculation is based on the full-time equivalent staff of the Trust as at 31 March 2017 on an annualised basis.

Table 1 – senior managers' salary and allowances (the following table has been subject to audit)

Name and title	1 April 2016 to 31 March 2017						1 April 2015 to 31 March 2016					
	Salary	Other remuneration	Performance related bonuses	Taxable benefits	Pension related benefits	Total	Salary	Other remuneration	Performance related bonuses	Taxable benefits	Pension related benefits	Total
	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £2,500) £000	(bands of £5,000) £000
Bernard Pilkington, Chairman	45 - 50					45 - 50	45 - 50					45 - 50
Philippa Tubb, Non-Executive Director	10 - 15					10 - 15	10 - 15					10 - 15
Derek Taylor, Non-Executive Director (until 31 August 2016)	5 - 10					5 - 10	15 - 20					15 - 20
Allan Chan, Non-Executive Director (until 30 June 2015)							0 - 5					0 - 5
Colin Dale, Non-Executive Director (until 31 August 2015)							5 - 10					5 - 10
Richard Sear, Non-Executive Director (from 1 September 2016)	5 - 10					5 - 10	N/A					N/A
Alison Tumilty, Non-Executive Director (with effect from 27 September 2015)	10 - 15					10 - 15	5 - 10					5 - 10

Name and title	1 April 2016 to 31 March 2017						1 April 2015 to 31 March 2016					
	Salary	Other remuneration	Performance related bonuses	Taxable benefits	Pension related benefits	Total	Salary	Other remuneration	Performance related bonuses	Taxable benefits	Pension related benefits	Total
	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £2,500) £000	(bands of £5,000) £000
Brian Marshall, Non-Executive Director	15 - 20					15 - 20	15 - 20					15 - 20
Helen Bellairs, Non-Executive Director	10 - 15					10 - 15	10 - 15					10 - 15
Simon Barber, Chief Executive	180 - 185		25 - 30		40.0 - 42.5	245 - 250	175 - 180		25 - 30		15.0 - 17.5	220 - 225
Dr Louise Sell, Medical Director	35 - 40	135 - 140*	20 - 25		155.0 - 157.5	350 - 355	30 - 35	130 - 135*	15 - 20		232.5 - 235.0	415 - 420
Gail Briers, Chief Nurse and Executive Director of Operational Clinical Services	115 - 120		15 - 20			130 - 135	110 - 115		15 - 20		117.5 - 120.0	250 - 255
Nick Rowe, Director of Corporate Services (until 31 December 2015)							75 - 80		5 - 10		32.5 - 35.0	115 - 120
Tracy Hill, Director of Strategy and Organisational Effectiveness	115 - 120		15 - 20		32.5 - 35.0	165 - 170	110 - 115		15 - 20		97.5 - 100.0	230 - 235
Sam Proffitt, Chief Finance Officer	120 - 125		15 - 20		25.0 - 27.5	165 - 170	115 - 120		10 - 15		40.0 - 42.5	175 - 180

* These payments relate to clinical duties rather than board director responsibilities.

Table 2 – pension benefits (the following table has been subject to audit)

Name and title	Real increase in pension at age 60	Real increase in lump sum at age 60	Total accrued pension at age 60 at 31 March 2016	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash equivalent transfer value at 31 March 2016	Cash equivalent transfer value at 31 March 2015	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	£000
Simon Barber, Chief Executive	2.5 - 5	0 - 2.5	20 - 25	45 - 50	369	311	58	25
Louise Sell, Medical Director	7.5 - 10	22.5 - 25	75 - 80	230 - 235	1,527	1,332	195	25
Gail Briers, Chief Nurse and Executive Director of Operational Clinical Services	0 - 2.5	0 - 2.5	55 - 60	170 - 175	1,084	1,044	40	17
Tracy Hill, Director of Strategy and Organisational Effectiveness	0 - 2.5	0 - 2.5	35 - 40	90 - 95	583	539	44	17
Sam Proffitt, Chief Finance Officer	0 - 2.5	(0) - (2.5)	35 - 40	90 - 95	525	491	34	17

The Trust contributed £100,000 to the pension scheme of the above directors during 2016/17, (£98,000 in 2015/16).

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2017

Staff Report

The Trust recognises the challenges an ever-changing NHS landscape, alongside financial pressure, brings not only to its service delivery but also to its workforce. The Trust acknowledges that its greatest resource and the key to its future success is its people so we are able to provide the best possible care to our patients and service users.

1. Number of male and female employees

A breakdown of male and female employees at 31 March 2017 in the following categories is outlined in the table below:

- Directors – Trust Board, including Chief Executive and Chairman
- Other senior managers – band 8a and above
- Employees, including consultants

	Male	Female
Directors	4	7
Senior managers	61	178
Employees	572	2,603
Total	**637**	**2,788**

2. Analysis of staff costs (the following table has been subject to audit)

	2016/17			2015/16		
	Total	**Permanently employed**	**Other**	Total	Permanently employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages *	**97,754**	**84,588**	**13,166**	93,495	80,899	12,596
Social security costs	**8,693**	**7,934**	**759**	6,395	5,776	619
Employer contributions to NHS Pension Scheme	**11,394**	**10,399**	**995**	11,093	10,019	1,074
Other post-employment benefits	**-**	**-**	**-**	-	-	-
Termination benefits	**170**	**170**	**-**	1,034	1,034	-
Agency / contract staff	**6,776**	**-**	**6,776**	8,178	-	8,178
Total gross staff costs	**124,787**	**103,091**	**21,696**	120,195	97,728	22,467
Less income in respect of staff costs netted off expenditure	**-**	**-**	**-**	-	-	-
Total staff costs	**120,195**	**97,728**	**22,467**	120,195	97,728	22,467
Of the total above:						
Costs capitalised as part of assets	**91**	**143**	**-**	143	143	-
Analysed into operating expenditure:						
- Employee expenses – staff	**123,548**	**101,852**	**21,696**	117,847	95,380	22,467
- Employee expenses – executive directors	**978**	**978**	**-**	1,171	1,171	-
- Redundancy	**170**	**170**	**-**	1,026	1,026	-
- Special payments	**0**	**0**	**-**	8	8	-
Total employee benefits excluding capitalised costs	**124,696**	**103,000**	**21,696**	120,052	97,585	22,467

* Salaries and wages exclude non-executive directors as per annual reporting guidance for NHS foundation trusts.

3. Analysis of staff numbers (the following table has been subject to audit)

	2016/17			2015/16		
	Total Number	**Permanent Number**	**Other Number**	Total Number	Permanent Number	Other Number
Medical and dental	**143**	**82**	**61**	145	84	61
Administration and estates	**718**	**687**	**31**	662	608	54
Healthcare assistants and other support staff	**225**	**219**	**6**	253	242	11
Nursing, midwifery and health visiting staff	**1,382**	**1,346**	**36**	1,334	1,303	31
Nursing, midwifery and health visiting learners	**12**	**12**	**-**	6	6	-
Scientific, therapeutic and technical staff	**540**	**505**	**35**	500	461	39
Social care staff	**-**	**-**	**-**	-	-	-
Agency and contract staff	**122**	**-**	**122**	142	-	142
Bank staff	**120**	**-**	**120**	110	-	110
Other	**6**	**6**	**-**	6	6	-
Total	**3,268**	**2,857**	**411**	3,158	2,710	448
Of the above:						
Number engaged on capital projects	**2**	**2**	**-**	3	3	-

4. Sickness absence

Our annual cumulative sickness and absence figure remains above our target of five per cent, at 5.4 per cent, slightly down from 5.6 per cent in March 2016. Quarterly statistics are detailed in the table below, followed by a more detailed breakdown of staff absence.

Quarter	2016/17	Criteria
One	5.53%	12-month cumulative percentage July 15 to June 16
Two	5.59%	12-month cumulative percentage October 15 to September 16
Three	5.81%	12-month cumulative percentage January 16 to December 16
Four	5.44%	12-month cumulative percentage April 16 to March 17

	2016/17
Days lost (long-term)	38,276
Days lost (short-term)	23,897
Total days lost	**62,183**
Total staff years	2,936
Average working days lost	13
Total staff employed as at 31 March 2017 (headcount)	3,425
Total staff employed as at 31 March 2017 with no absence (headcount)	1,311
Percentage of staff with no sick leave	38.3%

Attendance data is analysed corporately and provided to the Trust Board on a monthly basis. Human Resources business partners horizon scan for sickness hot spots to commission targeted interventions from Human Resources advisors who are aligned to boroughs. These include attendance management clinics, case conferences, and training on policies and procedures.

Human Resources also now reviews all absence at stage two and above, to ensure all boroughs are correctly managing attendance and this is centrally managed on a case tracker system.

Further work to support preventative initiatives has been developed in our Occupational Health department, with the piloting of both a mindfulness course and a stress management course, to support those on long term absence back in to the workplace.

5. Staff policies and actions

During 2016/17, Jobcentre Plus renewed our accreditation to use the Two Ticks ‘positive about disabled people’ symbol, which is used on all adverts through NHS Jobs. This shows applicants we actively support disabled people and that, as a Trust, we meet the following five commitments:

- To interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities.
- To discuss with disabled employees at any time, but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities.
- To make every effort when employees become disabled to make sure they stay in employment.

- To take action to ensure all employees develop the appropriate level of disability awareness needed to make these commitments work.
- To review these commitments each year and assess what has been achieved, plan ways to improve on them, and let employees and Jobcentre Plus know about progress and future plans.

During the year, staff from the Equality, Diversity and Inclusion Team, Occupational Health and Human Resources departments have worked together with managers and disabled staff to make reasonable adjustments to their roles and working environment, which has enabled them, wherever possible, to remain in employment with the Trust.

During 2016/17, reports have been produced to support the Trust's Workforce Race Equality Standard (WRES) publication and declaration, which was submitted to NHS England. The Trust continues to engage with national NHS bodies on the introduction of the Workforce Disability Equality Standard which is due for introduction in 2018.

Information is taken from the Trust's electronic staff record system and the TRAC system which is used to administer and monitor all job applications.

Analysis provided in the reports aims to identify any significant differences in various diversity classifications. This intelligence is used to influence policy and strategy development.

We acknowledge the main key to measuring the success of our actions is to ensure patients, service users, carers, staff, the public and other stakeholders have the opportunity to share their experiences with us in a way which is convenient for them, and that we use these shared experiences to inform the design of future services.

In particular, we understand that only by recognising the value of patient, service user, carer and staff experiences can we have due regard for human rights, dignity and respect.

In response to the Public Sector Duties introduced through the Equality Act 2010, and in order to demonstrate our commitment to the national Equality Delivery System, we produced an Equality Strategy 2012-16. The strategy included four equality objectives and an overarching action plan. The strategy and actions are currently under review and an updated strategy will be published in 2017.

We believe good two-way communications help us to engage effectively with our people. We listen to our people and their views. We communicate with our people through a range of different channels including a face-to-face monthly core brief; a weekly e-bulletin; and our intranet site. The news section on the homepage of our intranet is refreshed daily to keep staff up-to-date with the latest news from around the Trust.

We have held four 'Afternoon with the Chief Executive' sessions during 2016/17, offering people the opportunity to submit online questions about any work-related subject to Simon Barber through our intranet for an immediate response. The response to these sessions has been very positive with a wide variety of questions being asked from all areas of the organisation.

The Trust regularly consults with staff and staff side representatives on a range of matters, including organisational change, TUPE transfers and policy changes. The governance structure for this includes the Trust's Joint Working Group, which is the forum to agree all

changes to policies, and the Trust's Joint Operational Meeting which, in the main, agrees changes to organisational structures. The Chief Executive also hosts a Joint Consultation Negotiating Committee on a quarterly basis which includes staff side and union representation as well as members of the Executive Leadership Team.

The Trust has a Council of Governors which works with the Trust Board to decide on the future of services and priorities. The governors have the opportunity to talk to, and speak up for the needs, wants and ideas of members and feed back to them. They represent members' views and can influence the way the Trust delivers services to continually improve in the future. Applications to be a governor are open to staff, who can then attend the quarterly Council of Governors meeting.

Minutes and papers of every Trust Board meeting are published online and a summary of discussions at each meeting is shared with staff. Within this, staff have access to the minutes of various committees, including the Quality Committee, Risk Committee and Audit Committee. Staff can also access the Trust's monthly performance reports which are broken down by strategic aims and boroughs, including safe delivery of services.

We provide high-quality, evidence-based occupational health services which promote and protect the health and wellbeing of all staff, ensuring they are fit to deliver safe, effective and efficient patient care. The service is Safe Effective Quality Occupational Health Service (SEQOHS) accredited and meets national quality standards through the delivery of six core services:

- Prevention of ill-health caused or made worse by work
- Timely interventions
- Rehabilitation
- Health assessments for work
- Promotion of health and wellbeing
- Teaching and training

All services, including rapid access to physiotherapy and counselling, are available through management or self-referral.

Countering fraud and corruption

The Trust is committed to reducing fraud, bribery and corruption in the NHS and will seek the appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters, and, where possible, will attempt to recover losses.

The Trust has a policy for dealing with suspected fraud and other fraudulent acts, dishonesty or damage to property involving employees, contractors, consultants, vendors and other internal and external stakeholders. The policy aims to provide a guide for employees and managers on what fraud is in the NHS, what everyone's responsibility is to prevent fraud, bribery and corruption, how to report it and its intended outcomes.

The procedure sets out the responsibilities and actions which will be taken by the Trust, managers and employees if they suspect theft, fraud bribery or corruption has taken place.

The Trust also has a Local Counter Fraud Specialist, whom staff may contact confidentially if they suspect a fraudulent act. There is mandatory counter fraud training for all staff as part of induction and through e-learning.

6. Staff survey

The NHS Staff Survey is designed to establish the effectiveness of agreed national human resources policies across the NHS and – in our Trust – specifically to gauge the mood, opinions and views of the people who work for us.

The staff survey represents one of the ways in which we engage with staff to seek their feedback. Other mechanisms include:

- **Core brief** – this monthly session sees the Chief Executive sharing important current and forthcoming issues from around our Trust with all senior leaders, prompting discussion and feedback in relation to these. These messages are then cascaded to all staff through face-to-face team briefs delivered by managers and team leaders.
- **Safety walkabouts** – these are carried out by executive and non-executive directors on a regular basis across all services and wards. With a focus on safety, these visits offer staff an opportunity to discuss any concerns or issues they may have with a member of the Trust Board. They are also an opportunity for staff to highlight any successes or examples of good practice.
- **Lessons Learned Forum** – this forum meets bi-monthly and is chaired by our Medical Director. One of the key aims of this forum is to provide staff with an opportunity to share ideas and initiatives which can help improve safety across the Trust.

6.1. Summary of performance – NHS Staff Survey 2016

The Trust's response rate for 2016 is shown below, compared with last year's data:

	2015		2016		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
Response rate	35%	41%	42%	44%	7% improvement

Our largest areas of improvement from last year are shown in the following table, with comparisons to this year's data. Our Trust has no areas of deterioration when compared with last year's data.

Largest areas of improvement	2015	2016	Trust improvement/ deterioration
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	20%	15%	5% improvement and statistically significant positive change
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	25%	20%	5% improvement and statistically significant positive change
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.68*	3.79*	0.11 improvement and statistically significant positive change
Staff confidence and security in reporting unsafe clinical practice	3.68*	3.78*	0.1 improvement and statistically significant positive change

Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	56%	51%	5% improvement and statistically significant positive change

Trust's top five ranking scores for 2016 with 2015 comparators:

Top five ranking scores	Trust 2015	Trust 2016	National average 2016	Trust improvement/ deterioration
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	20%	15%	24%	5% improvement and statistically significant positive change
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	91%	85%	Same score as last year
Percentage of staff working extra hours	68%	66%	71%	No statistically significant change
Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	56%	51%	56%	5% improvement and statistically significant positive change
Percentage of staff experiencing discrimination at work in the last 12 months	8%	8%	12%	No statistically significant change

Trust's bottom five ranking scores for 2016 with 2015 comparators:

Bottom five ranking scores	Trust 2015	Trust 2016	National average 2016	Trust improvement/ deterioration
Quality of non-mandatory training, learning or development	4.02*	4.04*	4.06*	No statistically significant change
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	94%	92%	90%	No statistically significant change
Support from immediate managers	3.9*	3.85*	3.76*	No statistically significant change
Percentage of staff satisfied with the opportunities for flexible working patterns	53%	57%	52%	No statistically significant change
Percentage of staff agreeing that their role makes a difference to patients / service users	88%	89%	90%	No statistically significant change

* A scale of 1-5 is used for questions where staff are able to answer 'strongly disagree – strongly agree'. The overall score is an average of the responses.

6.2. Future priorities

In response to our 2016 staff survey and localised borough and corporate service area results, our senior leadership team members will lead their teams to develop staff survey action plans for 2017/18 which ensure their borough or corporate service addresses one or more of the following:

- Improving staff engagement and communication between senior managers and staff
- Encouraging staff to report and ensuring they know how to report errors, near misses or incidents witnessed
- Ensuring staff are able to contribute towards improvements at work and that patient experiences and data is regularly and effectively shared

At a Trust-wide level, we will:

- Adopt a 'you said, we did together' model which ensures staff know how to provide feedback and what action is taken as a result of this
- Review and evaluate our Trust non-mandatory training, learning and development offers
- Develop a management and leadership development strategy and programme which includes a key focus on staff health and wellbeing and the management and prevention of violence, bullying, harassment and abuse in the workplace

In order to receive more timely feedback, it is also our intention to invite all staff to participate in six-monthly pulse surveys.

7. Consultancy expenditure

The Trust has spent £259,000 in total on external consultants during 2016/17, compared with £144,000 during 2015/16. These costs have covered specialist skills required to deliver our new mental health hospital, Atherleigh Park, and to implement our electronic patient record and clinical information system, RiO.

8. Off-payroll engagements

All Trust Board-level appointments are on-payroll. The Trust only uses off-payroll engagements where there is a genuine commercial requirement to allow the Trust to buy in specialist skills on a short-term basis for which no in-house expertise exists and for which we would have no long-term or ongoing requirement.

Disclosures relating to off-payroll engagements are included in the following tables.

The table below shows all off-payroll engagements as of 31 March 2017 for more than £220 per day and which last for longer than six months.

Number of existing engagements at 31 March 2017	5
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	4
Number that have existed for between two and three years at the time of	1

reporting	
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment in line with the updated IR35 guidelines.

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

Number of new engagements, or those which reached six months in duration between 1 April 2016 and 31 March 2017	6
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	6
Number for whom assurance has been requested	6
Of which:	
Number for whom assurance has been received	6
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

The table below shows off-payroll engagements of board members and/or senior officers with significant financial responsibility between 1 April 2016 and 31 March 2017.

Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility during the financial year	0
Number of individuals that have been deemed "board members and/or senior officers with significant financial responsibility". This figure includes both off-payroll and on-payroll engagements.	12

9. Exit packages

The following disclosures and tables relating to exit packages have been subject to audit.

There were five compulsory redundancies in 2016/17, at a cost of £170,000. All payments were contractual. These were as a result of restructures within some of our corporate services teams.

Staff exit packages 2016/17

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
Exit package cost band (including any special payment element)	**Number**	**£000s**	**Number**	**£000s**	**Number**	**£000s**	**Number**	**£000s**
<£10,000	3	16	0	0	3	16	0	0
£10,001 – £25,000	0	0	0	0	0	0	0	0
£25,001 – 50,000	0	0	0	0	0	0	0	0
£50,001 – £100,000	2	154	0	0	2	154	0	0
£100,001 – £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**5**	**170**	**0**	**0**	**5**	**170**	**0**	**0**

2015/16 figures are available within the Annual Accounts starting on page 194.

Exit packages: other (non-compulsory) departure payments – 2016/17

	2016/17 Payments agreed Number	2016/17 Total value of agreements £000	2015/16 Payments agreed Number	2015/16 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0	5	56
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	1	8
Total	**0**	**0**	**6**	**64**
Of which, on-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

NHS Foundation Trust Code of Governance Disclosures

5 Boroughs Partnership NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance – most recently revised in July 2014 – is based on the principles of the UK Corporate Governance Code issued in 2012.

During 2016/17, the Trust further embedded the systems and assurances which underpin the Provider Licence, the Risk Assessment Framework, Single Oversight Framework and the Code of Governance. The Trust commissioned an audit from its internal audit provider which took place during 2016/17. The Board Assurance Framework and risk management processes were reviewed under two main objectives – Board Assurance Framework and risk management. The level of assurance received was significant with minor improvements.

1. Our Trust Board

Our Trust Board has responsibility for strategic development, approving policy and monitoring performance. This includes ensuring the delivery of effective financial stewardship, high standards of clinical and corporate governance and promoting effective relations with the local community we serve.

The Board collectively considers that it is appropriately composed with a balanced spread of expertise to fulfil its function and the terms of licence. The Chairman and non-executive directors meet the independence criteria laid down in the NHS Foundation Trust Code of Governance.

Annex 6 of the Trust's constitution (which can be found on our website at: www.5boroughspartnership.nhs.uk/constitution) – Standing Orders for the Practice and Procedure of Council of Governors for 5 Boroughs Partnership NHS Foundation Trust – defines the process for resolving any disagreements between the Council of Governors and the Trust Board.

Our Executive Leadership Team provides organisational leadership and takes appropriate action to ensure we deliver our strategic and operational objectives. It maintains arrangements for effective governance throughout the organisation; monitors performance in the delivery of planned results; and ensures corrective action is taken when necessary.

There were 10 Trust Board meetings held during 2016/17 (there was no meeting in August or December). Individual attendance is disclosed in the following tables. Where directors were not eligible to attend due to their start or leaving date or date they joined the Trust Board, this is indicated with N/A (not applicable).

Trust Board attendance – executive directors

Board member	25/04/16	31/05/16	27/06/16	25/07/16	26/09/16	31/10/16	28/11/16	30/01/17	27/02/17	27/03/17
Simon Barber, Chief Executive	✓	×	✓	✓	✓	×	✓	✓	✓	✓
Gail Briers, Chief Nurse and Executive Director of Operational Clinical Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tracy Hill, Director of Strategy and Organisational Effectiveness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Louise Sell, Medical Director	✓	✓	✓	✓	✓	×	✓	✓	✓	✓
Sam Proffitt, Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Trust Board attendance – non-executive directors

Board member	25/04/16	31/05/16	27/06/16	25/07/16	26/09/16	31/10/16	28/11/16	30/01/17	27/02/17	27/03/17
Helen Bellairs, Non-Executive Director and Vice Chair	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Brian Marshall, Non-Executive Director	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Bernard Pilkington, Chairman	✓	✓	✓	✓	✓	×	✓	✓	✓	✓
Derek Taylor, Non-Executive Director and Senior Independent Director	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A
Philippa Tubb, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alison Tumilty, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	×
Richard Sear, Non-Executive Director	N/A	N/A	N/A	N/A	✓	✓	✓	✓	✓	✓

1.1. The Trust Board for the period 1 April 2016 to 31 March 2017 comprised:

Simon Barber
Simon joined as Chief Executive on 1 December 2007. He has extensive commercial experience obtained through working as Finance Director and Commercial Director in a number of industries including utility supply, advertising, retail, telecommunications and manufacturing. Simon joined the NHS in 2006 to use his skills within the public sector. Simon is qualified at postgraduate level as an executive and business coach and a graduate of the European Health Leadership Programme at INSEAD. He is currently working at a national level supporting NHS England's programme to transform care for people with learning disabilities and chairs the Greater Manchester Health and Social Care Partnership Children and Young People's Mental Health work stream with the aim of improving services across the whole of Greater Manchester.

Bernard Pilkington
Our Chairman Bernard first became involved with the health service in 1984, serving as a non-executive director of St Helens and Knowsley Health Authority where he was Vice Chair. He is currently Chair of St Helens Mind – a voluntary organisation working with people who are isolated due to mental health problems. He became Chairman of our Trust on 17 May 2007, later championing our successful bid for foundation trust status in 2010. Bernard retires in 2017 and will be succeeded by current Vice Chair, Helen Bellairs from 17 May 2017.

Our executive directors are:

Gail Briers
Gail was appointed Chief Nurse and Executive Director of Operational Clinical Services on 1 December 2014. Prior to this, she was Director of Nursing and Governance. Gail started out at Winwick Hospital, Warrington, as a nursing assistant 34 years ago. Since then, she has worked in a variety of different services including adults, learning disabilities, older people and forensics. Gail is responsible for professional leadership for nurses, allied health professionals and psychological therapists across the Trust. She holds the Executive Lead Nurse role at Trust Board, and oversees executive management and leadership of the Trust's clinical services.

Tracy Hill
Tracy was appointed Director of Strategy and Organisational Effectiveness on 1 April 2015. Prior to this, she had been Director of People and Integrated Governance from 1 December 2014 and previously, Director of Human Resources and Organisational Development. Tracy is responsible for leading the development of our organisational strategy and ensuring our people are skilled and sufficient to support the delivery of our services. She also leads our integrated governance function which supports clinical services to deliver safe and high-quality care in line with the expectations of the Care Quality Commission. Tracy continues to lead on the development of our organisational culture and works with senior leaders to embed the behaviours we aspire to at the Trust.

Sam Proffitt
Sam was appointed to the post of Chief Finance Officer on 4 September 2013. She had previously been Director of Finance at the Alternative Futures Group and, prior to that, Deputy Director of Finance at Mersey Care NHS Trust. Sam is responsible for advising our Trust Board on the best use of our resources by keeping members updated on how we are performing against our financial duties and how we are spending our money. Sam also

has executive lead responsibility for informatics, performance, procurement, business development, and estates and facilities.

Dr Louise Sell

On 1 October 2011, Louise was appointed as our Medical Director and is responsible for medical services within our Trust. Louise, who is a consultant psychiatrist, joined us from Greater Manchester West Mental Health NHS Foundation Trust, where she worked for 15 years.

Our non-executive directors are:

Helen Bellairs

Helen has worked in the NHS for more than 40 years. She has previously worked as a clinician and chief executive and has more than 17 years' experience operating at Board-level. She has also worked as an independent management consultant with acute and community providers and commissioners. Helen is a member of the Audit Committee, Remuneration Committee and Quality Committee. Helen is also our Vice Chair; and on 1 February was appointed to the role of Chair which she takes up from May 2017. Helen was appointed at a non-executive director in September 2013.

Brian Marshall

Brian is a qualified accountant with extensive experience in national and international businesses at a senior level. In addition, he has NHS experience as an internal auditor for local health authorities. Brian is the Trust's Senior Independent Director, Chair of the Audit Committee and is a member of the Remuneration Committee. Brian was appointed in December 2009.

Richard Sear

Richard is an independent strategic business consultant and advisor. He has previously held a number of leadership roles in the health and life insurance sector. He also has expertise in change management and is passionate about supporting staff through periods of organisational change. Richard is Chair of the Quality Committee. Richard was appointed in September 2016.

Derek Taylor

Derek was a non-executive director from September 2008 to the end of August 2016. He had a broad range of commercial experience in the financial services sector in the UK and Australia. Derek was a member of the Audit Committee and Remuneration Committee and Chair of the Quality Committee; he was also the Senior Independent Director and supported the Membership and Communications Committee of the Council of Governors.

Philippa Tubb

Philippa is a registered general nurse with a clinical background in tropical diseases and is the Managing Director of Well-travelled Clinics at the Liverpool School of Tropical Medicine. She has considerable NHS experience and worked previously as the Assistant Director of Clinical Governance at an acute NHS foundation trust in Liverpool. Philippa is a member of the Quality Committee. She was appointed in May 2011 and her role was this year extended by a year to May 2018.

Alison Tumilty

Alison is currently employed as Group Finance Director for North West social housing provider Your Housing Group and brings a wealth of finance-related experience to the role,

as well as a passion for mental health services. Alison was appointed in September 2015 and is a member of the Audit Committee.
The terms of office for our non-executive directors are outlined below.

Non-executive director	Term commenced	Term ends
Helen Bellairs	11 September 2013	16 May 2017
Brian Marshall	17 December 2015	16 December 2017
Bernard Pilkington	17 May 2014	16 May 2017
Richard Sear	1 September 2016	31 August 2019
Derek Taylor	1 September 2015	31 August 2016
Philippa Tubb	31 May 2014	30 May 2018
Alison Tumilty	24 September 2015	23 September 2018

Non-executive directors' appointments may be terminated on performance grounds or for contravention of the qualification criteria set out in the constitution with the approval of three quarters of the Council of Governors or by mutual consent for other reasons. There is no provision for compensation for early termination or liability on the Trust's part in the event of termination.

The process for appointment of the Chairman and non-executive directors is agreed by the Council of Governors' Nominations and Remuneration Committee. In summary, the process includes: a review of the balance of skills, knowledge and experience on the Trust Board; preparation of the role description and person specification; agreement of a suitable process of open competition to identify potential candidates; agreement of a shortlisting and interview process; and finally, a recommendation to the Council of Governors on the appointment.

1.2. Remuneration Committee

This committee advises Trust Board on the appropriate remuneration and terms of service for the Chief Executive and other executive directors. It is concerned with all aspects of salary (including any performance-related elements and bonuses) and provisions for other benefits, including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

Its responsibilities are to:

- Be advised of, monitor and evaluate the performance of the executive directors.
- Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments – taking account of employment law and national guidance as is appropriate.
- Be informed of disciplinary matters arising relating to executive directors.
- Have responsibility for the ratification of appointments of directors. This requires the Chief Executive to be invited to attend the committee for those agenda items related to appointments of directors.
- Ensure executive directors are fairly rewarded for their individual contribution to the Trust. Proper regard must be given to the Trust's circumstances; size; difficulty of the job as benchmarked against other organisations; individual performance; and provision of any national guidance and arrangements for such staff as appropriate.

The performance of the executive directors is evaluated by the Chief Executive. The performance of the Chief Executive and non-executive directors is evaluated by the Chairman on an annual basis. The performance of the Chairman is evaluated by the Senior Independent Director having sought input from directors and governors on an annual basis. Performance of the Trust Board has been evaluated through an internal review of the Board against the NHS Improvement Well-Led Framework to ensure continual improvement.

Member	13/04/16	31/05/16
Helen Bellairs, Non-Executive Director	✓	✓
Brian Marshall, Non-Executive Director	✓	✓
Bernard Pilkington, Chairman	✓	✓
Derek Taylor, Non-Executive Director	✓	✓

1.3. Quality Committee

Linking closely with the Audit Committee, the Quality Committee assures Trust Board that appropriate structures, systems and processes are embedded in the organisation and on the effectiveness of our arrangements for quality – ensuring there is a consistent approach throughout the Trust and specifically in the areas of:

- Safety (patient, and health and safety)
- Effectiveness
- Patient experience

This includes ensuring appropriate actions are taken to address any deviation from accepted standards and informing Trust Board of any significant lapses and also that learning occurs as a result of risk analysis and feedback to services. The committee has the following duties:

- To oversee the development and publication of an annual Quality Report and Quality Account; ensuring the quality priorities are agreed by the Council of Governors are appropriately influenced by stakeholders.
- To receive assurance on the quality and safety of services provided by the Trust's operational services; including quality components of business plans.
- To receive progress and exception reports against the Quality Report and Quality Account.
- To seek assurance from the Trust's Integrated Governance Department of effective risk systems and processes. Examine in-depth, by exception, key risk issues impacting on quality as referred by the Quality and Safety Committee.
- To seek assurance that learning from complaints, inquests and serious incidents is shared across the Trust.
- To oversee the development and implementation of the Trust's Quality Strategy.
- To initiate investigation of areas of serious concern regarding quality, and seek assurance of completion of any associated resultant actions.
- To review, as required, intelligence and information from internal quality and compliance visits, external Care Quality Commission visits, Mental Health Act visits, service Care Quality Commission self-declarations, serious case reviews, serious incident reviews, and external homicide reviews; with a focus on the impact on quality and quality improvement.

- To receive assurance that in-depth reviews of themes from complaints, claims and serious incidents in relation to quality and safety are completed, reported and monitored by the relevant meeting group(s).
- To undertake a quarterly in-depth ‘deep dive’ review of a completed serious incident review.
- To receive assurance in relation to key performance indicators relevant to areas of quality and safety.
- To receive assurance in relation to systems and opportunities for patients, carers and the public to influence quality decisions and raise any concerns regarding quality.
- To receive summaries of annual reports from groups with a statutory or regulatory requirement to report directly to a sub-board committee:
    - Medicines Management
    - Infection Control
    - Records Management
    - Research and Development
    - Medical Education
    - Safeguarding Annual Report
    - Mental Health Law Annual Report
    - Patient Experience Annual Report
    - Medical Education Board Report
    - Clinical Audit Planning and Priorities Review
- To receive update reports from the Quality and Safety Committee, Clinical Leadership Group and Lessons Learned Forum.
- To receive additional reports relating to quality and safety as required by the Quality Committee.

Derek Taylor, Non-Executive Director, chaired the committee between 1 April 2016 and 31 August 2016. Philippa Tubb, Non-Executive Director, chaired the committee between 1 September 2016 and 31 December 2016, and Richard Sear, Non-Executive Director, chaired the committee between 1 February 2017 and 31 March 2017.

The committee met on 10 occasions between 1 April 2016 and 31 March 2017. In addition to executive and non-executive directors, the committee also includes co-opted roles as determined by the terms of reference. Details of the executive and non-executive directors’ attendance are disclosed in the following table. Where members were not eligible to attend due to their start or leaving date or the date they joined the committee, this is indicated with N/A (not applicable).

Quality Committee attendance

	06/04/16	04/05/16	06/07/16	03/08/16	07/09/16	05/10/16	02/11/16	07/12/16	08/02/17	08/03/17
Gail Briers, Director of Nursing and Quality / Chief Nurse and Executive Director of Operational Clinical Services	×	✓	✓	✓	✓	✓	✓	×	×	✓
Tracy Hill, Director of Strategy and Organisational Development	✓	✓	✓	✓	×	✓	✓	✓	✓	✓
Dr Louise Sell, Medical Director	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Helen Bellairs, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Derek Taylor, Non-Executive Director	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A
Philippa Tubb, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Sear, Non-Executive Director	N/A	N/A	N/A	N/A	✓	✓	✓	✓	✓	✓

1.4. Audit Committee

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) which supports the achievement of the organisation's objectives. It achieves this by:

- Reviewing the adequacy of all risk and control-related disclosure statements, together with any accompanying head of internal audit statements, external audit opinion or other appropriate independent assurances prior to endorsement by Trust Board.
- Ensuring there is an effective internal audit function which provides independent assurance to the Audit Committee, Chief Executive and Trust Board.
- Reviewing the work and findings of the external auditor.
- Reviewing the findings of other significant assurance functions (both internal and external) to the organisation and considering the implications to the governance of the organisation.
- Reviewing the work of other committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work.
- Requesting and reviewing reports and positive assurances from directors and managers on the overall arrangements for integrated governance, risk management and internal control.
- Reviewing the Annual Report and Annual Accounts before submission to Trust Board.
- Ensuring the systems for financial reporting to Trust Board (including those of budgetary control) are subject to review as to the completeness and accuracy of the information provided to the Board.

Brian Marshall chairs the Audit Committee. Full membership and details of attendance at meetings is disclosed in the following table. Where members were not eligible to attend due to their start or leaving date or the date they joined the committee, this is indicated with N/A (not applicable).

	06/04/16	08/06/16	03/08/16	05/10/16	07/12/16	08/02/17
Helen Bellairs, Non-Executive Director	✓	✓	✓	✓	✓	✓
Richard Sear, Non-Executive Director	N/A	N/A	N/A	✓	✓	✓
Brian Marshall, Non-Executive Director	✓	✓	✓	×	✓	✓
Derek Taylor, Non-Executive Director	✓	×	✓	N/A	N/A	N/A
Alison Tumilty, Non-Executive Director	✓	✓	✓	✓	✓	✓

There was also an extra-ordinary meeting held on 20 May 2016 to approve the Annual Report and Accounts for the financial year 2015/16.

In discharging its responsibilities in 2016/17, the committee considered the following matters in relation to the financial statements, governance and compliance:

Governance and compliance

- The committee received a risk management update at each meeting. At each meeting, the committee also requested a risk challenge session whereby responsible officers for high-risk areas were required to present progress against mitigations and actions. The committee offered challenge where appropriate and facilitated support where required.
- The Chair of the Quality Committee provided an update to each Audit Committee meeting on the work of the Quality Committee and any issues for consideration.
- The committee received regular updates on the register of interests and the gifts and hospitality register. Any material or regular entries in the gifts and hospitality register were challenged to ensure acceptance was appropriate.

Clinical Audit

- The annual Clinical Audit plan was reviewed at the April 2016 Audit Committee meeting. Progress against this plan was reviewed at subsequent meetings during 2016/17.

Financial matters and reporting

- The external auditor presented her annual plan to the committee in February 2017. At this meeting, elevated risk areas relevant to the statutory accounts were discussed and agreed. The Trust's Annual Accounts timetable and plan was also presented to this meeting. This included management's proposals for dealing with any elevated risk areas.
- The Annual Accounts for 2016/17, including the auditor's report to those charged with governance, were reviewed and approved at the extra-ordinary meeting on 18 May 2017.
- Aged debt, salary overpayments and losses were reviewed and challenged throughout the year.
- The waivers register was presented periodically in 2016/17 for review. The committee provided scrutiny and challenge as appropriate.
- The Trust's Standing Financial Instructions and Scheme of Reservation and Delegation were reviewed and updated as appropriate throughout the year.

Fraud

- The Trust's counter fraud service is provided by KPMG. The counter fraud annual plan was agreed at the April 2016 Audit Committee meeting. This plan covered five strategic areas: inform and involve; prevent and deter; detection; hold to account; and strategic governance. Updates on progress against plan were provided to each meeting.
- A number of counter fraud investigations were instigated in 2016/17. Progress and outcomes were reported to the committee.
- Progress against the Standards for Providers action plan was reviewed at each meeting. An updated self-assessment was submitted in March 2017.

1.5. Internal audit function

The Trust's internal audit function is provided by KPMG. The service provided is fully compliant with the NHS internal audit standards. Through the internal audit contract with KPMG, we have been assigned a named director at KPMG who is responsible for the management and coordination of the internal audit service to the Trust.

A significant role of the internal auditor is to provide an annual opinion on the overall adequacy and effectiveness of our risk management, control and governance processes. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee to provide a reasonable level of assurance. Regular progress reports against this plan have been presented to the Audit Committee throughout 2016/17.

1.6. External audit

PricewaterhouseCoopers were appointed as the Trust's external auditor in 2012 for a period of three years with an option to extend for up to two further years. The option to extend was endorsed by the Audit Committee and Council of Governors at a meeting on 5 August 2015. The agreed fee for the audit work for 2016/17 was £56,800 (excluding VAT).

The Audit Committee has assessed the effectiveness of the external audit service through the quality of their audit findings and management's responses; their continuing challenge; their focused reporting; and their discussions with both management and the Audit Committee.

1.7. Auditor independence and objectivity

PricewaterhouseCoopers issued the following statement with regard to independence and objectivity:

We have made enquiries of all PricewaterhouseCoopers' teams and of those responsible in the UK Firm for compliance matters and we are not aware of any relationships that, in our professional judgement, may be perceived to impact upon our independence and the objectivity of our audit team as at the time of preparing this audit plan.

1.8. Additional director responsibilities

Our Chief Nurse and Executive Director for Operational Clinical Services has a non-executive director role at Advancing Quality Alliance. This is an unpaid role.

1.9. Register of interests

Registers of interests for both Trust Board members and our Council of Governors are available on our website.

Trust Board: www.5boroughspartnership.nhs.uk/trust-board-members-register-of-interests

Council of Governors: www.5boroughspartnership.nhs.uk/cog-register-of-interests

Our Chairman has had no other significant commitments or any that have changed during the reporting year.

2. Our Council of Governors

Governors have responsibility for the following decisions:

- Appointing the Chairman
- Appointing the non-executive directors
- Approving the appointment of the Chief Executive
- Removing the Chairman and non-executive directors
- Agreeing non-executive directors' terms and conditions
- Approving changes to the constitution

Governors' responsibilities include:

- Holding the non-executive directors individually and collectively to account for the performance of the Board
- Appointing and removing auditors
- Receiving the Annual Report and Accounts
- Being consulted on proposed changes and providing feedback on the future direction of the Trust
- Representing the interests of members and the public.

The governors have not exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006 to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties. They have not proposed a vote on the Trust's or directors' performance during the reporting year. However, our Chairman and/or Chief Executive were in attendance at the meetings in order to develop an understanding of the views of the governors and members.

There is an open invitation from the governors to Trust Board members, both executive and non-executive directors, to attend the Council of Governors' meetings.

During 2016/17, our nominated lead governor was Chris Whittle.

During the reporting year, 14 governors claimed a total of £1,586.55 in expenses. In the previous reporting year, 21 governors claimed a total of £2,211.91in expenses.

Our governors met five times during the period 1 April 2016 to 31 March 2017.

Attendance of governors is detailed in the following table. Where governors were not eligible to attend due to their start or leaving date, this is indicated with N/A (not applicable).

Public, staff and appointed governors (alphabetical by surname)	11/05/16	13/07/16	14/09/16	21/11/16	01/02/17
Bernard Pilkington, Chairman	✓	✓	×	✓	✓
Michael Ashley – Public, Warrington, Elected	✓	×	✓	✓	×
Trevor Barton – Public, Wigan, Elected	×	×	×	✓	×
Norman Bradbury – Public, Wigan, Elected	✓	✓	✓	✓	✓
John Brennan – Public, Wigan, Elected	×	×	×	×	×
Dr Marian Catalan – Staff, Medical, Elected	✓	✓	×	×	✓
Chris Coffey – Public, St Helens, Elected	✓	×	×	✓	✓
Ann Cunliffe – Staff Side Chair, Appointed	×	×	×	✓	×
Amber Dickinson – Staff, Nursing, Elected	×	×	×	✓	×
Damian Edwardson – Wigan Council, Appointed	N/A	N/A	N/A	N/A	×
Alan Griffiths – Public, St Helens, Elected	×	✓	✓	✓	✓
Hazel Hendriksen – Staff, Allied Health Profession, Elected	×	✓	✓	×	✓
Jackie Hughes – Staff, Managers, Elected	✓	×	✓	✓	✓
Chris Hugo – Public, Warrington, Elected	×	×	✓	×	×
Rev. Lyn Cavell McIver – Public, Halton, Elected	N/A	N/A	N/A	✓	×
Andy Jones – Public, Halton, Elected	N/A	N/A	N/A	✓	✓
Charlie Leonard – Staff, Supporting Services, Elected	×	×	✓	×	✓
Denis McFarland – Public, Other, Elected	✓	×	✓	✓	✓
Jacqui McGloin – Public, Halton, Elected	×	✓	×	✓	×
Wendy Mitchell – Staff, Supporting Services, Elected	×	✓	✓	✓	✓
Chris Molyneux – Public, Warrington, Elected	N/A	N/A	N/A	N/A	✓
Sheila Ratcliffe – Public, Wigan, Elected	×	✓	×	✓	✓
Kevin Redmond – Staff, Nursing, Elected	✓	✓	✓	×	×
John Richards – Public, St Helens, Elected	✓	✓	×	✓	✓

Sue Rimmer – Public, Wigan, Elected	✓	×	×	N/A	N/A
Ron Rotheram – Public, Knowsley, Elected	×	✓	×	×	×
Jim Sinnott – Public, Warrington, Elected	✓	✓	✓	✓	×
Chris Whittle – Public, Knowsley, Elected, Lead Governor	×	✓	✓	✓	✓
Councillor Marie Wright – Halton Council, Appointed	×	×	×	✓	×
Councillor Pat Wright – Warrington Council, Appointed	×	×	×	×	×

Public and staff governors are appointed for a term of three years. Should a governor resign mid-term, a governor may be appointed to serve the remaining duration of the term. Owing to the fact that some of the governors are service users and carers themselves, we accept some governors cannot attend when they are unwell or have pressing carer responsibilities. Governors are asked to notify us of this. An annual attendance review is planned (to be led by the Chairman) and an appropriate plan of action will address any areas of concern.

In addition to governors, the above meetings were attended by Trust Board members as follows:

11 May 2016
- Simon Barber, Chief Executive
- Helen Bellairs, Non-Executive Director
- Derek Taylor, Non-Executive Director
- Brian Marshall, Non-Executive Director
- Philippa Tubb, Non-Executive Director

14 September 2016
- Tracy Hill, Director of Strategy and Organisational Effectiveness
- Helen Bellairs, Non-Executive Director and Vice Chair

21 November 2016
- Simon Barber, Chief Executive
- Helen Bellairs, Non-Executive Director and Vice Chair

1 February 2017
- Simon Barber, Chief Executive
- Helen Bellairs, Non-Executive Director – chaired the meeting, as Vice Chair
- Brian Marshall, Non-Executive Director

2.1. Committees

The committees of the governors are supported by directors (both executive and non-executive) and/or other managers from the Trust.

2.1.1. Membership and Communications Committee

The remit of the committee is to oversee the delivery of the Membership Strategy and to ensure effective communication with the membership of the Trust. The committee met four

times during the period 1 April 2016 to 31 March 2017. Attendance is detailed in the following table. Where committee members were not eligible to attend due to their start or leaving date, this is indicated with N/A (not applicable).

	05/07/16	18/10/16	05/12/16	21/03/16
Michael Ashley	×	×	×	×
Trevor Barton	×	×	✓	×
John Brennan	×	×	×	×
Dr Marian Catalan	×	×	×	×
Kaye Cunliffe	×	×	N/A	N/A
Chris Coffey	✓	✓	×	✓
Hazel Hendriksen	✓	✓	✓	×
Chris Hugo	×	×	×	×
Andy Jones	N/A	✓	×	✓
Denis McFarland	✓	×	✓	✓
Jacqui McGloin	×	×	×	×
Sheila Ratcliffe	✓	✓	×	✓
John Richards	✓	✓	×	✓
Sue Rimmer	×	N/A	N/A	N/A
Jim Sinnott	N/A	N/A	✓	×
Chris Whittle	✓	✓	×	✓

2.1.2. Nominations and Remuneration Committee

The Council of Governors has established a committee known as the Nominations and Remuneration Committee. The committee met five times during the period 1 April 2016 to 31 March 2017. The membership is made up of the Chairman, Bernard Pilkington, plus three members of the Council of Governors and the lead governor. The committee is supported by the Chief Executive, Company Secretary and Director of Strategy and Organisational Effectiveness. Attendance is outlined in the following table:

Member	27/04/16	11/07/16	21/12/16	13/01/17	24/01/17
Michael Ashley	✓	×	×	×	×
Trevor Barton	✓	✓	×	×	×
John Richards	✓	×	✓	✓	✓
Chris Whittle	✓	✓	×	✓	✓

In addition, the Senior Independent Director also attends and chairs the meeting for matters relating to the appointment, performance and remuneration of the Chairman.

An external search consultancy is used in our appointment processes.

The remit of the committee is to:

- Regularly review the composition of non-executive directors on the Trust Board to ensure they reflect the required expertise and experience and to make recommendations to the Council of Governors. This includes periodic consideration of information prepared for the Board and reviewing the independence, skills and experience required for non-executive directors to ensure the appropriate balance of experience and expertise.
- Evaluate the balance of skills, knowledge and experience on the Trust Board.

- To prepare a job description and person specification for the role and capabilities required for a particular appointment of a non-executive director (including the Chairman).
- To identify suitable candidates to fill non-executive directors posts through a process of open competition.
- To make recommendations to the Council of Governors as to the appointment of non-executive directors (including the Chairman).
- To evaluate and report to the Council of Governors on the performance of the Chairman and non-executive directors, including their retention or removal as appropriate.
- To consider and make recommendations to the Council of Governors as to the remuneration, allowances and other terms and conditions of office of the Chairman and non-executive directors.

2.1.3. Governors' Assurance Committee

The Council of Governors has established a committee known as the Governors' Assurance Committee which meets four times a year. Attendance is detailed in the following table. Where committee members were not eligible to attend due to their start or leaving date or the date they joined the committee, this is indicated with N/A (not applicable).

Member	22/06/16	01/12/16	10/01/17	14/03/17
Chris Coffey	✓	✓	×	×
Alan Griffiths	✓	×	✓	✓
Jacqueline Hughes	×	×	✓	N/A
Andy Jones	N/A	N/A	✓	✓
Denis McFarland	✓	×	✓	✓
Wendy Mitchell	×	×	×	N/A
Chris Molyneux	N/A	N/A	✓	✓
Sheila Ratcliffe	×	✓	×	✓
John Richards	N/A	✓	×	×
Jim Sinnott	✓	✓	✓	✓
Chris Whittle	✓	✓	✓	×

The committee is responsible for:

- Gaining understanding and evidence to review the Governors' Assurance Framework to support the governors to hold the non-executive directors to account for the performance of the Board.
- Receiving a report of the auditor on the Annual Accounts for onward presentation to the Council of Governors.
- Receiving a report from the Audit Committee and the Quality Committee to support the governors to hold the non-executive directors to account for the performance of the Board.
- Receiving a report for approval, from the Audit Committee, on the appointment of the Trust's external auditors.
- Receiving an annual report on the effectiveness of the Trust's system of internal control, in the form of the Head of Internal Audit Opinion.
- Assurance on the Quality Accounts process throughout their annual cycle.

3. Membership of our foundation trust

As a foundation trust, we have a membership to give local people a say in how we respond to the specific needs of the population we serve. Our membership is made up of both staff and the public.

Members of our Trust can:

- Receive information about the Trust and be consulted on plans for future development of our Trust and services
- Elect representatives to serve on the Council of Governors
- Stand for election to the Council of Governors

It has been one of our aims to develop a membership which enables varying levels of participation according to the needs and degree of involvement of individual members.

Anyone who is a member of the public can become a member of the Trust, providing they are aged 14 or over. Members of the public constituency must complete a membership form and submit it to the membership office.

The boundaries for determining membership are set in line with local authority boundaries. Public members at 31 March 2017 are shown below.

Constituency	Number of members
Halton	758
Knowsley	666
St Helens	905
Warrington	1,307
Wigan	1,078
Other	980
Total	**5,694**

Trust staff are automatically members but may opt out if they wish. On 31 March 2017, there were 3,689 staff members.

The staff constituency is sub-divided into the following classes:

- Allied health professions (qualified)
- Managers (band 8 or above)
- Medical staff
- Nursing staff (qualified)
- Supporting services (including nursing assistants, healthcare workers and administrators)

Maintenance of the membership numbers is managed through attending external events as well as establishing links with our partners in the voluntary sector to ensure representation of minority and vulnerable groups. The diversity of our membership is reviewed annually by our Equality and Diversity Working Group, where an opportunity is taken to address any under representation. This area will be further examined in our Membership Strategy.

We communicate regularly with members, patients and the public using a range of communication methods and feedback channels. These include:

- Trust website – www.5boroughspartnership.nhs.uk
- Social media – Twitter and Facebook
- Direct email
- Service users, carers and members' magazine – Reflect
- Annual members' meeting and involvement scheme events
- Service user and carer forums

This year, we have undertaken a number of different engagement projects involving members and the public with the aim of gathering feedback about services to help plan, design and improve services. These included:

- Development of Atherleigh Park, our new mental health hospital – members and the public have contributed to, amongst other things, the design of the building, accessibility, artwork and furniture.
- Redesign of Halton Later Life and Memory Services
- Trust name change consultation

In addition, in September 2016, we held a Trust Board and Council of Governors away day to develop the strategy and annual plan. This provided the opportunity for the Council of Governors to contribute the views of members and the public and, for appointed governors, the body they represent to the forward plan.

Directors are encouraged to attend meetings of the Council of Governors, the annual members' meeting and other engagement events to develop an understanding of the views of governors and members.

Meaningful engagement with our membership base is an on-going priority for the Council of Governors and an area they are continuing to develop. Our Membership Strategy has been reviewed, with activities identified to further develop two-way communication between governors and the wider membership.

Governors and members attend regular service user and carer forums as well as events such as Disability Awareness Day, our annual service user involvement event, Ignite Your Life and our annual members' meeting. Our governors have also attended meetings in their local areas, including dementia support groups, carers' groups, Healthwatch and veterans' group meetings, as well as events in their local communities. This enables our governors to share views about areas of particular interest and new developments at the Trust.

Members can find out who their governor is on the membership section of our website at: www.5boroughspartnership.nhs.uk/members-area

Members can contact their governor by calling the Membership Office on 01925 664869 or emailing ft.membership@nwbh.nhs.uk – marking it for the attention of their governor.

Single Oversight Framework

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

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

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

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

Segmentation

The Trust has been segmented according to the level of support required across the five themes and has been segmented as '1', requiring the lowest level of oversight.
This segmentation information is the Trust's position as at 31 March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2016/17 quarter 3 score	2016/17 quarter 4 score
Financial sustainability	Capital service capacity	3	2
	Liquidity	3	3
Financial efficiency	I and E margin	3	3
Financial controls	Distance from financial plan	1	1
	Agency spend	1	2
Overall scoring		**2**	**2**

Statement of the Chief Executive's Responsibilities as the accounting officer of 5 Boroughs Partnership NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions which require 5 Boroughs Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 5 Boroughs Partnership NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

- Observe the accounts direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements.
- Ensure the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- 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 to ensure 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 168 responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2017

Annual Governance Statement

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control which supports the achievement of 5 Boroughs Partnership 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 the 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 the 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 the Trust for the year ended 31 March 2017, and up to the date of approval of the Annual Report and Accounts.

3. Capacity to handle risk

3.1. Risk management governance arrangements

I, as a member of the Trust Board, and through delegation to the Audit Committee and Quality Committee, which report to the Board, provide leadership and strategic direction to the risk management processes.

The day-to-day responsibility for the risk management process (and support for the Quality Committee) is delegated to the Director of Strategy and Organisational Effectiveness and through them to the Chief Nurse and Executive Director of Integrated Operational Clinical Services and the Medical Director as necessary.

The Trust has two sub-committees of the Board, which have remits relating to risk – the Audit Committee and the Quality Committee.

The Audit Committee has a role in satisfying itself that all aspects of governance and risk management are appropriate and effective. Day-to-day responsibility for the Audit Committee, as well as the management of financial and information risks, is delegated to the Chief Finance Officer.

The Audit Committee gives assurance to the Board that it has satisfied itself the governance arrangements are functioning as required and the risk management arrangements are robust. It also satisfies itself that the Trust's resources (financial,

workforce and estates) are being effectively managed. The committee receives assurance through reports from the executive team, the internal and the external auditor, and other external bodies.

The Audit Committee is chaired by a non-executive director, who has knowledge and experience relevant to that committee. The Quality Committee is also chaired by a non-executive who, in order to provide objectivity and challenge, has been purposely appointed without NHS knowledge and experience, but who has a wealth of commercial knowledge of boards and governance. Additionally, other non-executive directors are members.

The role of the Audit Committee includes the review of the adequacy of the risk management systems and strategy. To enable this, the committee receives regular monitoring reports about the management of strategic risks and those judged as 'extreme'. They also provide verification to the Trust Board, through the assurance framework, on the systems in place for the management of risk within the Trust.

The Quality Committee oversees aspects of risk which impact on quality. On a quarterly basis, the chair chooses a serious incident which has been through the governance approval process for intensive scrutiny at the meeting. Supportive challenge is offered to the executive directors on the lessons learned from the incidents, and the committee receives assurance that actions are taken to prevent future incidents. A bi-annual report on the work and decisions of the committee is provided to Trust Board.

On a monthly basis, the Trust Board receives an update on all serious incidents and inquests which have occurred.

The Trust's Quality and Safety Meeting is chaired by the Director of Strategy and Organisational Effectiveness. This meeting is made up of deputy and assistant clinical directors from both corporate and operational services. The meeting receives information relating to risks and serious incidents from across the Trust. Members ensure risks are monitored and managed effectively. Reporting from the Quality and Safety Meeting is monthly to the Trust Board through the Chief Executive's report and quarterly to the Quality Committee. Additionally, exception reports are provided to highlight any areas for escalation or of concern.

The Clinical Leadership Group meets monthly and is made up of the senior clinical leads across the Trust and chaired by the Medical Director. The group provides professional leadership, clinical advice and specific clinical responses and management action for implementation to mitigate risks. This group has scrutiny over the quality and safety aspects of the cost improvement schemes and completes the quality impact assessments on services. The group has the authority to reject schemes which have a significant detrimental impact on clinical services. This is reported to the Quality Committee, providing assurance to the committee that the process for measuring the impact on quality within the cost improvement process is robust. Quarterly update reports on the general work of the group are provided to the Quality Committee.

The Quality and Safety Meeting is the point of dissemination both upwards as described above, and also through to borough teams and clinical teams.

Borough quality and safety meetings are in operation and incorporate items and topics from the Trust Quality and Safety Meeting (incidents, risks, themes, lessons learned) as standing agenda items. Items of concern or good practice from the borough meetings are

escalated and shared through a monthly reporting template to the Trust Quality and Safety Meeting.

3.2. Leadership

As the Accounting Officer and Chief Executive of the Trust, I take lead responsibility and accept accountability for ensuring a sound system of internal control and a robust assurance framework is in place. The organisational management structure illustrates the Trust's commitment to effective governance, including the risk management processes.

The delegated responsibility for the coordination of risk management sits with the Director of Strategy and Organisational Effectiveness, who is supported by the Chief Nurse and Executive Director of Operational Clinical Services, Medical Director and Chief Finance Officer, who are responsible for overseeing risk management activities within their individual areas of responsibility.

The Risk Management Strategy defines risk governance, risk appetite and risk management structures across the Trust. This is underpinned by a Risk Management Policy and Procedure which further describes the devolvement and accountabilities within each Trust directorate.

The breadth and depth of experience on the Trust Board is clearly reflected in the way important decisions are developed, challenged and achieved. Strategic planning and decision making is carried out by the full Trust Board, without compromising the required independence and challenge of the non-executive directors as appropriate. The governance structures in place are effective in ensuring the Trust Board agenda is aligned to risks and directs attention to areas for involvement, scrutiny and decision making.

The Director of Strategy and Organisational Effectiveness is responsible for leading strategy within the Trust, taking account of external and internal influences including national strategy, local needs, and the Trust's competitors' plans.

Independent assurance on our systems and processes is received through the Trust's internal auditors KPMG. There have been four governance-related audits undertaken in 2016/17, as follows:

- KPMG completed a review of corporate governance in March 2017, with an overall rating of significant assurance with minor improvement opportunities.
- KPMG completed a review of the Risk Management and Board Assurance Framework in March 2017, with an overall rating of significant assurance with minor improvement opportunities.
- KPMG completed a policy process review in November 2016, with an overall rating of significant assurance with minor improvement opportunities.
- KPMG completed a clinical audit review in January 2017, with an overall rating of significant assurance with minor improvement opportunities.

3.3. Risk management accountability

The Trust's Risk Management Strategy and Policy sets out the overall aims for risk management across the Trust, delivered through an annual work plan against a set of specific risk management objectives:

Objective 1: Ensure effectiveness of the risk management system and incident management systems across the Trust.

Objective 2: Improve operational management and accountability of risk management.
Objective 3: Improve dissemination of actions and lessons learned from incidents and risks.
Objective 4: Improve service delivery and patient safety.
Objective 5: Ensure compliance with statutory and regulatory requirements.

The Risk Management Strategy and Policy describes the structured and systematic approach to the management of all risk across financial, clinical, non-clinical, strategic and project risk management.

The Risk Management Policy sets out both the collective responsibilities of the Trust Board and its committees, and individual responsibility of the Chief Executive, directors and all levels of staff across the Trust.

The Trust's Audit Committee seeks assurance that the risk management process is comprehensive, effective, complies with regulatory requirements and is fit for purpose by taking independent, objective advice through the appointment of internal auditors. The committee also approves the Annual Governance Statement.

The Trust Board receives an Assurance and Risk Report at alternate meetings to review the identification, evaluation and control of organisational financial, clinical and non-clinical risk, and the risks against the achievement of the Trust strategic objectives and high level objectives. Detailed reporting mechanisms for risk management are included within the table in section 7.1 of this report.

3.4. Staff education and development

3.4.1. Induction

The principles of risk management are included as part of the mandatory corporate induction, covering an introduction to a wide range of topics including subjects such as risk, governance, health and safety, fire awareness, handling complaints, equality and diversity, safeguarding children and adults, patient and public involvement and human resource issues for all staff.

Induction is extended for clinical staff to include clinical skills such as basic life support and breakaway techniques. Also included is training on the electronic care records system and the care planning approach process. The Trust training needs analysis identifies additional risk-based training is available to staff as appropriate to their duties.

3.4.2. Statutory, core and developmental training

This is available to all staff groups within the training programmes as stated within the Trust's Core and Statutory Training Policy. In addition to the statutory and core training schedule, staff are further developed based on the outcomes of their performance and development review, leading to the development of a personal development plan.

3.4.3. Incident management

During 2016/17, we have continued to improve our serious incident process, which included additional scrutiny of our reports by the Medical Director, to ensure quality of reporting.

In 2015/16, we engaged the services of a national company – Consequence UK – which specialises in undertaking serious incidents and works regularly for NHS England,

providing independent reviews of serious incidents. The company provided a diagnostic on our processes, policies and procedures, which gave assurance to the Trust and our commissioners on our reporting and how we conduct investigations. In 2016/17, we have continued this work with Consequence UK to improve and build on the serious incident investigation processes further. This is currently being evaluated with a view to enhanced improvements to our procedures, templates and dissemination of lessons learned across the Trust.

Following engagement across our stakeholders, one of the quality priorities for 2017/18 is to review the implementation and monitoring of Duty of Candour processes. This will build on the work of the 'being open' requirements and provide the formal elements of this process.

3.4.4. Policy and procedures

A range of clinical and non-clinical policies and procedures guided by statutory duty, legislative requirements and best practice guidelines are available to staff in electronic format on the intranet to assist them in managing risk.

All policies and procedures undergo equality analysis impact assessment in relation to training, equality and diversity, safeguarding, and NHS Litigation Authority requirements. A system is in place to ensure due process has been followed before policies are ratified by the Audit Committee.

Following the Trust's comprehensive Care Quality Commission inspection in July 2015, it was highlighted in the report that some policies and procedures were out of date. This was rectified and, by April 2016, the Trust was able to report all policies and procedures had been reviewed and were in date. The addition of a robust escalation process has ensured this improvement has been sustained throughout 2016/17.

3.4.5. Quality and safety learning

A Patient Safety Panel consisting of the Medical Director, the Chief Nurse and Executive Director of Operational Clinical Services, the Director of Strategy and Organisational Effectiveness, the Assistant Director of Integrated Governance, the Deputy Director of Nursing and Quality, and the Clinical Director of Operations and Integration meets on a weekly basis. They discuss any serious incidents which have occurred in the preceding week, together with any local reviews undertaken, to determine actions needed and next steps.

A Lessons Learned Forum was formed in 2015, chaired by the Medical Director. All serious incident themes are reviewed at this forum and actions for improvement monitored.

A communications plan for the sharing of lessons from incidents is in place with regular bulletins in Trust-wide publications. Acknowledgement of the success of this process was made in the Care Quality Commission inspection revisit which took place in July 2016. Internally, it is reported by the executive and non-executive directors on their safety walkabouts that teams visited are aware of the lessons learned communications and do discuss these in team meetings.

The Trust is proud to be a learning organisation and is continually striving to improve. Thematic reviews of incidents are presented at the Quality and Safety Meeting and at the Quality Committee for information and discussion. In addition, the Quality Committee

completes a deep dive on a serious incident each quarter to look at how these have been managed and to focus on the outcomes to make sure lessons are learned.

4. Risk and control framework

4.1. Risk management strategy

Our Risk Management Strategy describes the way the Trust identifies and develops risks, together with the risk tolerance or 'risk appetite' of the organisation – that is the level of risk the Trust is willing to accept. This is determined by how much loss the Trust is prepared to accept, combined with the cost of correcting errors. The strategy describes how risks are developed and managed from strategic risks at Trust Board level, corporate risks in Corporate Services to operational risks at Borough and Team level.

If risks are properly assessed and managed, this can help set all priorities for NHS organisations, teams and individuals, and improve decision-making to reach a balance of risk, benefit and cost.

The Trust Board utilises a 'risk universe' approach to identify strategic risks which plots risks against two axes – 'stable and known' through to 'changing and new' and 'internal' through to 'external'.

The risk universe is reviewed and updated in a joint session of the Trust Board and Council of Governors during September. These are further discussed and agreed by the Executive Leadership Team. The final draft is shared with the wider Trust leadership group for additional input and agreement. The risks identified are categorised as:

- High or strategic risk areas
- Other risks requiring additional focus in year
- Routine systems and risks which require periodic review

The risk universe is intended to be a dynamic risk tool and is reviewed periodically throughout the year with the opportunity to add and remove risks as appropriate and agreed by Trust Board.

The high level or strategic risk areas are considered by the Trust Board and, in order to mitigate these risks, high level objectives for the coming year are agreed.

4.2. Risk management policy

The overall aim of risk management is to ensure high quality healthcare services are delivered with the safety and health and wellbeing of services users, carers and staff at the forefront of everything we do. Additionally, the policy describes the assurance processes in place through clear reporting structures which ensure risk management systems across the Trust are embedded and effective.

The Trust is committed to ensuring the safety of service users, staff, and the public through an integrated approach to managing risk, whether financial, organisational, clinical or non-clinical, within systems which are open and transparent and demonstrate sound governance.

4.3. Risk management process

In pursuit of implementing effective risk management processes across the Trust, the Risk Management Strategy is the overarching process for managing all risk within a single framework. The Risk Management Policy and Procedure detail the framework for identification, evaluation, analysis, treatment, control, monitoring and review of risks, within a single Trust-wide risk register. The Risk Management Procedure provides associated step-by-step guidance on what to do following identification of a potential risk and the process of risk management.

The risk management process begins with the identification of risks throughout the Trust. Risks are identified through a number of sources, including risk assessment, audit, incidents, complaints, safety alerts, external reviews and inspection, emerging financial and environmental risks and compliance with statutory and regulatory requirements.

The Trust's risk grading matrix has been adopted from the IS) 31000:2009 Risk Management, Risk Assessment Guidelines and is also the model recommended in the National Patient Safety Agency – A Risk Matrix for Managers; (2008). The methodology used is a consequence and likelihood matrix which facilitates the evaluation and prioritisation of risks within the management decision-making process. The risk grading matrix is available at Appendix 1.

The Risk Management Policy clearly describes the process, accountability and authority to manage risk within the Trust and the escalation process with low level risks being managed locally, and high level risks escalated to the Trust's Executive Leadership Team and reported to Trust Board.

The Trust Board receives bi-monthly reports on the current status and management of all risks within the Trust. Executive directors review specific, relevant risks at the meetings they chair, such as the monthly Trust Quality and Safety Meeting, Clinical Leadership Group, Operations and Integration Committee and the Trust-wide Performance Meeting. The Audit Committee scrutinises these risks further. At each meeting, a risk is chosen for a supportive challenge session by the committee and the risk owner is asked to present the risks controls, gaps, mitigations and actions taken to reduce the risk.

The Trust Board receives an integrated Assurance and Risk Report, which includes the risk register and Board Assurance Framework reporting. This provides the Trust Board with an overarching view of the organisational risks with a regular risk management report to fully consider the risks to achieving the Trust's high level objectives. On a monthly basis, all risks are reviewed at the Trust's Quality and Safety Meeting, involving all Trust assistant clinical directors. Further scrutiny of clinical risks is undertaken at the Clinical Leadership Group.

Risk movement and control is monitored monthly at the Trust and borough Quality and Safety Meetings and Operations and Integration Committee, where emerging risks, accountabilities for risk control and risk movement are discussed. Risk appetite, risk movement and control for the Trust's high level risks are also monitored and discussed monthly at Trust Board.

The Trust accepts some risks cannot be completely eliminated, however, may be managed and minimised. The risk appetite is the level of risk the Trust is prepared to accept in pursuit of its objectives, and before action is deemed necessary to reduce the risk. It represents a balance between the potential benefits of innovation and the threats

that change inevitably brings. All risks rated 12 and above, with limited or fair controls, are escalated to Trust Board, where the risk and Board Assurance Framework reports are discussed at alternate Trust Board meetings.

4.4. Quality governance arrangements

4.4.1. Care Quality Commission

The Trust is expected to maintain its registration with the Care Quality Commission to undertake the regulated activities it provides. The Trust is routinely visited by the Care Quality Commission, including the Mental Health Act Commission, as part of their programme of inspections.

The Trust continually assesses itself against the fundamental standards, reporting monthly as part of the performance report; alongside the Care Quality Commission Intelligent Monitoring Reports. During 2016/17, monitoring changed to reflect the new fundamental standards. Assurances are provided through the clinical quality assurance cycle which incorporates the following three areas:

- **Internal quality reviews** – a programme of internal inspections of teams undertaken by staff, service user and carer volunteers, and non-executive directors, against the standards of quality and safety (changed to fundamental standards from April 2015) and Trust policy.
- **Safety walkabouts** – visits undertaken by executive and non-executive directors. A total of 39 have taken place up to the end of March 2017, which has included all inpatient areas. Following each visit, the Trust Board member feeds back the findings and recommendations to the Trust Board. Following safety walkabouts, local managers are accountable to act on any issues identified.
- **Continuous clinical improvement** – a review of outcomes from the above elements which identifies areas for improvement. These are either carried out at a local level within teams, or on a Trust-wide basis which informs the quality agenda for the Trust.

During 2016/17, there have been a total of 15 inspections to the Trust from the Care Quality Commission. Of these, 11 were unannounced Mental Health Act Commission inspections.

In addition, there was a targeted safeguarding inspection of child and adolescent mental health services and adult mental health services in Warrington during April 2016. A Trust action plan is in place and good progress continues to be made. This is a shared action plan with Warrington Clinical Commissioning Group and other providers of Warrington health services.

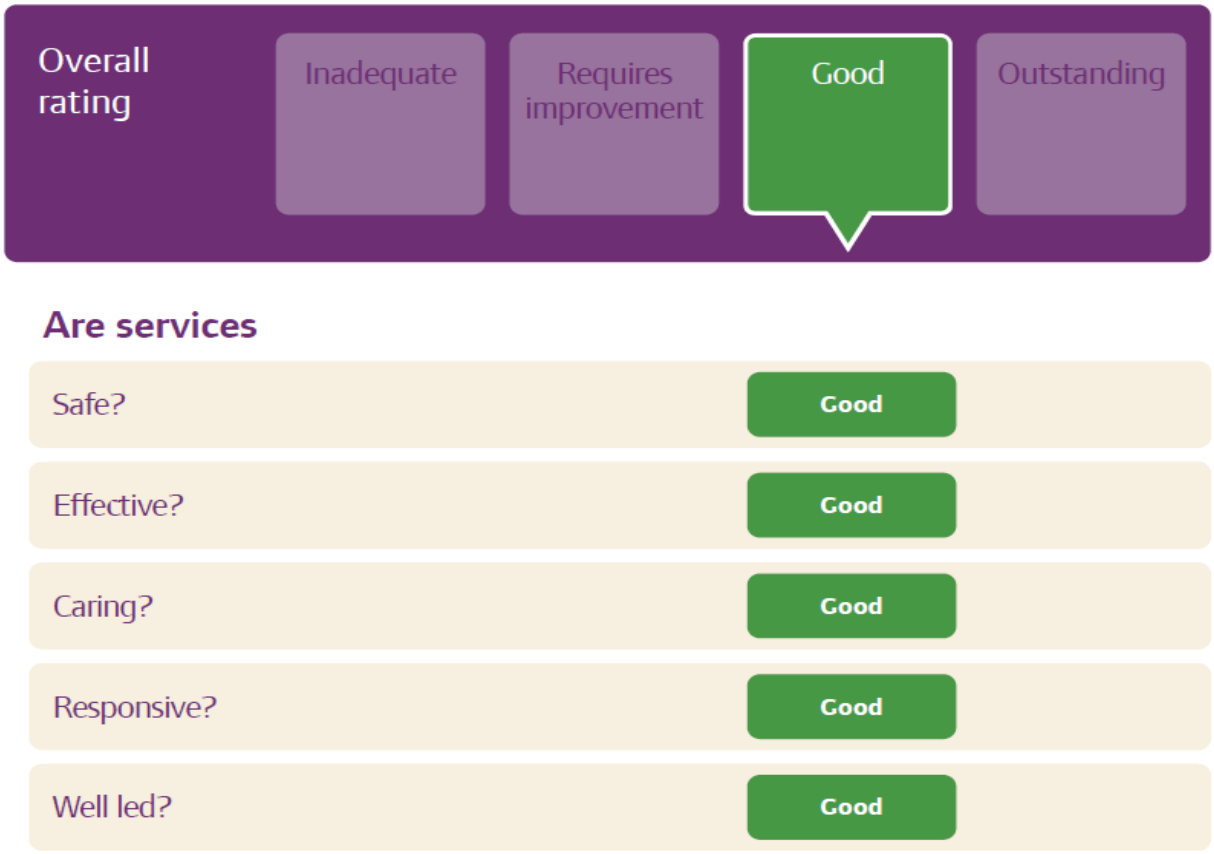
There was also a Care Quality Commission review of services for looked after children and safeguarding in Knowsley during November 2016. An action plan has been implemented; as part of a joint health providers' action plan and the Trust remains on target with actions, with updates being submitted to Knowsley commissioners through the Designated Nurse for Safeguarding Children.

The table below details the inspections undertaken by the Care Quality Commission in 2016/17.

Month of visit	Team visited and borough	Type of visit Mental Health Act Commission	Outcomes or areas covered
April 2016	Chesterton, Warrington	Routine unannounced	**Domain 2** Detention in hospital
April 2016	Marlowe, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
April 2016	Fairhaven, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
April 2016	Warrington	Safeguarding targeted inspection	**Child and adolescent mental health and adult mental health**
May 2016	Lakeside, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
May 2016	Coniston, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
May 2016	Grasmere, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
June 2016	Rydal, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
June 2016	Tennyson, Warrington	Routine unannounced	**Domain 2:** Detention in Hospital
June 2016	Austen, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
July 2016	Trust-wide	Announced Reinspection of core services	**Core services**
July 2016	Auden, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
August 2016	Byron, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
November 2016	Knowsley	Looked after children and safeguarding	**Looked after children and safeguarding**
March 2017	Halton	Joint SEND review – Ofsted and Care Quality Commission jointly inspect local areas to see how well they fulfil their responsibilities for children and young people with special educational needs or disabilities	**Local area joint Inspection Feedback has not yet been received**

Following a comprehensive Care Quality Commission inspection which took place in July 2015, a reinspection of the services which were rated as ‘Requires Improvement’ took place in July 2016. The report was published on 15 November 2016. The Trust received an overall rating of ‘Good’.

An area of note was the increased rating from ‘Requires Improvement’ in the July 2015 inspection to ‘Outstanding’ in July 2016 for End of Life Care.



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

4.4.2. Monitor's Quality Governance Framework

The Trust Board is confident and assured that it will continue to comply fully with NHS Improvement's Well-Led Framework.

4.4.3. Quality of our data

The Trust attaches a high level of importance to data quality and believes it is a foundation for the delivery of quality care, good patient experience, the delivery of cost-effective services and assists with clinical decision making.

The Trust has a Data Quality Strategy and an associated Data Quality Policy. The Trust has three schemes in place which are contributing to data quality improvements across the Trust:

- Rollout of an electronic patient record and clinical information system – RiO
- Data quality improvement plan
- Information management platform

The rollout of an electronic patient record system across all services will continue into 2017/18 and will contribute to timeliness of data entry along with enhanced data validation.

The data quality improvement plan was initiated in 2015/16. In 2016/17, the following key deliverables were achieved:

- Rollout of RiO clinical information system to child and adolescent mental health services, adult mental health services, later life and memory services and secure services. This has improved consistency of collection and recording of data.
- All reporting associated with these services has been refreshed to contain data from RiO. This exercise involved reviewing key performance indicators to ensure they are robust and fit for purpose.
- Procurement of the Trust information management platform and commencement of the first phase to bring corporate systems in to the data warehouse.
- Rollout of the indicator assurance programme which entailed a complete review of the processes for all key NHS Improvement measures, including standard operating procedures and data review.

The Trust produces monthly reports at executive, management, and operational level to enable the continued improvement of data quality. These reports highlight any areas for improvement and provide recommended actions to achieve this.

Supporting documentation and guidance is available to staff regarding the collection, storage, reporting, and disposal of data, with detailed operating procedures for staff use. All policies are stored on the Trust's intranet and are available to all staff members.

A range of systems and processes are in place for the collection, recording and analysis of reporting of data and, as part of the RiO project, the Trust has placed a dedicated resource to look at reporting of data from RiO.

System-specific training is provided to ensure staff have the skills for the effective collection, recording and analysis of data. Data quality is incorporated into relevant job descriptions throughout the Trust.

During 2016/17, in addition to the schemes outlined above, the Trust has taken the following actions to improve data quality:

- Publication of monthly data quality and completeness data at executive, management and operational levels.
- Publication of quarterly benchmarking reports comparing Trust achievement nationally and at regional level.
- Continued engagement and training for operational teams to support improvement of data quality across all services.
- Continued engagement with consultants and their medical teams in relation to clinical coding and the availability of discharge and clinical information.
- Report developments in both frontend RiO and intranet-based reports which will allow operational teams to see key information in a timelier manner to allow daily reviewing rather than monthly.

The Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data which included the patients' valid NHS number are below:

- Admitted patient care 99.9%
- Outpatient care 99.98%
- Accident and emergency care 96.64%

The percentage of records which included the patients' valid General Practitioner Registration Code are below:

- Admitted patient care 100%
- Outpatient care 100%
- Accident and emergency care 100%

4.5. Information governance risk management / data security

The management of information governance has significant profile across the Trust. Information governance requires strong governance and risk management processes to ensure compliance with relevant legislation and NHS Codes of Practice. Integration of information governance risks and incidents into the Trust's Risk Management and Incident Management policies ensures effective local and strategic management and scrutiny of risks and incidents.

The reporting of information governance incidents into the DATIX risk management system has been reviewed and a bespoke reporting system developed to ensure specific information is captured. Two reports are in use – the Information Governance Incident Report and the Caldicott Issues Log. This enables a proactive approach towards information governance incidents to be undertaken. In addition, these incidents are reported monthly through local and strategic aggregated incident reports and quarterly to the Information Governance and Records Steering Group. This allows a broader analysis of incidents and a Trust-wide approach to improvement and learning.

The Trust continues to submit its Information Governance Toolkit self-assessment and declared 70 per cent (satisfactory) for 2016/17 (version 14). The Trust provides comprehensive information governance training, mainly through e-learning; however, ad-hoc specific training is offered as required. This is coupled with extensive awareness raising and communications throughout the Trust.

The Chief Nurse and Executive Director of Operational Clinical Services continues to be the Senior Information Risk Owner and the Medical Director is the Caldicott Guardian. The Chief Information Officer is the Information Governance Lead.

4.6. Information governance incidents

The Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation (HSCIC, 2015) states that the Trust must publish information relating to its information governance incidents in its Annual Report and Statement of Internal Control. The guidance classifies incidents into three levels:

- Level 2 incidents constitute personal data breaches (as defined by the Data Protection Act 1998) or incidents which place the Trust at high risk of reputational damage. These incidents are all reported to NHS England and the Information Commissioner's Office. The Trust had one Level 2 incident in 2016/17.
- Level 1 incidents are other personal data-related incidents and the numbers are aggregated. The Trust's figures for 2016/17 are shown in the table below.
- Level 0 incidents are not required to be included in the Trust's Annual Report.

Summary of Serious Incident Requiring Investigations Involving Personal Data as Reported to the Information Commissioner's Office in 2016/17				
Date of incident (month)	**Nature of incident**	**Nature of data involved**	**Number of data subjects potentially affected**	**Notification steps**
May	Lost or stolen paperwork	Hospital ID number; name; address; contact number; name of parent/guardian; school attended; referral reason	16	Individuals notified by telephone and post
Further action on information risk	A detailed local review was undertaken with recommendations and an action plan. The lessons learned were shared across other services and communications were sent reminding staff to only carry information securely. A standard operating policy was written to support agency staff with information governance and this incident was built into information governance training given to all staff.			

The Level 1 incidents in the following table occurred between 1 April 2016 and 14 March 2017 inclusive.

Category	Breach type	Total
A	Corruption or inability to recover electronic data	10
B	Disclosed in error	77
C	Lost in transit	0
D	Lost or stolen hardware	10
E	Lost or stolen paperwork	0
F	Non-secure disposal of hardware	0
G	Non-secure disposal of paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access or disclosure	24
K	Other	2
Total:		**123**

The annual audit against the Information Governance Toolkit was undertaken by KPMG. The results are as follows:

- KPMG audited the Information Governance Toolkit submission in November 2016, with a follow-up in March 2017, with an overall rating given of significant assurance.
- The Trust's Information Governance Self-Assessment Report overall score for 2016/17 was declared as 70 per cent (satisfactory) for 2016/17 (version 14).

4.7. Trust's main risks

Effective risk management in the organisation ensures risks remain live and the level of control required is sufficient to mitigate the consequence of negative impact to the Trust, and actions to mitigate risks are achieved within acceptable timescales.

The Trust's risk appetite means all risks rated 12 and above with limited or fair controls are escalated to the Trust Board through the Risk and Board Assurance Framework reports which are discussed at alternate Trust Board meetings.

4.7.1. Risk summary year-end position 2016/17

Below is a summary of risks as at 31 March 2017.

There are a total of 84 open risks, 15 of which have been mapped against the Board Assurance Framework.

There are 13 open risks identified which may impact on the Trust's achievement of the high level objectives. These include 12 from the 2016/17 high level objectives and one from the 2015/16 high level objectives. The Board Assurance Framework includes 12 risks from the 2016/17 high level objectives.

At the end of March 2017, 15 risks remained open on the Board Assurance Framework. Of these, two have limited controls and are rated as 12, therefore making these the top risks for the Trust.

The Trust's top two Board Assurance Framework risks as at year-end 2016/17 are shown below.

Theme: Are we delivering our services safely? **Risk:** There is a risk that the St Helens 0-19 service does not have the infrastructure to support record keeping in line with Trust policy or to provide accurate recording of activity performance data due to a lack of electronic records systems in place leading to the use of paper records and manual collection of data, which means a reduction in time spent for clinicians to provide care and inability to respond to urgent requests.
Theme: Are we delivering our services safely? **Risk:** There is a risk of acutely unwell patients which require an emergency ambulance deteriorating within the Trust's walk-in centres due to North West Ambulance Service being unable to consistently respond to emergency calls, leading to a delay in transfer to an appropriate care setting.

4.7.2. High level risks 2016/17

The Trust Board has sight of all high level risks. High level risks are those risks which may impact on the achievement of the Trust's overall purpose which is to:

> *"Take a lead in improving the wellbeing of our communities in order to make a positive difference throughout people's lives."*

The high level risks are determined through the 'risk universe' and translate into the organisation's high level objectives for each year.

The Trust ensures quality initiatives and goals take into account the local health economy and national commissioning intentions. It can demonstrate this by the reporting mechanisms and relationships with our commissioners. There are three Clinical Quality and Safety Commissioning Groups across the five clinical commissioning groups within the Trust's footprint. One group meets monthly and the others bi-monthly. They provide

opportunities for the Trust to offer assurance and enter into constructive dialogue on core issues of service delivery.

The Trust provides updates for areas of clinical priority in the delivery of services, including models of care and clinical outcome indicators, and is responsible for reviewing the delivery of quality, innovation, developments and improvements within our services.

The groups ensure the contract is aligned to the achievement of national and local quality standards and targets, and robust systems for contract monitoring of clinical quality performance indicators are in place. The groups identify new developments, opportunities and threats relating to quality for consideration within the contracting process, and agree clinical quality performance indicators, commissioning for quality and innovation and service development improvement plans for future contract years.

In addition, the Trust hosts a clinical quality collaborative attended by all the clinical commissioning quality leads where we are able to discuss Trust-wide issues and showcase successes and innovations.

4.8. Embedding risk management

The Trust seeks and assesses assurance that the risk management process is comprehensive, effective, understood and embedded at all levels of the organisation, from team to Board.

Effective risk management ensures risks remain live, the level of control required is sufficient to mitigate the consequence of negative impact to the Trust, and actions to mitigate risks are achieved within acceptable timescales.

During 2016/17, the Trust further embedded the systems and assurances which underpin the Provider Licence, the Risk Assessment Framework and the Code of Governance.

The Trust commissioned an audit from KPMG which took place during February 2017. The Board Assurance Framework and risk management processes were reviewed under two main objectives – Board Assurance Framework and risk management. The results are shown below:

- KPMG completed a review of the systems the Trust had implemented for the Board Assurance Framework and risk management processes during March 2017. An overall rating was given of significant assurance with minor improvement opportunities.

4.9. Governance structures

The Trust recognises effective and flexible governance arrangements need to be in place and regularly evaluated for effectiveness, ensuring they are sufficient to support the overarching strategic objectives of the Trust, as well as ensuring the structure supports Trust processes and procedures for risk management, business planning and strategic development.

- The Trust's governance structure is broadly in line with practice across the sector in terms of both the quantity of committees and their remit.
- A committee handbook is in place which outlines the roles of all Trust strategic committees and the meetings which feed into these. Standard templates are included for terms of reference, agendas and how to write and present reports to

encourage standardisation. The handbook is updated as a minimum on an annual basis.
- Terms of reference at the Trust are reviewed regularly and, on the whole, clearly outline the key functions of the committees and groups which they refer to.
- All Board sub-committees appear to be operating broadly in line with their terms of reference and role descriptions.
- All committees, as well as Board meetings, are well-attended and well-minuted.
- The Board is aware of risks which are most likely to impact on the Trust's strategic objectives.

Between December 2016 and January 2017, the Trust undertook an evaluation of the Board and its main sub-committees. The evaluation was based around the 10 questions from NHS Improvement's Well-Led Framework, supported by related questions to the Trust Board, Audit Committee and Quality Committee, with the aim of evaluating the interaction between the committees.

All members and regular attenders of the meetings were invited to provide views and comments. The responses were grouped to allow for qualitative analysis and to identify areas where improvements could be made.

The Trust Board reviewed the findings at a Board development day held on 27 January 2017 and established actions for the Trust Board, Audit Committee and Quality Committee.

The Trust continues to review its principal committees. It will use the internal audit review recommendations and benchmarking undertaken against similar organisations to further improve corporate governance arrangements during 2017/18.

Full details of responsibilities are included in the table within section 7.1.

4.10. Corporate governance statement

The Director of Strategy and Organisational Effectiveness has been identified as the director with overarching responsibility for the Provider Licence. She has been responsible for ensuring robust governance arrangements are in place to assure the Board on the validity of the Corporate Governance Statement, prior to this being signed and submitted to NHS Improvement.

The Trust has reviewed and responded to the joint NHS Improvement and Care Quality Commission consultation for use of resources and well-led assessments, which will be the new framework used to assess the Trust during 2017.

4.11. 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 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.

4.12. Equality impact assessments

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

The Trust takes an integrated approach to equality, human rights and inclusion. All Trust polices undergo an equality impact assessment which involves a narrative commentary prior to policy ratification from a member of staff from the Equality Diversity and Inclusion Team. All major service reviews and changes within the Trust are also subject to an equality analysis process. Equality and diversity activity is reported to the Quality Committee.

4.13. Carbon reduction and climate change

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

The Trust recognises and monitors its environmental impacts. Energy and carbon management plans are in place to reduce carbon emissions, ensuring it meets its obligations of climate change mitigation and adaptation under the Climate Change Act. These plans are monitored throughout the year and reviewed annually by the Sustainability Working Group.

4.14. Emergency planning

The Trust recognises its emergency preparedness, resilience and response duties under the Civil Contingencies Act 2004 and Health and Social Care Act 2012. Risks have been identified and there are specific plans in place to mitigate the effects of major incidents and emergencies which would impact on the Trust's ability to continue to provide safe services. This includes a Major Incident Policy, Business Continuity Procedure, and incident specific plans such as severe weather, pandemic influenza, disruption to road fuel supplies, and chemical, biological, radiological and nuclear threats.

The Trust's major incident arrangements were reviewed against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (2016), obtaining the following assurances: fully compliant = green.

Actions have been identified and are being implemented to improve the Trust's assurances where required.

The Trust plays a full part in local health and social care economy planning, working with NHS England, clinical commissioning groups, other NHS trusts and providers of non-NHS-funded care. The Trust runs on-call systems which ensure a senior operational manager is available out-of-hours for mental health and learning disability as well as community health services, supported by Estates on-call and Trust strategic on-call, comprising executive directors and deputy directors.

The Director of Strategy and Organisational Effectiveness has lead responsibility for emergency preparedness, resilience and response, and sits on the NHS England Local Health Resilience Partnership for Cheshire and Merseyside and Greater Manchester.

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

The Trust has a dynamic process for setting business objectives across the whole organisation, which is documented and reviewed on an ongoing basis in order to drive forward improvements in clinical and non-clinical services, and to ensure key national and

local targets are met. All objectives are quantifiable, measurable, risk-assessed, and are regularly reviewed through the robust performance management arrangements embedded within the Trust. Performance management arrangements are such that each directorate is challenged and held to account for the objectives they are responsible for.

Throughout the year, the Board has received regular reports providing information about the economy, efficiency and effectiveness of the use of resources. Integrated performance reports have provided data in respect of financial, clinical, workforce and national targets and objectives. Any areas of concern are highlighted and mitigating actions taken where deemed necessary.

The Trust has a successful track record of delivery against its historic cost improvement plan targets and future cost improvement plans have been drawn up. Performance against plans is reviewed and monitored on a monthly basis and management action taken where appropriate to ensure successful delivery against targets. Cost improvement plans are an output from borough strategies.

Achievement of economy, efficiency and effectiveness is an underpinning focus of the Trust's internal governance arrangements, which are supported by internal and external audit reviews. Findings and recommendations from audits undertaken are monitored and reported through the Audit Committee. The Audit Committee provides appropriate challenge to management to ensure recommendations are actioned and that significant assurance can be provided to the Trust Board.

6. Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended), to prepare quality accounts for each financial year. NHS Improvement 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 Trust Board is committed to ensuring high-quality services, as shown in the overall purpose:

> *"We take a lead in improving the wellbeing of our communities in order to make a positive difference throughout people's lives."*

And also through the Trust Board statement:

> *"We make the best decisions we can in order to advance the best interests of our patients and staff."*

The Director of Strategy and Organisational Effectiveness is the identified Board member responsible for the Provider Licence; and the Chief Nurse and Executive Director of Operational Clinical Services is the Trust Board Member responsible for quality.

An agreed definition of quality is in place, created and approved by members of the Trust Board, Council of Governors and clinical leaders, with the support of the Advancing Quality Alliance:

"The users of our services are the first priority in everything we do, ensuring that they receive effective care from caring, compassionate, and committed people, working within a common culture and protected from harm."

The Quality Committee continues to provide leadership and assurance to the Trust Board on the effectiveness of Trust arrangements for quality, ensuring there is a consistent approach throughout the Trust, under the domains of safety, effectiveness and patient experience.

6.1. Quality report – quality priorities

To demonstrate the Trust's continual commitment to quality improvement, each year we engage with our five Healthwatch organisations, five local authorities, and five clinical commissioning groups, as well as our service users and carers and the Council of Governors, to establish the Trust's quality priorities.

These quality priorities demonstrate improvements in the domains of safety, experience and effectiveness, and will be monitored throughout the year. The 2016/17 quality priorities and their final status are listed below. Full details are included within the Trust's Quality Report 2016/17.

Safety – Lessons Learned Strategy
This quality priority was met during 2016/17.

Effectiveness – End of Life Care Strategy
The Trust met this quality priority during 2016/17.

Experience – Living Life Well Strategy
The Trust met this quality priority during 2016/17.

The majority of the design and content of the Quality Report is determined by the guidance under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations. However, when determining the quality measures to show Trust performance, there is a level of scope to use appropriate measures to demonstrate the quality of care at a local level. In determining these quality measures, the Trust consulted widely to ensure a balanced and transparent view of the Trust's services was included.

Monitoring of quality priorities is undertaken by the Quality Committee. In addition, performance against each quality priority is reported to relevant internal groups.

The Trust Board agreed the delegation of authority to the Chairman and Chief Executive for the approval and sign-off of the annual Quality Report. The statement of directors' responsibilities in respect of the Quality Account identifies how the directors were satisfied with the content of the Quality Report, including data quality and evidence used as assurance. The Trust Chairman and Chief Executive signed the Quality Report.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust, who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached

to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

7.1. Systems in place to review the effectiveness of systems of control

The Trust Board holds responsibility for assuring the effectiveness and suitability of internal control systems.

The Audit Committee reviews the establishment and maintenance of effective systems of internal control and risk management, and also reviews the validity of the Annual Governance Statement. The Audit Committee also sets and approves the annual internal audit programme and holds delegated Board responsibility to monitor implementation of actions identified for improvement.

The Audit Committee has a remit to review the adequacy of assurance for all risk and control related disclosure statements. This is supported by the Head of Internal Audit Opinion provided to the Audit Committee, founded on a risk-based audit programme. The audit plan covers risks to the achievement of Trust objectives identified through the assurance framework process. Progress against implementation of audit recommendations is stringently monitored by the Audit Committee to ensure any identified gaps in control are closed and, where not evident, the Audit Committee may call individuals from within the Trust to explain the progress of recommendations.

Maintaining and reviewing systems of internal control throughout the Trust is monitored through the Trust Board, its committees and an effective governance structure. Specific roles are detailed in the table below.

The Quality Committee is chaired by a non-executive director and meets 11 times a year. The Quality Committee routinely receives reports on patient safety, complaints, claims and clinical processes. The Quality Committee provides key updates to the Audit Committee and reports directly to the Trust Board.

The Quality and Safety Group meets monthly and is chaired by the Director of Strategy and Organisational Effectiveness. The meeting focuses attention on timely management of incidents and commissioning of the review process. Its responsibilities include the monitoring of the management of serious incidents, complaints and claims to ensure effective and timely action is taken. The Quality and Safety Meeting reviews aggregated thematic data and emerging themes for learning and dissemination across the organisation.

The table below provides an overview of the governance arrangements in place to review the system of internal control.

Group	Chaired by	Functions
Trust Board (monthly with the exception of August and	Trust Chairman	• Holds responsibility for assuring the effectiveness and suitability of internal control systems, discusses the Trust's risk appetite, risk movement and control systems

Group	Chaired by	Functions
December)		The Trust Board receives: • Bi-monthly Risk and Assurance Report detailing Trust-wide significant and current risk status • Reports on risks mapped to the achievement of the high level Trust objectives through a bi-monthly Board Assurance Framework Report • Monthly review of serious incidents and high-profile inquests report • Assurance updates from the Trust Board sub-committees • Update on other key Trust meetings through the Chief Executive's Report
Audit Committee (seven meetings a year, including an extra-ordinary meeting)	Non-executive director	• Reviews the establishment and maintenance of effective systems of internal control and risk management, approving the Statement of Internal Control • Sets and approves the annual internal audit programme and holds delegated Board responsibility to monitor implementation of actions identified for improvement • Receives and reviews internal audit reports relating to the Board Assurance Framework and risk management • Progress report on risk management process provided at each meeting • Devises a yearly risk-based internal audit plan based on the Assurance Framework, to provide external assurances to the Audit Committee and then the Trust Board • Reports to Trust Board
Executive Quality and Performance Meeting (monthly)	Chief Executive	• Receives reports on quality, performance and financial risk • Focuses attention on assurance framework high-level risks and improvement on all risks on the risk register
Quality Committee (minimum of 10 meetings a year)	Non-executive director	• Receives Quality Account and quality priority updates • Receives patient experience information which includes complaints and concerns • Receives thematic analysis of serious incidents and how lessons learned are disseminated • Receives reports which may affect quality of services • Reports to Trust Board
Quality and Safety Meeting (monthly)	Director of Strategy and Organisational Effectiveness	• Focuses attention on the timely management of incidents and commissioning of the review process • Monitors the management of serious incidents, complaints and claims to ensure effective and

Group	Chaired by	Functions
		timely action is taken • Reviews aggregated thematic data and emerging themes for learning and dissemination across the organisation • Reports any areas of concern to the Quality and/or Audit Committee where appropriate and commissions reviews • Monthly review of non-clinical and clinical risks with fair or limited controls – discussion regarding further action/support required • Receives updates from the borough quality and safety meetings • Dissemination of topics for discussion at borough quality and safety meetings
Operations and Integration Meeting (monthly)	Chief Nurse and Executive Director of Clinical Operations	• Discusses operational issues relating to Care Quality Commission inspections • Discusses impact of risks and agree programmes of work to manage risk
Clinical Leadership Group (monthly)	Medical Director	• Monthly review and discussion of clinical risks
Borough Quality and Safety Meetings (monthly)	Assistant Clinical Director	• Senior representation from integrated governance team at borough meetings • Terms of reference for borough quality and safety meetings are now standardised; reporting directly into the Trust Quality and Safety Meeting
Borough Leadership Meetings (monthly)	Assistant Director/ Business Manager	• Reports and shares risk-related issues, complaints management, audit findings, improvement and local learning • Examines performance and identifies areas of risk
Information Governance Executive Committee (quarterly)	Senior Information Risk Owner / Chief Nursing and Executive Director of Operational Clinical Services	• Receives reports on progress towards achieving the Information Governance Toolkit and approves its annual submission • Monitors information governance objectives and information risks and incidents, ensuring appropriate actions are undertaken and lessons are learnt • Reports to the Quality Committee
Clinical Audit Committee	Deputy Medical Director	• Stimulates and supports national and local quality improvement interventions and through re-auditing to assess the impact of such interventions • Approves the clinical audit calendar identifying the areas for audit, and reports the progress against this to the Quality and Safety Meeting • Reports outcomes from clinical audit internally

Group	Chaired by	Functions
		through the Clinical Leadership Group, professional forums such as the Research and Audit Forum, Joint Academic Forum, clinical networks and through borough quality and safety meetings for review of recommendations and implementation of action plans

In addition, my review is also informed by other explicit reviews and assurance mechanisms.

The Head of Internal Audit overall opinion for the period 1 April 2016 to 31 March 2017 is stated below:

'Significant with minor improvements' – assurance can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Commentary

The commentary below provides the context for our opinion and, together with the opinion, should be read in its entirety.

Our opinion covers the period 1 April 2016 to 31 March 2017 inclusive, and is based on the nine audits we completed in this period.

The design and operation of the Assurance Framework and associated processes

Overall, our review found that the Assurance framework in place is founded on a systematic risk management process and does provide appropriate assurance to the Board.

The Assurance Framework does reflect the organisation's key objectives and risks and is reviewed on at least an annual basis by the Board.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

We issued no 'no assurance' opinions in respect of our 2016/17 assignments. We completed one review in-year for which one objective, relating to estates procurement, was rated 'partial assurance'. We draw the Trust's attention to the recommendations raised within this report.

None of our 2016/17 assignments prevent us from issuing 'significant with minor improvements' assurance.

During 2016/17, the following internal audit work was conducted – four mandatory reviews and five discretionary reviews, which the above audit opinion was based upon. Below are details of these reviews and the outcomes.

- Workforce (recruitment): significant assurance with minor improvement opportunities
- Trust policy processes: significant assurance with minor improvement opportunities
- Clinical audit: significant assurance with minor improvement opportunities
- Safeguarding: significant assurance with minor improvement opportunities
- Estates – Objective 1: significant assurance, Objective 2: partial assurance with improvements required
- Core financial management and controls: significant assurance
- Corporate governance: significant assurance with minor improvement opportunities
- Risk management and Board Assurance Framework: significant assurance with minor improvement opportunities
- Information Governance Toolkit: significant assurance

The Trust appointed KPMG to provide its counter fraud service from October 2011. The Trust has access to a Local Counter Fraud Specialist who delivers both a proactive and reactive counter fraud service. The Audit Committee has approved a work plan and receives regular progress reports from the Local Counter Fraud Specialist. The Trust is committed to creating a lasting and robust anti-fraud culture throughout the organisation, with continued training and awareness initiatives.

We also gain assurance from results from the Community Mental Health Patient Survey, National Staff Survey and Friends and Family Test.

The Trust has participated in the Quality Improvement Programme set up by the Royal College of Psychiatrists, benchmarking prescribing practice across all participating mental health trusts known as the Prescribing Observatory for Mental Health, as well as national confidential inquiries and national clinical audits as described in the Quality Report.

The Trust has received external reports from organisations which have assessed the Trust and provide assurance. These include Ofsted, Liverpool John Moores University, NHS England and Health Education England North West.

8. Conclusion

My review confirms 5 Boroughs Partnership NHS Foundation Trust has a generally sound system of internal control which supports committees, the Audit Committee and the achievement of its policies, aims, and objectives.

The further improvements to governance arrangements during 2016/17 have worked well and delivered a continuous learning, evaluation and improvement cycle. During 2016/17 the Trust has been successful in acquiring new business and the coming year will see the Trusts governance processes embedded within these services.

No significant internal control issues have been identified.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2017

Appendices

Appendix 1 – Risk matrices

Risk matrix	Likelihood / probability of repeat				
Consequences	Remote	Possible 20% chance	Likely 60% chance	Highly likely 90% chance	Certain
Insignificant	**1**	**2**	**3**	**4**	**5**
Minor	**2**	**4**	**6**	**8**	**10**
Significant	**3**	**6**	**9**	**12**	**15**
Serious	**4**	**8**	**12**	**16**	**20**
Major	**5**	**10**	**15**	**20**	**25**

Trust risk matrix

Description	Financial	Patient / staff safety	Business continuity	Reputation	Corporate objectives	Regulatory / legal
Insignificant	<£0.25m	No harm	<0.5 days	No media interest	<5% variance	No breach / action likely
Minor	£0.25>0.5m	Low harm	0.5>1 day	Minor media interest	5-10% variance	Potential breach
Significant	£0.5>1m	Significant harm	1>7 days	Headline local media interest	10-25% variance	Significant breach
Serious	£1m>2m	Serious/ permanent harm / death	7>30 days	National media interest	25-50% variance	Serious breach
Major	>£2m	Multiple death / pandemic	>30 days	Media campaign	>50% variance	Major breach / legal or regulatory action

This can be used as guidance when assessing the level of risk which may potentially arise as the result of the assessed risk.

Quality Report

Contents:

1. Our commitment to quality

1.1. Our Quality Report 2016-17

This is the eighth Quality Report produced by 5 Boroughs Partnership NHS Foundation Trust. Our Quality Report is published as the Quality Account alongside our Annual Report, which we will continue to produce each year and make available as a public statement of our commitment to improving quality and safety within the Trust.

The purpose of our Quality Report is to demonstrate the Trust's commitment to improving quality and safety for the people who use our services. It presents:

- Where improvements in quality are required
- What we are doing well as an organisation
- How service users, carers, staff and the wider community are engaged in working with us to improve quality of care within the Trust

1.2. Chief Executive's statement

All providers of NHS healthcare services are required to produce a Quality Report – an annual report to the public about the quality of services delivered.

We welcome this opportunity to take an honest look at how well we have performed during the reporting year and to outline future improvements we aim to make.

We have worked with the following groups to produce our Quality Account:

- Quality Committee
- Council of Governors and its sub-committee, the Governors' Assurance Committee
- Our staff
- Service users and carers from across our organisation

We have also consulted with key external stakeholders including:

- Overview and scrutiny committees
- Healthwatch organisations
- Clinical commissioning groups

You can read what our stakeholders have to say about our quality performance in Annexe 1 of this report.

Throughout 2016/17, I have overseen continued challenge and improvement in the way the Trust delivers on quality and safety. During 2016/17, the Quality Committee continued

to implement the 2015-18 Quality Strategy and Quality Improvement Plan, which includes the following elements:

- Quality objectives – all quality initiatives are categorised into these objectives
- Quality Big Dots – longer term aspirational goals with yearly quality initiatives
- Quality priorities – yearly quality initiatives developed in partnership with our service users, carers and stakeholders
- Quality improvement cycle – measurement of quality to inform future quality improvement
- Sign up to safety – national safety campaign
- Lessons learned – continual learning and improvement from experience

The Quality Strategy is overseen by the Quality Committee, a main committee of the Trust Board. The committee provides leadership and assurance to the Trust Board on the effectiveness of Trust arrangements for quality and safety, ensuring there is a consistent approach throughout the Trust, specifically in the areas of safety, effectiveness and patient experience.

I am pleased to comment on progress made on achieving our 2016/17 quality priorities:

- **Safety: Lessons Learned Strategy**
  It has never been more important for organisations to ensure a culture wherein lessons are learned and embedded to prevent recurrence. Over the past year, the Lessons Learned Strategy has been implemented, which has included:

  - Revising Trust policies and procedures.
  - Creating a robust system to record and track lessons learned themes from different sources and using this to develop themed reporting, examining patterns and trends to identify areas of focus, and reviewing outcomes to determine the impact from actions.
  - A suite of lessons learned communications have been developed and cascaded for discussions at team level.

  The impact of the Lessons Learned Strategy has seen a reduction of recurring themes, which will be further reviewed and evaluated.

- **Effectiveness: End of Life Care Strategy**
  The strategy outlines the Trust's approach to ensuring we meet the needs of patients approaching the end of life, based on best practice and innovation. Achievement of this quality priority includes:

  - Development of robust governance arrangements, including the evaluation of the care provided by regular clinical audits. Outcomes from the audits show good results, with the Trust exceeding its expected targets.
  - Improvements to the care provided to patients, by providing high quality training to staff; this has included the verification of expected death by nurses and administration of subcutaneous fluids.
  - The above improvements have been supported by the implementation of the electronic patient record system.

  The End of Life Care Service received an 'Outstanding' rating from the Care Quality Commission following an inspection in July 2016.

- **Experience: Living Life Well Strategy**
  The strategy is an important element of our programme of cultural change. It supports and is supported by our Culture of Care Strategy and our Trust values in relation to our patients and service users, our colleagues and ourselves. Achievement of this quality priority is demonstrated by the six teams which have incorporated the principles of Living Life Well into their everyday work and how they could use them as a service improvement tool. These teams are:

  - Later Life and Memory Service, St Helens
  - Integrated Wellness Service, Knowsley
  - Cavendish Unit, Wigan
  - Improving Access to Psychological Therapies Team, Halton
  - Learning Disabilities Team, Knowsley
  - Chesterton Unit, Warrington

  The Trust now has a number of people – staff, service users and carer representatives – versed and experienced in Living Life Well. This was recognised in 2016 at the Staff Recognition Awards where the Living Life Well support team won the award for improving patient experience.

  Living Life Well is now accepted as the cultural framework on which all service improvement, development or change is based.

In July 2015, the Care Quality Commission undertook a comprehensive inspection of the core services provided by the Trust and returned in July 2016 to undertake a reinspection. I am very pleased with the outcome, which rated the Trust as 'Good' overall, with 'Good' achieved in all five domains of safe, effective, caring, responsive and well-led. This achievement demonstrates and recognises the high quality care the Trust provides and how our staff work together to jointly address tangible issues for those we care for.

You can read more about all our inspections during 2016/17 in section 3.3.2 of this report, along with our Trust-wide achievements and initiatives, and view detailed information about our performance against quality and safety priorities and indicators.

During 2016/17, the Trust has grown. As part of competitive tendering processes there have been a number of services transferring to the Trust. As a result, the Trust has increased its geographical footprint, which has meant that the name 5 Boroughs Partnership NHS Foundation Trust, no longer reflected the geography of the Trust.

It is important that the name of the Trust is one to which all staff and service users can relate, and therefore it was agreed to consult on changing the Trust's name. Following discussions with NHS Identity, three options were available. We consulted stakeholders, staff, service users, carers and the general public to vote on their preferred name. There was a clear majority for North West Boroughs Healthcare NHS Foundation Trust, and, following ratification from the Board and the Council of Governors, the Trust changed its name on 1 April 2017 to North West Boroughs Healthcare NHS Foundation Trust.

Simon Barber
Chief Executive

1.3. Chairman's statement

In March 2017, we were delighted to open our new £40 million mental health hospital in Leigh – Atherleigh Park – following two years of construction. The new hospital provides the people of the Wigan borough with a purpose-built environment which promotes enhanced privacy, dignity and respect and will facilitate new ways of working and improved patient care with a focus on holistic care.

The hospital comprises 40 en-suite bedrooms for adults with mental health problems who require short-term hospital treatment and eight beds for more intensive care. Additionally, there is a 26-bed unit providing short-stay, intermediate care for patients with dementia and memory conditions, and a 16-bed unit for older people with mental ill-health.

The facilities include a therapy hub which has a gym, sports hall, activity room and therapy kitchen. A therapy courtyard allows service users to get involved in gardening – an activity which research has shown improves mental wellbeing. A therapeutic activity model combining psychology, occupational therapy, physiotherapy and activity work provides a weekly programme within the hub and on the wards. This will enable all patients to participate in educational, social and physical activity to enhance their recovery.

Service users, carers, staff and local residents have been central to the design and development process from the outset and throughout the project. We have particularly valued the lived experience of past and present service users. You can read more about Atherleigh Park within section 3.3.8 of this report.

This year saw the continuation and further development of safety walkabouts undertaken by executive and non-executive directors. 38 were undertaken during 2016/17, with feedback provided at the beginning of each Trust Board meeting. The Board has found these very valuable, as they provide the opportunity to visit our teams and talk openly with staff and service users directly. We also continue to hear a patient story at the beginning of each Board meeting, providing an increased understanding at Board-level of the work we do and the care we provide.

The quality priorities for 2017/18 have been agreed by our Council of Governors, following engagement with our stakeholder organisations. These priorities are a real indicator of how we want to make improvements in areas which are important to people who use our services. All three quality priorities are inherently linked to each other and the high level objectives of the Trust, and we look forward to seeing progress made throughout the year.

On 9 December 2016, we were proud to host our Child and Adolescent Mental Health Service Awards at the DW Stadium in Wigan. The Christmas-themed event was a celebration of involvement and achievement, which included an awards ceremony for both young people and staff. The event was a great success.

Engagement with our service users, carers and the public continues to be a priority. The Chief Executive and I have continued to support events such as the annual involvement event and Ignite your Life, along with regular service user and carer forums, which enhance our ability to communicate with the wider community.

Bernard Pilkington
Chairman

1.4. Our overall purpose

"We will take a lead in improving the wellbeing of our communities in order to make a positive difference throughout people's lives."

1.5. The Trust's values

- "We **value** people as individuals ensuring we are all treated with **dignity and respect**."
- "We **value** quality and strive for **excellence** in everything we do."
- "We **value**, encourage and recognise everyone's **contribution** and **feedback**."
- "We **value** open, two-way communication, to promote a **listening** and **learning** culture."
- "We **value** and **deliver** on the **commitments** we make."

1.6. Definition of quality

An agreed definition of quality is in place which was created and approved by members of the Trust Board, Council of Governors and clinical leaders, with the support of the Advancing Quality Alliance:

'"The users of our services are the first priority in everything we do, ensuring that they receive effective care from caring, compassionate, and committed people, working within a common culture and protected from harm."

1.7. Supporting statements

In order to help demonstrate the Trust's commitment to quality improvement, supporting statements have been provided by the following:

- Chair of the Quality Committee
- Council of Governors (Governors' Assurance Committee)

These statements are included at Annexe 1 of this report.

1.8. Statements from external stakeholders

Supporting statements have been invited from:

- Overview and scrutiny committees
- Healthwatch organisations
- Lead commissioner statement
- Clinical commissioning groups
- Health and Wellbeing Boards

These are also included at Annexe 1.

1.9. Chief Executive's written statement and signature

I confirm that to the best of my knowledge the information in the 2016/17 Quality Account is accurate in all material respects.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2017

2. Our commitment to quality

The Quality Committee is a sub-committee of the Trust Board. Its purpose is to provide leadership and assurance to the Trust Board on the effectiveness of Trust arrangements for quality and safety. It ensures there is a consistent approach to care throughout the Trust under the domains of safety, effectiveness and patient experience.

The Quality Committee is responsible for overseeing the implementation and monitoring of the Trust's Quality Strategy, quality objectives, quality goals and quality priorities. The strategy is supported and monitored through the Quality Strategy Implementation Plan, and includes quarterly reporting and monitoring of the Trust's quality goals and quality priorities.

2.1. Trust quality and safety priorities 2016/17

We start this section by reporting on our achievement against the Trust quality priorities we set ourselves for 2016/17.

The following tables outline the indicators and progress over the past year. All are applicable to the Trust as a whole – including services within mental health, learning disabilities and community health.

2016/17 quality priority one – safety
Lessons Learned Strategy

Rationale	Outcome	Indicator / measure
In an increasingly scrutinised health economy, it has never been more important for organisations to ensure a culture wherein lessons are learned and embedded to prevent recurrence. The Trust is keen to foster a culture for reviewing and analysing areas when things go wrong and then ensuring we communicate the lessons learned and embed key actions to help prevent future issues, particularly in relation to service delivery and care. The Lessons Learned Forum was formed to provide assurance to the Trust that lessons are learned from incidents. This is to prevent recurrence by holding to account strategic and operational groups to deliver on actions from incidents	**Met**	Quarter 1 • We will review the incident reporting policy to incorporate lessons learned. • We will develop a system for recording and tracking progress against lessons learned themes which have been identified from serious incidents. Quarter 2 • We will develop a system for capturing and following up on actions from lessons learned themes. • Actions identified will be measurable, with realistic timescales and allocated to a responsible individual or group who will be accountable for delivery. Monitoring of actions and outcomes will be undertaken by the Lessons Learned Forum. Quarter 3 • Lessons learned from incidents will be examined to look for patterns and trends so reporting and actions become more proactive and preventative. • Actions from quarter 1, 2 and 3 will be measured through reporting which will show a reduction in the number of

linked to rapid improvement. The group is tasked with monitoring and testing improvements made to ensure they are sustained and embedded.		incidents identified and communicated as part of the lessons learned Trust-wide communication portfolio (Core Brief, In View and Patient Safety Alerts) which recur. Quarter 4 • The Lessons Learned Forum will expand its remit to incorporate reports from patient safety walkabouts, internal quality reviews, complaints and disciplinaries so information is triangulated. Data will be used to highlight concerns for early intervention. • A process for evaluation of actions from lessons learned themes will be determined. • A 'deep dive' into one incident theme identified as part of lessons learned will be undertaken and the outcomes reported to determine if the Trust-wide publications are having an impact on learning from incidents.

How we achieved this quality priority

- The Trust revised the incident reporting policy and procedure to incorporate lessons learned.
- A system to record and track progress against lessons learned themes arising from serious incidents, patient experience reports, disciplinary investigation and medicines safety was developed, reporting in to the Lessons Learned Forum.
- A summary report for each lessons learned theme identified was developed to identify areas for focus, and which groups of individuals have responsibility for actions. A 'deep dive' into incident themes identified as part of lessons learned was undertaken at the Lessons Learned Forum, reviewing outcomes to determine whether the actions were having an impact on learning from incidents.
- A lessons learned report is provided quarterly to the Quality Committee which examines patterns and trends from serious incident reports to determine proactive and preventative actions.
- Lessons learned communications continue to be implemented across all teams for cascade and discussion through In View and Core Brief. Thematic analysis of lessons learned from incidents was discussed in detail at the Lessons Learned Forum, and at the borough-based lessons learned events.
- The number of recurring themes identified from serious incidents has reduced and this will be further reviewed as part of the evaluation.

• The Lessons Learned Forum membership has been widened to include representation from People's Services and Patient Experience to enable themes from disciplinaries and complaints to be included on the agenda. Information is triangulated through the summary report. • An evaluation of the actions from lessons learned themes has been developed, with a full lessons learned evaluation taking place, which includes the outcome from the 'deep dive' into a theme.

2016/17 quality priority two – effectiveness
End of Life Care Strategy

Rationale	Outcome	Indicator / measure
The End of Life Care Strategy sets out the Trust's approach to ensuring we meet the needs of patients approaching the end of life, both imminently or when they are likely to die within the next 12 months. It includes patients whose death is expected within a few days or hours, as well as patients with progressive, life-limiting illness in the last year of life. End of life care is defined as the total care of a person with an advanced incurable illness and does not just equate with dying. This care helps those with advanced, progressive, incurable illness to live as well as possible until they die and this reflects the principles of our Living Life Well Strategy. The strategy also focuses on ensuring the Trust is able to meet the needs of families and carers. During 2016/17, we want to build on work completed in 2015 in developing this strategy and accompanying policies and procedures. We want to ensure all care delivered at end of life is of high quality, evidenced as	**Met**	There are four indicators which demonstrate standardised and effective quality care at end of life: 1. Safe management of controlled drugs 2. Standardised recording of care using or following the requirements of the Care and Communication Record 3. The number of appropriate patients on the GP Practice Gold Standards Framework Register 4. Achievement of the preferred place of care Quarter 1 • The electronic patient record system within community health services will be developed in order to accurately record the above four indicators. • We will develop an audit tool to capture all four indicators Quarter 2 • We will audit 10 care records per district nursing team per month using the new audit tool. • We will report the findings of the audits to the Quality Committee on a quarterly basis, identifying any trends and themes. Quarter 3 • Action plans will be developed and implemented for any improvement

best practice and standardised.		areas from the audits results. Quarter 4 • Re-audits will take place to ensure improvements have been made and are embedded in practice.

How we achieved this quality priority

The Trust has continued to develop and improve end of life care services during 2016/17. An electronic patient record system within community health services has been developed, and a series of actions taken to ensure this is fit for purpose and all staff trained in its use.

Community health services has an established End of Life Care Operational Group which reports to the Trust End of Life Care Steering Group. The groups are responsible for ensuring national and regional end of life care strategies are embedded in practice and monitored on a regular basis. This enables the Trust to demonstrate the delivery of end of life care which is, well-led, responsive, safe, effective and caring.

Audits of practice in end of life care have been undertaken every quarter in care delivery and medicines management using the end of life care audit framework. These are:

- End of Life Care Audit (this includes achievement of preferred place of care and evidence the patient is on the GP Practice Gold Standards Framework Register)
- Care and Communication Record documentation audit
- Second documentation audit focussing on end of life care documentation for patients not on the Care and Communication Record
- Existing Trust-wide controlled drugs audit which requires regular audits of controlled drug documentation and storage

The results have been reviewed at each End of Life Care Operational Group and the information shared with senior managers and staff. The controlled drug audits have demonstrated there are no concerns regarding disposal of injectable controlled drugs. Additional Medicines Management Trust procedures have been developed to support staff including the End of Life Care Medicines Management Procedure and Syringe Driver Procedure for Adults.

Achievements have been celebrated and staff contribution recognised through the Trust's Staff Recognition Awards.

All staff have access to end of life care training and resources to make sure they are confident and competent to deliver end of life care at home to support people to achieve their preferred place for care. By quarter three, the end of life care audit demonstrated achievement of the patient's preferred place of care was 92 per cent, exceeding the Trust target of 75 per cent.

In addition, the operational group actively seeks out new and emerging practices and, this year, staff have been trained to undertake verification of expected death by nurses and administration of subcutaneous fluids.

The Gold Standards Framework Register is populated by general practitioners; district nurses are involved with patients on the Gold Standards Framework Register through

multidisciplinary meetings. It should be noted that not all patients are registered on the Gold Standards Framework Register because sometimes they have a rapidly deteriorating condition and there may be no time to complete the register dependent on the time and day of decline. Our end of life care audit reports results in regard to patients on the district nursing caseload who are on the Gold Standards Framework Register. Our results demonstrated an upward trend with 90 per cent registered by quarter two.

All community health services nursing bases use 'patient status at a glance' boards to record important information which is easily accessible for the team in line with the North West End of Life Model and Gold Standards Framework. Teams attend General Practice Gold Standards Framework meetings and patient status boards are updated with information discussed.

In line with Trust values, staff have delivered end of life care which supports each individual's needs, wishes and preferences. Patient experience stories demonstrate our patient experience is in line with our Culture of Care which delivers the 'six Cs' – compassion, courage, communication, commitment, care and competence. In July 2016, our End of Life Care Service was inspected by the Care Quality Commission. Our service was rated as 'Outstanding' in caring for patients at the end of life.

2015/16 quality priority three – experience
Living Life Well Strategy

Rationale	Outcome	Indicator / measure
The Living Life Well Strategy is an important element of our programme of cultural change. It supports and is supported by our Culture of Care Strategy and our Trust values in relation to our patients and service users, our colleagues and ourselves. The Trust's overall purpose states: *"We will take a lead in improving the wellbeing of our communities in order to make a positive difference throughout people's lives."* Making a positive difference is about supporting people who use our services to live their life well. The Living Life Well Strategy is based on 12 key principles:	**Met**	In 2015, we established a Living Life Well Programme Board and an Expert Reference Group. We protected time for six teams to have facilitated workshops to look at how they would incorporate the principles of Living Life Well into their everyday work and how they could use them as a service improvement tool. Quarter 1 • We will report on the work done, celebrate and communicate the achievements of the first wave sites. • We will identify where the outcomes and products of the first wave sites can be spread and adopted. • We will identify a second wave of teams to develop their projects. • We will audit the number of patients who are receiving care according to the principles of Living Life Well. Quarter 2 • We will begin the second wave sites,

1. People who use our service have their basic needs identified and addressed. 2. People who use our services have their goals identified and addressed. 3. All our teams provide personalised services. 4. All services are strengths based. 5. All services promote social inclusion. 6. All services work in partnership with people who use services and their carers as equals. 7. Informal carers are involved. 8. Services encourage advance planning. 9. Services encourage self-management. 10. Staff are supported and valued. 11. All the above principles are evident in the way we deliver our services and work with our partners. 12. Our strategic intentions reflect our commitment to supporting our communities to live their lives well.		affording them facilitated protected time. • We will support adoption of first wave products and audit their implementation. • We will grow teams of facilitators from previous wave teams. • We will audit the number of patients who are receiving care according to the principles of Living Life Well. Quarter 3 • We will begin third wave sites, affording them facilitated protected time. • We will support adoption of second wave products and audit their implementation. • We will grow teams of facilitators from previous wave teams. • We will audit the number of patients who are receiving care according to the principles of Living Life Well. Quarter 4 • We will begin fourth wave sites, affording them facilitated protected time. • We will support adoption of third wave products and audit their implementation. • We will grow teams of facilitators from previous wave teams. • We will audit the number of patients who have received care according to the principles of Living Life Well in 2016/17.

How we achieved this quality priority

It is considered that the Trust has met this objective.

In 2015, a Living Life Well Programme Board and an Expert Reference Group had been established and time protected for six teams to have facilitated workshops to look at how they would incorporate the principles of Living Life Well into their everyday work and how they could use them as a service improvement tool.

Summaries of the first six projects is outlined below:

1. St Helens Later Life and Memory Service focused on the assessment team, memory clinic and community mental health team with various diagnoses. One principle was identified as an area for development – principle 8 – 'service encourages advance

planning and self-management'.

The team designed a simple questionnaire to gauge whether service users were interested in advanced care planning. From their findings, they have developed a passport-style book which is personal to the patient and split into sections to incorporate various aspects of a person's preferences, for example food and drink, personal care, health choices. Service users can complete and amend with support from family and professionals, and the passport can move around with them wherever they go – hospital, respite care, permanent 24-hour care.

2. Integrated Wellness Service implemented a programme of peer observations between the therapist, the client and the observer, linking the scoring criteria to the 'six Cs' (care, compassion, commitment, competence, communication, courage). They also used the Trust's coaching conversations principles to provide feedback and encourage reflection. This helped them to identify any training issues within the team.

3. Cavendish Unit audited five care plans against the principles using a multidisciplinary team. The team decided to focus on improving carer involvement representation on care plans and thereby improving social inclusion representation on care plans. They have developed a carer leaflet which informs about the ward routines and signposts to carer agencies.

4. The Improving Access to Psychological Therapies team decided to focus on staff wellbeing. A team development day was held which looked at addressing staff issues, addressing the waiting list and discussing step two work.

   They now have processes in place to support staff in new step two staff role by asking practitioners to review their regular practise. The team also worked on increasing service user and carer involvement and talked to those clients who have not recovered in their service and consider what they could do differently.

5. The Knowsley Learning Disability Team reflected on a sample group of service users' recent care against Living Life Well principles by reviewing care plans and care records through interview. This led to the creation of easy-read information describing the Living Life Well principles in tangible terms to be used with service users with a learning disability to facilitate their engagement.

6. Chesterton Unit looked at all 12 principles of Living Life Well and developed a patient interview. They found the responses given in the interviews were not reflected in the care plans and that there were differences between staff and patient interpretations of the principles. They discussed the findings of the audit during patient meetings on the ward and asked for their opinions on how this could be taken forwards. With the patient's involvement, they have developed a workbook with each section designed by the patients on the ward who took ownership of the booklets. These booklets were introduced during patient meetings and are used alongside the 'my shared pathway' folders. Since the introduction of the Living Life Well booklets, all the women on the unit have contributed and signed their care plans.

However, a pause was taken before beginning the second wave of teams. It was felt it was important to scale up the rollout and adoption of Living Life Well into all our service delivery. A high level objective was set to incorporate the principles of Living Life Well into all that we do and any changes the organisation would make during 2016/17. A Living Life

Well implementation group has been established by combining the previous programme board and expert reference group to support the delivery of the high level objective by:

- Maximising the potential for individuals who use any of our services to Live Life Well.
- Ensuring organisational commitment to continually develop a sustainable Living Life Well culture.
- Supporting the inclusion of the Living Life Well Strategy into all clinical transformation programmes.
- Ensuring the clinical networks maximise opportunities to reference Living Life Well in all activity.
- Responding to services which require support to embed the principles of Living Life Well.

Examples of how this has translated into practice include:

- The use of the Living Life Well principles in all our bids for new business and their mobilisation.
- Integration of care delivery aligned to start well, live well, age well across mental and physical health care in Knowsley.
- Incorporation of the Living Life Well principles into the development of care pathways.
- A learning guide for how to benchmark services against the Living Life Well principles and then to engage in service improvement work is available on our intranet.
- Translation of the principles from a staff focus incorporated into a refreshed approach to the performance and development review process.

The Trust now has a number of people – staff, service users and carer representatives – versed and experienced in Living Life Well. This was recognised in 2016 at the Staff Recognition Awards where the Living Life Well support team won the award for improving patient experience.

It has not been possible, nor deemed necessary, to count the number of individual patients who have received care according to the principles of Living Life Well in 2016/17. This is because Living Life Well is now accepted as the cultural framework on which all service improvement, development or change is based and it is not seen as a service-by-service initiative.

2.2. Improving on 2016/17 quality measures

The Trust's quality and safety priorities for 2016/17 have all been met and continue to be quality initiatives for the Trust, but have been replaced with new quality priorities for 2017/18 as agreed with our stakeholder organisations.

Below details how the Trust will continue to develop and monitor the 2016/17 quality priorities.

Safety: Lessons Learned Strategy
This remains one of the main areas of the Trust's three-year Quality Strategy 2015-18. The governance arrangements now in place for lessons learned will continue, including the recording and tracking of lessons learned themes from various sources; the Lessons

Learned Forum will continue to undertake ‘deep dive’ reviews against themes and review the outcomes to determine if the actions are having an impact. The valuable communications which inform staff of incidents and the lessons to learn from these will also continue, and, during 2017/18, a full lessons learned evaluation will take place to shape any further developments.

Effectiveness: End of Life Care Strategy
The governance arrangements will continue to be in place, evaluating the services and care provided. Clinical audits will continue to be undertaken, with actions being disseminated and implemented to completion. The service and care provided will continue to be reviewed against new and emerging guidelines, best practice and innovation.

Experience: Living Life Well Strategy
The strategy is an important element of our programme of cultural change. It supports and is supported by our Culture of Care Strategy and our Trust values in relation to our patients and service users, our colleagues and ourselves.

As this approach was successfully piloted in six teams as part of the 2016/17 quality priorities, it is now accepted as the cultural framework on which all service improvement, development or change will be based. The Trust will use the experienced staff and service user and carer representatives versed in Living Life Well when implementing future service improvement and change.

2.3. Quality and safety priorities for improvement 2017/18

In order to make sure the views of service users, carers, staff and the wider public have been taken into account, the Trust held the annual quality account stakeholder event on 25 January 2017, with representatives from our stakeholder organisations invited to attend. This included local authorities, Healthwatch groups and commissioners from Knowsley, Halton, St Helens, Warrington and Wigan, representatives from our Council of Governors, and staff. The event provided an update on progress on the 2016/17 priorities and the opportunity to engage and discuss any suggested areas or themes for the 2017/18 quality priorities.

The Council of Governors and its sub-meeting the Governors’ Assurance Committee were fully engaged in the process. They agreed the themes for 2017/18 from the annual event and approved the final quality priorities along with the Quality Committee.

The three quality priorities will demonstrate improvements in patient safety, patient experience, and effectiveness of our services. The Quality Committee will monitor progress of the quality priorities throughout the forthcoming year.

These three quality and safety priorities have been chosen and designed for the Trust as a whole and are markers for improvement for mental health, learning disabilities and community healthcare. The priorities align to Trust objectives for 2017/18 and will be quality targets agreed with our commissioners.

2017/18 quality priority for safety
Always events (two-year priority)

Rationale	Indicator / measure
NHS England defines 'always events' as: *"aspects of the patient experience that are so important to patients and families that healthcare providers must perform them consistently for every patient, every time."* We have undertaken a piece of work led by a task and finish group to determine what 'always events' should be adopted by the inpatient wards to ensure quality and safety levels and standards are consistently achieved. The aims of this initiative: • to use the collective expertise to explore how we can identify what should 'always' happen • to establish a list of 'always events' • to determine a data use methodology which can highlight developing or potential safety issues • to establish an 'always event' approach to support patient safety However, it was quickly identified that there were two groupings of 'always events' – those which addressed safety and those which addressed quality. In addition, it was identified this approach should not be limited to inpatient care delivery but should also be translated to care delivery in the community. The anticipated outcome of this quality initiative is evidence of sustained safe and quality care delivery given a set of parameters against which to measure compliance.	**Year one – inpatients:** Quarter 1 • Finalisation of set of 'always events' for safety through Operations and Integration Committee • Short test on two wards • Monitoring and reporting processes for 'always events' for safety defined and agreed at Clinical Leadership Group • Communications strategy for rollout to remaining 18 wards Quarter 2 • Implementation in all wards of 'always events' for safety • Agreement through Operations and Integration Committee of set of 'always events' for quality for inpatient wards Quarter 3 • Short test of 'always events' for quality on two wards and roll out to remaining wards • Monitoring of 'always events' for safety carried out • Monitoring processes for 'always events' for quality defined Quarter 4 • Evaluation of 'always events' for safety and quality in inpatient wards • Development of 'always events' for safety for community mental health services • Short test in two mental health community teams **Year two – community:** Quarter 1 • Roll out of 'always events' for safety for all community teams in mental health services • Development of 'always events' for quality for community teams in mental health services Quarter 2 • Monitoring of 'always events' for safety in community mental health teams • Short test and roll out of 'always events' for

	quality in mental health teams • Development of 'always events' for safety for community teams in physical health services Quarter 3 • Short test and roll out of 'always events' for safety in community physical health • Development of 'always events' for quality in physical health teams Quarter 4 • Short test and roll out of 'always events' for quality in community physical health teams • Evaluation of community 'always events' for safety and quality • Second year evaluation of safety and quality 'always events' for inpatient wards

Further details to note:

- In all inpatient wards, safety 'always events' will be one standardised set of measurable actions.
- In all community teams, safety 'always events' will be one standardised set of measurable actions, although these will be different from those adopted by inpatient units.
- Quality 'always events' may require specificity to the service delivered and population served.
- Short test will be a two-week adoption with opportunity to refine wording of 'always event'.
- Statement or measurement.
- Monitoring will review processes introduced to oversee and measure compliance with each 'always event', plus analyse actions taken when compliance is not achieved.
- Evaluation will, through a report within the Quality Account, provide a view of how services have been provided from a sustained quality and safety perspective.

2017/18 quality priority for effectiveness
Complaints, concerns and compliments

Rationale	Indicator / measure
While the NHS strives to provide a quality service, it is recognised that things can and do go wrong.	Quarter 1 • A system to capture feedback from complainants will be piloted. • Processes to ensure data from concerns is

Responding to complaints and concerns in a respectful and efficient manner is a key element in developing an open learning culture which values the patient and their family by listening to their experience. The handling of complaints and concerns is outlined in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and provides guidance as to how complaints and concerns are acknowledged, investigated and responded to. A concern is defined as: *"Any anxiety or worry, regarding Trust services, expressed by service user, patient, their relatives and/or carers which they do not wish to be treated as a complaint."* A complaint is defined as: *"An expression of dissatisfaction requiring a response that cannot be provided by the end of the next working day and which the individual does not wish to be treated as a concern."* A compliment is defined as: *"An expression of praise, admiration or congratulation."* The desired outcome from this priority is to ensure the Trust identifies learning from complaints, concerns and compliments.	captured in line with complaints will be introduced. • Capture of data to identify demographic makeup of complainants will be rolled out. • A system will be implemented to monitor all actions from complaints • Further complaint template letters will be developed to support follow-up contact with complainants following completion of complaint actions. • Training will be commissioned for complaint investigators to ensure a consistent approach. • A review of promotional literature will begin to ensure information is inclusive and accessible. Quarter 2 • The pilot to capture feedback from complainants will be rolled out and incorporated in all complaint responses. • An analysis will be undertaken to identify if protected characteristic group(s) are under or over represented in voicing their concerns. • A review of actions from complaints in quarter one will be undertaken to identify themes and trends. Findings from this review will be shared with the Lessons Learned Forum. Quarter 3 • An audit of feedback received from complainants will be completed. • Actions from the analysis of protected characteristic group(s) will be implemented. • Work to develop consistent capture of compliments will begin. Quarter 4 • Actions will be implemented in relation to any areas of improvement following the audit results. • Compliments data will be incorporated in the quarterly patient experience report to Quality and Safety Committee.

2017/18 quality priority for experience Duty of Candour	
Rationale	**Indicator / measure**
Being open is a long-standing commitment of the Trust, supporting a culture of truthfulness and transparency. In particular this has involved acknowledging, apologising and explaining what has happened to service users, families and carers when things have gone wrong. The implementation of a statutory Duty of Candour has ensured several elements of the being open principles are now regulated. It is a priority for the Trust that the being open principles are embedded in to all elements of care. The statutory Duty of Candour requires the Trust to identify notifiable safety incidents and as soon as reasonably possible provide the person(s) involved with an apology, an honest account of the incident and details of any further inquiries to take place. This notification must then be followed up in writing. A notifiable safety incident is an unintended or unexpected incident during the provision of care which resulted in death of the service user, severe harm, moderate harm or prolonged psychological harm.	Quarter 1 • Duty of Candour will be emphasised as a key topic during incident reviewer training sessions. • A system will be implemented to monitor all Duty of Candour actions following a notifiable incident. • Further Duty of Candour template letters will be made available to support the range of potential notifiable safety incidents. • All Duty of Candour letters will be reviewed by either assistant clinical directors or matrons before sending. • During this quarter, all Duty of Candour letters will be reviewed by the Risk Team to offer feedback to operational services. Quarter 2 • An awareness raising campaign will be developed and implemented for staff, service users and carers. • A system will be developed to highlight any delays or gaps in the Duty of Candour processes to the relevant assistant clinical director. • Any delays or gaps in Duty of Candour processes will be explored to identify any barriers or knowledge deficit regarding the process. • A process will be implemented for all Duty of Candour letters to be received by the Medical Director for review and to send further apologies, offering support and assurance that patient safety remains a key priority within the Trust. Quarter 3 • An audit of the Duty of Candour process will be completed. The audit will include the quality of the written notifications. Quarter 4 • Actions will be implemented in relation to any areas of improvement following the audit results.

2.4. Quality Strategy and Improvement Plan

The use of quality and safety improvement methodology has been embedded Trust-wide. Standard tools are used to develop, manage and monitor the Trust's Quality Strategy and Improvement Plan. Service improvement knowledge, support and expertise to teams has been provided and supported with a range of online tools.

During 2016/17, the Trust has worked with Advancing Quality Alliance (AQuA) to support its service improvement agenda. We will continue to work with AQuA to ensure service improvement remains a key expectation for all Trust employees.

The Quality Strategy is overseen by the Quality Committee, which is supported by the Quality Strategy Implementation Plan. The Quality Strategy articulates the Trust's quality goals; the strategy focuses on the quality requirements of the Trust as objectives, which include promoting quality at an operational level.

The Trust has robust quality governance arrangements in place, which will continue to support the Trust quality initiatives in the future.

The Quality Accounts can be found on the Trust's website:
www.5boroughspartnership.nhs.uk/quality-accounts

2.5. Statements of assurance provided by the Trust Board

As part of our Quality Account we are required to present a series of statements which have been agreed by the Trust Board relating to the quality of our services. These statements serve to offer assurance to our members and the general public that we are:

- Performing to the standards which regulate quality and safety as detailed within the Health and Social Act.
- Measuring and improving our clinical performance in audit and research activity.
- Engaging in innovative projects (Commissioning for Quality and Innovation Payment Framework).
- Maintaining compliance with targets within the Single Oversight Framework, included at section 3.2 of this document.

2.5.1. Review of contracted services

During 2016/17, 5 Boroughs Partnership NHS Foundation Trust provided and/or sub-contracted 70 relevant health services.

The Trust has reviewed all the data available to it on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of relevant health services by 5 Boroughs Partnership NHS Foundation Trust for 2016/17.

The Trust ensures data available for these services covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. This allows for regular service reviews against the strategies set out in the Trust's integrated business plan.

2.5.2. Participation in clinical audits and national confidential inquiries

The Trust's clinical audit programme for 2016/17 incorporated all relevant national clinical audits and confidential inquiries, providing the opportunity to benchmark the quality of our services against other participating providers, and to make improvements where identified.

The audit programme has also supported elements of the Quality Strategy, and other quality initiatives such as Commissioning for Quality and Innovation targets during 2016/17, providing evidence and assurance that agreed actions have been successful in improving the quality of care provided.

Other, locally agreed clinical audit activity during 2016/17 has been used effectively to review new and specific areas, allowing us to understand and establish our working practices against specific policies, procedures, standards and best practice. Outcomes from re-audits during 2016/17 have continued to show improvements in the care we provide.

During 2016/17, 11 national clinical audits and one national confidential inquiry covered relevant health services that 5 Boroughs Partnership NHS Foundation Trust provides.

During that period, 5 Boroughs Partnership NHS Foundation Trust participated in 100 per cent national clinical audits and 100 per cent national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries 5 Boroughs Partnership NHS Foundation Trust was eligible to participate in during 2016/17 are as follows:

- NCAPOP – National Clinical Audit and Patient Outcomes Programme Audit) National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH) 16/17
- NCEPOD – National Confidential Enquiry into Patient Outcome and Death Young People's Mental Health 16/17
- National Learning Disability Mortality Review
- National Early Intervention in Psychosis – Self Assessment
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Organisational)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Clinical)
- Sentinel Stroke National Audit Programme (SSNAP) (Clinical) 16/17
- POMH – Topic 11c: Antipsychotic in dementia
- POMH – Topic 7e: Monitoring of patients prescribed lithium
- POMH – Topic 16a: Rapid tranquillisation
- POMH – Topic 1 and 3: Prescribing high dose and combination psychotics
- POMH – Topic 15: Prescribing valproate for bipolar disorder

The national clinical audits and national confidential inquiries that 5 Boroughs Partnership NHS Foundation Trust participated in during 2016/17 are as follows:

- NCAPOP – National Clinical Audit and Patient Outcomes Programme Audit) National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH) 16/17
- NCEPOD – National Confidential Enquiry into Patient Outcome and Death Young People's Mental Health 16/17
- National Learning Disability Mortality Review
- National Early Intervention in Psychosis – Self Assessment
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Organisational)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Clinical)
- Sentinel Stroke National Audit Programme (SSNAP) (Clinical) 16/17
- POMH – Topic 11c: Antipsychotic in dementia
- POMH – Topic 7e: Monitoring of patients prescribed lithium

- POMH – Topic 16a: Rapid tranquillisation
- POMH – Topic 1 and 3: Prescribing high dose and combination psychotics
- POMH – Topic 15: Prescribing valproate for bipolar disorder

The national clinical audits and national confidential inquiries 5 Boroughs Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

Name of audit	Number of cases submitted	Percentage of required cases provided
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH) 16/17	Suicide questionnaires: 22 Homicide questionnaires: 2 SUD questionnaires: 1	88% 100% 100%
National Learning Disability Mortality Review	1	100%
National Early Intervention in Psychosis – Self Assessment	321	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme (Organisational)	1	100%
Sentinel Stroke National Audit Programme (SSNAP) (Clinical) 16/17	40	N/A
POMH – Topic 11c: Antipsychotic in Dementia	40	100%
POMH – Topic 7e: Monitoring of patients prescribed lithium	78	100%
POMH – Topic 16a: Rapid tranquillisation	51	100%
POMH – Topic 1 and 3: Prescribing high dose and combination psychotics	161	100%

Reports have been received for the following national audits in 2016/17:
- POMH – Topic 11c: Antipsychotic in dementia
- POMH – Topic 7e: Monitoring of patients prescribed lithium

The reports of two national clinical audits were reviewed by the provider in 2016/17 and 5 Boroughs Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
- Action plans are completed and agreed at the appropriate committee or group
- Timescales for each action are established and agreed
- Follow-up actions are agreed by the Trust

The reports of 66 local clinical audits were reviewed by the provider in 2016/17 and 5 Boroughs Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Action plans are completed and agreed at the appropriate committee or group
- Timescales for each action are established and agreed
- Follow-up actions are agreed by the Trust

2.5.3. Participation in clinical research

Evidence suggests that when healthcare organisations engage in research it is likely to have a positive impact on healthcare performance. Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. It also helps to ensure our clinical staff stay well informed of the latest treatment possibilities.

The number of patients receiving relevant health services provided or sub-contracted by 5 Boroughs Partnership NHS Foundation Trust in 2016/17 who were recruited during that period to participate in research approved by a research ethics committee was 199.

The Trust was involved in 55 research studies in mental health, learning disabilities and community health services in 2016/17. Of these, 20 were new studies granted Trust permission during this time. The studies have included UK Clinical Research Network portfolio research funded by the National Institute for Health Research or other grant programmes, commercially-funded clinical trials of investigational medicinal products, and student research projects seeking to recruit patients, carers and members of staff. This has included both observational and interventional research covering a range of areas such as trials of new therapeutic drugs, testing the effectiveness of online support tools, and questionnaire-based studies. They have been across all ages in areas such as dementia, schizophrenia, psychosis, bi-polar disorder, autism, perinatal mental health, personality disorder, self-harm, and back and leg pain due to spinal stenosis.

The Trust is a member of the Clinical Research Network: North West Coast hosted by the Royal Liverpool and Broadgreen University Hospitals NHS Foundation Trust and is strongly committed to supporting the activities of the network. The Trust was successful in meeting and exceeding the portfolio study recruitment target set by the Clinical Research Network: North West Coast for 2016/17.

During 2016/17, seven publications were produced by Trust employees.

2.5.4. Commissioning for Quality and Innovation Payment Framework

A proportion of 5 Boroughs Partnership NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between 5 Boroughs Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation Payment Framework.

Knowsley Clinical Commissioning Group acts as the coordinating commissioner for St Helens, Knowsley, and Wigan Clinical Commissioning Groups through the Commissioning for Quality and Innovation Payment Framework. Targets are also agreed separately with Halton and Warrington Clinical Commissioning Groups and NHS England.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically at www.5boroughspartnership.nhs.uk/quality-accounts.

Section 3.1 of this report includes progress against Commissioning for Quality and Innovation targets for 2016/17.

During 2016/17, the Trust attracted 2.4 per cent of our contract value as CQUIN (Commissioning for Quality and Innovation) payments. The total available within the CQUIN framework during that period was £3.1 million.

During 2015/16, the Trust attracted 2.3 per cent of our contract value as CQUIN payments. The total available within the CQUIN framework during that period was £3.1 million.

2.5.5. Registration with Care Quality Commission

5 Boroughs Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with no conditions attached to registration.

The Care Quality Commission has not taken enforcement action against 5 Boroughs Partnership NHS Foundation Trust during 2016/17.

The Trust had a comprehensive inspection in July 2015 when the overall outcome was a rating of 'Requires Improvement'. During 2016/17, the Trust was reinspected by the Care Quality Commission and is now rated as 'Good' overall for all five domains of safe, effective, caring, responsive and well-led.

5 Boroughs Partnership NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The registration of the new Atherleigh Park Hospital was completed.

Further information about the Care Quality Commission comprehensive assessment is included at section 3.3.2 of this document.

2.5.6. Quality of our data

5 Boroughs Partnership NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

- 99.90% for admitted patient care
- 99.98% for outpatient care
- 96.64% for accident and emergency care

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

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

2.5.7. Information Governance Toolkit

5 Boroughs Partnership NHS Foundation Trust's Information Governance Self-Assessment Report overall score for 2016/17 was 70 per cent and was graded 'green' – satisfactory.

The Trust commissioned an independent review of its proposed Information Governance Toolkit submission, which was undertaken by the Trust's internal auditors in November 2016 and reviewed in March 2017. The overall level of assurance given was 'significant assurance' – the highest level in a four-point scale.

2.5.8. Clinical Coding

5 Boroughs Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The Trust commissioned an internal audit of clinical coding which was undertaken by Mersey Internal Audit Agency in February 2017. The overall level of assurance was 'significant assurance' – the highest level in a four-point scale – and the Trust achieved Level 3 of Requirement 514 of the Information Governance Toolkit.

The audit results were as follows:

- Primary diagnosis 94%
- Secondary diagnosis 87%
- Primary procedures 100%
- Secondary procedures 100%

The audit consisted of 50 patient records relating to inpatient discharges from adult services, later life and memory services and children and young people's services during May-July 2016. The results should not be extrapolated further than the actual sample audited.

5 Boroughs Partnership NHS Foundation Trust will be taking the following actions to improve data quality:

- Data quality metrics are monitored on a monthly basis through the Trust's Quality and Performance Report
- Data quality compliance information is available at team and individual staff level and is refreshed on a daily basis

2.5.9. Core quality indicators

The Quality Account regulations require the following core quality indicators be included within the 2016/17 Quality Account. The following tables show the Trust's performance compared with the Health and Social Care Information Centre data representing all of England.

Table 1	**Health and Social Care Information Centre benchmarking data** (quarter 3 2016/17)			**Trust percentage**	
	National average	**Highest reported**	**Lowest reported**	**Full year 2015/16**	**Full year 2016/17**
The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period Ⓐ	96.7%	100%	73.3%	96%	96.5%

Ⓐ This indicator has been audited.

5 Boroughs Partnership NHS Foundation Trust considers that this data is as described for the following reasons: Robust operational policies and procedures are in place within operational services to ensure patients are followed-up within 72 hours which we feel is a measure of quality, hence follow-up will have taken place well within the NHS Improvement timescales. The supporting data has been collated by the Trust's Performance Team against robust guidelines which comply with NHS Improvement guidance. These processes and the outputs of them have been audited by internal and external bodies. These audits have resulted in a clean return of data.

5 Boroughs Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by utilising data quality reporting which looks at team-level data quality at an individual patient and practitioner level. Exceptions are reported at borough and Trust-level within the monthly Quality and Performance Report to Trust Board.

Table 2	**Health and Social Care Information Centre benchmarking data** (quarter 3 2016/17)			**Trust percentage**	
	National average	**Highest reported**	**Lowest reported**	**Full year 2015/16**	**Full year 2016/17**
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period Ⓐ	98.7%	100%	88.3%	99.2%	98.3%

Ⓐ This indicator has been audited.

5 Boroughs Partnership NHS Foundation Trust considers that this data is as described for the following reasons: Operational policies and procedures are in place within operational services to comply with this indicator. The supporting data has been collated by the Trust's Performance Team against robust guidelines which comply with NHS Improvement guidance. These processes and the outputs of them are subject to audit.

5 Boroughs Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by utilising data quality reporting which looks at team-level data quality at an individual patient and practitioner level. Exceptions are reported at borough and Trust-level within the monthly Quality and Performance Report to Trust Board.

Table 3	Health and Social Care Information Centre benchmarking data (most recent data available 2011/12 – released April 2014)			Trust percentage	
	National average	Lowest	Highest	Full year 2015/16	Full year 2016/17
The percentage of patients aged 0-15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	0 for mental health trusts	0 for mental health trusts	0 for mental health trusts	0%	0%
The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	11.45%	0%	14.18%	6.7%	6.3%

5 Boroughs Partnership NHS Foundation Trust considers that this data is as described for the following reasons: Robust operational policies and procedures are in place within operational services to comply with this indicator. The supporting data has been collated by the Trust's Performance Team against robust guidelines which comply with NHS Improvement guidance. These processes and the outputs of them are subject to audit.

5 Boroughs Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by utilising data quality reporting which looks at team-level data quality at an individual patient and practitioner level. Exceptions are reported at borough and Trust-level within the monthly Quality and Performance Report to Trust Board.

Table 4	Health and Social Care Information Centre benchmarking data	Trust percentage	
	National 2016	2015	2016
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	61.5%	62%	65%

5 Boroughs Partnership NHS Foundation Trust considers that this data is as described for the following reasons: Staff engagement has and continues to be a high priority for the Trust. We have a number of forums in place to listen to our staff and act upon their

feedback in order to improve the quality of our services and their experiences at work. Such forums include our Trust's quality and safety meeting and:

Safety walkabouts – these are carried out by executive and non-executive directors on a regular basis across all services and wards. With a focus on quality and safety, these visits offer staff an opportunity to discuss any concerns or issues they may have with a member of the Trust Board. They are also an opportunity for staff to highlight any successes or examples of good practice.

Lessons Learned Forum – this forum meets bi-monthly and is chaired by our Medical Director. One of the key aims of this forum is to provide staff with an opportunity to share ideas and initiatives which can help improve quality and safety across the Trust.

5 Boroughs Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by providing further investment in the Organisational Effectiveness function. This has allowed the introduction of Organisational Effectiveness business partners who work closely with staff and senior leadership teams from across our Trust enabling greater, more targeted awareness-raising of the importance of completing the friends and family survey.

The data in table five and six is the latest available from the Health and Social Care Information Centre benchmarking data which is now 12 months old.

Table 5	Health and Social Care Information Centre benchmarking data	Trust percentage	National
	National 2014	2015	2015
The trust's 'patient experience of community mental health services' indicator score with regard to a patients' experience of contact with a health or social care worker during the reporting period	7.7/10	7.8/10	About the same

5 Boroughs Partnership NHS Foundation Trust considers that this data is as described for the following reasons: This information is directly generated from the Patients' Experience Survey which is collated and reported by the Care Quality Commission.

5 Boroughs Partnership NHS Foundation Trust has taken the following actions to improve this figure, and so the quality of its services, by using the annual Patients' Experience Survey as an important source of information to shape and improve the services we provide. Actions are established by using service-level information which has been utilised within service development projects.

Table 6	Health and Social Care Information Centre benchmarking data				
	Reporting period latest available	National average	Lowest reported	Highest reported	Trust performance
Number of patient safety incidents reported	1 Oct 2015 to 31 Mar 2016	2,629	599	5,572	2,572
	1 Apr 2015 to 30 Sept 2015	2,587	8	6,723	2,913
Rate of patient safety incidents (per 1,000 bed days)	1 Oct 2015 to 31 Mar 2016	42	14	85.1	48.7
	1 Apr 2015 to 30 Sept 2015	42	6.5	83.7	53
Number of patient safety incidents that resulted in severe harm or death	1 Oct 2015 to 31 Mar 2016	31	0	119	23
	1 Apr 2015 to 30 Sept 2015	27	0	97	35
Percentage of patient safety incidents that resulted in severe harm or death	1 Oct 2015 to 31 Mar 2016	1.18%	0%	2.13%	0.89%
	1 Apr 2015 to 30 Sept 2015	1.04%	0%	1.44%	1.2%

5 Boroughs Partnership NHS Foundation Trust considers that this data is as described for the following reasons: the information in table six shows we have reported an increased number of patient safety incidents during 2015/16. We believe this is as a result of scrutiny across the organisation at all levels to ensure all patient safety incidents are reported. Organisations with high reporting of incidents have been shown to have a heightened safety culture.

Robust procedures are in place, including a quality assurance process to ensure all incidents are reported and reviewed. The Trust is in line with the national average in respect of the number of patient safety incidents resulting in severe harm and death. The Risk Management Team ensures the National Patient Safety Agency data is uploaded accurately.

Current reporting in 2016/17
For the full reporting period for 2016/17, the Trust percentage of National Patient Safety Agency reported patient safety incidents that resulted in severe harm or death is 1.11 per cent.

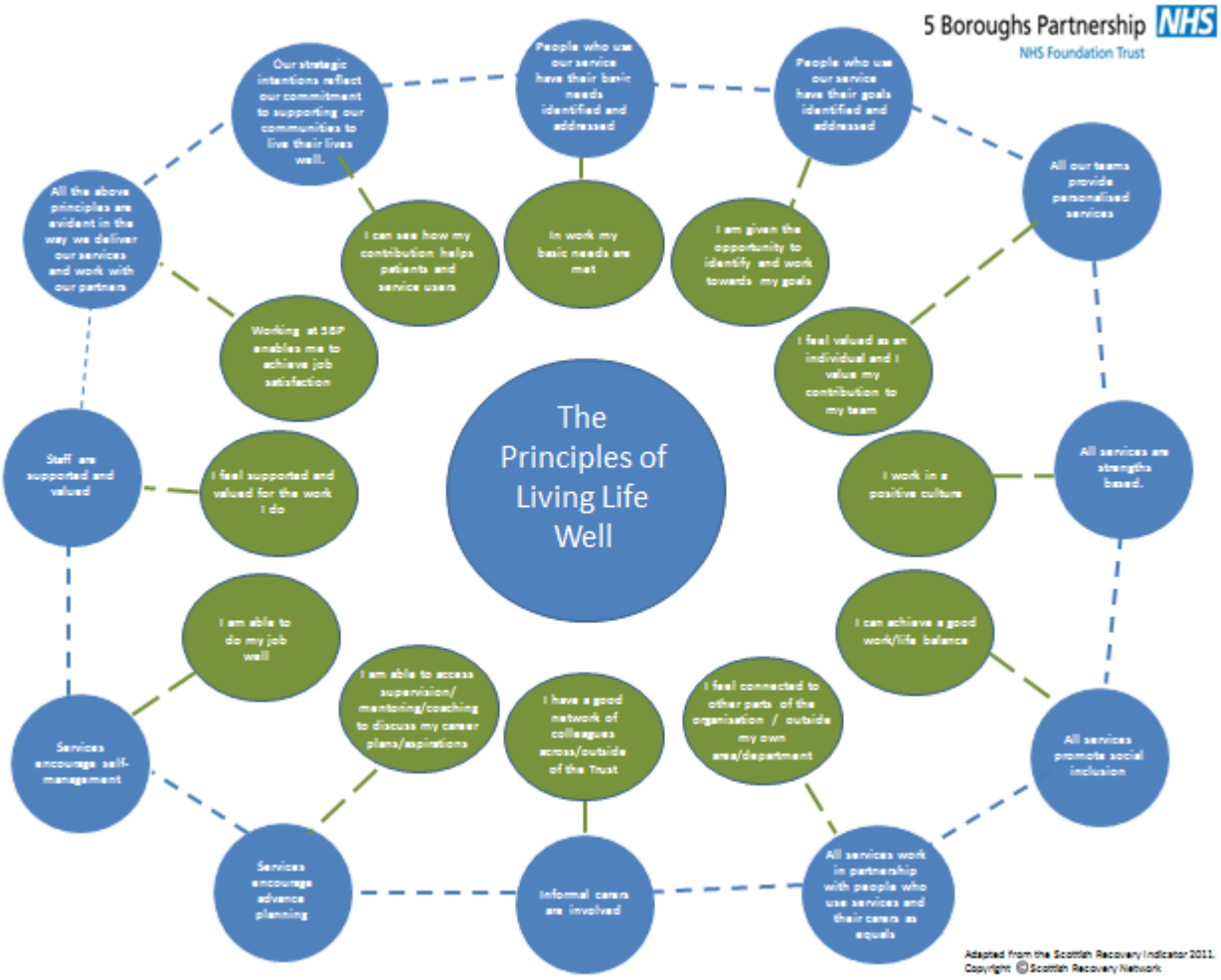
5 Boroughs Partnership NHS Foundation Trust has taken the following actions during 2016/17 to improve this percentage, and so the quality of its services, by ensuring patient safety remains a priority within the Trust and the focus of significant attention. Scrutiny of incidents takes place in a number of areas, including performance reports and reports to the Trust Board and its sub-committees. Actions identified and undertaken are included within the quality priority for safety in this report, as well as within the Quality Strategy, which defines the Trust's quality objectives.

3. Other information

The 2015-18 Quality Strategy and Quality Improvement Plan has driven a number of work programmes within the Trust, including development of a lessons learned culture, Living Life Well culture, and has led to a cultural shift towards a collaborative approach to quality and safety improvement.

The Quality Committee, a sub-committee of the Trust Board, provides leadership and assurance on the effectiveness of Trust arrangements for quality and safety. The Quality Committee ensures there is a consistent approach throughout the Trust, specifically in the areas of safety, effectiveness and patient experience.

Throughout 2016/17, we have delivered on a number of key objectives to ensure our quality definition continues to be brought to life. Our Culture of Care is fully embedded within our Staff Recognition Awards, including the monthly employee and team of the month. It underpins our Living Life Well Strategy which describes the personal lived experience and journeys of the people we care for as they work towards living meaningful and satisfying lives. It defines what people can expect from us to achieve this aim. The continuing presence of symptoms is not considered an impediment to achieving these goals. This represents a move away from pathology, illness and symptoms to health, strength and wellbeing. Living Life Well takes account of the struggles and obstacles people may face, as well as the creative paths entered into in the personal journey through life. The strategy (see diagram below) is described both from the service user's perspective and a staff perspective. The principles will be embedded within the 'maximising your potential' conversation in the annual performance development reviews all staff members engage with.



The embedding of values-based recruitment ensures we recruit the right people who are caring, compassionate and committed, in line with our Culture of Care and essential to providing good quality care.

Our programme of internal quality reviews continued during 2016/17, complimented by the safety walkabouts undertaken by executive and non-executive directors. The programme of visits included all inpatient wards across the Trust, and a focus on the community services has begun. Feedback is provided at the beginning of each Trust Board meeting, following the patient story, providing an increased understanding of the work we do and the care we provide. Both review visits follow a structured process with opportunity to talk and discuss safety and quality of care issues with staff, service users and carers.

During 2016/17, the Future Fit transformation programme was fully embedded, providing a structure in which clinical services were fully aligned to our boroughs. The benefits of the changes are already influencing the services we provide, ensuring we meet the needs of the different populations we serve.

Gail Briers
Chief Nurse and Executive Director of Operational Clinical Services

Tracy Hill
Director of Strategy and Organisational Effectiveness

3.1. Trust quality measures

In addition to the achievement of our quality priorities during 2016/17 and establishing our quality priorities for 2017/18 (part 2), the Trust has also established a set of quality measures.

When selecting the quality measures, we wanted to ensure we were measuring quality across our different client groups and used information from a range of sources.

The quality measures were established by the Chief Nurse and Executive Director of Operational Clinical Services and the Director of Strategy and Organisational Effectiveness on behalf of the Trust Board, following feedback received from stakeholders for last year's Quality Account. The indicators remain the same as those reported in our previous Quality Account and provide a balanced and transparent view of quality and safety indicators used by the Trust. We continue to use the Commissioning for Quality and Innovation targets within our quality measures to provide further information about the Trust's performance.

These measures cover inpatient and community mental health and learning disabilities and community services across our business streams below – and fit to the same domains of patient safety, patient experience and clinical effectiveness.

Progress against the quality measures is routinely reported to the Trust Board. The following table shows our progress during 2016/17.

Domain	Indicator to be measured	Detailed definition	2016/17 in-year movement against previous year	2015/16 full year position	2016/17 full year position	Data source	Comments
Patient safety	Proportion of incidents with outcome of no harm	The percentage of incidents that had an outcome of no harm		76.3%	**77.4%**	Internal reporting of National Patient Safety Agency definition	There has been an increase in incidents reported resulting in no harm.
	Medicines reconciliation	Proportion of harm identified during medicines reconciliation reviews		0.25%	**0.25%**	Internal reporting of reconciliation reviews undertaken	The low level of harm identified during medicines reconciliation review has been maintained.
	Number of falls	Proportion of harm as percentage of falls		31.5%	**34%**	Internal reporting of National Patient Safety Agency and NICE guidance	There has been an increase in the proportion of falls that have resulted in harm during 2016/17. We have a steering group set up to address the number of falls across the Trust.

Domain	Indicator to be measured	Detailed definition	2016/17 in-year movement against previous year	2015/16 full year position	2016/17 full year position	Data source	Comments
Patient experience	Number of compliments (Trust)	Expression of satisfaction received verbally or written in year		1,857	**2,072**	Internal reporting	The level of compliments has increased during the 2016/17 year compared with the previous year.
	Number of complaints (Trust)	Expression of dissatisfaction requiring a response that could not be resolved locally within 24 hours		183	**180**	Internal reporting of Scottish Office; Citizens Charter definition	The number of complaints received by the Trust has decreased. This is as a result of improved systems for people who raise a concern. See quality priority for experience.
	Number of concerns (Trust)	A concern is defined as: *'Any anxiety or worry, regarding Trust services, expressed by service users, carers or their representatives which they do not wish to be treated as a complaint'.* Or an issue that cannot be resolved in 24 hours		473	**479**	Internal reporting	The Trust continues to adopt a local approach to capturing issues of concern. The increase is as a result of the improvements made, who would not require a formal complaint.

Domain	Indicator to be measured	Detailed definition	2016/17 in-year movement against previous year	2015/16 full year position	2016/17 full year position	Data source	Comments
Effectiveness	Re-admissions	The percentage of patients who have been re-admitted to hospital within 28 days of discharge	 Target 9%	6.7%	**6.3%**	Internal reporting of Department of Health definition	The Trust has maintained a similar percentage as last year, and remains well below the National Target of nine per cent.
	Self-harm	The proportion of harm as percentage of self-harm		37.1%	**33.7%**	Internal reporting of National Patient Safety Agency and NICE guidance	There was a further decrease in the percentage of self-harm incidents causing patient harm in 2016/17.
	Violence and aggression	The proportion of harm as percentage of violence and aggression		23.8%	**22.5%**	Internal reporting of National Patient Safety Agency and NICE guidance	There has been a reduction in the proportion of violence and aggression incidents that have resulted in harm during 2016/17.

Quality measures – Commissioning for Quality and Innovation targets 2016/17

Domain	Indicator name	Definition/goal	Q1-Q3 actual and Q4 forecast
National	NHS staff health and wellbeing	• Introduction of health and wellbeing initiatives • Health food for NHS staff, visitors and patients • Improving the uptake of flu vaccinations for front line staff within providers	**Indicator met in Q1, 2, 3 and 4**
	Physical health of mental health patients	Cardio metabolic assessment for patients with schizophrenia	**Indicator met in Q1, 2 and 3** **Partially met in Q4**
		Communication with GPs – programme of audit focussing on patients on Care Programme Approach (CPA)	**Indicator met in Q1, 2, 3 and 4**
Local: mental health and learning disabilities	Mental health training	Development of mental health training delivered to: • Urgent care centres • Walk-in centres including out of hours services • North West Ambulance Service paramedics Development of a mental health pathfinder	**Indicator met in Q1, 2, 3 and 4**
	Children and young people support scoping CQUIN	Improvement in the identification and support to children and young people who have a parent or carer with a mental health diagnosis who are in receipt of secondary care provision	**Indicator met in Q1, 2, 3 and 4**
	Smoking Cessation	Implement full National Institute for Health and Care Excellence Guideline (NICE PH48) across the organisation	**Indicator met in Q1, 2, 3 and 4**
	Learning disability communication profiles	Develop a communication profile in a person-centred format for young people with a learning disability at transition from special school to adult services referred to senior leadership team	**Indicator met in Q1, 2, 3 and 4**
	Readmissions within 30 days of discharge	Emergency readmissions within 30 days of discharge from hospital: a deep dive analysis	**Indicator met in Q1, 2, 3 and 4**
	Frailty	To develop a robust multidisciplinary team for frail patients across the healthcare boundaries	**Indicator not met in Q1, met in Q2, 3 and 4**

Domain	Indicator name	Definition/goal	Q1-Q3 actual and Q4 forecast
	Child and adolescent mental health service (eating disorders)	Data quality improvement to support reporting of a range of quality standards	**Indicator met in Q1, 2, 3 and 4**
	Learning disability care coordination	Increased identification of a care coordinator for people with a learning disability accessing healthcare, and who have more than one long-term condition	**Indicator met in Q1, 2, 3 and 4**
	Depression in older people	Improved screening, assessment and further clinical investigation of depression in older people	**Indicator met in Q1, 2, 3 and 4**
Local: community health services	Wheelchair PROMS/PREMS	Supports the development of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) within the wheelchair Service.	**Indicator met in Q1, 2, 3 and 4**
	Health visiting antenatal contacts	• Establishment of a system for identifying pregnant women who are due their antenatal visits • Ensuring all pregnant women are offered and receive an antenatal visit in their homes from a health visitor between 28 weeks and two weeks before their expected date of delivery	**Indicator met in Q1, 2, 3 and 4**
	School-age immunisations	Targeted review and engagement exercise with primary schools to identify best practice approaches, service delivery models and engagement activities in achieving safe, efficient and effective seasonal flu vaccination programmes at scale	**Indicator met in Q1, 2, 3 and 4**
Secure services	Recovery college for low secure patients	The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services. This approach supports transformation and is central to driving recovery-focused change across these services	**Indicator met in Q1, 2 and 3** **Q4 forecast to be met**
	Reducing restrictive practices within adult secure services	This CQUIN scheme proposes to support secure services in meeting this national guidance in an innovative and systematic way by producing and implementing a framework to reduce restrictive interventions, restrictive practices and blanket restrictions in a number of domains	**Indicator met in Q1, 2 and 3** **Q4 forecast to be met**

Domain	Indicator name	Definition/goal	Q1-Q3 actual and Q4 forecast
	Living Life Well project	To introduce the Living Life Well principles for care planning across all secure services inpatient wards	**Indicator met in Q1, 2 and 3** **Q4 forecast to be met**
Fairhaven (tier 4)	Improving child and adolescent mental health service care pathway journeys by enhancing the experience of family/carer	Implementation of good practice regarding the involvement of family and carers through a child and adolescent mental health service journey, to improve longer term outcomes	**Indicator met in Q1, 2 and 3** **Q4 forecast to be met**

Quarter four position for secure services will be available during May 2017.

3.2. Achievements against Single Oversight Framework 2016/17

On a monthly basis throughout 2016/17 the Trust reported progress against the Risk Assessment Framework and the Single Oversight Framework. Our performance is as follows:

Single Oversight Framework 2016/17	Threshold	Full year 2016/17
Monitor mental health and learning disability targets reported throughout the year		
Patients seen, treated and discharged within four hours of arrival at Accident and Emergency Quality rationale: To reduce the time that patients wait to be seen, treated and discharged at walk-in centres	95%	99.5%
Patients on Care Programme Approach (CPA) receiving contact within seven days of discharge Quality rationale: Evidence shows safer outcomes for patients who receive early follow-up by staff following discharge *(The Trust has made the assumption that because of the availability of a specialist professional at EMI nursing homes, patients transferred to these locations are classified as an 'automatic pass' for the purpose of measuring this indicator)*	95%	96.5%
Patients having a formal review with their care coordinator within 12 months Quality rationale: Effective care coordination facilitates access for individual service users to the full range of community support they need in order to promote their recovery and integration	95%	Not on Single Oversight Framework
Access to crisis resolution / home treatment Quality rationale: To ensure patients receive a speedy and effective 'step up' in the support and treatment they receive, yet avoiding hospital admission	95%	98.3%
Meeting commitment to serve new Psychosis cases by Early Intervention Teams Quality rationale: Patients detected and diagnosed with a first episode of Psychosis by Early Intervention Teams gain prompt and appropriate treatment which reduces their duration of untreated psychosis	95%	Not on Single Oversight Framework
Early intervention in psychosis: People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	79.3%
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to IAPT programme will be treated within six weeks of referral	75%	98.9%
People with common mental health conditions referred to IAPT programme will be treated within 18 weeks of referral	95%	99.9%

3.2.1. How we are implementing Duty of Candour

The care across the Trust has always aimed at being open, honest and transparent and the importance to apologise when harm has occurred is understood. In order to meet Duty of Candour requirements, there has been a drive to promote understanding at all levels of the organisation to ensure this is firmly embedded in practice. This has included a review of the Being Open Strategy, education sessions, patient safety alerts and monitoring of Duty of Candour.

To increase the support for frontline staff to implement Duty of Candour, all incidents reported that result in moderate or severe harm or death are discussed with the Trust's Risk Team to review the application of Duty of Candour. Incidents where Duty of Candour has been applied continue to be recorded on the Trust's incident reporting system, and all completed Duty of Candour letters are stored on this system to capture all instances where Duty of Candour is implemented.

Based on the existing work, we consider our services to be compliant with all Duty of Candour requirements

3.2.2. Patient safety improvement plan

The Trust adopted the Sign Up to Safety campaign with aims to reduce avoidable harm by 50 per cent by 2018. The patient safety improvement plan builds on and brings together all of the quality and safety work in the organisation. The work streams identified are prevention and management of violence and aggression, self-harm, suicide, falls and physical health.

To date, this has resulted in:

- 27.5 per cent reduction in restraint across the wards involved.
- The implementation on three female wards of an evidence-based self-injury pathway.
- A review of the Trust's Suicide Strategy has begun.
- A fluctuating pattern of falls, but overall reduction in falls and harm from falls continues.
- A comprehensive review and education awareness raising programme regarding the use on our inpatient wards of a modified early warning score (MEWS) which highlights when a person's physical health is deteriorating.
- A sepsis task and finish group working to ensure all staff recognise sepsis.
- Procurement of clinicalskills.net licence, which provides an evidence-based, up to date database of clinical procedures to further standardise physical health care practice in all settings.

The Trust is about to enter into the last year of the current Sign up to Safety pledges and a refreshed work plan has been developed. The aims of the Sign up to Safety steering group are to fully understand and adopt the successes made in each area and continue to use those approaches as we continuously drive improvement in patient safety.

The Trust's patient safety improvement plan can be viewed at Annexe 5.

3.3. Trust-wide achievements

This section represents quality and safety achievements for the Trust realised throughout 2016/17.

3.3.1. Assessing the quality of our services

The Trust is expected to maintain its registration with the Care Quality Commission to undertake the regulated activities it provides. The Trust is routinely visited by the Care Quality Commission, including monitoring visits to inpatient areas in respect of the Mental Health Act, as part of their programme of inspections. The Trust continually assesses itself against the fundamental standards, reporting monthly as part of the performance report. Assurances are provided via the Quality Strategy and clinical assurance cycle and incorporate the following three areas:

- **Internal quality reviews** – a programme of internal inspections of teams undertaken by staff and service user or carer volunteers, against the standards of quality and safety and Trust policy.
- **Safety walkabouts** are visits undertaken by executive and non-executive directors. A total of 38 have taken place between April 2016 and March 2017. Following each visit, the Trust Board member feeds back the findings and recommendations to the Trust Board. Following safety walkabouts, local managers are encouraged to act on issues identified.
- **Continuous clinical improvement** – a review of outcomes from the above elements which identifies areas for improvement. These are either carried out at a local level within teams, or on a Trust-wide basis and inform the quality agenda for the Trust.

The following table shows the Trust's rated year-end position for 2016/17 against each of the Fundamental Standards which were introduced in April 2015.

Fundamental Standard Regulations		
Regulation	**Accountable director**	**March 2017**
5 - Fit and Proper Person – directors	Simon Barber	**Green**
9 - Person-centred care	Norah Flood	**Green**
10 - Dignity and respect	Norah Flood	**Green**
11 - Need for consent	Louise Sell	**Green**
12 - Safe care and treatment	Gail Briers	**Green**
13 - Safeguarding service users from abuse and improper treatment	Gail Briers	**Green**
14 - Meeting nutritional and hydration needs	Gail Briers	**Green**
15 - Premises and equipment	Sam Proffitt	**Green**
16 - Receiving and acting on complaints	Tracy Hill	**Green**
17 - Good governance	Tracy Hill	**Green**

18 - Staffing	Tracy Hill	**Green**
19 - Fit and proper persons employed	Tracy Hill	**Green**
20 - Duty of Candour	Tracy Hill	**Green**

The Trust uses a three point rating scale of red, amber, green to show the level of compliance with each of the 13 Fundamental Standards. A key to each of the indicators used follows:

Red	Major issues	The system for providing assurance/evidence has not been designed effectively and is not operating effectively. Evidence is limited by ineffective system design and significant attention is needed to address the controls. Might be indicated by one or more priority one recommendations and fundamental design or operational weaknesses in the standard (i.e. the weakness or weaknesses identified have a fundamental and immediate impact preventing achievement of the standard or result in an unacceptable exposure to reputation or other risks)
Amber	More issues with higher priority recommendations for action	The means both the design of the system of assurance/evidence and its effective operation need to be addressed by management. Indicated by a number of high-level recommendations that taken cumulatively suggest a weak control environment (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of the standard or result in an unacceptable exposure to reputation or other risks)
Green	Minor or no issues	The systems are generally well designed to capture evidence and assurances, however only low or minor improvements have been identified. Actions have been identified to address minor weaknesses or to achieve best practice which could improve the efficiency or effectiveness of the standard

3.3.2. Care Quality Commission inspections

During 2016/17, there have been a total of 14 inspections to the Trust from the Care Quality Commission. These were as follows:

- 11 unannounced Mental Health Act monitoring inspections.
- A targeted safeguarding inspection of child and adolescent mental health services and adult mental health services in Warrington during April 2016.
- A review of services for looked after children and safeguarding in Knowsley during November 2016.
- A reinspection of core services during July 2016.

The table below details the inspections undertaken by Care Quality Commission during 2016/17.

Month of visit	Ward/area visited and borough	Type of visit	Outcomes or areas covered
April 2016	Chesterton, Warrington	Routine unannounced	**Domain 2** Detention in hospital
April 2016	Marlowe, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
April 2016	Fairhaven, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
April 2016	Warrington	Safeguarding targeted inspection	**Child and adolescent mental health services and adult mental health services**
May 2016	Lakeside, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
May 2016	Coniston, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
May 2016	Grasmere, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
June 2016	Rydal, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
June 2016	Tennyson, Warrington	Routine unannounced	**Domain 2:** Detention in Hospital
June 2016	Austen, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
July 2016	Trust-wide	Reinspection of core services	**Core services**
July 2016	Auden, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
August 2016	Byron, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
November 2016	Knowsley	Looked after children and safeguarding	**Looked after children and safeguarding**

The Care Quality Commission undertook a reinspection of core services during July 2016. The report was published on 15 November 2016. The Trust received an overall rating of 'Good', with 'Good' achieved in all five domains of safe, effective, caring, responsive and well-led.

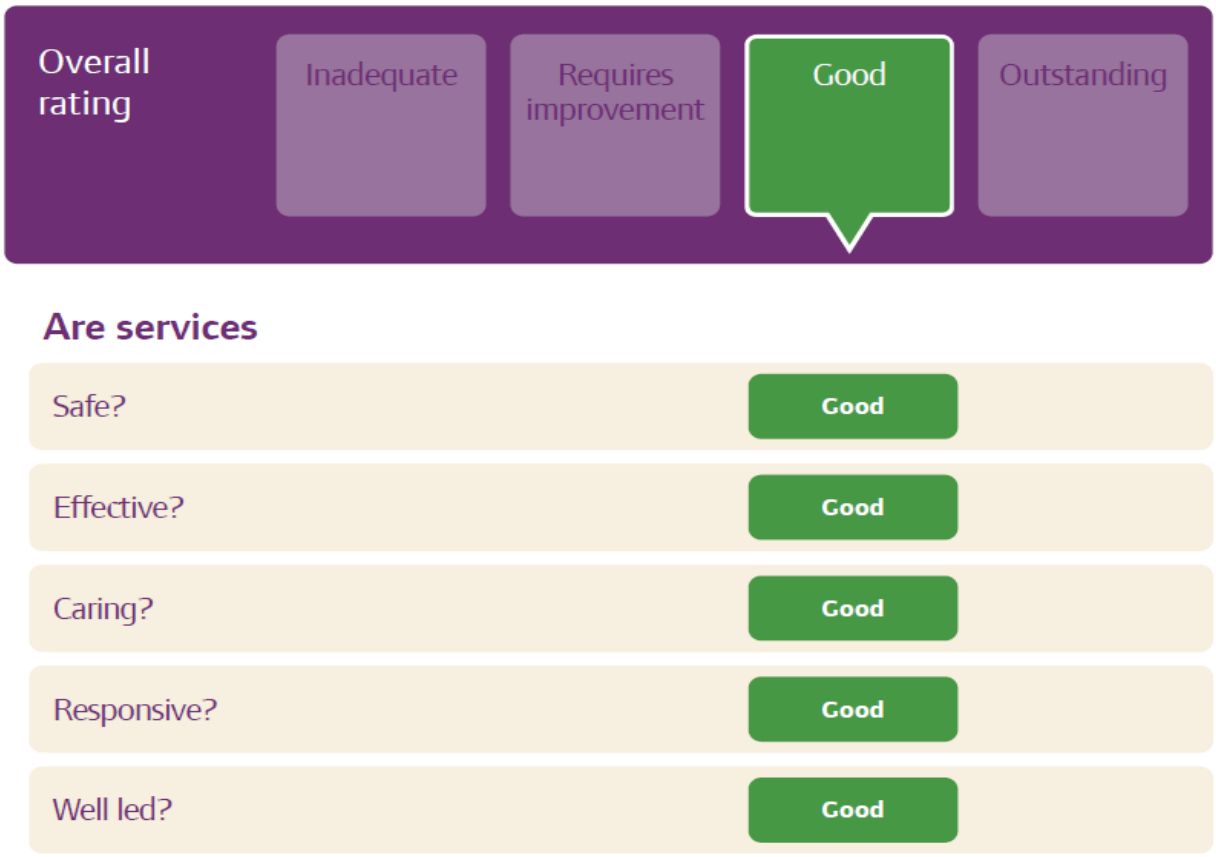
The Trust received one Requirement Notice in relation to a breach of Regulation 10(2) (a).

This related to wards for older people with mental health problems where staff left door observation windows into patients bedrooms open as the default position.

Actions have been taken to address the issue and continual monitoring of compliance has been implemented. An action plan has been provided to the Care Quality Commission.

An area of note was the increased rating from 'Requires Improvement' in the July 2015 inspection to 'Outstanding' in July 2016 for End of Life Care.

The table below shows the Care Quality Commission overall ratings.



The table at Annexe 6 shows the Care Quality Commission ratings for each of the core services provided by the Trust.

Following the Care Quality Commission reinspection in July 2016, we received the following feedback:

Dr Paul Lelliott, Deputy Chief Inspector of Hospitals, Mental Health: "We were impressed with the improvements we saw."

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

A number of other visits also took place during 2016/17. These are detailed in the table below.

Month of visit	Ward/area visited and borough	Visiting organisation
August 2016	Children's services, Knowsley	Ofsted
October 2016	Fairhaven Ward, Warrington	Ofsted
November 2016	Student education, Warrington	Liverpool John Moores University

November 2016	Children's services – permanence planning and looked after children, Knowsley	Ofsted
December 2016	Pre-quality visit, junior doctor advisory team, Trust-wide	Health Education England North West (HEENW)
January 2017	Medical education visit, Trust-wide	Health Education England North West (HEENW)
January 2017	Psychological therapies, Knowsley	NHS England
February 2017	Secure and specialised services: Fairhaven Unit – Warrington Marlowe Unit – Warrington Tennyson Unit – Warrington Chesterton Unit – Warrington	NHS England
March 2017	Children's services, Knowsley	Ofsted
March 2017	Security management arrangements, Trust-wide	NHS Protect

On the whole, feedback from the various visits has been positive. The Trust has developed action plans for areas of improvement identified and is working closely with relevant services to enable monitoring.

3.3.3. Guardian of safe working hours

Under the 2016 terms and conditions for doctors and dentists in training introduced by the Department of Health, there is a requirement for the guardian of safe working hours to submit an aggregated annual report to the Trust Board (delegated to the Quality Committee). The annual report is also required to be included in the Trust's annual Quality Account.

Under the 2016 terms and conditions, each NHS Trust is required to appoint a guardian of safe working hours. The guardian is a senior appointment and the appointee should not hold any other role within the management structure of the Trust. The guardian ensures issues of compliance with safe working hours are addressed by the doctor or Trust as appropriate.

The guardian role supports safe care for patients through these protection and prevention measures to stop doctors working excessive hours. The guardian has the power to levy financial penalties against departments where safe working hours are breached.

The Trust appointed a guardian of safe working hours from 1 August 2016 who is currently the chair and host of the Mental Health North West Guardian of Safe Working Hours Peer Group.

From 7 December 2016, the Trust received the first doctors on the 2016 contract. These were nine Foundation Year 1 doctors.

From 1 February 2017, the number increased to 15 doctors in training under the 2016 contract.

The Trust has five out-of-hours rotas staffed by junior doctors. All rotas meet New Deal and Working Time Regulations for hours of work and rest by design. The rotas are monitored for compliance every six months for two weeks.

Monitoring activity does not highlight any issues with shift lengths, rest or breaks and the rotas have been compliant.

3.3.4. Safety walkabouts

From 1 April 2016 to 31 March 2017, there have been 38 safety walkabouts across the Trust. The focus of the last 12 months was to ensure many of the community teams and smaller specialist services such as the Admiral Nursing Team and A&E liaison teams have been visited. This has been well received by the staff as it has increased the visibility of directors, provided staff with the opportunity to meet and discuss achievements and challenges with directors, and has provided clarity about the function and role of the non-executive directors.

The reporting template has been prioritised with less questions but keeping the structured focus to the visits, ensuring the key issues are captured when feedback is given to the Board each month. Key themes added to the refreshed framework include the implementation of smokefree across the Trust and the introduction of the new electronic patient record system, RiO.

To improve the governance processes for safety walkabouts, from January 2017 the Trust has introduced a formal documented process to make sure actions are tracked to completion. This will be presented to the Quality Committee on a six-monthly basis.

3.3.5. REsTRAIN project

During 2016/17, the Trust has continued to work with the Advancing Quality Alliance (AQuA) on the roll out of the REsTRAIN project within acute mental health services. The project has seen a collective reduction in restraint across the wards that have been involved of 27.5 per cent.

The Trust has initiated the programme on 11 of the 14 wards meeting these criteria. The remaining three wards will be prioritised for 2017/18.

A REsTRAIN Yourself toolkit has been developed and is available for use by the Trusts involved in the original research project. The toolkit contains training materials, assessment tools, safety plans, information on debriefs and templates for quantitative and qualitative data collection.

The Trust has a working group previously known as Prevention and Management of Violence and Aggression which has taken on a broader role as the Least Restrictive Practice Group and is responsible for oversight and accountability of the REsTRAIN project.

3.3.6. National award winners

We have enjoyed another year of awards success, having been shortlisted and highly commended for a number of national awards. These achievements evidence our progress towards achieving our Trust's overall purpose:

"We will take a lead in improving the health and wellbeing of our communities in order to make a positive difference throughout people's lives."

In July 2016, we were highly commended at the Positive Practice in Mental Health Awards in the Partnership Working category for our work with the State of Mind charity, which aims to raise awareness of mental health amongst the rugby league community. The charity was co-founded by the Trust's nurse consultant in dual diagnosis Dr Phil Cooper, who has worked tirelessly to build and maintain the strong link between the charity and our Trust.

In October 2016, our partnership work with State of Mind was also recognised at the prestigious Nursing Times Awards. Together with State of Mind, we were shortlisted in the HRH Prince of Wales Award for Integrated Approaches to Care category. The award aims to recognise nurses who have joined forces with other organisations to help promote public health and manage long-term conditions in a holistic way to improve patients' quality of life and independence.

In January 2017, Norah Flood, our Clinical Director of Operations and Integration, was presented with a Bronze award for her work as an Innovation Scout, as part of a network of innovation champions organised by the Innovation Agency, the academic health science network for the North West. The award recognises her involvement in events and study trips to learn about innovation and share best practice, and her work championing innovation across the Trust.

In February, we were shortlisted in two categories at the North West Coast Research and Innovation Awards.

Gary Lamph, Advanced Practitioner in Personality Disorder was shortlisted in the Outstanding Contribution to Patient and Public Involvement in Research category. Gary is currently completing a Clinical Doctoral Research Fellowship through the National Institute for Health Research.

The Trust's 'Live Well' integrated care project team was also shortlisted in the North West Coast Partner Priority Award category. The project aims to reduce health inequality and improve access to physical health screening for people with mental ill-health.

Our Trust's 'Shabby Chic' furniture restoration project was shortlisted in both the NHS Sustainability Day Awards 2017 in the Reuse category and in the National Recycling Awards 2017 in the Public Sector Waste Prevention category.

The 'Shabby Chic' project involves service users on our inpatient wards restoring and decorating unwanted furniture from across the Trust during activity sessions, which provides a therapeutic activity for patients whilst ensuring furniture does not go to waste. The winners will be announced at ceremonies in May (NHS Sustainability Day Awards) and June (National Recycling Awards).

3.3.7. Infection prevention and control

The Trust continues to maintain compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, and also adheres to national cleaning standards. There is a rigorous education, audit and monitoring programme to prevent healthcare associated infections within the Trust.

The Infection Prevention and Control Team has worked extremely hard to increase education opportunities for staff and has held two well attended education days for mental health, community, care home staff and GPs. The study day included sessions on various infections which arise in healthcare settings and raised awareness around antimicrobial

prescribing and sepsis. The days evaluated excellently and were commended by a representative from Knowsley Clinical Commissioning Group.

The team has continued to deliver the responsibilities under our service level agreement with Knowsley Clinical Commissioning Group and Knowsley Council. The team provides support, advice, auditing and education to Knowsley GPs, dentists, schools, care homes, nurseries and the general public.

The audit programme has continued to be reviewed and revised over the last 12 months and plans are in place to introduce an award system to highlight the achievements of our staff and in particular the infection prevention and control link practitioners. The Infection Prevention and Control Team continues to undertake quality assurance spot-checks involving our service user involvement representatives, whose continued support is invaluable to ensure delivery of this important agenda. We are very pleased to report that all the wards have now achieved a green rating (pass of greater than 90 per cent) in their spot-check infection control audits.

Weekly surveillance continues to be undertaken by the Infection Prevention and Control Team and this identifies organisms and infections occurring on the wards within the Trust.

The Trust continues to report on healthcare associated infections as part of the national mandatory return which currently includes Clostridium Difficile Infection (CDI), bloodstream infections due to Methicillin-Resistant Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA) and Escherichia Coli (E-coli). We have had a nil return for MRSA, MSSA and E-Coli bloodstream infections.

The Trust has reported one case of Clostridium Difficile Infection attributable to the Trust in June 2016. A full root cause analysis was undertaken which identified the infection had not originated within the Trust but due to the 72-hour attribution rule it had to be added to the Trust's figures.

The Infection Prevention and Control Team has supported Occupation Health with the flu campaign for the second year running which has been a great success and has no doubt made the Trust workforce much more resilient and healthy and, in turn, protected many of our patients and families.

The Infection Prevention and Control Team remains vigilant in surveillance and monitoring of emerging multi-drug resistant organisms (MDRO) such as Carbapenemase Resistant Enterobacteraciae (CPE). There have been no known cases of CPE identified in the Trust during 2016/17. The antimicrobial resistance agenda is of upmost importance and is one of the biggest threats to the public's health in recent times. The team has undertaken many activities around education, public and staff awareness as required in the Government's five-year antimicrobial resistance strategy, with much more planned for the year ahead. The team is working closely with local partners and the medicines management team to deal with the raising concerns over anti-microbial prescribing and emerging multi-drug resistant organisms.

3.3.8. Atherleigh Park

Atherleigh Park is our new mental health hospital in Leigh providing the people of the Wigan borough with a purpose-built environment which promotes enhanced privacy, dignity and respect.

It opened to patients in March 2017, following two years' of construction, and will facilitate new ways of working and improved patient care with a focus on holistic care.

It is a £40 million investment which supports local regeneration by developing a previously derelict 3.9-hectare site – formerly Leigh East Amateur Rugby League ground – in the heart of a disadvantaged community.

The hospital comprises 40 en-suite bedrooms for adults with mental health problems who require short-term hospital treatment and eight beds for adults who require more intensive care. Additionally there is, a 26-bed unit providing short stay, intermediate care for patients with dementia and memory conditions, and a 16-bed unit for older people with mental ill-health

The facilities include a therapy hub which has a gym, sports hall, activity room and therapy kitchen. A therapy courtyard allows service users to get involved in gardening, an activity, which research has shown improves mental wellbeing. A therapeutic activity model combining psychology, occupational therapy, physiotherapy and activity work provides a weekly programme within the hub and on the wards. This will enable all patients to participate in educational, social and physical activity to enhance their recovery.

Service users, carers, staff and local residents have been central to the design and development process from the outset and throughout the project. We have particularly valued the lived experience of past and present service users.

Past service users volunteered at Atherleigh Park, meeting and greeting visitors and showing them around the building. They supported the transfer of patients from the old wards to the new site, helping to orientate people and settle them in. This important role has boosted the volunteers' confidence and is valuable experience towards taking the next steps in their own recovery journeys.

Innovative design is evident both externally and internally. The combination of natural timber cladding sourced from environmentally friendly forests, traditional brick and floor-to-ceiling glass panelling create a contemporary, asymmetrical appearance and a bright, airy interior.

Close partnership working between the Trust, architects AFL UK, building contractors Kier and financial consultants Rider Hunt has ensured creative design solutions and effective budget management.

The wards
There are five adult inpatient wards at Atherleigh Park:

- Sovereign Unit – 20-bed ward for male adults
- Westleigh Unit – 20-bed ward for female adults
- Priestner's Unit – eight-bed psychiatric intensive care unit
- Golborne Unit – 26-bed unit for patients with dementia and memory conditions
- Parsonage Unit – 16-bed unit for older people with mental ill-health

On site facilities
Atherleigh Park is a purpose-built hospital for mental health patients.

All wards have the following:

- Individual en-suite patient bedrooms accessed by a wristband

- Large, light shared dining / lounge area
- Relaxation room
- Activity room and outdoor activity courtyard
- Secure outdoor space

There are also the following communal facilities:

- The Leigh Baker café – open to patients, visitors, staff and public and run by local charity, Compassion in Action
- Child visiting room
- Multi-faith room
- Therapy hub – with sports hall, gym, therapy room and therapy kitchen
- 400-metre nature trail around the grounds

Home treatment services for Wigan are also based at Atherleigh Park.

What people say:

Simon Barber, Trust Chief Executive:
"I'm incredibly proud of all the hard work that has gone into making Atherleigh Park a reality. It is a fantastic facility and will make a huge difference to the lives of not only the patients who are treated here, but their families too.

"We have involved service users from the start of the design process to help us achieve our aim of providing a purpose-built mental health environment which promotes enhanced privacy, dignity and respect with a focus on improving patients' physical health as well as their mental wellbeing.

"I'm grateful for the continued support, involvement and positive encouragement we have received from local residents, councillors, Leader of Wigan Council Lord Peter Smith, and Leigh MP Andy Burnham.

"Atherleigh Park is a facility the Wigan and Leigh community, and indeed the North West, can be proud of."

Susan Gredecki, Chair of Leigh Neighbours and Residents in the area:
"From the beginning, the Trust and its partners have been excellent in considering the neighbours. They have kept us informed at all stages of the build, included us in the design and fabric of the building, been easily contacted throughout the process and invited residents on site visits when safe.

"The completed building is magnificent in appearance and has turned what was a complete eyesore in the area into a beautiful site with lovely gardens."

Andy Burnham, Leigh MP:
"On behalf of the Leigh community, I want to thank you and your team for trusting in our town and for giving people here this 21st century facility."

Atherleigh Park exterior

Atherleigh Park reception

Golborne Unit lounge

Soveriegn Unit bedroom


Therapy hub gym

3.3.9. Coaching programme

During 2016/17, further investment was made to increase the Trust's coaching capacity to 26 senior leaders holding professional coaching qualifications to support the delivery of the Trust's coaching strategy.

This strategy focuses on the continuous development of a coaching culture across the Trust to improve performance and to enable staff at all levels to take personal accountability, encourage them to take responsibility, make their own decisions and take action to deliver quality improvements for staff, patients and service users. Furthermore, we took the decision to update and refresh the Trust's externally accredited Coaching Conversations Programme to include a key focus on coaching conversations set within the context of performance and development reviews. This decision was taken to improve the overall quality of performance and development reviews for all members of staff to further enhance their performance and motivation at work. Ongoing feedback from attendees on the programme has confirmed increased levels of confidence in the facilitation of quality performance and development reviews with their team members.

3.3.10. Healthy eating project

The Integrated Wellness Service, which supports adults and families to adopt healthier lifestyles, was a wave one team implementing the Living Life Well initiative; one of the 2016/17 quality priorities. The element of the service that Living Life Well initiative focused on was one-to-one lifestyle support. Based on motivational interviewing and goal setting, the service already reflected the principles of Living Life Well.

The service took the opportunity to scrutinise quality of one-to-one support based on the Living Life Well principles. An observation checklist was developed to support wellbeing coordinators and team leads to provide constructive feedback following observations of clinics.

Observation checklists incorporated the principles of the 'six Cs' as outlined in the Culture of Care (care, compassion, communication, competence, commitment, courage). Feedback was based on principles from coaching ensuring reflection on practice with constructive feedback, identification of training and action plans to improve performance.

The peer review process allowed staff to focus on performance improvement, assures quality of service provision, and ensured staff members felt valued.

Key themes identified for improvement across the observations include the time ratio of practitioner/client dialogue and personalised goal setting.

3.3.11. Chesterton project

During 2016/17, Chesterton Unit, based in Warrington, has introduced significant changes to the management of the unit with the aim of improving service delivery and enhancing our patients' journey through secure services. The team has adopted the ethos of Living Life Well, which aims to promote recovery-focused care, enabling patients to plan for the future, enhance social inclusion and focused on individual's strengths and their abilities to manage their own distress. Since the introduction of Living Life Well, the service users have been involved in all revisions to the service and have been paramount in driving the changes forward.

We initially developed a booklet with patients to improve collaborative care planning and risk assessments to ensure their voices were heard and incorporated into their care plans. All staff attended training on structural clinical management to enhance understanding about our patients' difficulties and to improve our clinical approach. The training and regular clinical supervisions have provided the team with the competence and confidence to engage patients in open and honest conversations about their risk in a caring and compassionate manner. Before the training, staff did not always feel confident in having challenging conversations with service users regarding risk. This has been helpful in allowing service users to take ownership of their risks, and ultimately aid recovery.

Since beginning Living Life Well, the Chesterton team conducts regular staff and patient post-incident debriefs to make sure there is a shared understanding of psychosocial triggers contributing to incidents of self-harm or aggression for a patient. Weekly combined patient and staff meetings are useful in addressing any difficulties on the unit. The establishment of daily multidisciplinary meetings has been essential in allowing team decision-making, providing more opportunities to discuss potential challenges, allowing all staff to have an equal voice and ensuring we are all working towards unified goals for each patient.

We have started daily evidence-based and custom-made therapy groups to address the patient needs (eg anger management, building my self-esteem, assertiveness, anxiety management) and help individuals to reduce risk to themself and others. Patients are asked to complete electronic questionnaires on a weekly basis for an opportunity to reflect on their recovery and tell staff how they are feeling. The individual questionnaires include assessment of depression, psychosis, mental wellbeing, difficulties with interpersonal problems, impulsivity and emotions, and satisfaction with the service. The scores over the last 12 months have demonstrated improved satisfaction with the care offered on the unit.

The team feels proud of the significant changes we have implemented and the subsequent improvements observed in the culture of the unit. Both the patients and staff feel more empowered and we are all working towards a shared vision.

Patients told us about the therapy groups:

- *"They help you to learn about yourself and how you act in different situations."*
- *"I have built my self-esteem in social situations."*
- *"It is good to be able to speak to other people who have the similar feelings and difficulties… and it makes you feel are not alone."*
- *"They help you to get your thoughts and feelings across."*

Patients told us about the Living Life Well booklet:

- *"It is a useful tool to allow me to think about my goals and future plans."*

Patients told us about the electronic questionnaires:

- *"It is good to be able to see your scores and track how you are doing."*
- *"The graphs help to see where you can improve and remind yourself you can always climb up again."*

3.3.12. Physical health in-reach hub

The Trust's physical health in-reach hub had a phased launch during 2016/17 with the first services going live in July 2017. It was identified that there was a lack of consistent and timely physical health experts providing interventions to the inpatient population. Following a review of arrangements in place, a decision was taken for the services to be brought back in-house. This has ensured the best quality and value of care can be provided from our own staff. Physical health expertise from within the organisation is now being utilised to benefit as many patients as possible.

The hub provides a range of experts, including speech and language therapy, podiatry, dietetics, tissue viability nurses and physiotherapy. The staff in-reach where a physical health need is identified and that profession is not available as part of the core ward offer. The service is enhancing the overall care provided and ensuring whole patient care is achieved.

Having seen the many benefits of the service, it has been identified that the scope of the hub will extend in 2017/18 to include moving and handling assessments and also continence assessments.

Since the go live in July 2016, the service has received more than 350 referrals with 92 per cent being accepted and an assessment being provided. Work continues to develop the care pathways for the hub and the future developments will include internal referrals to the service via the Trust's new electronic patient record system, RiO.

3.3.13. Quality showcase event

The quality showcase event on 10 November 2016 was very successful. It was attended by 85 staff, and many have asked for a further event during 2017/18.

The idea for the event came from excellence observed in services across the Trust during internal quality reviews and safety walkabouts, which included best practice and new, innovative initiatives which improve the quality of care we provide.

We received an overwhelmingly positive response when we asked staff if they would be keen to showcase their initiatives. These were then divided between a programme of presentations and marketplace poster presentations and two workshops facilitated by the Advancing Quality Alliance NW (AQuA) and the Trust's Transformation Team.

Some of the teams and initiatives showcased included:

- Early Intervention Team
- REsTRAIN project
- Men's mental health
- Child and adolescent mental health ervices
- Service user involvement in quality improvement
- Living Life Well

Following the presentations, staff were offered a choice of attending one of two workshops, offering opportunities to learn more about quality improvement and further information about the tools available.

Staff fed back that they felt it was extremely useful to have this event and to understand what other teams were promoting and influencing in other areas.

Community health services staff fed back that they would like more presentations from their particular teams to be considered for future events.

3.3.14. End of Life Care

The Trust has continued to develop and improve End of Life Care services during 2016/17. There is an established End of Life Care Operational Group which reports into the Trust End of Life Care Steering Group which ensures national and regional End of Life Care strategies are embedded in practice and monitored on a regular basis. The operational group actively seeks out new and emerging practices and, this year, has trained staff to undertake verification of expected death by nurses and administration of subcutaneous fluids.

Audits of practice in End of Life Care are undertaken every quarter in care delivery and medicines management using an End of Life Care audit framework. Achievements are celebrated and staff contribution has been recognised through the Trust's Staff Recognition Awards. All staff have access to End of Life Care training and resources to make sure they are confident and competent to deliver End of Life Care at home to support people to achieve their preferred place for care.

In line with Trust values, staff have delivered End of Life Care which supports each individual's needs, wishes and preferences. Patient experience stories demonstrate our patient experience is in line with the 'six Cs' – compassion, courage, communication, commitment, care and competence. In July this year, the Trust's End of Life Care services were inspected by the Care Quality Commission and were rated as 'Outstanding' in caring for patients at the end of life.

3.3.15. Business development

The Trust's Council of Governors and the Trust Board hold an annual strategy session to support the review and refresh of the Trust's strategy. At its 2015 session, they agreed a growth strategy in line with the Trust's overall purpose statement. This growth strategy was based on developing and delivering services directly or in partnership with other organisations to support the Trust's vision of delivering joined up, whole person care.

Over the last 12 months, the Trust has invested in its infrastructure by creating a Business Development function and recruiting a full time Director of Business Development with business development officers aligned to each of the Trust's boroughs. This new infrastructure supports the Trust and the existing borough leadership structures to identify opportunities to develop the Trust's clinical offer and win new business in line with the Trust's purpose.

During 2016/17, the Trust has been particularly successful in winning new business across the original five borough footprint, as well as in new areas for the Trust in Greater Manchester and Sefton. Alongside the new business wins for the Trust, there has been a particular emphasis on developing our partnerships with neighbouring trusts and other providers across the system supporting the Trust. For example, to develop clinical

networks to support new services spanning large geographic footprints and also working together in formal consortia arrangements to bid for new contracts to enhance the patient pathway.

The Trust faces onto two Five-Year Forward View (previously sustainability and transformation plan) footprints – Cheshire and Merseyside for its services delivered across Warrington, Halton, St Helens, Knowsley and Sefton, and Greater Manchester for services delivered in Wigan and the remainder of the sub-region. The Trust is actively engaged across both planning footprints to lead and contribute to the transformation of the wider system.

As one of the mental health trusts in the Cheshire and Mersey Five-Year Forward View planning footprint, the Trust worked in close collaboration with Mersey Care NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust and Alder Hey Children's NHS Foundation Trust to develop the plan for the cross-cutting theme of mental health. The plan outlined the collective vision of the trusts to deliver the aspirations of the Five-Year Forward View for Mental Health and the requirements of the planning guidance for 2017-19.

The Cheshire and Mersey Mental Health Programme Board was created to ensure delivery across the nine areas of transformation. The Trust will lead the health and justice and dementia work-streams which mirror the requirements of the planning guidance and Five-Year Forward View for Mental Health.

The Transformation Board has identified a small number of key priorities for the first year of the programme. These are to:

- Eliminate out-of-area placements in mental health care
- Develop integrated clinical pathways for those with a personality disorder
- Enhance psychiatric liaison services across the footprint and establish a Medically Unexplained Symptoms (MUS) service

3.3.16. Health and wellbeing

Health and wellbeing is firmly established throughout the Trust and, during 2016/17, a number of activities and initiatives have taken place. These included the Manchester 10k Run, Liverpool Santa Dash, NHS Games, Work Out at Work Day, Sport Relief and weekly exercise classes such as pilates, circuit training and yoga.

In addition, staff have 24-hour access to a free health and wellbeing centre containing a fully equipped gym and a virtual exercise class facility called Wellbeats which enables staff to choose and perform a wide variety of exercise classes.

Following the opening of Atherleigh Park, a health and wellbeing engagement event took place with approximately 200 staff who received an induction for the free on-site gym.

New for 2016/17 was the introduction of a national health and wellbeing CQUIN which involved a 75 per cent flu uptake target which the Trust achieved in December 2016; radical changes to the provision of food and vending machines throughout the Trust; and schemes to address mental health and emotional wellbeing of staff. These schemes involved a stress management programme devised and delivered through Occupational Health during February and March 2017. Results showed the programme was highly effective, with all participants showing a significant reduction in stress, anxiety, depression

and functional impairment. An eight-week mindfulness course was launched during 2017 and, upon completion, staff showed reduced stress and increased resilience.

The Trust has re-written its Health and Wellbeing Strategy and will identify health and wellbeing champions to drive participation locally. Mental health first aid for staff is a priority.

The Trust is proud of its health and wellbeing provision and was pleased to receive an award from the Sport and Physical Activity at Work Partnership in recognition for its health and wellbeing work.

3.3.17. NHS Improvement reporting requirements 2016/17

NHS Improvement is the sector regulator for health services in England. Its role is to protect and promote the interests of patients and ensure that care organisations are well-led and run efficiently so they can continue delivering quality services for patients in the future.

NHS Improvement requires the Trust to include the following in our Quality Report:

- The director's statement of responsibility at Annexe 2
- The external assurance on the content of the Quality Report. This is the report of an audit undertaken by an independent organisation on both the content of the Quality Report and assurance for indicators 1 and 2 below:
    1. Care Programme Approach seven day follow-up
    2. Admissions to inpatient services had access to crisis resolution home treatment teams
    3. Waiting time to begin treatment for Improving Access to Psychological Therapies (IAPT)

Details of the criteria for indicators 1 and 2 are included within Annexe 9.

PricewaterhouseCoopers LLP undertook the audit on the above elements. Their external assurance statement is included at Annexe 8.

3.4. Engagement and responsiveness

3.4.1. Council of Governors

As a Foundation Trust, local people can become members of our Trust and can elect governors. One of the roles of the governors is to represent the interests of members and the public. The Council of Governors and the Trust Board work together to determine the future strategy and forward plan of the Trust.

The Council of Governors and the Governors' Assurance Committee have contributed to the Quality Account through:

- Influencing and agreeing the quality priorities for the year ahead
- Receiving regular reports detailing progress against the Quality Account
- Providing a supporting statement for the Quality Account (Annexe 1)
- Choosing a quality indicator to be externally audited
- Receiving the external assurance statement in the form of a Governors' Report from the Trust external auditors

Governors' local indicator for audit
At the Council of Governors meeting on 1 February 2017, a number of areas were identified for potential areas for auditing as part of the Quality Account requirements. Following discussions with the Information Team and Pricewaterhouse Coopers LLP, the Trust's external auditor, the following indicator was agreed by the Governors' Assurance Committee:

- Waiting time to begin treatment – Improving Access to Psychological Therapies (IAPT)

The indicator covers IAPT services provided throughout the Trust, measured against the six-week target of 75 per cent.

The Trust reports monthly on this indicator as part of the Single Oversight Framework within the Quality and Performance Report under 'Are we delivering to our patients and service users'. Past performance for this indicator is shown in the table below:

Indicator	2016/17
Quarter 1 – April 2016 to June 2016	97.5%
Quarter 2 – July 2016 to September 2016	98.9%
Quarter 3 – October 2016 to December 2016	99.4%
Quarter 4 – January 2017 to March 2017	99.7%

Following the audit, the governors will receive an independent report (Governors' Report) with the findings of the audit.

3.4.2. Children and young people's involvement

Each borough has its own participation group for young people – SHOUT – engaging young people in working alongside trust staff to improve our child and adolescent mental health services. These meet regularly throughout the year.

Our Chairman and Chief Executive, welcomed 84 people to a Christmas-themed celebration of SHOUT's achievements in December 2016 at the DW stadium in Wigan.

Awards were presented in 10 categories including:

- Contribution to Service – individuals who have contributed their time to the Trust
- Innovator of the Year – an individual young person or group who has designed or created a piece of artwork to be used within our child and adolescent mental health services
- Inspiration of the Year – a member of Trust staff who has contributed to young people's participation and shown a commitment to improving services
- Volunteer of the Year – celebrates the volunteering efforts of a young person to SHOUT

3.4.3. Involving service users in patient safety

Patients, service users and carers are seen as a vital component of the Patient Safety Framework. They are involved in the following ways:

- Membership of the Quality Committee – a sub-committee of Trust Board

- Membership of the Lessons Learned Forum
- Collaborative framework review teams
- Patient-led assessments of the Care Environment Inspection Teams

By involving service users in the patient safety framework and taking into account their insight and experience, the Trust has been able to improve the quality of the actions implemented to enhance patient safety within the services provided.

3.4.4. Trust service user and carer forums

Forums are a crucial part of our work in involving communities in the business of the Trust. Forums enable members of the community, irrespective of whether or not they have had any engagement with the Trust previously or currently, to raise queries and have conversations with the most senior members of the organisation, including the Chief Executive.

Our key partners all have robust connections within their communities and they support the forums by attending and publicising across their membership. The list below is not exhaustive, but is representative of our third sector partners who regularly participate in their borough forum:

- Healthwatch
- Carers' centres
- Local Speak Out/Up learning disability groups
- MIND
- Clinical commissioning group engagement leads (as central liaison with patient participation groups)
- Alzheimer's Society
- Age Concern

Trust representation from:

- Chief Executive and/or Chairman
- Borough leadership team representative(s)
- Council of Governors

3.4.5. Trust Involvement Scheme

The Trust is committed to involving patients, service users, carers and volunteers in a wide range of our business. We acknowledge and appreciate the unique contribution they make by sharing their experience of living with a health problem and using health services personally or in a caring role. This form of 'experts by experience' is not available from any other source.

In recognition, the Trust has developed an Involvement Scheme designed to provide a safe and efficient process to enable volunteers to become involved in all stages of designing, delivering and monitoring Trust services. Recent work undertaken by volunteers includes:

- Running guided tours for visitors during the Atherleigh Park open day and supporting staff to welcome and help orientate inpatients transferred to Atherleigh Park from Leigh Infirmary.
- Successful implementation of a transition plan regarding service user and carer representation on the Quality Committee, ensuring each new volunteer is fully supported by a retiring one.

- Supporting community staff to provide activities including obtaining donation of equipment support from a private sector construction company to enable a gardening project to proceed.
- Working in partnership with Liverpool University to train and support 18 mental health service users to mentor trainee psychologists.
- Work in partnership with a number of NHS trusts and education establishments to train and support eight service users from the Trust to be mentors for associate nurses.
- Work placements for two mental health services users with the Trust's catering contractors, ISS.
- Service users working alongside staff in the Criminal Justice Team to design and deliver training for Trust staff external partners.
- Service users and carers embedded within the Transformation Team as part of a number of reviews.

3.4.6. Annual involvement events

On 13 July 2016, the Trust held a joint annual involvement event and annual members meeting, attended by more than 150 patients, service users, carers, volunteers, staff and representatives from local third sector organisations.

This celebration of the past year's involvement began with a play describing the positive impact of volunteering, written and presented by volunteers, with support from Newfound Theatre Company.

There were joint presentations from service users, carers and staff describing the involvement opportunities they had carried out together.

The event also included the presentation of the 100 Hours Recognition Awards to 52 volunteers. The Harry Blackman Memorial Trophy for 2016 was presented to Lisa Pleavin. Lisa has volunteered five days a week as a receptionist in the Education Centre since before the Trust was formed. Her nomination specifically made reference to her helpful and willing nature and how her colleagues will miss her when she leaves our area as planned later in the year.

The Trust's Ignite Your Life event in Walton Hall Gardens on Wednesday 6 July 2016 was a great success. Community and inpatient staff joined third sector organisations and volunteers in delivering a range of interactive workshops to Involvement Scheme members and others who have supported the Trust during the previous year.

Creative workshops included flower arranging, jewellery making, sculpting, ornament making, 'bags of hope', and furniture painting. Other sessions included yoga, song writing and storytelling.

Feedback from both those who ran the workshops and those who attended was overwhelmingly positive.

3.4.7. Working with local Healthwatch groups

During the year, we have worked closely with five local Healthwatch groups, this included attending and speaking at events. Healthwatch members are actively involved in our patient-led assessment of the Care Environment Inspection Teams. They also attend quarterly meetings of the Trust's Patient and Public Involvement Working Group.

3.4.8. Patient experience

The Trust recognises that feedback from patients, service users, carers and families can – when gathered and used appropriately – form evidence to inform service improvements and share good practice. Overall, it can lead to improved experience and quality of care.

We produce reports from feedback captured from:

- NHS Friends and Family Test
- Patient Opinion postings
- Service user and carer forums
- Patient Advice Liaison Services (PALS)
- Compliments, complaints and incidents
- Other feedback (Healthwatch, National Patient Survey etc)

The outcomes from concerns identified and actions taken are reported via 'You said, together we did' posters which are displayed locally and made available from the patient experience section of the Trust website.

3.4.9. Friends and Family Test

The NHS Friends and Family Test consist of two sections:

- A single question asking patients whether they would recommend the NHS service they have received to their friends and family if they needed similar care or treatment.
- Open question(s) designed to ascertain the patients' reasons for their decision.

In learning disability services the wording of the first question 'How likely are you to recommend our service to friends and family if they needed similar care or treatment?' has been amended, in line with NHS England guidance, to 'Is your care good?' with 'yes', 'no' and 'I don't know' as possible responses. These are then converted to the standard question and responses using a specified formula.

Between April 2016 and March 2017, the Trust received 8,960 responses to the first question. See Annexe 4 for tables highlighting results from Friends and Family Test for April 2016 to March 2017.

3.4.10. Equality analysis

The Trust takes an integrated approach to equality, diversity and human rights analysis with all Trust policies having an equality impact assessment carried out prior to their ratification. This includes a narrative response as part of the governance process. All major service reviews and changes within the Trust are also subject to the same equality analysis process.

3.4.11. Equality Delivery System 2

The Equality Delivery System 2 benchmarking tool was published at the end of 2013. The changes to the tool now allow a more integrated approach with services and give trusts the opportunity (in partnership with their key stakeholders) to identify particular areas for priority and tailor the analysis to meet the needs of individual trusts.

Following discussion with our commissioners, the Trust concentrated its efforts on outcome 2.4 – 'People's complaints about services are handled respectfully and efficiently' – and involved clinical and corporate services in its Equality Delivery System 2 assessment with evidence collection.

Following internal self-assessment, our performance was assessed by a large group of service users, carers, staff, third sector organisations and Healthwatch representatives brought together from across the Trust footprint.

The result of our assessment in 2017 was that the Trust was assessed as ‘Developing’.

Equality Delivery System 2 grading key

Excelling	Standards are delivered for all or nearly all of the protected characteristics
Achieving	Standards are delivered for five or more of the protected characteristics
Developing	Standards are delivered for three or more of the protected characteristics
Undeveloped	Standards are delivered for two or fewer of the protected characteristics

4. Annexes

Annexe 1 – Supporting statements from NHS England or relevant clinical commissioning groups, local Healthwatch organisations and Overview and Scrutiny Committees

Please note: Any references to North West Boroughs Healthcare NHS Foundation Trust included within the commentaries shown is due to the Trust changing its name on 1 April 2017, from 5 Boroughs Partnership NHS Foundation Trust to North West Boroughs Healthcare NHS Foundation Trust. (Further information about the Trust's change of name is included within this report at section 1.2 – Chief Executive's Statement.)

5 Boroughs Partnership NHS Foundation Trust – Quality Committee

The Quality Committee is one of the two sub-committees of the Trust Board. The Committee meets 11 times a year and, following each meeting, the minutes are formally received by the Trust Board. The Quality Committee has close links with the Audit Committee and directly communicates with the Audit Committee by way of a verbal report from the Chairman, who is a member of both.

The purpose of the Quality Committee is to provide leadership and assurance to the Trust Board on the effectiveness of Trust arrangements for quality, ensuring there is a consistent approach throughout the Trust, specifically in the areas of:

- Safety (patient and health and safety)
- Effectiveness
- Patient experience

Each quarter the committee reviews and discusses a serious incident report. In addition there are a number of regular reports made to the Quality Committee which are agreed as part of the work plan.

A primary function of the committee is the monitoring of the Trust's Quality Strategy. The strategy covering 2015-18 was approved by the Quality Committee in November 2015. The Quality Strategy has the following elements;

- Quality objectives – all quality initiatives are categorised into these objectives
- Quality Big Dots – longer term aspirational goals with yearly quality initiatives
- Quality priorities – yearly quality initiatives developed in partnership with our service users, carers and stakeholders
- Quality improvement cycle – measurement of quality to inform future quality improvement
- Sign Up to Safety – national safety campaign
- Lessons learned – continual learning and improvement from experience

The Quality Committee reviews progress against elements of the Quality Strategy regularly, and receives the Quality Report.

This Quality Report reflects the work being undertaken by the Trust to continuously improve the quality of the care that it provides to the people who use our services.

Richard Sear
Quality Committee Chair, Non-Executive Director

Statement on behalf of the Council of Governors on the Trust's Quality Report

During 2016/17, membership of the Quality Committee continued to include the Chair of the Governors' Assurance Committee, a sub-meeting of the Council of Governors. This has proved to strengthen the quality governance and scrutiny within the Trust.

The Council of Governors has continued to be involved in the Trust's Quality Report. For 2016/17 this has been demonstrated by:

- The Council of Governors and the Governors' Assurance Committee received regular updates on progress to achieve the Trust's quality priorities during 2016/17.
- Attendance and involvement at the Quality Account stakeholder event on 25 January 2017, both reviewed progress of 2016/17 quality priorities and development of 2017/18 quality priorities. The event was also attended by representatives from Healthwatch, local overview and scrutiny committees and clinical commissioning groups.
- At the Council of Governors' meeting on 1 February 2017, the governors reviewed feedback and responses from the stakeholder event and agreed themes for the 2017/18 quality priorities.
- Governors' Assurance Committee meeting on 14 March 2017 – agreed the detailed quality priorities for 2017/18 and will continue to monitor progress against the quality priorities for the coming year.
- This year, the Council of Governors chose 'waiting time to begin treatment for Improving Access to Psychology Therapy services' as the quality indicator to be audited as part of the assurance processes for the Quality Report 2016/17.
- The Council of Governors received the external assurance on the Trust's Quality Report (Governors' Report) from the external auditors for 2015/16

The Council of Governors feels these processes, and the results of external audit throughout the year, help provide assurance that the data presented in the Quality Report 2016/17 is accurate and representative of the Trust's position.

The Council of Governors is committed to improving quality across the organisation and to be engaged in the 2017/18 quality and safety agenda as set out in the Trust's Quality Report.

Alan Griffiths
Chair of Governors' Assurance Committee / Governor

Knowsley and St Helens Clinical Commissioning Groups – joint response

St Helens Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

Nutgrove Villa
Westmorland Road
Huyton
Liverpool
Merseyside
L36 6GA

0151 244 4126

Our Ref: HM/AMD/050

22nd May 2017

Simon Barber
Chief Executive
North West Boroughs Healthcare NHS Foundation Trust
Mail to: Simon.Barber@nwbh.nhs.uk

Dear Simon

North West Boroughs Healthcare NHS Foundation Trust Quality Account 2016/17

NHS Knowsley Clinical Commissioning Group and NHS St Helens Clinical Commissioning Group welcome the opportunity to comment on the North West Boroughs Healthcare NHS Foundation Trust Quality Account for 2016/17.

The CCGs acknowledge the July 2016 Care Quality Commission (CQC) re - inspection report for the trust, which highlighted many areas of good practice. The commitment of the trust to deliver high quality care is evident from the CQC report. We want to commend the trust on the excellent improvement in End of Life Services and hope that the trust is sharing it's good practice with neighbouring providers facing similar issues.

The CCGs are keen to continue to monitor this information in 2017/18, work with the trust to identify greater quality markers (including outcomes measures) within community services, and look forward to seeing the quality of care continue to improve.

There will be challenges for this 2017/18 as the trust grows geographically and embeds new services. This has the potential to impact on the quality of services delivered and therefore, we would want to ensure action to address this is prioritised and we will monitor this through the CQPG meetings.

There has been ongoing improvement in the management of serious incidents with the lessons learned forum noted as excellent by CQC, taking themes from disciplinaries, serious incidents and complaints through internal governance routes, ensuring dissemination to all staff.

Although the trust's focus on improving standards is commendable it may wish to reconsider using the "Always Event", terminology as there is a national framework for "Always Events" which defines aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system.

NHS Knowsley Clinical Commissioning Group and NHS St Helens Clinical Commissioning Group will continue to monitor North West Boroughs Healthcare NHS Foundation Trust through the Clinical Quality and Performance Group meetings, to gain assurance that the quality and safety of services delivered to patients continues to improve and that effective governance processes are in place and embedded throughout the organisation.

Yours sincerely

Dianne

S O'Brien

DIANNE JOHNSON
CHIEF EXECUTIVE
NHS KNOWSLEY
CLINICAL COMMISSIONING GROUP

SARAH O'BRIEN
INTERIM CLINICAL CHIEF EXECUTIVE
NHS ST HELENS CLINICAL COMMISSIONING GROUP

HALTON
BOROUGH COUNCIL

Simon Barber
Chief Executive
North West Boroughs Partnership NHS Foundation Trust
Hollins Park House
Hollins Lane
Winwick
Warrington
WA3 8WA

Our Ref DD
If you telephone please ask for Debbie Downer
Your ref
Date 12th May 2017
E-mail address Debbie.Downer@halton.gov.uk

Dear Simon,

Quality Accounts 2016 - 2017

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 26th April that your colleagues Norah Flood, Julie Chadwick and Alan Griffiths attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2016/17 the Board were pleased to note that the Trust achieved all three of their priorities. The Board noted in particular, the following:

- The Living Life Well Strategy Living Life Well is now accepted as the cultural framework on which all service improvement, development or change is based.
- Under the Quality of Services overall, the Trust were rated as outstanding by CQC for End of Life Care following an inspection which rated the service as 'Requires Improvement'.
- The Lessons Learnt Strategy ensures that best practice is shared across the organisation and that where common issues exist across teams; they are identified and used to drive improvements. The impact of the Lessons Learned Strategy has seen a reduction of recurring themes, which will be further reviewed and evaluated.

In terms of Patient Safety, the Board were pleased to note the following:

- The low level of harm identified during Medicines Reconciliation review has been maintained.
- There has been an increase in incidents reported resulting in no harm.
- The Trust has set up a steering group to address the increase in the number of falls across the Trust.

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The Board are pleased to note the following Improvement Priorities for 2017 – 2018:

- That under the Duty of Candour, CQC was happy that staff apologised verbally but written follow up would be an area of improvement.
- Complaints, Concerns and Compliments would be dealt with in a timely and consistent manner. Whilst the complaint investigation was often very good, the written response could be inconsistent.
- Always events approach for Quality and Safety adopted within in-patient settings with a planned move into community settings. On every shift there would be a North West Borough employee in charge, this would always happen and would be flagged if not.
- For young people with mental health problems, the Trust was looking at a model which supports young people as an alternative to being admitted to hospital.

The Board would like to thank North West Boroughs NHS Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

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Wigan Borough Clinical Commissioning Group

NHS
Wigan Borough
Clinical Commissioning Group

Wigan Borough Clinical Commissioning Group Response the 5 Boroughs Partnership NHS Foundation Trust Quality Report 2016 / 17

Wigan Borough Clinical Commissioning Group (the CCG) appreciates the opportunity to comment on the 2016 / 17 Quality Account for 5 Boroughs Partnership NHS Foundation Trust.

Notable successes for the Trust in 2016 / 17 have included:

- Achieving an overall Care Quality Commission (CQC) rating of 'Good', with 'Good' achieved by the Trust in each of the five domains of *Safe, Effective, Caring, Responsive and Well-led;*
- The opening of Atherleigh Park Hospital located in the Leigh area of the Wigan Borough on 2 March 2017. This purpose built site will support the provision of high quality inpatient services for adults suffering from mental ill health as well as patients with dementia and memory conditions. Atherleigh Park will also act as a community hub, providing space for use by other mental health and related community service providers including charities, voluntary groups and housing organisations;
- Achievement of the 2016 / 17 Quality Priorities, including improvements as to how the Trust learns lessons from patient safety events and the roll out of the 'Living Life Well' Strategy, *and the,*
- Ongoing Service User involvement in the Trusts Patient Safety Framework.

Whilst we recognise that the Trust has made considerable improvement across a number of areas during 2016 / 17 as is reflected within their CQC Quality Report; there have also been challenges in the Wigan Borough. Towards the end of the year the CCG became aware of a number of capacity issues within the Wigan Child and Adolescent Mental Health Service and continues to work closely with the Trust to ensure these issues are addressed in a timely fashion. In 2017 / 18 the CCG requires the Trust to continue to focus on improving the quality and safety of this service.

In respect of the 2017 / 18 quality priorities the CCG welcomes the:

- Plans to implement the Trusts 'Always Events' for both quality and safety
- Plans to improve how the Trust learns from Complaints, Concerns and Compliments
- Embedding of the 'Being Open' principles (Duty of Candour) into all elements of care

The CCG will continue to work with the Trust during the coming year to build on the progress made and to provide support to initiatives that will improve the quality of care and outcomes for the resident population of the Wigan Borough.

Dr Tim Dalton, Chairman, Wigan Borough Clinical Commissioning Group
11 May 2017

Wigan Life Centre • College Avenue • Wigan WN1 1NJ • www.wiganboroughccg.nhs.uk
Chairman: Dr Tim Dalton • Chief Officer: Trish Anderson

Healthy People, Healthy Place.

NHS
Halton Clinical Commissioning Group

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12th May 2017

Mr S Barber
Chief Executive
North West Boroughs Partnership NHS Foundation Trust
Hollins Park House
Hollins Lane
Winwick
Warrington
WA3 8WA

Dear Simon,

Quality Accounts 2016 - 2017

I am writing to express my thanks for the submission of North West Boroughs Partnership NHS Foundation Trust Quality Report for 2016-2017 and for the presentation given by Norah Flood, Julie Chadwick and Alan Griffiths to local stakeholders on 26th April 2017. This letter provides the response from NHS Halton Clinical Commissioning Group to the Quality Report 2016-2017.

NHS Halton CCG understands the pressures and challenges for the Trust and the local health economy in the last year and would like to congratulate and thank the Trust for the level of partnership working and support in this year.

NHS Halton CCG noted the service improvements in 2016 – 2017:

1. **Safety: Lesson Learned Strategy** in which the Trust has been working towards ensuring a culture where lessons from incidents and complaints are embedded to prevent recurrence. During 2016-2017 the Trust have:
    - Revising Trust policies and procedures.
    - Created a robust system to record and track lessons learned themes from different sources and using this to develop themed reporting, examining patterns and trends to identify areas of focus, and reviewed outcomes to determine the impact from actions taken.
    - Improved communications by developing a cascade system for discussion at team level within the organisation. The impact of the Lessons Learned Strategy has seen a reduction of recurring themes, which the Trust will continue to review and evaluate.

2. **Effectiveness: End of Life Care Strategy** in which the Trust outlined its approach to ensuring it meets the needs of patients approaching the end of life, based on best practice and innovation. Achievement of this quality priority have included:
    - Development of robust governance arrangements
    - Evaluation of the care provided by regular clinical audits.
    - Improvements to the care provided to patients, by providing high quality training to staff.
    - Implementation of the electronic patient record system.
    - NHS Halton CCG noted that the End of Life Care Services received an 'Outstanding' rating from the Care Quality Commission following an inspection in July 2016.

3. **Experience: Living Life Well Strategy** which the Trust highlighted as an important element of their programme of cultural change. It was noted that there are six teams that incorporated the principles of Living Life Well into their every-day work and how the used them as a service improvement tool. In NHS Halton CCG this related to the Improving Access to Psychological Therapies Team.

The Trust recognised all six teams in the 2016 Staff Recognition Awards where the Living Life Well support team won the award for improving patient experience.

NHS Halton CCG recognised the significant amount of work that has been undertaken following the CQC inspection in July 2015. Noting the CQC returned in July 2016 to undertake a re-inspection, which resulted in the Trust receiving a 'Good' overall; with 'Good' achieved in all five domains of Safe, Effective, Caring, Responsive and Well-led to which the Trust should be congratulated.

It was also noted that during 2016-17, the Trust has grown, following a number of competitive tendering processes and as a result the Trust has expanded in terms of service delivery. This has resulted in consideration that the name (5 Boroughs Partnership) no longer reflected the geographical footprint. After consultation with stakeholders, NHS Halton CCG noted the name change of the organisation to North West Boroughs Healthcare NHS Foundation Trust from 1 April 2017.

NHS Halton CCG noted the Trusts Improvement Priorities for 2017 – 2018:

- **Always Events** will be adopted by the in-patient wards to ensure quality and safety levels and standards are consistently achieved.
- **Complaints, Compliments and Concerns** raised by patients will be responded to in a respectful and efficient manner, which will be a key element in developing an open learning culture, and ensuring that the Trust values the patient and their families by listening to their experience
- **Duty of Candour** will be emphasised as a key topic during incident reviewer training sessions and a system will be implemented to monitor all Duty of Candour actions following a notifiable incident.

NHS Halton CCG recognises the challenges for providers in the coming year but we look forward to working with the Trust during 2017-2018 to deliver continued improvement in service quality, safety and patient experience and also on the partnership work as we move forward with our One Halton model of service delivery.

NHS Halton CCG would like to congratulate the trust on the hard work of its staff and their commitment to the care of the people of Halton thanking local staff and managers for their on-going commitment locally and for the opportunity to comment on the draft Quality Account for 2016/2017.

Yours sincerely,

Michelle Creed.

Michelle Creed
Chief Nurse

Healthwatch Warrington

Healthwatch Warrington
The Gateway
89 Sankey Street
Warrington
WA1 1SR

Tel 01925 246892
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17th May 2017

Dear Pat,

Re: Healthwatch Watch Warrington's Response to 5 Boroughs Partnership (5BP) NHS Foundation Trust Draft Quality Account Document 2016 - 2017 (May 2017)

Healthwatch Warrington is pleased to have the opportunity to respond to 5BP's 2016 - 2017 Quality Account and reflect on the examples of positive practice outlined in the document.

Alongside the opening narrative of the QA and what it aims to achieve (e.g. where quality improvements are required, what the Trust is doing well), the introduction states that it will explore "how service users, carers, staff and the wider community are engaged in working with us to improve quality of care within the Trust". From the outset, the QA sets out that staff, patients and carers are part of the Trust's quality approach and their engagement is a key element of the QA. As a consumer champion for health and social care, we recognise that this type of values-based and personal approach sets an encouraging tone for the QA (and the organisation's general approach), and is a positive method of introducing the document and Trust.

The QA goes on to define quality, stating: "The users of our services are the first priority in everything we do, ensuring that they receive effective care from caring, compassionate, and committed people, working within a common culture and protected from harm". Again, as a Healthwatch, we recognise the fundamental impact that positive, lived values and a person-centred approach like this have in shaping the quality and safety of service delivery, as well as enhancing patient experience. This is especially important in mental health services, as we often find mental health/wellbeing is one of the most frequent issues in our overall engagement work.

Throughout 2016/17 the Trust has identified three key priorities; Lessons Learned, End of Life Care and the Living Life Well Strategy.

Lessons Learned is led by experiences, reflection of which are used to develop quality within the Trust. The Trust holds bi-monthly Lessons Learned Forums, chaired by the Medical Director, to share staff ideas and initiatives that could improve safety and quality. The Trust's efforts to monitor, improve, sustain and embed this strategy shows a clear commitment to develop and enhance care by 'reviewing and analysing areas when things go wrong'. The Trust reports that this collaborative approach and staff involvement is already having a positive impact. The QA also recounts that it is working in association with Liverpool

University to train and support 18 mental health service users to mentor trainee psychologists, as well as enabling 8 service users to be mentors for Associate Nurses. This initiative to 'buddy' new recruits in mental health with services users will hopefully lead to a much higher level of awareness and genuine understanding of needs for those they will eventually be working to support, as well as engendering relationships and trust for service users.

The End of Life Care Strategy seeks to identify and meet the needs of those patients at palliative care stage; ensuring recording is standardised, working with the Gold Standards Framework, achieving Preferred Place of Care and supporting self-management of medications. The Trust states that this work seeks to embed a 'Culture of Care which delivers the '6Cs'' (Care, Commitment, Communication, Compassion, Competence and Courage), also extending this approach to values based recruitment. The Strategy could also be enhanced by linking with other providers (e.g. Hospices) to utilise their training programmes e.g. "Difficult Conversations" training, which is delivered internally and externally in Warrington by St Rocco's Hospice. Through our advocacy support work we are continually aware of the need for honest, inclusive, personal and supportive conversations during end of life care - this work looks to achieve this with service users, families and carers, which is to be commended.

The Living Life Well Strategy aims to address holistic needs in patient care, and this is 'now accepted as a cultural framework' in the Trust. The approach works to address immediate need as well as working on the goals/aims of individuals, providing personalised care, social inclusion, partnership working, inclusion of informal carers, self-management/planning and staff support. As a Healthwatch we are aware through our engagement and advocacy work that people have needs in all spheres of life e.g. physical and mental wellbeing, housing, social care, etc. The Trust's approach to identify and support these wider elements of 'everyday life' is a step in the right direction. The St Helens staff team are identified in the QA as an example of how 'Living Life Well' can work. The team developed a personal "Passport" for service users, including various aspects of personal preferences i.e. food & drink, personal care, and health choices, to ensure a person's wants and needs are identified, recorded and acted upon during their care journey. This consistency of support and personal attention to needs is something valued by patients, and again has been encountered in our engagement work. This work provides evidence of the Trust's aims to be service user led in their changes and improvements to services.

To incorporate the views of service users, carers, staff and the wider public in the QA, the Trust held an Annual Quality Account Stakeholder Event in early 2017 (which we attended) alongside representatives from local authorities, other Healthwatch, volunteers, commissioners and Trust representatives. The event offered updates on the Trust's progress in 2016-17, and enabled those attending to suggest themes for the 2017-18 Quality Priorities. In our experience, this approach is an effective way to engage with people collectively to not only draw together a piece of work but to look at developing priorities in partnership for the forthcoming year.

The Trust's three 2017/18 priorities are clearly defined as; Always Events, Complaints, Concerns and Compliments, and Duty of Candour.

Always Events will aim to standardise experiences of care by committing to a series of actions/aspects that will 'always' happen in the Trust. The Always Events were identified by the Task and Finish Group, and grouped into two categories; those that addressed safety

and those that addressed quality. The QA cites a comprehensive Action Plan to instigate this work on in-patient wards, with an aim to extend it into care in the community. This approach will hopefully lead to equitable, enhanced quality experiences of care and safer interactions with patients throughout the Trust - Healthwatch can evaluate the effect of this in the next QA, with our collected feedback.

As a Healthwatch, we are often contacted by service users and patients who wish to complain but are not sure of how to/are not confident in doing so independently, which we work to support and inform - we are often told "you can't change what happened to me but I don't want this to happen to someone else". In the forthcoming year, the Trust has prioritised their aims to be responsive, honest and transparent (through Duty of Candour) and to address complaints, compliments and concerns in a 'respectful and efficient manner'. The Trust will monitor this work by capturing data and scrutinizing follow up actions. Use of standardised letter templates will help the Trust to have a consistent response process, while identifying potential learning from positive and negative experiences will improve identification of trends or recurrent issues, to develop services. The Trust's work throughout the QA evidences this type of service-user informed method of improving quality, so it is positive to hear this strongly echoed in the plan to review and enhance complaints handling.

The QA's complaints overview highlights the top issues from 2015/16 to 2016/17, where some changes are noticed. In 2015/16 Staff Attitude comprised 18.2% of complaints, and was the most pertinent issue, while Care issues in complaints comprised 15.7%. Communication was 15.4%, Appointments were 11.3% and finally Clinical treatment comprised 10.6% of complaints. In 2016/17, though many of these issues are still prevalent, priorities have shifted. Communication has now become the top issue in complaints, with 35% of feedback. Care issues comprise 30% of complaints, Staff attitude 25%, Clinical Treatment 10% and Medication 10%. Though some shifts in ranking are positive and indicate developments, the changes in each of the three top rated issues is equal to or more than a 10% increase. The Trust could do more to address these top three issues by improving/enhancing communication both within and outside the Trust, continuing to develop and standardise quality of care, and engaging with service users to investigate and address what care issues are having a negative effect, as is addressed throughout the QA - it will be interesting to see how/if complaints data changes as a result.

Falls prevention is a key area for most trusts and the local authority - it is unfortunate that the QA reports there has been a rise in falls reported, increasing from 31.5% to 34% and it there appears to be no exploration or commentary to address the reason for this increase. Establishment of a Trust SG to look at this issue is positive and will hopefully lead to a robust action plan. Learning from good practice within other acute trusts could also help inform this work e.g. falls prevention work with infrared technology sited in bathrooms/toilets at The Walton Centre, awareness raising poster campaigns on keeping patients mobile ("Let's Keep Moving") at James Paget University Trust, at a glance 'falling leaf' magnets on patient's bed boards at Clatterbridge Cancer Centre etc.

The Trust QA refers to its adoption of the Sign Up to Safety campaign with an aim to reduce avoidable harm by 50% by 2018 - a welcome ambition. The Patient Safety Improvement Plan work streams around Prevention and Management of Violence and Aggression, self-harm, suicide, falls and physical health are also vital areas to support and sustain patients within the Trust. The QA also outlines the Trust suicide reduction strategy which is being reviewed,

and aspires to reduce service user suicide to zero by 2017-18. Details of this strategy are unfortunately not provided within the QA.

The safety measures implemented are already showing impacts, with a 27.5% reduction in restraint across all wards, using learning from working with (AQuA), and the roll out of the REsTRAIN project within Acute Mental Health Services. The QA further states that three female wards are now implementing self-injury pathways - again, details of this are not provided within the QA. The QA states high levels of compliance with IAPTS referrals, 98.9% are actioned within 6 weeks, while 99.9% of referrals are undertaken within 18 weeks. There is still, however a need for interim support while service users are waiting to access these services. As a Healthwatch we have identified this need and, as partners on Warrington's Mental Health Partnership Board, we have encouraged development/promotion of empathic listening services to not only offer early intervention but to support active listening and improved awareness of other services that can be used e.g. Warrington Wellbeing.

The QA also refers to the new facility, Atherleigh Park - a purpose built mental and physical health facility, which hosts a suite of holistic and educational programmes, groups, and sessions. Healthwatch hope to soon visit the site and reflect on the provision therein.

The staff Friend and Family Test "How likely are you to recommend our Service to friends and family if they needed similar care or treatment?" is rated at 65%, slightly higher than the national average of 61.5%. Though this indicates a positive (though slightly neutral) response, it indicates that there could be more work undertaken to encourage staff to feel involved and engaged with their work within the Trust.

The Annual CQC Patient Experience Survey reports a 26% return of random sample of users. Overall the feedback is average - views and experiences are rated as 7.7/10, while planning, organising and reviewing care is rated at over 7.5/10. Changes in people seen is rated as 6.4/10, crisis care is rated as 6.7/10 with support and wellbeing rated as 5.3/10. These ratings though not negative indicate that there could be more work undertaken to reflect more positive experiences, like those seen in the Friends and Family Test. Monthly responses as a percentage of those who said they were "Extremely likely" or "Likely" to recommend the Trust's services consistently records monthly ratings of over 94%.

5BP engage well and consistently with Healthwatch Warrington through meetings, events and activities, enabling us to share activity and ideas. In the year ahead, we look forward to supporting the Trust's engagement strategy by encouraging wider public participation in events/sub groups and strengthening the voice of patients in partnership.

We look forward to hearing from you and being involved in future developments.

Kind regards,

Lydia Thompson
Chief Executive Officer
Healthwatch Warrington

Healthwatch Warrington
Charitable Incorporated Organisation
Registered Charity Number 1172704

Annexe 2 – Statement of directors' responsibility in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance

- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2016 to 24 May 2017
    - Papers relating to quality reported to the board over the period April 2016 to 24 May 2017
    - Feedback from commissioners
    - Joint response from Knowsley and St Helens Clinical Commissioning Groups dated 22/05/2017
    - Wigan Borough Clinical Commissioning Group dated 11/05/2017
    - Halton Clinical Commissioning Group dated 12/05/2017
    - Feedback from governors dated 20/04/2017
    - Feedback from local Healthwatch organisations
    - Warrington Healthwatch dated 17/05/2017
    - Feedback from Overview and Scrutiny Committee
    - Halton Borough Council dated 12/05/2017
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18/04/2017
    - The (latest) national patient survey 15/11/2016
    - The (latest) national staff survey 7/03/2017
    - The Head of Internal Audit's annual opinion of the Trust's control environment dated 18/05/2017
    - The Care Quality Commission inspection report dated 15/11/2016

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

- The performance information reported in the Quality Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the board.

24.5.17 Date..... Chairman
Helen Bellairs

24.5.17 Date..... Chief Executive
Simon Barber

Annexe 3 – National Patient Survey results 2016

Background

Each year since 2004, all NHS trusts providing mental health services have taken part in the Care Quality Commission National Patient Survey designed to gather information about service user experiences and assess how trusts are performing.

Response rate

At the start of 2016, 850 randomly selected service users who had been in contact with our Trust were contacted. A total of 211 service users from the Trust responded, representing 26 per cent of those sampled. This figure is lower than the national average (28 per cent).

Interpreting the report

For each question in the survey, the individual responses were converted into scores on a scale of 0 to 10. A score of 10 represents the best possible response. The Care Quality Commission asks that we note that a score of 8/10 does not mean that 80 per cent of people who have used services in the Trust have had a particular experience (eg ticked 'yes' to a particular question), it means the trust has scored eight out of a maximum of 10.

A rating is also given to show how the Trust compares to other mental health service providers.

Category	Ranking	Comparison with other trusts
Health and social care workers	7.8 / 10	Average
Organising care	8.8 / 10	Average
Planning care	7.5 / 10	Average
Reviewing care	7.9 / 10	Average
Changes in who people see	6.4 / 10	Average
Crisis care	6.7 / 10	Average
Treatments	7.6 / 10	Average
Support and wellbeing	5.3 / 10	Average
Overall views and experiences	7.7 / 10	Average

Annexe 4 – Friends and Family Test

Monthly responses as a percentage who said they were ‘extremely likely’ or ‘likely’ to recommend our services.

Metrics	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Total responses	773	1,077	696	984	799	661	788	825	533	734	519	571
% recommended (extremely likely and likely)	97%	96%	93%	97%	97%	95%	94%	97%	97%	98%	97%	98%
% non-recommended (unlikely and extremely unlikely)	1%	1%	1%	2%	1%	2%	3%	1%	1%	0%	1%	1%

Annexe 5 – Patient Safety Improvement Plan

The aim of the Trust's safety improvement plan

The Trust has adopted the Sign Up to Safety campaign and aims to Reduce avoidable harm by 50 per cent by 2018.

The Trust submitted its Sign up to Safety pledges in December 2014. It will build on and bring together all of the quality and safety work in the organisation.

The following pledges were made by the Trust:

1. **Put safety first** – Will strive to achieve the Trust quality priority for safety 2014/15 and reduce harm in relation to falls, violence and aggression and self-harm. Implement a range of initiatives to improve physical health competencies across the workforce.

2. **Continually learn** – Introduce the Friends and Family Test across all of our Trust services. Following the launch of the Mental Health Safety Thermometer, the Trust will subscribe and measure commonly occurring harm in people who engage with mental health services.

3. **Honesty** – Implement the Duty of Candour. Participate in Open and Honest Care: Driving improvement in Mental Health.

4. **Collaborate** – Work closely with service users and carers in carrying out serious incident investigations and root cause analysis. Every review team will include a representative from the Trust's Involvement Scheme.

5. **Support** – The promotion of a coaching culture within the organisation, including the provision of a coaching skills programme.

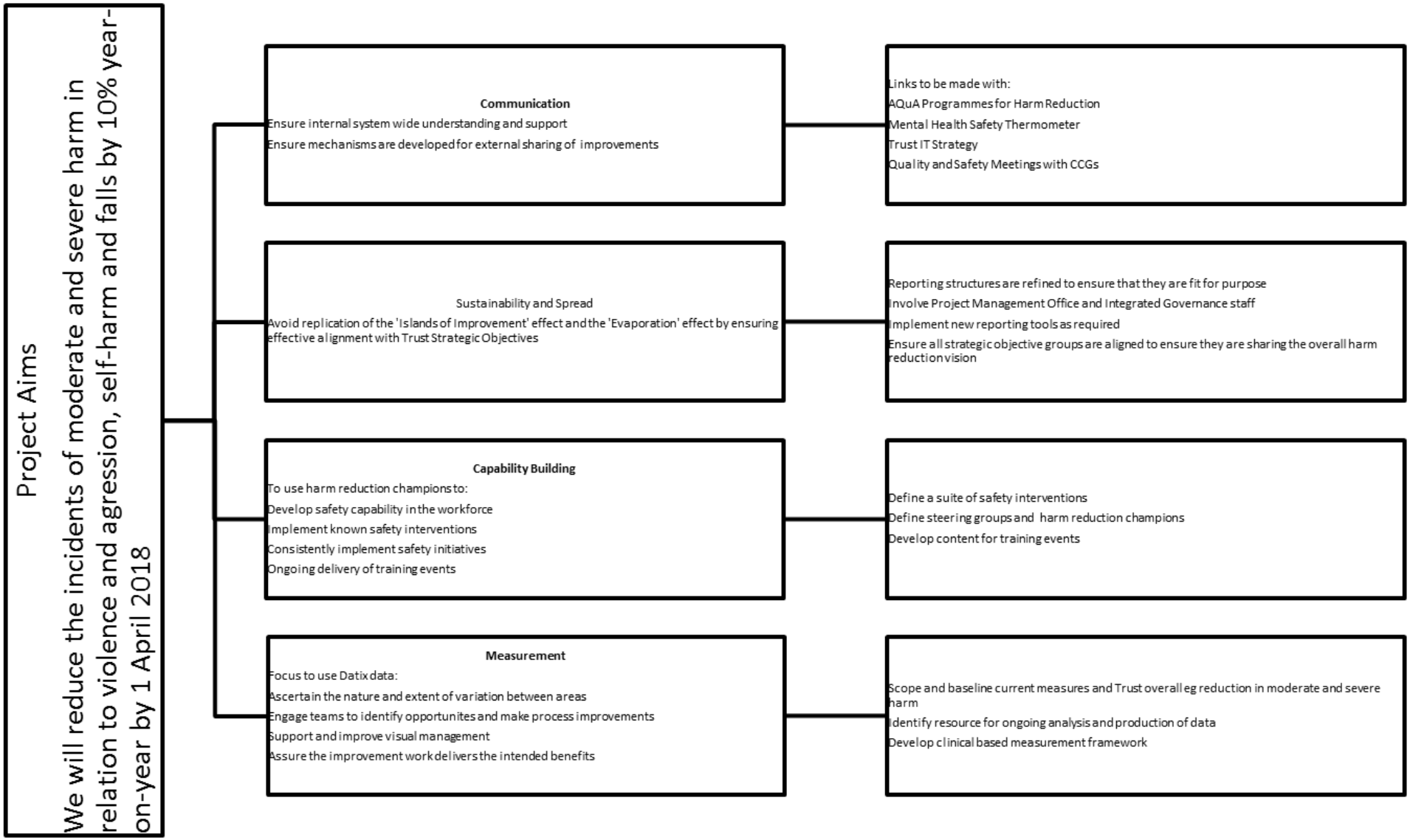
Reduction of harm in relation to falls, violence and aggression and self-harm are the Trust's quality priorities for safety. The Trust continues to concentrate on the reduction of moderate and severe harm, as it is these incidents which have the most impact on our patients. This reflects the Duty of Candour which came into effect in November 2014.

There is local ownership and accountability for the Safety Improvement Plan. The Trust has well established strategic groups with responsibility for specific work plans.

The strategic groups already established are as follows:

- Falls Steering Group
- Suicide Prevention Groups – borough-specific
- Prevention and Management of Violence and Aggression Group – the terms of reference have been reviewed for this group to enable a broader approach to least restrictive practice to be taken now incorporating self-harm
- Physical Health Committee – the Trust will be considering how to further strengthen the role of this committee and ensure its work is embedded within an Integrated physical health network

The lead for Sign Up to Safety for the Trust has transferred to the Head of Clinical Quality with leadership from the Clinical Director of Operations and Integration, and supported by the matrons for quality in addition to the leads from the strategic groups. Safety champions are also identified to support specific initiatives and training.


Project Aims
We will reduce the incidents of moderate and severe harm in relation to violence and agression, self-harm and falls by 10% year-on-year by 1 April 2018
Communication
Ensure internal system wide understanding and support
Ensure mechanisms are developed for external sharing of improvements
Links to be made with:
AQuA Programmes for Harm Reduction
Mental Health Safety Thermometer
Trust IT Strategy
Quality and Safety Meetings with CCGs
Sustainability and Spread
Avoid replication of the 'Islands of Improvement' effect and the 'Evaporation' effect by ensuring effective alignment with Trust Strategic Objectives
Reporting structures are refined to ensure that they are fit for purpose
Involve Project Management Office and Integrated Governance staff
Implement new reporting tools as required
Ensure all strategic objective groups are aligned to ensure they are sharing the overall harm reduction vision
Capability Building
To use harm reduction champions to:
Develop safety capability in the workforce
Implement known safety interventions
Consistently implement safety initiatives
Ongoing delivery of training events
Define a suite of safety interventions
Define steering groups and harm reduction champions
Develop content for training events
Measurement
Focus to use Datix data:
Ascertain the nature and extent of variation between areas
Engage teams to identify opportunites and make process improvements
Support and improve visual management
Assure the improvement work delivers the intended benefits
Scope and baseline current measures and Trust overall eg reduction in moderate and severe harm
Identify resource for ongoing analysis and production of data
Develop clinical based measurement framework

Governance
The Quality and Safety meeting reports to the Quality Committee, which is a sub-committee of the Trust Board.

Objectives
The work generated by the Trust Safety Improvement Plan will help to increase the understanding of patient safety across the organisation and will be shared with all stakeholders.

Falls
A systematic review of falls data has indicated that the Trust should focus on reducing patient falls by 20 per cent year-on-year for five years up to and including 2017/18. The work is led by the Falls Steering Group.

A refresh of the falls strategy began in October 2014 involving an external falls nurse specialist, commissioned by the Trust to work with the falls steering group. The falls policy and procedures are regularly reviewed in line with local learning and changes to broader evidence-based practice.

Prevention and management of violence and aggression
The quality priority target is to reduce harm from violence and aggression by 10 per cent year-on-year for five years up to and including 2017/18. This applies to all reported violence and aggression incidents and the information is taken from DATIX. The work is led by the Least Restrictive Practice Group and is based on the recommendations from the Department of Health document 'Positive and Proactive Care'.

The Trust is an early adopter of the research-based ReSTRAIN project which aims to reduce incidents of violence and aggression.

Suicide
The quality priority target outlines the Trust suicide reduction strategy and aspires to reduce service user suicide to zero by 2017/18.

The Trust has membership on the Greater Manchester Suicide Prevention Executive Group and the Cheshire and Merseyside Suicide Prevention Network Board and local groups in boroughs. The Trust's Suicide Prevention Strategy will be refreshed in year 2017/18 in relation to the national and local context of the services we provide and the communities we serve.

Self-harm
The aim is to reduce the incidence of harm in inpatient mental health services by 10 per cent by March 2016. Targeted training has been delivered to two of the three inpatient wards with the highest incidence of self-harm. As part of the training, the use and consideration of advanced directives in care planning was included.

A self-injury pathway is in development led by the clinical team on Cavendish Unit, which is a female acute admission ward. It is anticipated that, if positively evaluated, it will be introduced across all other female acute wards in the Trust.

Physical Health Committee
This group was developed to bring together a number of smaller groups to improve the physical health of everyone who accesses the Trust's services. It brings together mental

health, learning disability and community (physical) health services to provide a whole person approach to healthcare.

The Trust uses Modified Early Warning Signs (MEWS) in all inpatient areas to improve detection of the physically deteriorating patient.

The Trust has developed physical health competencies for nursing and medical staff and this is linked to the personal development review process.

Harm reduction champions

The Trust is working with Advancing Quality Alliance AQuA which delivers safety improvement training to matrons and quality leads.

Every ward has a falls champion and the Trust has a well-established falls prevention steering group and regular falls champions' forum.

Measurement and monitoring of the safety improvement plan

Each work stream has clear goals and actions.

Reports are produced retrospectively in such a way that trends are easily identified and both local and Trust learning can be identified and shared.

Ongoing support and resources are provided using the Advancing Quality Alliance six-step model for improvement and the Trust guide to service improvement, along with face-to-face training on safety and quality improvement. All are easily accessible for teams and individuals.

Annexe 6 – Care Quality Commission ratings table

Annexe 7 – Complaints Report 2016/17

Compliant with Regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

During the period 1 April 2016 to 31 March 2017:

- We received **180** complaints
- We closed **186** complaints; some were carried forward from the previous year

Of the **186** closed complaints:

- 149 (80%) complaints were acknowledged in three days or under following receipt.
- 37 (20%) complaints were acknowledged over three days following receipt.
- 78 (42%) had none of the issues complained about upheld.
- 96 (52%) were well-founded (some or all of the issues complained about upheld).
- 12 (6%) were withdrawn or not progressed by the complainant.

During the reporting period, we were informed of four complaints which were referred to the Parliamentary and Health Service Ombudsman. The Ombudsman also concluded investigated for a further four complaints that were carried forward from the previous year.

In total, three complaints were upheld during this period, a further four complaints were either not upheld or no further action was considered necessary by the Ombudsman. One complaint remains open and under investigation.

Breakdown of themes of complaints (top five):

Previous year (2015/16):		**2016/17:**	
Staff attitude	18.2%	Communication	35%
Care issues	15.7%	Care issues	30%
Communication	15.4 %	Staff attitude	25%
Appointments	11.3%	Clinical treatment	10%
Clinical treatment	10.6%	Medication	10%

Please note, complaints can have more than one theme, consequently the breakdown of themes can equate to more than 100 per cent.

- We received **2,078** compliments
- We received **43** Members' of Parliament enquiries
- We received **479** concerns

Annexe 8 – NHS Improvement's external assurance statement

Independent Auditors' Limited Assurance Report to the Council of Governors of 5 Boroughs Partnership NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of 5 Boroughs Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of 5 Boroughs Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	*Specified indicators criteria*
Patients on Care Programme Approach (CPA) receiving contact within 7 days of discharge (page 38 of the 2016/17 Quality Report)	*Annexe 9 to the 2016/17 Quality Accounts*
Admissions to inpatient services had access to crisis resolution/home treatment teams (page 39 of the 2016/17 Quality Report)	*Annexe 9 to the 2016/17 Quality accounts*

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2016/17" issued by Monitor (operating as NHS Improvement) ("NHSI").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17"; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- board minutes for the financial year, April 2016 and up to 24 May 2017;
- papers relating to quality report reported to the Board over the period April 2016 to 24 May 2017;
- feedback from the Commissioners - joint response from Knowsley and St Helens Clinical Commissioning Groups dated 22/05/2017, Wigan Clinical Commissioning Group dated 11/05/2017 and Halton Clinical Commissioning Group dated 12/05/2017;

- feedback from Governors dated 20/04/2017;
- feedback from Local Healthwatch organisations - Warrington Healthwatch dated 17/05/2017;
- feedback from Overview and Scrutiny Committee – Halton Borough Council dated 12/05/2017;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18/04/2017;
- the (latest) national and local patient survey dated 15/11/2016;
- the (latest) national and local staff survey dated 07/03/2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 18/05/2017; and
- CQC inspection report dated 15/11/2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.
We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of 5 Boroughs Partnership NHS Foundation Trust as a body, to assist the Council of Governors in reporting 5 Boroughs Partnership NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and 5 Boroughs Partnership NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;

- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2016/17"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by 5 Boroughs Partnership NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2017:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Manchester
26 May 2017

The maintenance and integrity of the 5 Boroughs Partnership NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Annexe 9 – Criteria for mandated indicators tested

1) 100 per cent enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital

Detailed descriptor
The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

Numerator
The number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care during the reporting period.

Denominator
The total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged from psychiatric inpatient wards are regarded as being on CPA during the reporting period.

Details of the indicator
All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. The seven-day period should be measured in days not hours and should start on the day after the discharge.

Exemptions include
- Patients who are readmitted within seven days of discharge
- Patients who die within seven days of discharge
- Patients where legal precedence has forced the removal of the patient from the country
- Patients transferred to an NHS psychiatric inpatient ward
- All child and adolescent mental health services patients are also excluded

Accountability
Achieving at least a 95 per cent rate of patients followed up after discharge each quarter. More detail about this indicator and the data can be found within the mental health community teams' activity section of the NHS England website.

Additional note: Risk Assessment Framework
The former Monitor *Risk Assessment Framework* used a simplified definition which referred to the indicator excluding patients transferred to another psychiatric unit without specifying 'NHS' unit as the definition above does. For foundation trusts affected by this distinction, we are content with the trust disclosing on either basis in the quality report, provided that:
- the basis is consistent between years and quality reports
- if specifying 'NHS' unit transfers as an exemption makes a difference to the reported indicator, the trust should disclose which basis is being applied

2) Admissions to inpatient services had access to crisis resolution home treatment teams

Detailed descriptor
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period.

Data definition
To prevent hospital admission and give support to informal carers, CRHT is required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of service users.

Numerator
The number of admissions to the Trust's acute wards that were gate-kept by the CRHT during the reporting period.

Denominator
The total number of admissions to the Trust's acute wards.

Details of the indicator
An admission has been gate kept by a CRHT if it has assessed the service user before admission and was involved in the decision-making process which resulted in an admission. An assessment should be recorded if there is direct contact between a member of the CRHT team and the referred patient, irrespective of the setting, and an assessment is made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient.

Exemptions include
- Patients recalled on community treatment order; patients transferred from another NHS hospital for psychiatric treatment; internal transfers of service users between wards in the trust for psychiatry treatment; patients on leave under Section 17 of the Mental Health Act; and planned admissions for psychiatric care from specialist units such as eating disorder units.
- Partial exemption is available for admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local area. The CRHT should assure itself that gatekeeping was carried out. This can be recorded as gate-kept by crisis resolution teams.
- This indicator applies to patients in the age bracket 16-65 years and only applies to child and adolescent services patients where they have been admitted to an adult ward.

Accountability
Achieving at least 95 per cent of patients in the quarter.

Detailed guidance
More detail about this indicator and the data can be found in the mental health community teams' activity section of the NHS England website.

Independent auditors' report to the Council of Governors of 5 Boroughs Partnership NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion, 5 Boroughs Partnership NHS Foundation Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of its income and expenditure and cash flows for the year then ended 31 March 2017; and
- have been properly prepared in accordance with the Department of Health Group Accounting Manual 2016/17.

What we have audited

The financial statements comprise:

- the Statement of Financial Position as at 31 March 2017;
- the Statement of Comprehensive Income for the year then ended;
- the Statement of Cash Flows for the year then ended;
- the Statement of Changes in Equity for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

Certain required disclosures have been presented elsewhere in the Annual Report and Accounts (the "Annual Report"), rather than in the notes to the financial statements. These are cross-referenced from the financial statements and are identified as audited.

The financial reporting framework that has been applied in the preparation of the financial statements is the Department of Health Group Accounting Manual 2016/17.

Our audit approach

Context

Our 2016/17 audit was planned and executed having regard to the fact that the Trust's operations were largely unchanged in nature from the previous year. As a result of the financial pressure that the Trust is facing, we have identified financial performance and economic uncertainty as an area of focus. RIO implementation costs have not been considered an area of focus for 2016/17 on the basis that the total expenditure in 2016/17 is not material and no issues were identified in previous years.

Overview

- Overall materiality: £3,107,000 which represents 2% of total revenue.
- We performed our audit of the financial information for the Trust at Hollins Park House, which is where the finance function is based.
- In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.
- Management override of controls and fraud in revenue and expenditure recognition;
- Financial performance and economic uncertainty; and
- Valuation of Property, Plant and Equipment.

The scope of our audit and our areas of focus

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") and, International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)").

We designed our audit by determining materiality and assessing the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain. As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as "areas of focus" in the table below. We have also set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

Area of focus	*How our audit addressed the area of focus*
Management override of controls and fraud in revenue and expenditure recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income.* We focused on this area because there is a heightened risk due to the Trust being under increasing financial pressure. Whilst the Trust is looking at ways to maximise revenue and reduce costs, there is significant pressure to report results in line with its annual plan and to demonstrate its ability to reduce its cost base via Cost Improvement Plans (CIPs). As all Trusts are under pressure to achieve their control totals there is a risk that the Trust could adopt accounting policies, make accounting judgements or estimates or treat income and expenditure transactions in such a way as to lead to material misstatement in the reported surplus or deficit position. Given these incentives, we considered the risk of management manipulation in each of the key areas of focus, which are: • Recognition of revenue and expenditure; • The inherent complexities in a number of contractual arrangements entered into by the Trust, for example intra-NHS transactions; • Manipulation through journal postings; and • Management estimates.	*Revenue* We evaluated and tested the accounting policy for income recognition and found it to be consistent with the requirements of the Group Accounting Manual 2016/17. For income/receivable transactions, we tested on a sample basis that the transactions and the associated income had been posted to the correct financial year by tracing them to invoices or other documentary evidence. Our testing did not identify any items incorrectly recorded. We tested a sample of contracts across Clinical Commissioning Groups ("CCG") and NHS England and management's reconciliations of the contract value to the income received in year. We agreed the income recognised in the year to the contract terms and any correspondence between the Trust and the CCG regarding over/under performance. We agreed income back to invoices and cash receipts. Our testing did not identify any material errors. We tested a sample of income to invoices and subsequent cash received (for NHS and non-NHS income) to check whether it had been correctly recorded, and this did not identify any items requiring amendment in the financial statements. *Expenditure* For invoices received/ balances paid for a period after the year-end we tested on a sample basis that the transactions and the associated expense had been posted to the correct financial year by tracing them to other documentary evidence or invoices. Our testing did not identify any items incorrectly recorded. We tested a sample of operating expenses through to invoice to ensure that this had been correctly accounted for. No differences were identified that required amendment within the financial statements. *Intra- NHS balances* We obtained the Trust's mismatch reports received from NHS Improvement ("NHSI"), which identified balances (debtor, creditor, income or expenditure balances) that were different with the counterparty. We checked that management had investigated disputed amounts above £250,000 (based on the National Audit Office's reporting criteria), then discussed with them the results of their investigation and the resolution, which we agreed to correspondence with the counterparty. We then considered the impact, if any, these disputes would have on the value of

Area of focus	*How our audit addressed the area of focus*
	income and expenditure recognised in 2016/17 and determined that there was no material impact. *Manipulation through journal postings* We selected a sample of manual and automated journal transactions that had been recognised in income, focusing in particular on those with unusual characteristics and those recognised near the end of the year. We considered the journals process and obtained an understanding of the user profiles, ensuring that a proper authorisation control was in place. We traced these journal entries to supporting documentation to check that the transaction was valid and had been correctly accounted for within the financial statements. Our testing identified no issues that required further reporting. *Management estimates* We evaluated and tested management's accounting estimates, focussing on: • accruals; • provisions; • deferred income; and • Property, Plant and Equipment Valuation (see specific area of focus below). We evaluated and challenged the key accounting estimates on which management's estimates were based and the basis of their calculation on a sample basis by comparing the assumptions used by management in the calculation of their estimate with independent assumptions and investigating any differences. Our testing identified no matters that required amendment within the financial statements of the Trust.
Financial performance and economic uncertainty *The Trust's future business plans and the Trust's finances for the year ended 31 March 2017 are discussed in detail in the Performance Report within the Annual Report.* The Trust achieved a deficit of £14.6m in the year ended 31 March 2017. This includes impairment of £14.5m and £1.6m of Sustainability and Transformation Funding ("STF"). The Trust's annual plan for 2017/18, which has been approved by the Board of Directors, identifies one key factor of risk around financial sustainability which is an increased CIP targets for 2017/18. We examined the Trust's cash flow forecast for 2017/18 and the subsequent period to May 2018 (inclusive). We noted throughout the period the Trust expects to maintain positive cash balances.	In considering the financial performance of the Trust we: • Understood the Trust's annual plan for 2017/18 and the cash flow forecasts. We understood the assumptions which the plan is most sensitive to, for example, delivery against CIP targets; • Challenged the assumptions within the plan, for example agreeing a sample of CIP schemes to supporting documentation and where possible, evidence of delivery to date; • Tested management's forecasting accuracy by comparing the current year actual results to those included in the prior year annual plan; and • Performed sensitivity analysis over the assumptions within the Trust's annual plan. The plan shows that whilst the Trust has increased CIP targets for 2017/18, the Trust has plans in place to achieve this. Our testing did not identify any material uncertainties in relation to the Trust's ability to continue as a going concern.
Valuation of property, plant and equipment *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements*	We obtained an impairment assessment undertaken by the Trust, evaluated the assumptions therein and tested where appropriate to source documentation. In particular, we:

Area of focus	*How our audit addressed the area of focus*
and estimates relating to property, plant and equipment and note 12 for further information. We focussed on this area because Property, plant and equipment ("PPE") represents the largest balance in the Trust's statement of financial position. PPE is valued at £82.3m as at 31 March 2017. Land and buildings are measured at fair value based on periodic valuations. The valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and are required to be performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date. A desktop valuation of the Trust's portfolio of land and buildings was undertaken by the Trust's valuation experts and this has resulted in an upward revaluation of £16.6m of the Land and Buildings balance. The last full valuation of the Trust's portfolio of land and buildings was performed in 2013/14.	• Tested a sample of the material assets by verifying that the input data used by the valuer as the basis of the valuation was consistent with the underlying estates and property asset information held at the Trust; • Assessed the assumptions and the estimates used in the valuation and considered the reasonableness of these using our valuation expertise and consideration of wider industry trend; • Checked that the accounting treatment of the valuation information has been correctly input into the Trust's financial statements; • Inspected the repairs and maintenance expenses codes to confirm that there had been no significant alterations to the existing value and use of assets; and • Physically inspected a sample of assets to confirm they were in use. Our testing did not identify any material issues.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the trust, the accounting processes and controls, and the environment in which the trust operates.

In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£3,107,000 (2016: £2,923,000).
How we determined it	2% of revenue (2016: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £155,000 (2016: £145,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Other reporting

Opinions on other matters prescribed by the Code of Audit Practice

In our opinion:

- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the parts of the Remuneration and Staff Reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017. We have nothing to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- information in the Annual Report is:
    - materially inconsistent with the information in the audited financial statements; or
    - apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
    - otherwise misleading.
- the statement given by the directors in the Annual Governance Statement within the Annual Report, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable and provides the information necessary for members to assess the Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual Report in the Annual Governance Statement, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.

We have no matters to report in relation to these responsibilities.

Respective responsibilities of the Directors and the Auditor

As explained more fully in the Accountability Report the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the Department of Health Group Accounting Manual 2016/17.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Code of Audit Practice, and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

This report, including the opinions, has been prepared for and only for the Council of Governors of Liverpool Women's NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

What an audit of financial statements involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice

Rebecca Gissing (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Manchester
26 May 2017

(a) The maintenance and integrity of the 5 Boroughs Partnership NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Annual Accounts

Foreword to the accounts

These accounts for the year ended 31 March 2017 have been prepared by the Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2017

Statement of Comprehensive Income
1 April 2016 – 31 March 2017

	Note	2016/17 £000	2015/16 £000
Operating income from patient care activities	3.1 - 3.2	**147,357**	146,152
Other operating income	3.4	**8,004**	5,899
Total operating income from continuing operations		**155,361**	152,051
Operating expenses	4	**(167,759)**	(150,618)
Operating (deficit) / surplus from continuing operations		**(12,398)**	1,433
Finance income	7	**20**	35
Finance expenses	8	**(683)**	(350)
PDC dividends payable		**(1,547)**	(1,788)
Net finance costs		**(2,210)**	(2,103)
Gains on disposal of non-current assets	9	**5**	-
Deficit for the year from continuing operations		**(14,603)**	(670)
Deficit for the year		**(14,603)**	(670)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	5	**(2,080)**	(4,161)
Other reserve movements		**-**	1
Total comprehensive expense for the period		**(16,683)**	(4,830)

Memorandum information			
Deficit for the year		**(14,603)**	(670)
Net impairments of property, plant and equipment *	5	**14,548**	1,805
Gain on disposal of non-current assets	9	**(5)**	-
(Deficit) / surplus for the year before impairments and gains on disposal of assets		**(60)**	1,135
Other exceptional items: **			
Exceptional income items	3.4	**(250)**	(525)
Exceptional expenditure items	4	**2,969**	3,656
Surplus for the year before impairments and other exceptional items		**2,659**	4,266

The Statement of Comprehensive Income records the Trust's income and expenditure in summary form in the top part of the statement and any other recognised gains and losses taken through reserves under other comprehensive income. It includes cash related items such as income from commissioners of our services and expenditure on staff and supplies. It also includes non-cash items such as depreciation and other changes in value of our land and buildings.

* Impairments are a non-cash expense, which represent a reduction in value of the Trust's assets beyond any relevant balances held in revaluation reserves. The majority of the £14.5m impairment relates to the writing down of the old buildings vacated at Leigh Infirmary and the impact of the full professional valuation of the new buildings occupied at Atherleigh Park.

** Exceptional items are one-off items of income and expenditure and therefore distort underlying performance. The exceptional items include implementation of the Trust's information strategy, re-structuring costs and implementation of the Trust's new clinical information system (RiO).

Statement of Financial Position
31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets:			
Intangible assets	11	**481**	100
property, plant and equipment	12	**82,253**	86,710
Total non-current assets		**82,734**	86,810
Current assets			
Inventories	13	**80**	85
Trade and other receivables	14	**4,281**	4,154
Non-current assets for sale and assets in disposal groups	15	**275**	1,625
Cash and cash equivalents	16	**4,883**	11,580
Total current assets		**9,519**	17,444
Current liabilities			
Trade and other payables	18	**(10,374)**	(12,138)
Other liabilities	19	**(202)**	(114)
Borrowings	20	**(1,621)**	(969)
Provisions	21	**(246)**	(436)
Total current liabilities		**(12,443)**	(13,657)
Total assets less current liabilities		**79,810**	90,597
Non-current liabilities			
Trade and other payables	18	**(7)**	(15)
Borrowings	20	**(31,010)**	(24,958)
Provisions	21	**(1,991)**	(2,139)
Total non-current liabilities		**(33,008)**	(27,112)
Total assets employed		**46,802**	63,485
Financed by			
Public dividend capital		**45,579**	45,579
Revaluation reserve		**11,755**	13,835
Other reserves		**10**	10
Merger reserve		**130**	130
Income and expenditure reserve		**(10,672)**	3,931
Total taxpayers' equity		**46,802**	63,485

The financial statements on pages 2 to 32 were approved by the Audit Committee (under delegated authority from the Trust Board) on 18 May 2017 and signed on its behalf by:

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2017

Statement of Changes in Equity
1 April 2016 – 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 – brought forward	**45,579**	**13,835**	**10**	**130**	**3,931**	**63,485**
Deficit for the year	-	-	-	-	**(14,603)**	**(14,603)**
Impairments	-	**(2,080)**	-	-	-	**(2,080)**
Other reserve movements	-	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2017	**45,579**	**11,755**	**10**	**130**	**(10,672)**	**46,802**

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital	Revaluation reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 – brought forward	45,579	17,995	10	130	4,601	68,315
Prior period adjustment	-	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2015 – restated	45,579	17,995	10	130	4,601	68,315
Deficit for the year	-	-	-	-	(670)	(670)
Impairments	-	(4,161)	-	-	-	(4,161)
Other reserve movements	-	1	-	-	-	1
Taxpayers' and others' equity at 31 March 2016	45,579	13,835	10	130	3,931	63,485

The Statement of Changes in Equity essentially shows the changes in reserves and public dividend capital from one year to the next.

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust.

Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

The Revaluation Reserve reflects the increases in asset values arising from revaluations, except where, and to the extent that, they reverse impairments previously recognised in operating expenses. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

The balance on the Income and Expenditure Reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows
1 April 2015 – 31 March 2016

	Note	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating (deficit) / surplus		**(12,398)**	1,433
Non-cash income and expense:			
Depreciation and amortisation	4	**1,232**	1,536
Net impairments	5	**14,548**	1,805
Increase in receivables and other assets		**(260)**	(1,210)
Decrease in inventories		**5**	-
Decrease in payables and other liabilities		**(776)**	(3,080)
Decrease in provisions		**(338)**	(423)
Other movements in operating cash flows		**-**	-
Net cash generated from/(used in) operating activities		**2,013**	61
Cash flows from investing activities:			
Interest received		**22**	37
Purchase of intangible assets		**(425)**	-
Purchase of property, plant and equipment		**(14,390)**	(20,150)
Sales of property, plant and equipment		**1,399**	-
Net cash used in investing activities		**(13,394)**	(20,113)
Cash flows from financing activities:			
Movement on loans from the Department of Health		**6,705**	16,427
Other interest paid		**(605)**	(292)
PDC dividend paid		**(1,416)**	(2,016)
Net cash generated from financing activities		**4,684**	14,119
Decrease in cash and cash equivalents		**(6,697)**	(5,932)
Cash and cash equivalents at 1 April		**11,580**	17,512
Cash and cash equivalents at 31 March	16	**4,883**	11,580

The Statement of Cash Flows summarises the cash flows in and out of the Trust during the accounting year. It analyses these cash flows under the headings of operating, investing and financing cash flows. The Statement of Cash Flows differs from the Statement of Comprehensive Income by focusing on the cash implications of the actions taken by the Trust during the year. The statement is useful in assessing whether the Trust has enough cash to be able to pay its bills as they fall due.

Notes to the accounts

1. Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State.

Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of land and buildings.

Going concern

These accounts have been prepared on a going concern basis. This has been assessed on the basis of the financial plans submitted to NHS Improvement and reviewed by them for the two-year period 2017/18 to 2018/19 and also contracts agreed with commissioners for this period.

1.1. 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 Trust will accrue for income not received to recognise the income in year, in 2016/17 the Trust had £714,000 accrued income which predominately relates to Sustainability and Transformation Fund income. The main source of income for the Trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

1.2. Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the 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.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

1.3. Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.4. Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar 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, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs 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 valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust revalued its asset base under the new modern equivalent assets methodology in July 2009. The Trust commissioned DTZ (professional valuer) to undertake a full valuation of all land and buildings as at 1 April 2013. The impact of this exercise was reflected in the accounts for 2013/14. Cushman & Wakefield (formerly DTZ) performed an interim valuation in March 2017. This exercise was used to update the Trust's buildings valuation to ensure that buildings were held at fair value as at 31 March 2017. The valuer confirmed that there has been no material movement in land valuations from their valuation as at 1 April 2013. The Trust's newly constructed building in Leigh, Atherleigh Park, became fully operational in March 2017. Cushman & Wakefield conducted a full valuation of this site as at 31 March 2017.

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

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 the Statement of Comprehensive 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
In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of 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 that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in the Statement of Comprehensive 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.

De-recognition
Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable ie: management are committed to a plan to sell the asset; an active programme has begun to find a buyer and complete the sale; the asset is being actively marketed at a reasonable price; the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’ and; the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in the table below:

	Minimum life Years	**Maximum life Years**
Buildings, excluding dwellings	1	90
Plant and machinery	5	10
Information technology	3	15
Furniture and fittings	5	10

1.5. Intangible assets

Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for use
- the trust intends to complete the asset and use it
- the trust has the ability to use the asset
- how the intangible asset will generate probable future economic or service delivery benefits
- adequate financial, technical and other resources are available to the Trust to complete the development and use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.6. Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In First Out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.7. Financial instruments and 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 'loans and receivables'.

Financial liabilities are classified as 'other financial liabilities'.

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

The Trust's loans and receivables comprise cash and cash equivalents, 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.

Other financial liabilities
All 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 long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

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.

1.8. Leases

Operating leases
Leases other than finance leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.9. Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

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. 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.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority 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 when the liability arises.

1.10. Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 22, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control.
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.11. Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.12. Value added and corporation 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.

5 Boroughs Partnership NHS Foundation Trust is a Health Service body within the meaning of s519A ICTA 1988 and accordingly is temporarily exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA), accordingly, the Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare and where the profits exceed £50,000 per annum. However, there is no tax liability in respect of the current financial year.

1.13. Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

1.14. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.15. 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 the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.16. Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

1.17. Standards, amendments and interpretations in issue but not yet effective or adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury Frem adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 - Financial Instruments
- IFRS 15 - Revenue from Contracts with Customers
- IFRS 16 – Leases
- IFRIC 22 - Foreign Currency Transactions and Advance Consideration

1.18. Critical accounting estimates and judgments

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. Where such judgements / estimations have been made, these have been referenced in the relevant notes to the accounts.

1.19. Comparative figures for 2015/16

The detail in which figures are analysed in some of the notes within the Foundation Trust Consolidation (FTC) forms has changed from the previous year. These changes have also been reflected in the notes to these accounts to ensure consistency. Prior year comparative figures have been re-analysed where appropriate to aid direct comparison.

1.20. Charitable funds

Charitable Funds have not been consolidated within the 2016/17 accounts on the grounds of materiality in accordance with the Foundation Trust Annual Reporting Manual.

1.21. Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

2. Operating segments

IFRS 8 requires disclosure of the results of significant operating segments.

The Trust has concluded that a single segment of healthcare should be reported in the financial statements on the basis that clinical services operate under the same regulatory framework and within the core business of healthcare within the same economic

environment.

Clinical services are reported to the Trust Board as one segment and the divisions are considered to meet the aggregation tests under the standard.

The Trust's revenues derive mainly from healthcare services provided to patients under contracts with commissioners within England.

The main commissioners of services from the Trust, accounting for 90% of healthcare revenues, are Knowsley Clinical Commissioning Group (26%), St Helens Clinical Commissioning Group (17%), Wigan Clinical Commissioning Group (17%), Warrington Clinical Commissioning Group (12%), Halton Clinical Commissioning Group (11%) and NHS England (7%).

3. Operating income

3.1. Operating income from patient care activities (by nature)

	2016/17	2015/16
	£000	£000
Other NHS clinical income	**2,593**	2,191
Cost and volume contract income	**727**	550
Block contract income	**106,401**	105,425
Other clinical income from mandatory services	**920**	1,064
Community services income from CCGs and NHS England	**27,014**	30,824
Community services income from other commissioners	**9,462**	5,851
Other clinical income	**240**	247
Total income from activities	**147,357**	146,152

3.2. Operating income from patient care activities (by source)

Income from patient care activities received from:	**2016/17**	2015/16
	£000	£000
CCGs and NHS England	**133,935**	136,843
Local authorities	**9,991**	6,387
Other NHS foundation trusts	**1,588**	1,418
NHS trusts	**1,151**	884
NHS other	**-**	89
NHS injury scheme (was RTA)	**144**	143
Non NHS: other	**548**	388
Total income from activities	**147,357**	146,152
Of which:		
Related to continuing operations	**147,357**	146,152
Related to discontinued operations	**-**	-

3.3. Private patient income

The Trust received no private patient income during the reporting year (2015/16 £nil).

3.4. Other operating income

	2016/17 £000	2015/16 £000
Research and development	**108**	157
Education and training	**3,023**	3,064
Non-patient care services to other bodies	**859**	185
Sustainability and Transformation Fund income	**1,616**	-
Income in respect of staff costs where accounted on gross basis	**191**	522
Other income*	**2,207**	1,971
Total other operating income	**8,004**	5,899
Of which:		
Related to continuing operations	**8,004**	5,899
Related to discontinued operations	**-**	-
Total operating income	**155,361**	152,051

Memorandum information:		
Total operating income after exceptional items	**155,361**	152,051
Exceptional income to support informatics transformational programmes	**(250)**	(525)
Total operating income before exceptional items	**155,111**	151,526

3.5. Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below.

	2016/17 £000	2015/16 £000
Income from services designated as commissioner requested services	**147,116**	145,885
Income from services not designated as commissioner requested services	**241**	267
Total	**147,357**	146,152

4. Operating expenses

	2016/17 £000	2015/16 £000
Services from NHS foundation trusts	**257**	780
Services from NHS trusts	**36**	66
Purchase of healthcare from non NHS bodies	**959**	558
Employee expenses – executive directors	**978**	1,171
		213

Remuneration of non-executive directors	**122**	126
Employee expenses – staff	**123,548**	117,847
Supplies and services – clinical (excluding drug costs)	**3,649**	3,612
Supplies and services – general	**3,023**	2,919
Establishment	**1,663**	2,118
Transport	**2,025**	2,165
Premises	**8,660**	7,223
(Decrease) / increase in provision for impairment of receivables	**(32)**	107
(Decrease) / increase in other provisions	**(62)**	48
Drug costs	**1,606**	1,634
Rentals under operating leases	**2,525**	2,881
Depreciation on property, plant and equipment	**1,188**	1,488
Amortisation on intangible assets	**44**	48
Net impairments	**14,548**	1,805
Audit fees payable to the external auditors: *		
- audit services – statutory audit	**68**	52
- other auditors' remuneration	**-**	36
Clinical negligence	**510**	459
Legal fees	**172**	164
Consultancy costs	**259**	66
Internal audit and local counter fraud costs	**118**	101
Training, courses and conferences	**654**	896
Patient travel	**11**	7
Car parking and security	**40**	40
Redundancy	**170**	1,026
Hospitality	**3**	6
Insurance	**131**	140
Other services	**461**	428
Losses, ex-gratia and special payments	**121**	9
Other	**304**	592
Total	**167,759**	150,618
Of which:		
Related to continuing operations	**167,759**	150,618
Related to discontinued operations	**-**	-

Memorandum information:		
Total operating expenses after exceptional items	**167,759**	150,618
Net impairments	**(14,548)**	(1,805)
Informatics strategy	**(405)**	(1,140)
Re-structuring costs	**(222)**	(1,119)
Clinical information system implementation costs (RiO)	**(2,342)**	(1,397)
Total operating expenses before exceptional items	**150,242**	145,157

* Auditors' liability limitation agreement.

Auditors' liability is limited with regard to the following:

Limitation period – Any claim must be brought no later than two years after the claimant should have been aware of the potential claim and, in any event, no later than four years

after any alleged breach.

Liability – Total liability (including interest) for all claims connected with the services (including but not limited to negligence) is limited to three times the fees payable for the services or £1 million, whichever is the greater.

5. Impairments

	2016/17 £000	2015/16 £000
Net impairments charged to operating (deficit) / surplus resulting from:		
Unforeseen obsolescence	**3,119**	-
Changes in market price	**-**	1,805
Other	**11,429**	-
Total net impairments charged to operating (deficit) / surplus	**14,548**	1,805
Impairments charged to the revaluation reserve	**2,080**	4,161
Total net impairments	**16,628**	5,966

Impairments include the following:

£3.3 million relating to the writing-down of the value of the old buildings vacated at Leigh Infirmary as part of the move to a brand new purpose built facility at Atherleigh Park.

£8.6 million which represents the impact of the full professional valuation of the newly constructed buildings at Atherleigh Park which became fully operational in March 2017. Such an impairment is commonplace for new builds.

6. Operating leases

6.1. As a lessee

	2016/17 £000	2015/16 £000
Operating lease expense		
Minimum lease payments	**2,525**	2,881
Total	**2,525**	2,881

	2016/17 £000	2015/16 £000
Future minimum lease payments due:		
- not later than one year	**2,003**	2,301
- later than one year and not later than five years	**7,484**	8,627
- later than five years	**22,192**	24,103
Total	**31,679**	35,031

7. Financial income

	2016/17 £000	2015/16 £000
Interest on bank accounts	**20**	35
Total	**20**	35

8. Finance expenses

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17 £000	2015/16 £000
Interest expense:		
Loans from the Department of Health	**683**	350
Total interest expense	**683**	350
Other finance costs	-	-
Total	**683**	350

9. Gains on disposal of non-current assets

	2016/17 £000	2015/16 £000
Gain on disposal of non-current assets	**5**	-
Net gain on disposal of non-current assets	**5**	-

10. Employee benefits and numbers

10.1. Employee benefits

	2016/17 Total £000	2015/16 Total £000
Salaries and wages	**97,754**	93,495
Social security costs	**8,693**	6,395
Employer's contributions to NHS pensions	**11,394**	11,093
Termination benefits	**170**	1,034
Temporary staff (including agency)	**6,776**	8,178
Total gross staff costs	**124,787**	120,195
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**124,787**	120,195
Of which:		
Costs capitalised as part of assets	**91**	143
Analysed into operating expenditure:		
Employee expenses - staff	**123,548**	117,847
Employee expenses - executive directors	**978**	1,171
Redundancy	**170**	1,026
Special payments	**-**	8
Total employee benefits excluding capitalised costs	**124,696**	120,052

10.2. Average number of employees (WTE basis)

	2016/17 Total number	2015/16 Total number
Medical and dental	**143**	145
Administration and estates	**718**	662
Healthcare assistants and other support staff	**225**	253
Nursing, midwifery and health visiting staff	**1,382**	1,334
Nursing, midwifery and health visiting learners	**12**	6
Scientific, therapeutic and technical staff	**540**	500
Agency and contract staff	**122**	142
Bank staff	**120**	110
Other	**6**	6
	3,268	3,158
Of which:		
Number engaged on capital projects	**2**	3

10.3. Early retirements due to ill-health

During 2016/17 there were four early retirements from the Trust agreed on the grounds of ill-health (five in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £81,000 (£178,000 in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

10.4. Staff exit packages

Exit packages 2016/17

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000	No. of departures where special payments made	Cost of special payments made £000
< £10,000 *	**3**	**16**	**-**	**-**	**3**	**16**	**-**	**-**
£50,001 - £100,000	**2**	**154**	**-**	**-**	**2**	**154**	**-**	**-**
Total	**5**	**170**	**-**	**-**	**5**	**170**	**-**	**-**

* The three redundancies in the banding '< £10,000' relate to redundancies which were accounted for on a best estimate basis in 2015/16 for which the Trust received finalised settlement figures in 2016/17.

Exit packages 2015/16

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000	Number of departures where special payments made	Cost of special payments made £000
< £10,000	5	7	5	15	10	22	1	8
£10,000 - £25,000	5	62	-	-	5	62	-	-
£25,001 - £50,000	8	189	1	49	9	238	-	-
£50,001 - £100,000	11	589	-	-	11	589	-	-
£100,001 - £150,000	1	123	-	-	1	123	-	-
Total	30	970	6	64	36	1,034	1	8

Exit packages: other (non-compulsory) departure payments

	2016/17 Payments agreed Number	**2016/17 Total value of agreements £000**	2015/16 Payments agreed Number	2015/16 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	**-**	**-**	5	56
Non-contractual payments requiring HMT approval	**-**	**-**	1	8
Total	**0**	**0**	6	64
of which:				
non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	**Nil**	**Nil**	Nil	Nil

10.5 Retirement benefits

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that 'the period between formal valuations shall be four years, with approximate assessments in intervening years'. An outline of these follows:

Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of scheme liability as at 31 March 2017 is based on valuation data as at 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out on data as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the

schemes relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the schemes change by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with relevant stakeholders.

11. Intangible assets

11.1. Intangible assets 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2016 – brought forward	**233**	**-**	**233**
Additions	-	425	**425**
Gross cost at 31 March 2017	**233**	**425**	**658**
Amortisation at 1 April 2016 – brought forward	**133**	**-**	**133**
Provided during the year	44	-	**44**
Amortisation at 31 March 2017	**177**	**-**	**177**
Net book value at 31 March 2017	**56**	**425**	**481**
Net book value at 1 April 2016	**100**	**-**	**100**

Amortised historic cost is considered to be a reasonable indicator of fair value. The economic life of the above software licenses is expected to be 5 years. Intangible assets under construction relates to the implementation of the Trust's Information Management Platform.

11.2. Intangible assets 2015/16

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 – as previously stated	233	-	233
Prior period adjustments	-	-	-
Gross cost at 1 April 2015 – restated	233	-	233
Valuation/gross cost at 31 March 2016	233	-	233
Amortisation at 1 April 2015 – as previously stated	85	-	85
Prior period adjustments	-	-	-
Amortisation at 1 April 2015 – restated	85	-	85
Provided during the year	48	-	48
Amortisation at 31 March 2016	133	-	133
Net book value at 31 March 2016	100	-	100
Net book value at 1 April 2015	148	-	148

12. Property, plant and equipment

12.1. Property, plant and equipment 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 – brought forward	5,486	72,626	26,707	396	25	2,735	2,289	110,264
Additions	-	11,247	775	39	-	742	606	13,409
Impairments	50	(2,130)	-	-	-	-	-	(2,080)
Reclassifications	2,500	24,178	(26,678)	-	-	-	-	-
Disposals / derecognition	(50)	-	-	-	-	-	-	(50)
Valuation/gross cost at 31 March 2017	7,986	105,921	804	435	25	3,477	2,895	121,543
Accumulated depreciation at 1 April 2016 – brought forward	212	18,710	-	358	25	2,036	2,213	23,554
Provided during the year	-	1,029	-	15	-	123	21	1,188
Impairments	-	14,986	-	-	-	-	-	14,986
Reversals of impairments	-	(438)	-	-	-	-	-	(438)
Accumulated depreciation at 31 March 2017	212	34,287	-	373	25	2,159	2,234	39,290
Net book value at 31 March 2017	7,774	71,634	804	62	-	1,318	661	82,253
Net book value at 1 April 2016	5,274	53,916	26,707	38	-	699	76	86,710

12.2. Property, plant and equipment 2015/16

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 – as previously stated	5,621	76,743	5,385	396	25	2,735	2,289	93,194
Prior period adjustments	-	-	-	-	-	-	-	-
Valuation/gross cost at 1 April 2015 – restated	5,621	76,743	5,385	396	25	2,735	2,289	93,194
Additions	-	228	21,453	-	-	-	-	21,681
Impairments	-	(4,161)	-	-	-	-	-	(4,161)
Reclassifications	-	131	(131)	-	-	-	-	-
Transfers to/ from assets held for sale	(135)	(315)	-	-	-	-	-	(450)
Valuation/gross cost at 31 March 2016	5,486	72,626	26,707	396	25	2,735	2,289	110,264
Accumulated depreciation at 1 April 2015 – as previously stated	212	15,573	-	336	25	1,923	2,192	20,261
Prior period adjustments	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2015 – restated	212	15,573	-	336	25	1,923	2,192	20,261
Provided during the year	-	1,332	-	22	-	113	21	1,488
Impairments	-	1,951	-	-	-	-	-	1,951
Reversals of impairments	-	(146)	-	-	-	-	-	(146)
Accumulated depreciation at 31 March 2016	212	18,710	-	358	25	2,036	2,213	23,554
Net book value at 31 March 2016	5,274	53,916	26,707	38	-	699	76	86,710
Net book value at 1 April 2015	5,409	61,170	5,385	60	-	812	97	72,933

12.3. Property, plant and equipment financing – 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned	**7,774**	**71,634**	**804**	**62**	**-**	**1,318**	**661**	**82,253**
NBV total at 31 March 2017	**7,774**	**71,634**	**804**	**62**	**-**	**1,318**	**661**	**82,253**

12.4. Property, plant and equipment financing – 2015/16

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016								
Owned	5,274	53,916	26,707	38	-	699	76	86,710
NBV total at 31 March 2016	5,274	53,916	26,707	38	-	699	76	86,710

As at 31 March 2017 there were no land and buildings valued at open market value.

During financial year 2013/14, DTZ (professional valuer) conducted a full valuation of the Trust's land and buildings as at 1 April 2013. Cushman and Wakefield (formerly DTZ) carried out an interim valuation of established buildings and a full valuation of the newly constructed building at Atherleigh Park in March 2017. This exercise was used to update the Trust's buildings valuation to ensure that buildings were held at fair value as at 31 March 2017. The professional valuer has confirmed that there have been no material movements in land values from 1 April 2013.

For all other items of property, plant and equipment, depreciated historic cost is considered to be a reasonable indicator of fair value.

13. Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	-	-
Work In progress	-	-
Consumables	**80**	85
Other	-	-
Total inventories	**80**	85

Inventories recognised in expenses for the year were £1,594,000 (£1,650,000 in 2015/16). Write-down of inventories recognised as expenses for the year were £0 (£0 in 2015/16).

14. Trade receivables and other receivables

14.1 Trade and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
Trade receivables due from NHS bodies	**856**	2,275
Other receivables due from related parties	**981**	322
Provision for impaired receivables	**(6)**	(123)
Prepayments (non-PFI)	**307**	246
Accrued income	**714**	371
Interest receivable	**1**	3
PDC dividend receivable	**33**	164
VAT receivable	**358**	332
Other receivables	**1,037**	564
Total current trade and other receivables	**4,281**	4,154

The vast majority of the Trust's trade is with clinical commissioning groups as commissioners of NHS patient care services. Due to the fact that clinical commissioning groups are funded by government to purchase NHS patient care services, no credit scoring of them is considered necessary. The credit risk exposure of the Trust is therefore low.

14.2 Provision for impairment of receivables

	2016/17 £000	2015/16 £000
At 1 April	**123**	16
Increase in provision	**-**	113
Amounts utilised	**(85)**	-
Unused amounts reversed	**(32)**	(6)
At 31 March	**6**	123

At the reporting period end, receivables are evaluated on an individual basis to determine the level of impairment required.

14.3 Analysis of financial assets

Ageing of impaired financial assets	**31 March 2017 Trade and other receivables £000**	31 March 2016 Trade and other receivables £000
0-30 days	**-**	-
30-60 days	**-**	-
60-90 days	**-**	-
90-180 days	**-**	-
Over 180 days	**6**	123
Total	**6**	123

Ageing of non-impaired financial assets past their due date		
0-30 days	**1,548**	2,078
30-60 days	**61**	140
60-90 days	**85**	207
90-180 days	**97**	106
Over 180 days	**451**	186
Total	**2,242**	2,717

15. Non-current assets for sale and assets in disposal groups

	2016/17	**2016/17**	2015/16
	Property, plant and equipment £000	**Total £000**	Total £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,625**	**1,625**	1,175
Prior period adjustment	-	-	-
NBV of non-current assets for sale and assets in disposal groups at 1 April – restated	**1,625**	**1,625**	1,175
Plus assets classified as available for sale in the year	-	**-**	450
Less assets sold in year	**(1,350)**	**(1,350)**	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**275**	**275**	1,625

During the year, the sales completed for Oakdene and Vista Road. The balance of £275,000 relates to The Elms which has been re-marketed.

16. Cash and cash equivalent movements

	2016/17	2015/16
	£000	£000
At 1 April	**11,580**	17,512
Net change in year	**(6,697)**	(5,932)
At 31 March	**4,883**	11,580
Broken down into:		
Cash at commercial banks and in hand	**96**	88
Cash with the Government Banking Service	**4,787**	11,492
Total cash and cash equivalents as in statement of cash flows	**4,883**	11,580

17. Third party assets held by the NHS foundation trust

5 Boroughs Partnership NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2017	31 March 2016
	£000	£000
Bank balances	**97**	137
	97	137

18. Trade and other payables

	31 March 2017	31 March 2016
	£000	£000
Current		
NHS trade payables	**1,310**	1,853
Amounts due to other related parties	**1,602**	1,485
Other trade payables	**1,631**	2,455
Capital payables	**1,525**	2,506
Social security costs	**1,403**	1,040
Other taxes payable	**1,070**	996
Other payables	**130**	234
Accruals	**1,703**	1,569
Total current trade and other payables	**10,374**	12,138
Non-current		
Accruals	**7**	15
Total non-current trade and other payables	**7**	15

19. Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Other deferred income	**202**	114
Total other current liabilities	**202**	114

20. Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Loans from the Department of Health	**1,621**	969
Total current borrowings	**1,621**	969
Non-current		
Loans from the Department of Health	**31,010**	24,958
Total non-current borrowings	**31,010**	24,958

21. Provision for liabilities and charge analysis

21.1. Provisions

	Current 31 March 2017 £000	Non-current 31 March 2017 £000	Current 31 March 2016 £000	Non-current 31 March 2016 £000
Pensions - early departure costs	**22**	**133**	22	206
Other legal claims	**224**	**1,858**	204	1,933
Restructurings	**-**	**-**	210	-
Other	**-**	**-**	-	-
	246	**1,991**	436	2,139

21.2. Analysis of provisions 2016/17

	Pensions – early departure costs	Other legal claims	Restructurings	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2016	**228**	**2,137**	**210**	**-**	**-**	**2,575**
Arising during the year	**-**	**172**	**-**	**-**	**-**	**172**
Utilised during the year	**(18)**	**(131)**	**(203)**	**-**	**-**	**(352)**
Reversed unused	**(55)**	**(96)**	**(7)**	**-**	**-**	**(158)**
At 31 March 2017	**155**	**2,082**	**-**	**-**	**-**	**2,237**
Expected timing of cash flows:						
- not later than one year	**22**	**224**	**-**	**-**	**-**	**246**
- later than one year and not later than five years	**88**	**425**	**-**	**-**	**-**	**513**
- later than five years	**45**	**1,433**	**-**	**-**	**-**	**1,478**
Total	**155**	**2,082**	**-**	**-**	**-**	**2,237**

Pensions relating to early departure costs

These are based on figures provided by the Benefits Agency.

Other legal claims

£1,873,000 relates to permanent injury claims. These claims are calculated using recommended policies relating to life span (thus indicating the length of the provision).

£182,000 relates to risk pooling arrangements, the amounts and timings of which are notified by the NHS Litigation Authority (NHSLA).

£2,215,000 is included in the provisions of the NHS Litigation Authority at 31 March 2017 (£1,747,000 at 31 March 2016) in respect of clinical negligence liabilities of the Trust.

22. Contingent assets and liabilities

	31 March 2017 £000	31 March 2016 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	**-**	-
Employment tribunal and other employee related litigation	**-**	-
Redundancy	**-**	-
Other	**-**	-
Gross value of contingent liabilities	**-**	-
Amounts recoverable against liabilities	**-**	-
Net value of contingent liabilities	**-**	-
Net value of contingent assets *	**-**	-

23. Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	**-**	3,278
Total	**-**	3,278

24. Financial instruments

24.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The interest rate on the Trust's borrowing is fixed at the point that the loan agreement is signed. The Trust therefore has no exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are predominantly incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust presently funds its capital expenditure from a combination of loans from the Department of Health and internally generated funds. The Trust stringently monitors its liquidity position on a routine basis.

24.2. Financial assets

	Loans and receivables	**Assets at fair value through the I&E**	**Held to maturity**	**Available-for-sale**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Assets as at 31 March 2017					
Trade and other receivables excluding non-financial assets	**3,582**	-	-	-	**3,582**
Cash and cash equivalents at bank and in hand	**4,883**	-	-	-	**4,883**
Total at 31 March 2017	**8,465**	**-**	**-**	**-**	**8,465**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as at 31 March 2016					
Trade and other receivables excluding non-financial assets	3,409	-	-	-	3,409
Cash and cash equivalents at bank and in hand	11,580	-	-	-	11,580
Total at 31 March 2016	14,989	-	-	-	14,989

24.3. Financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as at 31 March 2017			
Borrowings	**32,631**	-	**32,631**
Trade and other payables excluding non-financial liabilities	**7,908**	-	**7,908**
Provisions under contract	**2,082**	-	**2,082**
Total at 31 March 2017	**42,621**	**-**	**42,621**

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as at 31 March 2016			
Borrowings	25,927	-	25,927
Trade and other payables excluding non-financial liabilities	10,117	-	10,117
Provisions under contract	2,137	-	2,137
Total at 31 March 2016	38,181	-	38,181

24.4. Maturity of financial liabilities

	31 March 2017	31 March 2016
	£000	£000
In one year or less	**9,746**	11,276
In more than one year but not more than two years	**1,729**	1,285
In more than two years but not more than five years	**5,188**	3,859
In more than five years	**25,958**	21,761
Total	**42,621**	38,181

24.5 Fair values of financial liabilities at 31 March 2017

	Book value	**Fair value**
	£000	**£000**
Provisions under contract	**1,858**	**1,858**
Loans	**31,010**	**31,010**
Other	**7**	**7**
Total	**32,875**	**32,875**

For current financial instruments (less than one year), fair values are assumed to be equal to book values. Note 24.5 above therefore only includes non-current financial instruments.

25. Losses and special payments

	2016/17		2015/16	
	Total number of cases Number	**Total value of cases £000**	Total number of cases Number	Total value of cases £000
Losses				
Fruitless payments	**1**	**38**	1	2
Bad debts and claims abandoned	**14**	**4**	3	2
Total losses	**15**	**42**	4	4
Special payments				
Compensation payments	**1**	**1**	3	4
Special severance payments	**-**	**-**	1	8
Ex-gratia payments	**14**	**4**	8	2
Total special payments	**15**	**5**	12	14
Total losses and special payments	**30**	**47**	16	18
Compensation payments received				

The above amounts are reported on an accruals basis but exclude provisions for future losses.

26. Events after the reporting year

There are no events that require disclosure after the reporting date.

27. Related parties

Ultimate parent

The NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. NHS Improvement (NHSi) formerly Monitor, the Regulator of NHS Foundation Trusts has the power to control the NHS Foundation Trust within the meaning of IAS 27 'Consolidated and Separate Financial Statements' and therefore can be considered as the NHS Foundations Trust's parent. NHSi does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS Foundation Trust Consolidated Accounts are then included within the Whole of Government Accounts. NHSI is accountable to the Secretary of State for Health. The NHS Foundation Trust's ultimate parent is therefore HM Government.

27.1. Related party transactions

	2016/17		2015/16	
	Revenue	**Expenditure**	Revenue	Expenditure
	£000	**£000**	£000	£000
Value of transactions with board members for the year ended 31 March (excluding salaries)	**-**	**-**	-	-
Value of transactions with key staff members for the year ended 31 March (excluding salaries)	**-**	**-**	-	-
Value of transactions with other related parties:				
Department of Health	**-**	**139**	-	3
Other DH Group bodies	**142,386**	**10,498**	142,819	10,526
Charitable funds	**8**	**-**	8	-
Other	**11,077**	**20,227**	7,244	17,829
	153,471	**30,864**	150,071	28,358

27.2 Related party balances

	2016/17		2015/16	
	Receivables	**Payables**	Receivables	Payables
	£000	**£000**	£000	£000
Value of balances (other than salary) with board members at 31 March	**-**	**-**	-	-
Value of balances (other than salary) with key staff members at 31 March	**-**	**-**	-	-
Value of balances with other related parties at 31 March:				
Department of Health	**33**	**292**	164	75
Other DH Group bodies	**1,589**	**984**	2,763	2,114
Charitable funds	**71**	**-**	35	-
Other	**1,431**	**4,554**	642	3,662
	3,124	**5,830**	3,604	5,851

All bodies within the scope of the Whole of Government Accounts are considered to be related parties of the Trust. Transactions with such bodies are in the normal course of business and are conducted on an arm's length basis.

Contact us

To find out more about North West Boroughs Healthcare NHS Foundation Trust (previously 5 Boroughs Partnership NHS Foundation Trust), visit our website at: www.nwbh.nhs.uk

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