North West Boroughs Healthcare
NHS Foundation Trust

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Annual Report and Accounts 1 April 2017 to 31 March 2018

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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 North West Boroughs Healthcare NHS Foundation Trust's Annual Report and Accounts for 2017/18.

This report 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 in-year successes and acknowledges where our performance has not met targets set, why and how we plan to address this.

This was our first year as North West Boroughs Healthcare, having changed our name from 5 Boroughs Partnership on 1 April 2017. This was a result of significant growth during the previous year, extending the geography in which we deliver services. Our new name enables all our staff to identify with the organisation regardless of where they work.

We have continued to develop and grow during 2017/18, working in partnership with NHS and non-NHS organisations to win new contracts which strengthen our ability to deliver whole person care, supporting an individual's mental wellbeing as well as physical health needs to help them live their life well.

In May 2017, after an external recruitment process, previous non-executive director and Vice Chair Helen Bellairs took over as Chairman, following the retirement of Bernard Pilkington after 10 years as Chairman.

In September 2017, we amended our organisation structure slightly to create a separate division and leadership team for specialist services, which had previously sat within the Warrington borough.

We are committed to ensuring community and mental health services are delivered in a joined up way and, throughout the year, have played an active role in the emerging place-based healthcare systems, working in partnership with clinical commissioning groups, partner trusts and local authorities to shape the future of healthcare for our communities.

In the Annual Report and Accounts, you will see we have met our quality regulatory ratings and continued to deliver against our financial targets with good financial management.

Several of our services and staff have received national recognition for their innovation and excellent standards of care, more details are included within the Quality Report.

Finally, in March 2018, our Trust Board approved our strategy for 2018-2021. This sets out the direction and priorities for our organisation for the next three years. It will drive change and puts a clearer focus on quality, partnership and localism. It describes how we will continue to work in partnership with staff, our patients, service users and carers and partners to deliver whole person care.

Our number one priority every day is to provide the best care possible for our patients and service users. We continue to listen to and work with our patients, service users, carers, governors and clinicians to enhance, improve and shape services to meet local needs and improve patient experience.

Helen Bellairs, **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, our purpose, the key risks to the achievement of our objectives and how we have performed during the year.

1.2. Chief Executive's statement

During 2017/18, we have continued to grow, winning and mobilising a number of new contracts and services both within and outside of our existing boroughs.

These include:

- THRIVE school link service to support emotional health and wellbeing in schools in Wigan and Warrington
- Neurodevelopment service in St Helens
- Knowsley parent infant mental health service, working with mothers in Knowsley to support attachment with their baby
- Bolton child and adolescent mental health service, in partnership with Greater Manchester Mental Health NHS Foundation Trust
- Greater Manchester control room triage, in partnership with Greater Manchester Police, Pennine Care NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust, to provide mental health triage across Greater Manchester
- Enhancing our existing psychiatric liaison mental health service at St Helens and Knowsley Teaching Hospitals NHS Foundation Trust, which will improve response times in the Accident and Emergency department as well as inpatient wards across the Whiston site, ensuring the service meets the national standard for psychiatric liaison services
- A programme to support anti-stalking, in partnership with Cheshire Police, focusing on working with victims of stalking
- Working in partnership with the University of Salford to develop and deliver a psychiatric liaison mental health training awareness and knowledge programme across the North West
- New occupational health services in Knowsley

During 2017/18, we had a turnover of approximately £181 million (£155 million in 2016/17). We have achieved our financial goals in times of significant hardship and pressure across the NHS, delivering a surplus before impairments and transfers of £2.2 million (£55,000 deficit in 2016/17) in line with the control total set by NHS Improvement.

Finally, I am pleased to report we have fully achieved two of our 2017/18 quality priorities, with the third partially achieved and continuing as a priority for 2018/19, as outlined in detail within the Quality Report starting on page 110.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
25 May 2018

1.3. About us

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

On 1 April 2017, we became North West Boroughs Healthcare NHS Foundation Trust. The name change was a result of significant growth during the previous year, extending the geography in which we deliver services. Our new name enables all our staff to identify with the organisation regardless of where they work.

We deliver a range of health services across a population of more than 3.5 million people to support our local communities to live life well. These include community-based physical health services, as well as mental health and learning disability services.

We deliver community and inpatient mental health services across Halton, Knowsley, St Helens, Warrington, Wigan and Bolton. And provide physical health services for children and adults in Halton, Knowsley, Sefton and St Helens.

We also provide a range of specialist services across the North West, including specialist inpatient services and services for people with vulnerabilities within the criminal justice system across Greater Manchester.

We employ more than 3,800 staff across a range of professions and we are committed to integrating mental health and physical health services to deliver whole person care which supports our service users with all aspects of their health and wellbeing.

Our last comprehensive inspection by the Care Quality Commission took place in 2016 and we are proud to be rated as 'Good' across all five domains – 'caring', 'responsive', 'effective', 'well-led' and 'safe'. We are especially proud to have been rated as 'Outstanding' under the 'caring' domain for our community-based physical health services.

Our purpose

Our Trust Board and Council of Governors have defined our overall purpose as:

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

Our strategic priorities

Approved by our Trust Board in March 2018, our strategy for 2018-2021 sets out the direction and priorities for our organisation for the next three years. Our strategic priorities are:

- We will deliver **quality, safe and efficient services** with a highly skilled and motivated workforce.
- We will deliver **whole person care** through targeted growth.
- We will retain our **values and culture**.
- We will engage with our communities and staff to **deliver services differently**.
- We will play an active role in **place-based care systems** to maintain a whole person care focus and high clinical standards.
- We will **grow and develop** the Trust at scale, being seen as an equal partner in any system-wide collaboration.

Our values

Our values reflect the things that matter to us and are evidenced in the way we do things and how we behave:

- 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.

Our Culture of Care

Our Culture of Care puts a clear focus on delivering high-quality care for our patients, service users and carers. This is how we have chosen to implement NHS England's 6Cs – care, compassion, commitment, courage, communication and competence – which we believe don't just apply to our nursing staff, but to every member of staff.

How it all fits together

Our objectives

We set objectives at the start of each year. Our high-level objectives for 2017/18 can be found at Appendix 1.

Our structure and business model

Our Trust is structured around the boroughs in which we deliver services. Beneath our Trust Board, within operational services, we have borough leadership teams for each of our boroughs – Halton, Knowsley, Sefton, St Helens, Warrington and Wigan. We have an additional division and leadership team for specialist services.

Corporate and support services sit separately and wrap around the borough operational structure.

The majority of the services we provide are commissioned by clinical commissioning groups and local authorities within our footprint. In addition, some of our specialist services are commissioned by NHS England, local police and crime commissioners and Health Education England.

A number of our services are delivered in partnership with other NHS, third sector and private sector organisations. This strengthens our ability to deliver whole person care, integrating physical and mental health services wherever possible.

We play an active role in the emerging place-based care systems within our footprint, as well as the wider health economies across Greater Manchester and Cheshire and Merseyside – through the Greater Manchester Health and Social Care Partnership and Cheshire and Merseyside Health and Care Partnership.

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 82.

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 2018, there are 93 open risks identified which may impact on achievement of our objectives. These include 11 against the 2017/18 high-level objectives which are on track to close in April 2018 in line with the achievement of the Trust high level objectives for 2017/18.

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.nwbh.nhs.uk/board-meetings

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 2017/18 against the six key questions is detailed below.

Are we delivering our services safely?

- All the key measures are within tolerance.
- The number of serious incidents has increased slightly from seven reported each month to 10.
- The average number of incidents reported each month has increased slightly from 923 to 959.
- Self-harm actual has increased from an average of 75 a month to 97, and inpatient incidents have increased from around 325 a month to 439.
- These increases can be attributed to an increase in the number of services being provided across the Trust; further analysis illustrates that there are no themes or trends.
- During the year, complaints to the Trust stayed the same, with an average of 12 a month.

Do we have sufficient, highly motivated and skilled staff?

- This year, compliance with core and statutory training has increased. At the end of March 2018, the figures stood at 93 per cent and 87 per cent respectively – which is an increase on last year's figures of 82 per cent and 80 per cent respectively.
- Further analysis of all training illustrates compliance is much lower amongst those staff with the least service, ie those staff who have been with the Trust under three months have significantly lower completion rates across all core and statutory courses than those staff who have worked here longer. A new Trust induction process has been designed and implemented in April 2018 which will allow the

completion of all core and statutory training within the first few weeks of joining the Trust and should result in a significant improvement in compliance rates in 2018/19.
- Specialist training compliance rose more than four per cent this year to 92 per cent.
- The level of staff experiencing an annual performance development review (PDR) has reduced from 84 per cent in March 2017 to 83 per cent in March 2018. The rate still falls below the Trust target of 90 per cent.
- Attendance has fallen from 94.65 per cent in March 2017 to 94.03 per cent in March 2018. Trust attendance decreased over the winter months, particularly in January and February 2018, following a national influenza outbreak which affects the rolling 12-month attendance figure for March 2018.
- Staff turnover in March 2017 was at 13.5 per cent, peaking in July 2017 at 14.4 per cent. Since that time, we've been part of an NHS Improvement recruitment and retention programme with an action plan developed within the Trust to address this. The action plan has been monitored monthly at the Workforce Strategy Group and a number of initiatives have been implemented, with turnover reducing to 12.2 per cent in March 2018.
- The Trust has continued to monitor agency usage and the number of breaches has dropped to 131 in March 2018, down from 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 the recording of ethnicity status.
- Recording of ethnicity is at 91.9 per cent, against a target of 95 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 53.6 per cent against a target of 50 per cent.

Are we financially viable?

- 2017/18 has been a very challenging time for the NHS, but, despite this, the Trust has achieved its surplus before impairment and transfers of £2.2 million, in line with the control total set by NHS Improvement.
- We have delivered a £4.8 million cost improvement plan and carried forward £2.3 million of schemes as part of the plan for 2018/19.
- The Trust has spent £2.6 million of capital during the year against a plan of £3 million. Schemes worth £400,000 are being carried forward to 2018/19. These relate to our information management platform, and St John's building in Widnes.
- The Trust ends the year with a positive cash balance of £5.9 million.

Are we delivering on our strategy?

- The Trust set itself 12 high-level objectives for 2017/18 and all these have been achieved as outlined within this Annual Report.

Do our stakeholders support what we do?

- During 2017/18, the Trust has been well supported by its Council of Governors. Governors have contributed to a review of the Trust strategy in conjunction with the Trust Board, as well as supporting the development of the Trust's new strategy for 2018-2021.
- The Trust has continued to work positively with a range of external partners, stakeholders and commissioners during 2017/18. This includes clinical commissioning groups, local authorities, other mental health and community trusts

across Cheshire and Merseyside and Greater Manchester, acute hospital trusts and a number of third sector and independent sector providers.

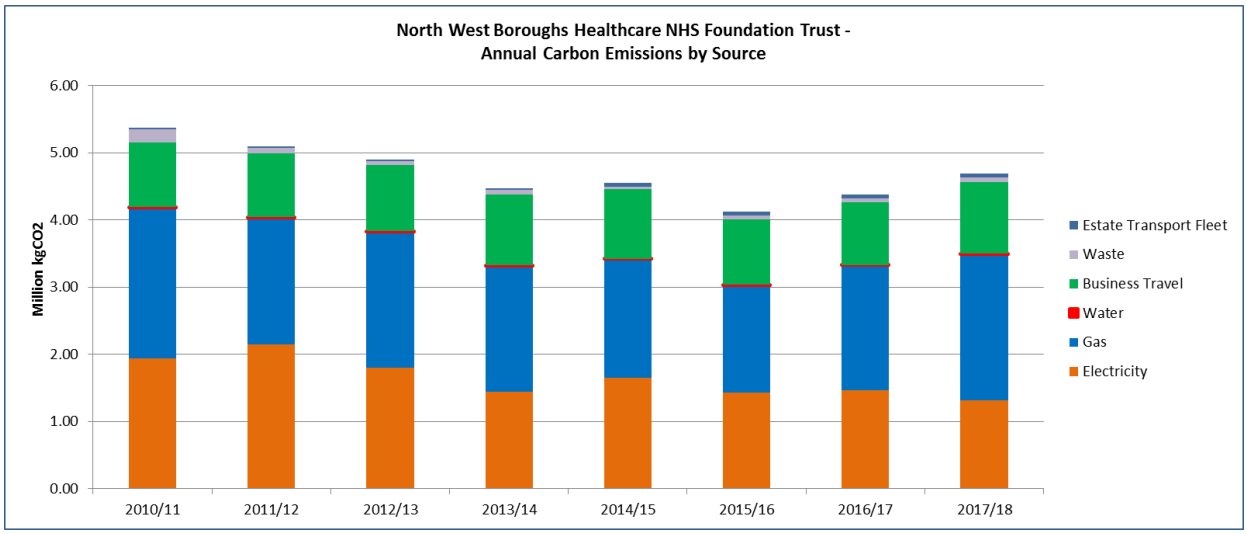
- In line with our planning assumptions for 2017/18, the number of formal tendering opportunities was much reduced as the emerging integrated care structures in each area develop. That said, during the year, the Trust was successful with a number of new business opportunities and in developing new and exciting partnerships to deliver services, as well as retaining a number of contracts when services were retendered by commissioners.
- During 2017/18, the Trust continued to engage and influence the work of the emerging integrated care systems in each of the localities where services are delivered. In addition, we remain an active part of Cheshire and Merseyside Health and Care Partnership and the Greater Manchester Health and Social Care Partnership.

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 Working Group (SWG) meets quarterly to progress actions on all areas of the Trust Sustainable Development Management Plan (SDMP), including carbon, energy, business travel, transport, waste, natural capital and social value.

The measures included in this report relate only to properties owned by the Trust and/or facilities, such as waste management services directly managed by the Trust.

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 total Trust emissions from 2010/11 to 2017/18.



The Trust and its estate grew significantly in 2017. Atherleigh Park hospital became fully operational in March 2017 and the Trust acquired two new premises in the Sefton borough in April 2017. The total number of staff employed by the Trust grew by 640 between March 2017 and March 2018. This growth has resulted in an increased carbon footprint. The majority of emissions are from gas, electricity and business travel.

To better reflect the growth of the Trust this year, we have normalised carbon emissions per member of staff which shows a reduction in emissions compared to the previous year. We will use this measure in future carbon reporting.

	2016/17	2017/18
Total emissions (kgC02e)	4,376,118.57	4,686,328.28
Total number of staff	3,425	3,935
Emissions per member of staff (kgC02e)	1,278	1,191

Energy

Total electricity consumed increased due to the addition of new buildings. However, electricity consumption dropped across all other sites where we had the previous year's consumption data to compare with – this is a very positive indicator. The carbon emissions due to electricity were also down in 2017/18 compared with 2016/17 as more of the electricity supplied through the national grid in 2017/18 was from renewable energy sources.

For the first time, the Trust can report it has generated renewable energy. The solar panels at Atherleigh Park generated 28,745kwh of electricity in 2017/18. This energy was produced and consumed on site and equates to more electricity than it takes to power two average households for one year.

Total gas consumed increased significantly this year. In addition to the increased consumption due to having three new buildings, consumption was unusually high during February 2018 and March 2018 across all sites compared with previous years. This increase correlates with the extended period of cold weather.

Travel

The number of miles travelled by staff to carry out Trust business also increased this year. This was expected due to the increased numbers of staff. For the first time, emissions statistics from business travel also includes travel by Trust volunteers, although these comprised less than one per cent of all travel.

Our travel plans aim to increase active and sustainable travel and reduce the number of single occupancy car journeys. The Trust continues to promote sustainable and active travel with a dedicated Liftshare group, a cycle to work scheme, borrow a bike scheme and various travel promotions throughout the year. To date, 133 people have purchased bikes through the cycle to work scheme, with 21 of these during 2017/18.

A new electric vehicle charger was installed at Peasley Cross Hospital in January 2018. The Trust now has a network of nine charge points in total and continues to promote the use of electric vehicles to support the UK Air Quality Plan.

Waste

In 2016/17, the Trust set an action in the SDMP that at least 90 per cent of all domestic (black bag) waste on every site would be recycled or used for energy recover. In 2017/18, this target was exceeded and all sites reported 100 per cent of domestic waste was either recycled or processed for energy recovery. Diverting all waste from landfill saved 177,503kg of carbon, or the equivalent of planting 155 trees.

All confidential paper waste is recycled. A total of 30,263kgs was recycled in 2017/18, diverting this waste from landfill reduced carbon emissions by the equivalent of planting 38 trees.

		Recycled (kg)	Energy recovery through Refuse Derived Fuel (RDF) process (kg)	Residual waste (kg)	Total waste collected (kg)	Percentage of total recycled / recovered
Atherleigh Park*	2016/17	-	-	-	-	-
	2017/18	18,132	42,308	0	60,440	100%
Dudley Wallis Centre	2016/17	2,206	3,688	86	5,981	98.56%
	2017/18	1,081	2,523	0	3,604	100%
Fairhaven and Alders	2016/17	7,551	3,567	7,166	18,284	60.81%
	2017/18	5,336	12,451	0	17,787	100%
Formby Clinic*	2016/17	-	-	-	-	-
	2017/18	345	805	0	1,150	100%
Hampton Road*	2016/17	-	-	-	-	-
	2017/18	526	1,228	0	1,755	100%
Harry Blackman House	2016/17	25,304	0	2,811	28,116	90%
	2017/18	17,315	11,543	0	28,859	100%
Hollins Park	2016/17	3,743	150,878	2,280	156,901	97.6%
	2017/18	53,317	124,407	0	177,725	100%
Hope and Recovery	2016/17	15,182	0	1,686	16,869	90%
	2017/18	10,389	6,916	0	17,315	100%
Leigh Infirmary	2016/17	8,942	5,864	2,536	17,332	85.42%
	2017/18	762	1,779	0	2,541	100%
Manchester Road	2016/17	1,204	1,425	426	3,056	86.06%
	2017/18	1,035	2,414	0	3,449	100%
Wakefield House	2016/17	2,337	1,656	2,062	6,057	65.9%
	2017/18	1,924	4,489	0	6,413	100%
Willis House	2016/17	2,309	3,806	0	6,115	100%
	2017/18	1,888	4,404	0	6,292	100%
Willow House	2016/17	1,183	1,950	0	3,134	100%
	2017/18	998	2,329	0	3,328	100%
Yew Trees	2016/17	255	420	0	675	100%
	2017/18	214	499	0	713	100%

*New site, previous data not available.

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
- Advocacy Policy and Procedure
- Supporting Trans Service Users Policy and Procedure
- Breastfeeding Policy
- Staff Dress Code and Uniform Policy
- Gender Reassignment Policy and Procedure

- Maternity Policy and Procedure
- Shared Parental Leave Policy and Procedure
- Respect at Work Policy and Procedure
- Anti-Fraud and Corruption Policy (including anti-bribery)

Enshrined within the Equality Act 2010 are 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 2017/18 has concentred on aspects of Outcome 4: 'Inclusive leadership'. We will be hosting an event around this in May 2018. It will involve a large group of patients and service users, carers, staff, third sector organisations and Healthwatch representatives being brought together from across the Trust footprint to assess the evidence provided. We hope to maintain or improve upon the previous score for 2016/17, where the Trust was assessed as 'developing'.

The full EDS 2 report about Trust compliance for 2017/18 will be published later in 2018.

Workforce Race Equality Standard (WRES)

The Trust completed the NHS Workforce Race Equality Standard and action plan for 2017/18. These can be viewed at: www.nwbh.nhs.uk/key-documents

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
25 May 2018

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 2017/18 (there was no meeting in August or December).

Names and roles of those who made up our Trust Board during 2017/18 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
Sam Proffitt	Chief Finance Officer
Dr Louise Sell	Medical Director
Bernard Pilkington	Chairman (until 16 May 2017)
Helen Bellairs	Non-Executive Director and Vice Chair (until 16 May 2017), Chairman (from 17 May 2017)
Jonathan Berry	Non-Executive Director (from 16 November 2017)
Tricia Kalloo	Non-Executive Director (from 2 June 2017)
Brian Marshall	Non-Executive Director
Richard Sear	Non-Executive Director (until 22 September 2017)
Philippa Tubb	Non-Executive Director
Alison Tumilty	Non-Executive Director

2. Declarations of interest

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

3. HM Treasury cost allocation and charging guidance

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

4. Political donations

The Trust has not made any political donations during 2017/18 (also none in 2016/17).

5. 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.

	2017/18		2016/17	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	25,123	23,619	30,557	39,804
Total non-NHS trade invoices paid within target	24,223	22,687	29,545	38,724
Percentage of non-NHS trade invoices paid within target	96%	96%	97%	97%
Total NHS trade invoices paid in the year	882	15,307	990	13,768
Total NHS trade invoices paid within target	858	14,933	951	13,525
Percentage of NHS trade invoices paid within target	97%	98%	96%	98%
Total invoices paid in the year	26,005	38,926	31,547	53,572
Total invoices paid within target	25,081	37,620	30,496	52,249
Percentage of invoices paid within target	96%	97%	97%	98%

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 2016/17.

6. Well-led framework

The Trust Board recognises that robust governance processes should give leaders of organisations, those who work in them and those who regulate them, confidence about their capability to maintain and continuously improve services.

To support the Trust's review of its effectiveness, an in-depth and externally facilitated developmental review of leadership and governance began in December 2017, using NHS Improvement's Well-led Framework Guidance published in June 2017.

The initial work was a self-review questionnaire, individually undertaken by the Trust Board members and senior leaders, against a questionnaire based on both the eight key lines of enquiry and the characteristics of 'Good'.

The Trust Board and senior leaders devoted a full development day in January 2018 to the effectiveness review, where analysis and comments were reviewed, assurance was gained from presentations given, and actions for improvement were determined.

Full details of the Trust's systems of internal control are included within the Annual Governance Statement starting on page 82.

This year, we have produced our ninth 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.

7. Patient care

The Trust has had foundation trust status since March 2010, and working in partnership has always been a key part of our strategy.

Over the last 12 months, we have continued to work in partnership with the clinical commissioning groups and local authorities covering the areas where we provide services.

During the year, we have significantly increased partnership working with the four local mental health trusts. Within Cheshire and Merseyside, we worked with Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust to develop and deliver specialist community perinatal mental health services, as well as working with both trusts and independent sector partners as part of the Prospect Partnership to develop a standardised approach to the delivery of low and medium secure adult mental health services. Within Greater Manchester, we worked with Pennine Care NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust and Greater Manchester Police to develop an approach to mental health triage. We have also developed a partnership to work with Greater Manchester Mental Health NHS Foundation Trust to deliver community child and adolescent mental health services in Bolton.

We are part of two planning footprints – Greater Manchester (for our services in Wigan and across Greater Manchester) and Cheshire and Merseyside (for our services in Halton, Knowsley, Sefton, St Helens and Warrington).

Our services in Wigan and across Greater Manchester form part of the devolved Greater Manchester Health and Social Care Partnership. To support our active engagement in Greater Manchester, 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 and Young People's Mental Health Strategic Health Group.

Our services in Cheshire and Merseyside form part of the Cheshire and Merseyside Health and Care Partnership. Our Chief Executive is a member of the Executive Board for Cheshire and Merseyside, representing the community and mental health providers. A key focus within Cheshire and Merseyside is mental health. To support this, a Programme Board has been established which has representation from our Chief Executive and senior leaders. Clinicians and managers from within our Trust play key roles in the work streams which have been established to take forward mental health priorities identified in Cheshire and Merseyside to deliver the priorities within the Five Year Forward View for Mental Health.

During 2017/18, each of the boroughs where we deliver services has developed integrated care systems. The developments in each area are evolving at different paces and we are actively involved in each of them, ensuring the opportunity to deliver improved population health through integrated mental health and community physical health services.

During 2017/18, we continued to work with commissioners, partners and the wider healthcare system towards delivering the aspirations of the Five Year Forward View for Mental Health, and pursuing opportunities for additional investment, either from local commissioners or through NHS England transformation funding. This approach will continue during 2018/19.

7.1. Quality

The Trust ensures it delivers best practice to all boroughs and offers equality for service users. During the past year, we have implemented the outcomes of an independent review of our borough-based leadership teams and the effectiveness of the clinical network structures, which were established in 2015 through the Future Fit Transformation Programme.

Assistant clinical director roles were introduced in 2016/17 to strengthen the provision of clinical leadership at local level and strategically across the organisation. Borough leadership teams continue to comprise 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.

Our last Quality Strategy demonstrated how we identified and made continuous improvement to the quality of care we provide. It outlined 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 this was a three-year strategy, the Trust has taken the opportunity to review and update the Quality Strategy in early 2018 to ensure there is a culture of continuous focus on quality embedded in all work streams. The new Quality Strategy for 2018-2021 is available on our website: www.nwbh.nhs.uk/key-documents

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.

During 2017/18, we have updated our Freedom to Speak Up Policy and identified Freedom to Speak Up champions across the organisation. We have raised awareness among staff of how to report anything they think could be harming the services we deliver which will help us make improvements and maintain quality care.

7.2. 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 2017/18, 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, including assistant clinical directors, at contract quality meetings and have valued the first-hand experience of the impact the initiatives have had within services. This has continued to provide a much more valuable experience for all involved and has led to rich discussions which have informed negotiations for the coming year.

7.3. National and local commissioning priorities

Throughout 2017/18, the Trust has attended clinical quality and safety meetings with commissioners to provide assurance on standards of care and service delivery in all boroughs where we are directly commissioned to provide services. This has included Halton, Knowsley, Sefton, St Helens, Warrington and Wigan.

For our children's 0-19 services we have delivered assurance to public health commissioners and the relevant local authorities.

In addition, the Trust has delivered a number of services under sub-contract arrangements, including those with St Helens and Knowsley Teaching Hospitals NHS Trust and Mersey Care NHS Foundation Trust.

The quality and safety meetings provide the opportunity for the Trust to provide assurance and enter into constructive dialogue with our commissioners and stakeholders on core issues relating to the quality and safety of service delivery.

At the meetings, we also ensure the contracts are 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.

7.4. Quality goals 2015/16 – 2017/18

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 priorities as defined below.

7.5. Sign up to Safety

The Trust adopted the Sign Up to Safety campaign with aims to reduce avoidable harm by 50 per cent over a three year period, 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:

- The implementation on three female wards of an evidence-based self-injury pathway.
- A reduction in the number of incidents of self-injury on inpatient wards.
- A fluctuating pattern of falls, but overall reduction in falls and harm from falls continues.
- Local ownership of incidents of falls, with the introduction of local falls prevention groups.
- Working with Advancing Quality Alliance (AQuA) for the REsTRAIN programme, demonstrating a reduction in the use of least restrictive practices and harm from violence and aggression for both patients and staff.
- A decreasing trend of patient violent and aggressive incidents which correlates with the Trust's least restrictive practices and therapeutic interventions.
- A relaunch of the Trust Suicide Strategy.

With the support of Advancing Quality Alliance (AQuA), we have successfully implemented improvement plans for reducing restrictive practices and have introduced positive behaviour support approaches within our specialist forensic service (Auden Unit).

The Trust has completed the final year of the Sign Up to Safety campaign, and commitment to maintaining the pledges are now part of business as usual activity in line with the Quality Strategy.

7.6. Quality priorities

To demonstrate the Trust's continual commitment to quality improvement, each year we engage with our six local Healthwatch groups, six local authorities, and six 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 2017/18 quality priorities. Progress against each is briefly described below.

Safety: Always events

It has never been more important for organisations to ensure a culture where there is a commitment to determining what events should always happen to ensure quality and safety levels and standards are consistently achieved. Over the past year, 'always events' have been introduced, which has included:

- Determining the ‘always events’ and an ‘always event’ approach to support patient safety across inpatient units.
- Creating a robust system to record and track ‘always events’ to identify areas of focus, and reviewing outcomes to determine the impact from actions.
- Developing a communications strategy to define and launch ‘always events’ across the Trust.

‘Always events’ is now accepted as the cultural framework on which services must perform consistently for every patient, every time.

Effectiveness: Complaints, concerns and compliments

The Trust approach to responding to complaints and concerns is respectful and efficient, and is central to developing an open learning culture which values the patient and their family by listening to their experience. Achievement of this quality priority includes:

- Development of a robust system to capture feedback from complainants.
- Reviewing complaint letter templates.
- Implementing a framework for capturing evaluation from complainants.
- Analysing whether protected characteristic groups are under or over represented in voicing their concerns.
- Improving complaints investigations by providing high-quality training to staff.
- Reviewing promotional literature will ensure information is inclusive and accessible.

Experience: Duty of Candour

Being open is a long-standing commitment of the Trust, supporting a culture of truthfulness and transparency to our patients and service users, our colleagues and ourselves. Achievement of this quality priority is demonstrated by the implementation of the principles of statutory Duty of Candour into everyday work and all elements of care. Achievement of this quality priority includes:

- Raising awareness Duty of Candour notifiable incidents and actions.
- Developing systems to record Duty of Candour conversations and correspondence.
- Reviewing Duty of Candour letter templates in consultation with staff, service users and carers.
- Revising Trust policies and procedures.
- A suite of lessons learned communications have been developed and cascaded for discussions at team level.

Full details and achievements of all three quality priorities are included in part two of the Quality Report, starting on page 110.

7.7. 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.

7.8. 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 priorities. These priorities, alongside

our clinical strategies, will make sure services are designed around and developed to meet the needs of the population.

7.9. Clinical transformation programme

During 2017/18, we have concluded 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 was divided into three programmes focusing on integrating care pathways, improving the mental fitness of the local population, and managing the journey.

We have taken the 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.

7.10. New and revised services

2017/18 has been a successful year for our Trust in terms of winning new business and retaining existing business.

Our focus on growth has resulted in us winning and mobilising a number of new contracts and services both within and outside our existing boroughs, these include:

- THRIVE school link service to support emotional health and wellbeing in schools in Wigan and Warrington
- Neurodevelopment service in St Helens
- Knowsley parent infant mental health service, working with mothers in Knowsley to support attachment with their baby
- Bolton child and adolescent mental health service, in partnership with Greater Manchester Mental Health NHS Foundation Trust
- Greater Manchester control room triage, in partnership with Greater Manchester Police, Pennine Care NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust, to provide mental health triage across Greater Manchester
- Enhancing our existing psychiatric liaison mental health service at St Helens and Knowsley Teaching Hospitals NHS Foundation Trust, which will improve response times in the Accident and Emergency department as well as inpatient wards across the Whiston site, ensuring the service meets the national standard for psychiatric liaison services
- A programme to support anti-stalking, in partnership with Cheshire Police, focusing on working with victims of stalking
- Working in partnership with the University of Salford to develop and deliver a psychiatric liaison mental health training awareness and knowledge programme across the North West
- New occupational health services in Knowsley

In addition, we have also focused on retaining existing contracts for services we already operate and working with our commissioners to redesign existing services, these include:

- Musculoskeletal service in St Helens
- 0-19 healthy child programme in Knowsley

- Cheshire liaison and diversion, in partnership with Cheshire and Wirral Partnership NHS Foundation Trust and Mitie Care and Custody Health

7.11. Service improvements

To ensure our culture of continuous service improvement is sustained, we have established three clinical networks aligned to Living Life Well – Start Well, Live Well and Age Well.

In August 2017, we appointed a new Director of Clinical Networks to lead a team to support the networks. During 2017/18, the structure, processes and quality improvement tools for the networks have been developed to ensure standardisation and transformation at pace is achieved through this non-hierarchical approach.

Following official launch events for staff in the last quarter of 2017/18, a number of ambassadors have been recruited to lead and develop communities of practice and learning sets within each network.

The clinical networks have supported the development of person-centric care pathways, in particular for personality disorder and adoption of the Cheshire and Merseyside perinatal pathway.

7.12. 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 has maintained a Care Quality Commission rating of '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.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2017/18.

The Trust continually assesses itself against the fundamental standards, reporting monthly as part of the performance report to Trust Board. Assurances are provided through the Quality Strategy and clinical assurance cycle and incorporate the following three areas:

- **Collaborative quality visits** – 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** – visits undertaken by executive and non-executive directors. A total of 31 have taken place between April 2017 and March 2018. 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.

7.13. 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, Care 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 Quality and Safety Meeting 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 our 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 six boroughs and various services.

7.14. 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.

7.15. 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 2017 to 31 March 2018, we received 1,871 compliments, 151 complaints and 479 concerns.

We closed 136 complaints during the reporting period – some of which were received during the previous year and were closed in the current one.

During the reporting period, we were informed of 10 complaints which were referred to the Parliamentary and Health Service Ombudsman.

In total, the Ombudsman investigated three complaints. One was upheld with recommendations, and two were not upheld and no further action considered necessary by the Ombudsman. Of the remaining seven complaints, three were not investigated. The Ombudsman requested further information for the remaining four and has made no further contact with the Trust regarding these complaints.

8. 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.

8.1. 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

During 2017/18, the key focus in Halton has been on the following:

- **Locality hub model**
  Within the borough, we have reviewed where our services are delivered from to ensure we have place-based provision so people can access services closer to home. As a result, all services will be delivered from both Widnes and Runcorn; however, the inpatient mental health provision will remain at the Brooker Centre in Runcorn. This will enable ease of access to all services and better partnership working with GPs in the two Halton towns.

- **Baby and Infant Bonding Support (BIBS)**
  Following a successful pilot during 2017/18, Halton Clinical Commissioning Group has agreed to invest in this service for 2018/19.

- **Vine Street**
  We have secured a lease at a previously vacant building in Widnes and, with the local authority and Halton Clinical Commissioning Group, have renovated the downstairs floor to provide a team base and clinical space. We intend to use Vine

Street to provide crisis prevention and 24/7 mental health services. There is a comfortable space where services users can stay while community services are put in place to support them. This will provide an alternative to inpatient admission. There will also be space for 10 hot-desks for all Trust staff to use.

- **Recovery Team**
  We have changed the way we offer clinics in the Recovery Team and are working closely with GPs to support discharge back to primary care.

- **Later Life and memory Service**
  The Later Life and memory Service has developed a specific training package to address dementia care and nursing within care homes. The training is for carers new to the role to support them to provide good quality and safe care to dementia patients. The rationale for this bespoke training package is to improve quality of care, reduce incidents and support care homes wishing to develop staff, and to provide an effective workforce, which, in turn, will improve staff retention.

- **Perinatal service**
  We are working in partnership with Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust to deliver an NHS England commissioned perinatal service across Cheshire and Merseyside. Our perinatal team has provided training to Trust staff on recognising perinatal mental health problems and the referral pathways. Work is ongoing to recruit service users as 'experts by experience' to input into our service development and feedback. Clinical commissioning groups across Cheshire and Merseyside have supported the service to bid for wave two funding to continue this service.

- **Child and adolescent mental health services**
  Our child and adolescent mental health services continue to provide support to Halton high schools and senior clinicians have recently attended educational psychology meetings at local primary school hubs.
  During 2017/18, we have been working with partners across Halton as we move towards implementing the THRIVE model during 2018/19.

- **Healthy New Town**
  The leadership team continues to work with Warrington and Halton Hospitals NHS Foundation Trust, Halton Borough Council and other partners around the Halton Healthy New Town programme and the proposed hospital and wellbeing campus at the Halton Hospital site. We have been involved with engagement events with the public, staff and elected members. If the proposals for the campus go ahead, mental health services will be housed within the new hospital and will have access to all the facilities within the campus.

- **Out of hospital care**
  We are working closely with Bridgewater Community Healthcare NHS Foundation Trust to support in shaping the future of out of hours hospital care and provision.

Knowsley

In April 2017, Knowsley welcomed our new Parent Infant Mental Health Service. The service supports parents to build loving bonds with their babies, whilst breaking negative life cycles. The service achieved national recognition earlier this year, winning the

Outreach to Vulnerable Groups award at the National Children and Young People's Mental Health Awards.

In September, we were commissioned by Knowsley Council to provide a new pre-school oral health program.

In October, we were given additional funding from NHS England to enhance our local acute hospital mental health liaison service. The service is due to begin in April and will provide a faster response to patients awaiting mental health services within the acute hospital.

During 2017/18, we launched our biggest transformation project to date which involved restructuring how our community services operate into a locality model of care. The project involved creating four locality hubs across Knowsley – Huyton, Whiston, Kirkby and Halewood – and wrapping core services into each of these hubs. In addition, we created specialist hubs where groups of specialist services are housed together to ensure expertise is shared. Running from March 2017 to January 2018, the project involved relocating more than 600 staff across the borough and closing four of our existing buildings. As a result, staff have begun to report better working relationships with other teams which is improving patient care delivery.

In December 2017, the Wellcroft Centre that housed our child and adolescent mental health services closed and the teams moved to a purpose-built Young People and Families' Wellbeing Hub based at the Whiston Hospital site. The new location brings together in one place Knowsley child and adolescent mental health services and the Cheshire and Mid-Mersey children's eating disorder service. Benefits include better transport links, a separate outpatient unit, greater consultation space and improved links to the paediatrics department and physical health services based at the onsite hospital.

Our new universal children's contract with Knowsley Council began in April 2017. Some of the previous services had changed to include greater peer support and the use of information technology to improve children's outcomes.

In September 2017, our new pan-borough immunisation team was launched. Previously, Sefton, St Helens and Knowsley managed immunisation separately; however, the Trust felt that greater outcomes would be achieved by merging all three services together.

Sefton

In April 2017, we began delivering the 0-19 Healthy Child Programme contract awarded by Sefton Council. The service aims to improve health and wellbeing outcomes, build resilience and reduce health inequalities for children and families in Sefton.

A service review was initiated at the point of transfer to the Trust which aimed to integrate the existing health visiting and school nursing teams and implement a locality-based service model which balances promotion, prevention, assessment, early identification and improved access to effective support.

Our staff have embraced the opportunities to transform and improve services and outcomes for children. The service review has involved the rationalisation of existing estates to facilitate the co-location of seven integrated teams, increase opportunities for agile working and create the potential for co-location with other partners at a later stage. From April 2018, six of the current sites will be vacated and seven newly created teams

will be located in six remaining office bases across the north, central and south areas of Sefton.

In February 2018, we launched the new enhanced 0-19 team to deliver an enhanced model of public health nursing, with an emphasis on early intervention for vulnerable families. This includes teenage parents, parents with learning disabilities, children not in education employment or training, asylum seekers and travelling families. The enhanced service uses the evidence base from the family nurse partnership model, utilising techniques such as motivational interviewing. We have also created a pre-school pathway and school age pathway to target the high impact areas in line with the Healthy Child Programme. The launch was well received by key partners and stakeholders, with some very powerful case studies shared to evidence the impact of the service on children and families.

In order to support the 0-19 service modernisation, a series of pan-borough developments have been created to mobilise the workforce to achieve some of the key transformational changes required within the 0-19 services across the Trust.

In June 2017, we began delivering on a sub-contract arrangement with Mersey Care NHS Foundation Trust to deliver further community services in Sefton. These include the integrated community equipment service, delivered in partnership with Sefton Council, Litherland Walk-in Centre, phlebotomy, safeguarding, and health provision to youth offending and looked after children services.

A service review has been carried out for each of the services, with findings and recommendations to be implemented during 2018/19 in consultation with partners and stakeholders.

The Litherland Walk-in Centre team won the Trust Star Team of the Year award in November 2017 for improving the way patients are assessed using a ‘See and Treat’ model. This model has resulted in a reduction in admissions to Accident and Emergency. Similar recognition was provided by the A&E Delivery Board which commended the walk-in centre for being ahead of developments for service changes.

During 2017/18, the Sefton leadership team has worked to establish the Trust as a respected provider within the Sefton partnership. This has included participation in the leadership collaborative, local commissioning academy, special education needs and disabilities strategic group and local safeguarding children’s board, where we explore opportunities to work together to tackle local challenges and ensure better outcomes for our communities.

St Helens

In April 2017, St Helens welcomed the community nursing directorate following a successful partnership bid with St Helens and Knowsley Teaching Hospitals NHS Trust and the GP-led Rota group. This saw the transition of more than 120 staff into our organisation, consisting of district nurses, community matrons, phlebotomists and many other staff. We have then begun on a 12-month transformation programme, profiling the workforce across a four locality footprint instead of five and developing the skill mix and clinical leadership within the directorate.

During 2017/18, the healthcare system within St Helens made bold moves to come together in a more formalised way under the banner of a large-scale, place-based

programme of work – St Helens Cares. This sees the combined efforts and resources of our Trust alongside the local authority, clinical commissioning group, hospital trust, and Torus, the local housing provider. A further step has seen the formal integration of the two commissioning functions within the clinical commissioning group and local authority, with a joint Chief Executive appointed and further changes and integration planned for 2018/19.

We have been invited to lead one of the four programmes, focussing on community-based services and how to transform locality-based provision into fully functioning multidisciplinary teams.

During 2017/18, we were successful in our submission to be the lead provider for child and adolescent mental health services within the borough and a transformed musculoskeletal provision. Work to mobilise the children's mental health services into a THRIVE model will begin in early 2018/19, with the formal contract changing in December 2018. Work on transforming the musculoskeletal pathways and provision began in early 2018. These are strong examples of a system-wide approach to designing service provision among the St Helens Cares partners, and bodes well for future partnership working and place-based care.

In 2017/18, we were subject to our first official special education needs and disabilities (SEND) inspection since the transfer of children's community services into the organisation in 2016. Whilst still a lot of work to do in this system, we were recognised as having a palpable vision and drive to improve the provision for children with special education needs and disabilities and commended for the innovative neuro-developmental pathway we have in place – led by our Trust, and the commitment and contribution from our children's practitioners, which we are very proud of.

Warrington

As a strong partner in the Warrington integrated care system, known as Warrington Together, we have strategic representation and leadership at board, senior change team and service redesign level. Warrington's assistant director and assistant clinical director have been instrumental in supporting the platform to move towards an integrated care model within the health and social care infrastructure of the borough. It is envisaged, as a strategic partner, we will move towards a neighbourhood hub and an all-inclusive healthcare approach with fellow statutory and non-statutory agencies for 2018/19 and beyond.

We continue to move towards a new model of care within our child and adolescent mental health service, which will include plans to reshape the assessment offer for children and young people with mental health needs. The implementation of the THRIVE model of care is expected during 2018/19.

Park House, a non-statutory crisis and safety house opened in February 2018 and we provide a clinical governance, gatekeeping and referral process to support individuals with mental health issues in crisis as a more appropriate alternative to admission.

Warrington piloted a home treatment and inpatient model after moving to a single consultant model within adult inpatient services in November 2017. The expectation is this will improve patient flow and give greater connectivity between home treatment services and inpatient care delivery. Warrington Recovery Team has also been undertaking transformational work to support the discharge of patients from secondary mental health services back to primary care through a transitional group work programme. This is fully

supported by Warrington Clinical Commissioning Group and will continue throughout 2018/19.

We received Memory Service National Accreditation Programme (MSNAP) accreditation for later life and memory services within Warrington from the Royal College of Psychiatrists. In November 2017, we implemented a delayed transfer of care process within the borough with our statutory partners in the local authority and clinical commissioning group, introducing a document which provides a benchmark and good practice to promote the management and prevention of delayed transfers of care.

We presented alongside Warrington Clinical Commissioning Group to statutory and non-statutory partners at the Warrington Partnership Board division for mental health services, encapsulating the Five Year Forward View, with particular emphasis on crisis concordant work, early intervention in psychosis, liaison mental health, and physical health of our patients with severe and enduring mental illness.

Warrington continues to lead and host the early intervention in psychosis services within the organisation, incorporating regional visits from NHS England, resulting in a self-assessment evaluation in January 2018. We continue to meet targets and expectations in accordance with NICE guidelines.

Aligned with our Trust strategic objectives for 2018/19, the work progressed in 2017/18 will guide a strategic direction which will incorporate some key demographics, including an increase in population of those aged 65 and over and an increase in families living within the borough.

Wigan

Over the past 12 months, the borough has seen leadership changes, with the appointment of a new assistant director, assistant clinical director, head of service for living life well, and two operational managers for living life well. This has brought positive changes in relation to visibility, increased communication and engagement with staff internally.

Externally, the leadership team has engaged with all organisations across the wider Wigan footprint and Greater Manchester. This has resulted in the Trust being seen as a leading provider in respect of the implementation of the adult mental health programme for delivering the Wigan Mental Health Strategy. This strategy incorporates the redesign and alignment of the community health services to the seven service delivery footprint model.

Our child and adolescent mental health services have worked collaboratively with our stakeholders both within the Wigan borough and wider Greater Manchester networks to support young people and families affected by the Manchester terrorist attacks in May 2017, developing a response package for local schools. We were involved in developing and providing bespoke support to children and schools across the borough and in devising support across Greater Manchester.

As part of the Wigan Future in Mind Strategic Group, we have worked alongside Wigan Borough Clinical Commissioning Group and Wigan Council to develop and enhance our child and adolescent mental health services. This work has led to the approval of business cases for a new school link service, all age rapid assessment interface and discharge (RAID), and ‘no wrong door’ – a new combined initiative for young people with mental health needs on the edge of care.

Our child and adolescent mental health service, in collaboration with the local authority, has implemented a new initiative to support the autistic spectrum conditions waiting list, with the intention of developing a new pathway. Future plans will see the development of a Wigan children's neurodevelopmental pathway.

Our personality disorder strategy leads presented the Wigan personality disorder pathway at the Greater Manchester Borderline Personality Disorder Strategy meeting. This was received very positively and the members were impressed with the pathway and the work done. Part of the presentation will be used to inform future mapping of service provision and it was clear that our system-wide model of link workers, Wigan multiagency strategy and carer-led initiatives, fits with what is wanted and needed, and the Trust's Wigan model, as a whole, is an excellent template.

In January 2018, we launched our new way of working within our psychological therapies service in Wigan – now called 'Think Wellbeing'. This increases opportunities for our population to access psychological therapies in a wider range of ways, therefore allowing more people to be helped by this service.

During 2017/18, there has been increase in acuity across all the urgent care services; this has been escalated both internally and externally by the leadership team. We are working closely with external stakeholders as part of the system resilience pathway to review the urgent care pathway in order to meet the ever-increasing demand. Our leadership team has received thanks from Wigan Borough Clinical Commissioning Group and our colleagues at the local hospital for its daily support over the winter period.

We have also implemented a number of short-term projects, funded by NHS England, in response to the seasonal pressures facing Accident and Emergency departments. These schemes are to assist with reducing and diverting appropriate cases away from A&E. These include a more senior presence from mental health at the point of triage and additional capacity to support service users within the acute hospital who are awaiting a mental health bed.

Specialist Services

From September 2017, Specialist Services became independent of the Warrington borough. Establishment of a robust leadership team and governance structure has been a key focus in-year, along with developing relationships with commissioning colleagues within NHS England and a diverse range of partner organisations.

Specialist Services encompasses secure inpatient wards commissioned through NHS England, including male and female low-secure units, a low-secure unit for adults with learning disabilities, a low-secure step-down unit for female service users and a young people's mental health inpatient unit. Byron Ward, the clinical commissioning group-commissioned learning disability unit on the Warrington site, also sits within the Specialist Services portfolio. Additional community services also form part of the portfolio, including criminal justice liaison services as well as the more recently acquired Greater Manchester Integrated Healthcare in Custody and Wider Liaison and Diversion Service.

During 2017/18, Specialist Services began mobilising a range of new and innovative services. These include:

- **Mental Health Liaison Education Programme**
  Commissioned through Health Education England, the Trust, in a unique partnership with the University of Salford, is in the process of designing a multiagency training programme, the first cohort of which will begin in September 2018. This training will upskill the existing and expanding workforce of liaison mental health teams across three North West sustainability and transformational partnerships as they develop to meet the 'Core 24' service standard, as outlined by the National Institute for Health and Care Excellence (2016) and the Five Year Forward View for Mental Health (2016). Work on developing this training programme began in October 2017.

- **Anti-stalking Unit (Warrington and Halton)**
  In collaboration with Cheshire Constabulary, the Trust is one of three 'proof of concept' sites in the country testing assumptions about the best way to reduce offending in stalkers through proactive and prevention strategies. Financially supported through the Police Transformation Fund and working alongside the Suzy Lamplugh Trust, learning from our multiagency intervention model will impact how, in the future, all police forces improve services for vulnerable victims to reduce the burden of stalking. The Anti-stalking Unit went live in March 2018.

- **Control Room Triage Service (Greater Manchester)**
  Designed to support police to respond to mental health-related calls, this NHS service based within Greater Manchester Police's communications centre is launching in summer 2018. In partnership with Greater Manchester Mental Health NHS Foundation Trust and Pennine Care NHS Foundation Trust, we will support mental health professionals to assess incidents relating to mental health and provide advice to support police staff, ultimately helping to avoid the unnecessary deployment of police officers. Expert clinical advice will be given to police officers, supporting them to make the right decisions when responding to incidents involving people who are experiencing mental health crisis.

- **Cheshire Integrated Healthcare Liaison and Diversion Service**
  In February 2018, the Trust, alongside Cheshire and Wirral Partnership NHS Foundation Trust and Mitie (providers of forensic medical services), secured the Cheshire Integrated Healthcare Liaison and Diversion Service, which will be mobilised by May 2018. This is an innovative partnership with NHS England and Cheshire Police to deliver services in custody, at court and in the community. Liaison and diversion services identify people who have mental health issues, learning disabilities, substance misuse or other vulnerabilities when they first encounter the criminal justice system as suspects, defendants or offenders. The service aims to improve health outcomes and support these people in reduction of offending.

The Specialist Services portfolio is also engaged in national initiatives, driven by NHS England, in respect of new models of care for secure services, the Transforming Care learning disability agenda, and new care model sites for child and adolescent mental health services.

- **Prospect Partnership**
  The Trust is working across Cheshire and Merseyside, with colleagues across Mersey Care, Cheshire and Wirral Partnership, Cygnet and Elysium, to develop new models of care for secure services in the North West. We have robust

representation across a range of work streams established to deliver best practice clinical models, with the Trust leading on the partnership's clinical network and nursing.

- **Transforming Care**
  The national Transforming Care agenda has resulted in the Trust being served notice by NHS England on its low-secure learning disability service at Hollins Park Hospital. The unit will close by the end of September 2018, and significant work is being undertaken alongside NHS England to support current service users with future placements. Through the regional Transforming Care programme, the Trust is scoping future opportunities to enhance its community learning disability services.

- **New care model for child and adolescent mental health services**
  Delivered in partnership across Cheshire and Merseyside, working alongside other NHS and independent providers, the Trust has collaborated, taking a whole system approach to enable local accountability for local children and young people and seamless provision of integrated mental health services which meet individual needs and those of their families. Work is underway to deliver new care models, across the footprint, culminating the knowledge, experience and expertise of the partnership to ensure needs-led and personalised care for children and young people, inclusive of the Trust's tier four young people's mental health inpatient unit in Warrington.

8.2. 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 six local overview and scrutiny committees and, for 2017/18, included a quality priority update event in February 2018. This event indicated the start of consultation with regard to priorities for 2018/19. Consultation continued throughout February and March 2018.

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 2018).

8.3. 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:

- Face Forward – service users deliver a wide range of activities covering health, art, and social activities to service users, carers and members of the community in Knowsley.
- Swapping Seats – a group of 18 service users and carers have been trained to provide mentoring to University of Liverpool trainee clinical psychologists.
- Ward activities – volunteers visit wards across Halton, Knowsley, Warrington and Wigan and carry out a range of activities with inpatients. This includes tea and biscuits, reading newspapers and general social interaction. Volunteers for St Helens wards have been identified and are currently being trained.

- Specialist Services Recovery College – volunteers have been recruited and trained to deliver a range of sessions, including cooking, dance, health and fitness, gambling awareness and relaxation. These have been run on both male and female secure inpatient wards and are currently underway on our child and adolescent inpatient unit.
- Criminal Justice Liaison Team – volunteers with lived experience of the criminal justice and mental health services work alongside staff in peer support groups.
- Gardening project on St Helens inpatient site – volunteers work with inpatients tending an area of raised beds and a copse.
- Walking basketball sessions at Atherleigh Park – volunteers deliver weekly sessions accessible to people of all abilities to inpatients on our Wigan inpatient wards.
- Smokefree – volunteers visit inpatient wards to promote the benefits of going smokefree and support service users to access community-based smokefree resources.

Two members of the Involvement Scheme have successfully used their experience of volunteering to obtain paid posts within the Trust. One is now employed in the Criminal Justice Liaison Team providing peer support, while the other is an activity worker based at Atherleigh Park.

Volunteers have also received references from the Involvement Scheme when applying for work outside the Trust.

The contribution of volunteers to Trust business is invaluable. During 2017/18, the Involvement Scheme had 162 trained and supported volunteers who carried out more than 10,000 hours of work.

Volunteers continue to actively participate in the production of our Trust newsletter, Reflect. Volunteers sit on the editorial panel, with their ideas shaping the content.

The Trust operates a robust engagement process to develop quality priorities for the annual Quality Account. In February 2018, an event was held and 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 2017/18 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 February 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.

8.4. 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 Halton child and adolescent mental health service showcases the offer of animal therapy to the SHOUT group – which focuses on 'caring for yourself' – demonstrating innovative ways to support young people in a therapeutic and caring way.

During 2017, the Trust worked closely with children and young people to redesign its service model for children and young people's mental health services to make services more accessible and ensure partners work more closely together, with a strong focus on prevention and early intervention.

Young people were involved through workshops and focus groups and helped to develop a visual representation of the new service model, which is based on the national THRIVE service specification and is grouped into four quadrants – getting advice, getting help, getting more help and getting risk support. Young people have been involved every step of the way, which has helped to ensure the needs of those who use our services are at the heart of the new service model.

The Trust sponsored and jointly led the organisation of the first national Children and Young People's Mental Health Awards held at Manchester Town Hall in January 2018. Young people from the Trust's child and adolescent mental health service, supported by our Chief Executive and Director of Clinical Networks judged the Contribution to Services category for an individual or group whose efforts in contributing to improving the quality of their local children and young people's mental health services has been exemplary and inspiring to professionals and children and young people. The young people from the judging panel were supported to attend the event and reported they had a wonderful time.

The Trust's Parent and Infant Mental Health Service won the Outreach to Vulnerable Groups Award for an individual young person or group which helps encourage individuals from groups who have had poor access to traditional services to seek support.

8.5. Third sector involvement

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

In May 2018 we are holding our annual Equality Delivery System 2 event where voluntary and community organisations have the opportunity to comment on the Trust's evidence regarding how we meet the needs of our communities concerning equality and diversity. Last year, 52 voluntary and community organisations were invited and 15 individuals attended.

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:

- Working closely with local carers' centres to deliver Training and Education Support (TES) to 111 carers at a variety of locations across the Trust.
- Extending the online confidential feedback system developed with Halton and Knowsley Healthwatch to Warrington Healthwatch, enabling local residents to share their experiences of services directly with frontline and corporate services.
- Working with local learning disability peer support group, Your Voice Your Choice, to develop a range of communication aids, including video, to encourage people with a learning disability to have their voice heard and raise concerns and complaints when necessary.

- Supporting Halton Carers' Centre to set up a peer support group for people caring for a person with a severe and enduring mental illness.

We have also developed a system to enable local community, voluntary and statutory groups to share information directly with targeted foundation trust members and members of the Involvement Scheme. In the last year, we have shared information about 283 community activities, national surveys and health promotion materials.

In July 2017, we were a corporate sponsor of the North West Disability Awareness Day which attracted 250-plus exhibitors (including more than 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.

9. Fees and charges

The Trust did not levy any income generation fees or charges in 2017/18 or 2016/17.

10. 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 208.

11. 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 2017/18, 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 year 2017/18, the Remuneration Committee determined that performance-related pay for executive directors would be consolidated into basic pay. This applied to all executive directors with the exception of the Medical Director, who had signalled her intent to retire from the Trust. The performance-related bonus – up to a maximum of 15 per cent of bonusable pay – was payable upon remaining in employment at the Trust until 31 March 2018 and successful delivery of previously agreed personal objectives as part of the annual performance and development review process for 2017/18.

Helen Bellairs, **Chair of Remuneration Committee**

2. Senior managers' remuneration policy

Table one on page 43 shows the following components of the remuneration policy for senior managers.

Salary and fees: This is annual basic pay. This is a spot salary and therefore is not subject to a maximum amount.

Other remuneration: This payment is in respect of duties outlined with the executive director role. This only applies to our Medical Director.

Performance-related bonuses: As noted above, performance-related pay is no longer offered as part of the remuneration package, with the exception of the Medical Director, for which the performance-related payment for 2017/18 was contingent on the successful delivery of previously agreed personal objectives, in line with the Trust's strategy, as part of the annual performance and development review process. This process was completed by the Chief Executive. The unsuccessful delivery of personal objectives would 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.

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.

2.1. Remuneration policy

Excepting two post holders, all staff 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.

Senior managers – as defined above – are employed on a personal contract and their remuneration is governed by the Remuneration Committee. All other terms and conditions are consistent with Agenda for Change.

2.2. Senior managers paid more than £150,000

During this period, one senior manager was paid more than £150,000. The Remuneration Committee satisfied itself, following consideration of market value, that this level of remuneration is reasonable.

2.3. 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 NHS Providers.

2.4. Service contract obligations

The Trust has no service contract obligations to report.

2.5. 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.

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

The Trust did make changes to the composition of some executive director and senior manager remuneration packages which resulted in no increase in their overall 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 60.

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 2017/18, the Remuneration Committee comprised the Chairman, Helen Bellairs, and non-executive directors – Jonathan Berry, Tricia Kalloo, Brian Marshall, Richard Sear, Philippa Tubb and Alison Tumilty. The committee met five times during the period 1 April 2017 to 31 March 2018 and was quorate. Full details of attendance are included within the NHS Foundation Trust Code of Governance Disclosures, starting on page 60.

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 2017/18, 11 executive and non-executive directors claimed a total of £6,366 in expenses. In the previous reporting year, 12 directors claimed a total of £10,549 in expenses.

Details relating to expenses claimed by governors during 2017/18 are included in the NHS Foundation Trust Code of Governance Disclosures, starting on page 60.

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

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director or member of their organisation and the median remuneration of the organisation's workforce. The fair pay multiple disclosures below have been subject to audit.

The banded remuneration of the highest paid director in the financial year 2017/18 was £200,000 to £205,000 (£205,000 to £210,000 in 2016/17). This was 7.9 times (also 7.9 in 2016/17) the median remuneration of the Trust workforce, which was £26,574 in 2017/18 (£26,302 in 2016/17). The median calculation is based on the full-time equivalent staff of the Trust at the reporting end date (31 March) on an annualised basis.

In 2017/18, no (also none in 2016/17) employees received remuneration in excess of the highest paid director.

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

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

Name and title	1 April 2017 to 31 March 2018						1 April 2016 to 31 March 2017					
	Salary and fees	Other remuneration	Performance related bonuses*	Taxable benefits	Pension related benefits	Total	Salary and fees	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
Simon Barber, Chief Executive	200 - 205				102.5 - 105	**305 - 310**	180 - 185		25 - 30		40.0 - 42.5	**245 - 250**
Gail Briers, Chief Nurse and Executive Director of Operational Clinical Services	130 - 135				182.5 - 185	**315 - 320**	115 - 120		15 - 20			**130 - 135**
Tracy Hill, Director of Strategy and Organisational Effectiveness	130 - 135				142.5 - 145	**275 - 280**	115 - 120		15 - 20		32.5 - 35.0	**165 - 170**
Sam Proffitt, Chief Finance Officer	140 - 145				142.5 - 145	**280 - 285**	120 - 125		15 - 20		25.0 - 27.5	**165 - 170**
Dr Louise Sell, Medical Director	35 - 40	140 – 145**	20 - 25		75 - 77.5	**270 - 275**	35 - 40	135 - 140*	20 - 25		155 - 157.5	**350 - 355**
Helen Bellairs, Chairman (from 17 May 2017 / Non-Executive Director until 16 May 2017)	40 - 45					**40 - 45**	10 - 15					**10 - 15**
Jonathan Berry, Non-Executive Director (from 16 November 2017)	0 - 5					**0 - 5**						
Tricia Kalloo, Non-Executive Director (from 1 June 2017)	10 - 15					**10 - 15**						

Name and title	1 April 2017 to 31 March 2018						1 April 2016 to 31 March 2017					
	Salary and fees	Other remuneration	Performance related bonuses*	Taxable benefits	Pension related benefits	Total	Salary and fees	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**
Bernard Pilkington, Chairman (until 16 May 2017)	5 - 10					**5 - 10**	45 - 50					**45 - 50**
Richard Sear, Non-Executive Director (until 22 September 2017)	5 - 10					**5 - 10**	5 - 10					**5 - 10**
Derek Taylor, Non-Executive Director (until 31 August 2016)							5 - 10					**5 - 10**
Philippa Tubb, Non-Executive Director	10 - 15					**10 - 15**	10 - 15					**10 - 15**
Alison Tumilty, Non-Executive Director	10 - 15					**10 - 15**	10 - 15					**10 - 15**

* The Remuneration Committee determines performance-related pay for executive directors. This was only applicable to the Medical Director during 2017/18. The performance-related bonus – up to of a maximum of 15 per cent of bonusable pay – was payable upon remaining in employment at the Trust until 31 March 2018 and successful delivery of previously agreed personal objectives as part of the annual performance and development review process for 2017/18.

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

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

Name and title	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at age 60 at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash equivalent transfer value at 31 March 2018	Cash equivalent transfer value at 31 March 2017	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Simon Barber, Chief Executive	5 - 7.5	7.5 - 10	25 - 30	55 - 60	476	373	103	29
Gail Briers, Chief Nurse and Executive Director of Operational Clinical Services	7.5 - 10	25 - 27.5	65 - 70	200 - 205	1,332	1,095	237	19
Tracy Hill, Director of Strategy and Organisational Effectiveness	5 - 7.5	12.5 - 15	40 - 45	105 - 110	739	588	151	17
Sam Proffitt, Chief Finance Officer	5 - 7.5	12.5 - 15	40 - 45	105 - 110	674	530	144	20
Louise Sell, Medical Director	2.5 - 5	12.5 - 15	80 - 85	245 - 250	1,718	1,543	175	25

The Trust contributed £111,000 to the pension scheme of the above directors during 2017/18, (£100,000 in 2016/17).

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
25 May 2018

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 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 2018 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	Total
Directors	3	8	11
Senior managers	67	216	283
Employees	591	3,050	3,641
Total	**661**	**3,274**	**3,935**

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

	2017/18			2016/17		
	Total	**Permanently employed**	**Other**	Total	Permanently employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages*	**114,401**	**97,935**	**16,466**	97,754	84,588	13,166
Social security costs	**10,156**	**9,333**	**823**	8,693	7,934	759
Apprenticeship Levy	**544**	**544**	**-**			
Employer contributions to NHS Pension Scheme	**13,522**	**12,426**	**1,096**	11,394	10,399	995
Other post-employment benefits	**-**	**-**	**-**	-	-	-
Termination benefits	**1,157**	**1,157**	**-**	170	170	-
Agency / contract staff	**4,236**	**-**	**4,236**	6,776	-	6,776
Total gross staff costs	**144,016**	**121,395**	**22,621**	124,787	103,091	21,696
Less income in respect of staff costs netted off expenditure	**-**	**-**	**-**	-	-	-
Total staff costs	**144,016**	**121,395**	**22,621**	124,787	103,091	21,696
Of the total above:						
Costs capitalised as part of assets	**54**	**54**	**-**	91	91	-
Analysed into operating expenditure:						
- Employee expenses – staff	**141,760**	**119,139**	**22,621**	123,548	101,852	21,696
- Employee expenses – executive directors	**1,045**	**1,045**	**-**	978	978	-
- Redundancy	**1,157**	**1,157**	**-**	170	170	-
- Special payments	**0**	**0**	**-**	0	0	-
Total employee benefits excluding capitalised costs	**143,962**	**121,341**	**22,621**	124,696	103,000	21,696

* 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)

	2017/18			2016/17		
	Total Number	**Permanent Number**	**Other Number**	Total Number	Permanent Number	Other Number
Medical and dental	**148**	**82**	**66**	147	82	65
Administration and estates	**825**	**736**	**89**	765	687	78
Healthcare assistants and other support staff	**238**	**235**	**3**	225	219	6
Nursing, midwifery and health visiting staff	**1,932**	**1,682**	**250**	1,547	1,346	201
Nursing, midwifery and health visiting learners	**9**	**9**	**-**	12	12	-
Scientific, therapeutic and technical staff	**624**	**568**	**56**	566	505	61
Social care staff	**-**	**-**	**-**	-	-	-
Agency and contract staff	**-**	**-**	**-**	-	-	-
Bank staff	**-**	**-**	**-**	-	-	-
Other	**6**	**6**	**-**	6	6	-
Total	**3,782**	**3,318**	**464**	3,267	2,856	411
Of the above:						
Number engaged on capital projects	**1**	**1**	**-**	2	2	-

4. Sickness absence

Our annual cumulative sickness and absence figure for the calendar year 2017 (1 January to 31 December 2017) remains above our target of five per cent, at 5.86 per cent, which is up from 5.81 per cent the previous year. Quarterly statistics are detailed in the table below, followed by a more detailed breakdown of staff absence.

Quarter	Period	Absence percentage	Criteria
Four (2016/17)	January – March 2017	5.44%	12-month cumulative percentage April 16 to March 17
One (2017/18)	April – June 2017	5.92%	12-month cumulative percentage July 16 to June 17
Two (2017/18)	July – September 2017	5.98%	12-month cumulative percentage October 16 to September 17
Three (2017/18)	October – December 2017	5.86%	12-month cumulative percentage January 17 to December 17

	Calendar year 2017
Days lost (long-term)	43,952
Days lost (short-term)	27,325
Total days lost	71,277
Total staff years	3,502.9
Average working days lost	13.23
Total staff employed as at 31 March 2017 (headcount)	3,926
Total staff employed as at 31 March 2017 with no absence (headcount)	1,628
Percentage of staff with no sick leave	41.5%

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

People Services 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 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 2017/18, the Trust was recognised as Disability Confident Committed. This shows applicants and employees we actively support disabled people and that, as a Trust, we meet the following five commitments:

- Inclusive and accessible recruitment
- Communicating vacancies
- Offering an interview to disabled people
- Providing reasonable adjustments
- Supporting existing employees

In 2018/19, we will progress to Level 2: Disability Confident Employer and be recognised as 'going the extra mile to make sure disabled people get a fair chance'.

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.

Gender pay gap

The Trust is required to comply with the Equality Act 2017 regulations for public sector organisations with more than 250 staff to publish their gender pay gap and bonus gender pay gap by 30 March 2018. The calculation is based on all staff including bank staff and on their net pay. The data in the analysis relates to the financial year 2016/17 and is for those who were employed on 31 March 2017. Our data shows an average gap of 15.39 per cent between men and women's pay, this compares to 17.7 per cent across all employers nationally.

Workforce Race Equality Standard (WRES)

During 2017/18, 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.

Employee networks

The Trust recognises the importance of a commitment to diversity, which includes engaging with the needs of all of our employees to further the equality agenda of the organisation.

The Trust has begun implementation of an employee network group to ensure we make our employees a visible element of the workforce. It will provide a forum for unique networking opportunities and a means of peer support between all employees. It will also enable us, as an employer, to engage directly with the needs of all employee groups and recognise which policies may impact on employees with protected characteristics, and what changes can be made to improve employees' experiences.

Employee networks are not a complete diversity solution, but they are an important step for the Trust as we want to demonstrate our commitment to eradicating discrimination at work. The employee network will give marginalised groups an opportunity to be heard.

Staff development

Having skilled, motivated well supported and developed staff is our greatest assurance that we can provide the necessary care to our patients and communities. If we put our staff first, they will take good care of our patients.

In April 2017, we launched the Maximising Your Potential Conversations Framework which explores ways in which we can establish people's potential through effective quality conversations. This is based on exploring their potential and performance based on behaviours and functional capability.

This piece of work stemmed from our recognition that, whilst operating in difficult times, it is possible to become focused on key performance indicators and performance targets above the behaviours which support our Trust's progression. By incorporating the values and behaviours into our performance and development review cycle, we have been able to effectively review the ways in which we work and, importantly, assess how we are achieving our aims.

We revised our existing practice to support our coaching conversations culture, placing an emphasis on our values to align the process more appropriately with talent and succession. The Maximising Your Potential Conversations Framework has allowed us to embed a cultural shift in how we spot, nurture and celebrate our successes. It has also provided a framework which feeds into our training cycle, leadership development and talent management.

Staff retention

In June 2017, the Trust signed up to an NHS Improvement retention support programme. This is a targeted, clinically-led programme where NHS Improvement's central workforce team works with trusts to improve turnover rates. The purpose of the programme is to increase the focus on retention and reduce variation across trusts.

As part of the programme, we have analysed our retention data; begun a review of how we onboard and induct new members of staff; we are monitoring our engagement activity; reviewing our clinical supervision processes; developing our rewards and recognition for staff; and reviewing our flexible working arrangements.

We have already seen an improvement of two per cent in terms of the yearly turnover figures – July 2017: 14.4 per cent compared with March 2018: 12.2 per cent. This shows a positive trend towards our target of 12 per cent turnover by the end of December 2018. Work will continue to progress on this during 2018/19.

We have identified a number of work streams which align to each stage in the recruitment and employee journey (touchpoints of the employee lifecycle). Remodelling our employee value proposition, we recognise a positive working relationship between employer and employee starts from the moment someone is attracted to work at the Trust. It continues throughout the employee lifecycle with values-based recruitment and selection, and supportive onboarding (appointment and commencement in post), welcome pack and induction. Once in post, we recognise this relationship between employer and employee continues and we offer great development and learning opportunities, real inclusion and engagement, celebrating and rewarding success and recognition for valued work. Even as an employee is considering succession and mobilisation options, our support continues and we continually listen, learn and make improvements.

Staff engagement

We believe good two-way communication helps us to engage effectively with our people. We listen to our people and their views. During 2017/18, we held listening forums within our boroughs and with different staff groups to identify areas of good practice and quick wins. In addition, we've produced engaging communications to share the importance of 'getting your voice heard' and how we commit to listening to our people.

We have recently reviewed and refreshed our internal communications in line with staff feedback. We believe effective internal communication should be a partnership between senior managers, leaders, the Communications Team and all staff.

Our aim is for internal communications to be open and honest, trusted, timely (where possible, staff will be the first to know), accessible, engaging and concise.

We use a range of different channels to communicate with staff, including a face-to-face monthly core brief; a weekly e-bulletin; targeted emails; 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 three 'Afternoon with the Chief Executive' sessions during 2017/18, offering staff the opportunity to submit online questions about any work-related subject to our Chief Executive 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.

Occupational health

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 meets Safe Effective Quality Occupational Health Service (SEQOHS) standards and was reaccredited in March 2018. The service also meets national quality standards through the delivery of six core services:

- Prevention – the prevention of ill-health caused or exacerbated by work.
- Timely intervention – staff have rapid access to treatment of psychological problems and musculoskeletal disorders.

- Rehabilitation – processes which enable staff to remain in work or return to work after illness or injury.
- Health assessments for work – fitness for work, specific medicals and risk assessments.
- Promotion of health and wellbeing – using work as a means of improving health and wellbeing and using the workplace to promote health.
- Teaching and training – education regarding managing your health, the health of others and promoting health and wellbeing amongst our people.

All services, including rapid access to physiotherapy and counselling, and programmes such as the stress management course and mindfulness, 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, who 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 provides an opportunity for staff to provide feedback on their experience of working in our Trust and provides evidence of where things are going well and where there are potential areas for improvement.

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** – 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.

As a Trust, we have demonstrated a real commitment to employee engagement and experience by introducing staff engagement action plans across the Trust. These have been tailored to each borough and individual teams to support their own engagement journey. Where engagement action plans have been monitored and senior teams have taken accountability for action, we have seen progressive improvement in areas of engagement.

6.1. Summary of performance – NHS Staff Survey 2017

The results of the 2017 survey were published on 6 March 2018. The survey enables each organisation to benchmark itself against similar organisations. Measuring staff experience through the survey has proved a vital way of demonstrating the relationship between staff experience and patient experience.

Our Trust's results have been compared with 29 other combined mental health, learning disability and community trusts in England.

The Trust's response rate for 2017 is shown below, compared with last year's data:

	2016		2017		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
Response rate	42%	44%	42%	45%	Same score as last year

The survey was sent to all staff through a mix of online and paper surveys. The survey was sent to an official sample size of 3,708, with 1,537 completed questionnaires returned – a response rate of 42 per cent. Although this is the same as last year, we consider our engagement has increased given the significant level of organisational change, resulting in an increase in the survey sample size for this year.

When compared with our 2016 results, 84 per cent of our key findings remain static and 81 per cent demonstrate better results than our comparator group.

Overall, our 2017 results demonstrate statistically significant positive changes in four of the 32 key findings when compared to last year, and there has been one statistically significant negative change.

Our largest areas of improvement from last year and one area of deterioration are shown in the following table, with comparisons to this year's data.

Largest areas of improvement	2016	2017	Trust improvement/ deterioration
Staff experiencing support from immediate managers	3.85*	3.96*	0.11 improvement
Staff reporting the organisation and management interest in and action on health and wellbeing	3.78*	3.86*	0.08 improvement
Percentage of staff appraised in last 12 months	92%	95%	3% improvement
Staff recommendation of the organisation as a place to work or receive treatment	3.75*	3.82*	0.07 improvement
Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	49%	53%	4% deterioration

Our top five ranking scores for 2017 with 2016 comparators:

Top five ranking scores	Trust 2016	Trust 2017	National average 2017	Trust improvement/ deterioration
Staff reporting the organisation and management interest in and action on health and wellbeing	3.78*	3.86*	3.70*	0.08 improvement and statistically significant positive change
Percentage of staff experiencing discrimination at work in the last 12 months	8%	7%	11%	1% improvement
Percentage of staff feeling unwell due to work related stress in the last 12 months	40%	35%	40%	5% improvement
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	91%	86%	Same score as last year
Percentage of staff appraised in last 12 months	93%	95%	92%	2% improvement and statistically significant positive change

Our bottom five ranking scores for 2017 with 2016 comparators:

Bottom five ranking scores	Trust 2016	Trust 2017	National average 2017	Trust improvement/ deterioration
Percentage of staff / colleagues reporting most recent experience of violence	91%	85%	88%	6% deterioration
Staff reporting quality appraisals	3.10*	3.07*	3.10*	0.03 deterioration
Percentage of staff satisfied with the opportunities for flexible working patterns	57%	57%	58%	Same score as last year
Staff reporting the effective use of patient / service user feedback	3.65*	3.63*	3.69*	0.02 deterioration
Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	49%	53%	53%	4% deterioration and statistically significant negative 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

It is recognised this year's results have, in the main, remained broadly similar to the 2016 survey results. The areas of focus from 2016 remain important and therefore it is recommended the shared leadership team objectives are committed to again for 2018/19.

Our shared staff survey objectives for last year were in relation to the following:

1) Improving staff engagement and communication between senior managers and staff.

2) Encouraging staff to report and ensure they know how to report errors, near misses or incidents witnessed.
3) Ensuring staff are able to contribute towards improvements at work and that patient experiences and data is regularly and effectively shared.

In addition, following our 2017 results, we will:

- Review and evaluate our non-mandatory training, learning and development offer. This action was not completed during 2016/17 due to additional demands on the learning and development team relating to the acquisition of services.
- Develop a management and leadership development strategy and begin implementation of this programme, with a key focus on staff health and wellbeing and the prevention and management of violence, bullying, harassment and abuse in the workplace.
- Communicate regularly with staff around progress being made on aspects of the People Strategy and annual plan, which responds to questions within the NHS Staff Survey. We will adopt a 'you said, we listened' approach to provide feedback on action being taken.

7. Consultancy expenditure

The Trust has spent £178,000 in total on external consultants during 2017/18, compared with £259,000 during 2016/17. These costs have covered specialist skills required to deliver our new information management reporting system and to support business development and growth.

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 2018 for more than £245 per day and which last for longer than six months.

Number of existing engagements at 31 March 2018	2
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	1
Number that have existed for between three and four years at time of reporting	1
Number that have existed for four or more years at 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 2017 and 31 March 2018 for more than £245 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 2017 and 31 March 2018	0

Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

The table below shows off-payroll engagements of board members and/or senior officers with significant financial responsibility between 1 April 2017 and 31 March 2018.

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.	13

9. Exit packages

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

There were 38 compulsory redundancies in 2017/18, at a cost of £1.157 million. All payments were contractual. These were as a result of restructures within some of our corporate services teams and planned service changes.

Staff exit packages 2017/18 (the following table has been subject to audit)

	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	9	20	0	0	9	20	0	0
£10,001 – £25,000	11	180	0	0	11	180	0	0
£25,001 – 50,000	12	477	0	0	12	477	0	0
£50,001 – £100,000	4	268	0	0	4	268	0	0
£100,001 – £150,000	2	212	0	0	2	212	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	**38**	**1,157**	**0**	**0**	**38**	**1,157**	**0**	**0**

2016/17 figures are available within the Annual Accounts starting on page 208.

Exit packages: other (non-compulsory) departure payments – 2017/18 (the following table has been subject to audit)

	2017/18	2017/18	2016/17	2016/17
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	**0**	**0**
Of which, non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

NHS Foundation Trust Code of Governance Disclosures

North West Boroughs Healthcare 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 2017/18, 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 2017/18. The Board Assurance Framework and risk management processes and corporate governance were reviewed as part of a well-led review. The level of assurance received for both was 'significant with minor improvement opportunities'.

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: www.nwbh.nhs.uk/documents/constitution) – Standing Orders for the Practice and Procedure of Council of Governors for North West Boroughs Healthcare 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 2017/18 (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	24/04/17	30/05/17	26/06/17	31/07/17	25/09/17	30/10/17	27/11/17	29/01/18	26/02/18	26/03/18
Simon Barber, Chief Executive	✓	✓	✓	✓	✓	✓	×	✓	✓	✓
Gail Briers, Chief Nurse and Executive Director of Operational Clinical Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tracy Hill, Director of Strategy and Organisational Effectiveness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sam Proffitt, Chief Finance Officer	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Dr Louise Sell, Medical Director	✓	✓	✓	✓	✓	×	✓	✓	✓	✓

Trust Board attendance – non-executive directors

Board member	24/04/17	30/05/17	26/06/17	31/07/17	25/09/17	30/10/17	27/11/17	29/01/18	26/02/18	26/03/18
Helen Bellairs, Chairman (from 17 May) / Non-Executive Director and Vice Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jonathan Berry, Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	✓
Tricia Kalloo, Non-Executive Director	N/A	N/A	✓	✓	✓	✓	✓	✓	✓	×
Brian Marshall, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bernard Pilkington, Chairman	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Richard Sear, Non-Executive Director	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A
Philippa Tubb, Non-Executive Director	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Alison Tumilty, Non-Executive Director	✓	×	✓	✓	✓	✓	✓	✓	✓	✓

1.1. The Trust Board for the period 1 April 2017 to 31 March 2018 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 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, and is on the System Management Board for the Cheshire and Merseyside Health and Care Partnership. He has previously worked at a national level supporting NHS England's programme to transform care for people with learning disabilities.

Bernard Pilkington
Bernard Pilkington first became involved with the health service in 1984, serving as a non-executive director for St Helens and Knowsley Health Authority, where he was Vice Chair. Bernard became Chairman of our Trust on 17 May 2007, later championing our successful bid for foundation trust status in 2010. Bernard retired on 16 May 2018, when his term of office ended following a successful 11 years with the Trust.

Helen Bellairs
Helen has worked in or with the NHS for 50 years. She started her NHS career as a nurse cadet and has more than 17 years' experience operating as an executive director and chief executive. She has also worked as an independent management consultant with acute and community providers and commissioners. Helen took on the role of Chairman on 17 May 2017. Helen was previously a non-executive director and served as a member of the Audit Committee, Remuneration Committee and Quality Committee.

Our executive directors are:

Gail Briers
Gail was appointed Chief Nurse and Executive Director of Operational Clinical Services on 1 December 2014. Before this, she was Director of Nursing and Governance. Gail started out at Winwick Hospital, Warrington, as a nursing assistant 35 years ago. Since then, she has worked in a variety of 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. Before this, she was Director of People and Integrated Governance 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. 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, before that, Deputy Director of Finance at Mersey Care NHS Foundation 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 with responsibility for medical and pharmacy 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. Louise retired on 31 March 2018.

Our non-executive directors are:

Jonathan Berry

Jonathan was a GP for 31 years and has had an active career in service redesign. In particular, he led work to improve integration between health services and to drive up standards of care in community and GP services. Jonathan is an experienced non-executive director in the NHS and commercial sector and runs his own consultancy business. He joined our Trust Board in November 2017.

Tricia Kalloo

Tricia is currently Chief Executive and owner of Wellness International Limited, an occupational health service provider, and is also a qualified cognitive behavioural therapist and coach. She previously worked in healthcare in the United States of America before moving to Antigua, where she became Director of Finance and Administration for the Eastern Caribbean Civil Aviation Authority. Tricia was appointed as a non-executive director in June 2017, and has chaired the Quality Committee since November 2017.

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 and chaired the Audit Committee until December 2017. Brian is also a member of the Remuneration Committee. Brian was appointed as a non-executive director 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 was appointed as a non-executive director in September 2016 and resigned on 22 September 2017. During this time, he chaired the Quality Committee.

Philippa Tubb

Philippa is a registered general nurse with a clinical background in tropical and infectious diseases and is the Managing Director of Well Travelled Clinics at the Liverpool School of Tropical Medicine. She is also the school's designated safeguarding officer. 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 as a non-executive director in May 2011 and her role was this year extended by a year to May 2018.

Alison Tumilty

Alison has a wealth of experience in senior financial roles, including Manchester Airport Group, Unite PLC and Your Housing Group. Alison also spent more than five years as Deputy Chief Executive of Rathbone Training, a nationwide charity supporting disadvantaged young people to gain skills and training to help them to move into independent living and paid employment. Alison was appointed as a non-executive director in September 2015 and has chaired the Audit Committee since January 2018.

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
Helen Bellairs (Chairman)	17 May 2017	16 May 2020
Jonathan Berry	16 November 2017	15 November 2020
Tricia Kalloo	2 June 2017	1 June 2020
Brian Marshall	17 December 2015	16 June 2018
Bernard Pilkington (Chairman)	17 May 2014	16 May 2017
Richard Sear	1 September 2016	22 September 2017
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 and Care Quality Commission well-led framework to ensure continual improvement.

Member	24/04/17	12/07/17	30/10/17	13/12/17	24/01/18
Helen Bellairs, Non-Executive Director	✓	N/A	N/A	N/A	N/A
Helen Bellairs, Chairman	N/A	✓	✓	✓	✓
Jonathan Berry, Non-Executive Director	N/A	N/A	N/A	✓	✓
Tricia Kalloo, Non-Executive Director	N/A	✗	✓	✓	✓
Brian Marshall, Non-Executive Director	✓	✓	✓	✓	✓
Bernard Pilkington, Chairman	✗	N/A	N/A	N/A	N/A
Richard Sear, Non-Executive Director	✓	✓	N/A	N/A	N/A
Philippa Tubb, Non-Executive Director	N/A	N/A	✓	✓	✓
Alison Tumilty, Non-Executive Director	N/A	N/A	✓	✓	✓

1.3. Quality Committee

Linking closely with the Audit Committee, the Quality Committee assures Trust Board that appropriate structures, systems and processes are embedded within 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 ensuring learning occurs as a result of risk analysis and feedback to services. The committee has the following duties:

- To oversee and receive exception reports on the development and publication of an annual Quality Report and Quality Account; ensuring the quality priorities 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 seek assurance from the Trust's Integrated Governance Team of effective quality, safety and risk systems and processes. Examine in-depth, by exception, key risk issues impacting on quality as referred by the Quality and Safety Meeting.
- To seek assurance from all the Trust's boroughs throughout the year through a presentation which aims to provide assurances regarding the quality, safety and risk systems and processes in place.
- To oversee the development and implementation of the Trust's Quality Strategy.
- To carry out a bi-monthly review of quality, safety and risk investigations of areas of serious concern regarding quality to seek assurance of learning and 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 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 reports from groups with a statutory or regulatory requirement to report directly to a sub-committee of the Trust Board:
    - Medicines Management – quarterly and annual report
    - Infection Prevention and Control – quarterly and annual report
    - Records Management – annual report
    - Research and Development – annual report
    - Medical Workforce and Education – annual report
    - Safeguarding – quarterly and annual report
    - Mental Health Law – quarterly and annual report
    - Patient Experience – quarterly and annual report
    - Clinical Audit Planning and Priorities – annual report
    - Freedom to Speak Up Guardian – bi-annual report
    - Guardian of Safe Working Hours – quarterly and annual report
- To receive bi-annual reports from the Quality and Safety Meeting, the Clinical Leadership Group and Mortality Review Group.
- To receive the approved minutes from the bi-monthly Lessons Learned Forums.
- To receive additional internal and external reports relating to quality, safety and risk as required by the Quality Committee.

The Quality Committee work plan will be reviewed on a quarterly basis in order to remain current to the needs of the organisation, reflecting any trends or themes for review.

Richard Sear, Non-Executive Director, chaired the committee between 1 April 2017 and 22 September 2017. Philippa Tubb, Non-Executive Director, chaired the committee between 23 September 2017 and 7 November 2017, and Tricia Kalloo, Non-Executive Director, chaired the committee between 8 November 2017 and 31 March 2018.

The committee met on 10 occasions between 1 April 2017 and 31 March 2018. 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

	12/04/17	10/05/17	14/06/17	12/07/17	02/08/17	13/09/17	11/10/17	08/11/17	13/12/17	14/02/18	14/03/18
Gail Briers, 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	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jonathan Berry Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	✓
Tricia Kalloo, Non-Executive Director	N/A	N/A	✓	×	✓	✓	✓	✓	×	✓	✓
Richard Sear, Non-Executive Director	✓	×	✓	✓	×	N/A	N/A	N/A	N/A	N/A	N/A
Philippa Tubb, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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 opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes (including the function of committees) that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. This will include a regular deep dive into the control and mitigation action relating to strategic or significant operational risks recorded in the risk register within the Risk Assurance Framework.
- The Trust's Annual Clinical Audit Programme and ensuring outcomes result in service improvement.
- The policies for ensuring compliance with relevant regulatory, legal and Code of Conduct requirements, performing an oversight role in relation to registers where interests, hospitality and partnerships are recorded.
- The policies and procedures for all work related to fraud and corruption as set out in the NHS Counter Fraud Authority Standards for Providers (published April 2012) and as required by the NHS Counter Fraud Authority and the revised NHS Contract.

Brian Marshall chaired the Audit Committee until December 2017, Alison Tumilty chaired the committee from January 2018.

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).

	12/04/17	14/06/17	02/08/17	11/10/17	13/12/17	14/02/18
Helen Bellairs, Non-Executive Director	✓	N/A	N/A	N/A	N/A	N/A
Tricia Kalloo, Non-Executive Director	N/A	✓	✓	✓	×	✓
Brian Marshall, Non-Executive Director	×	✓	✓	✓	✓	✓
Richard Sear, Non-Executive Director	✓	✓	×	N/A	N/A	N/A
Alison Tumilty, Non-Executive Director	✓	✓	✓	✓	✓	✓

There was also an extra-ordinary meeting held on 18 May 2017 to approve the Annual Report and Accounts for the financial year 2016/17.

In discharging its responsibilities in 2017/18, 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 and approved at the April 2017 Audit Committee meeting. Progress against this plan was reviewed at subsequent meetings during 2017/18.

Financial matters and reporting

- The external auditor annual plan was presented and approved by the committee in February 2018. 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.
- The Annual Accounts for 2017/18, including the auditor's report to those charged with governance, were reviewed at the extra-ordinary meeting on 22 May 2018 and approved on 25 May 2018.
- Aged debt, salary overpayments and losses were reviewed and challenged throughout the year.
- The waivers register was presented periodically during 2017/18 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.
- On 13 December 2017, the committee received and approved the Trust's Charitable Funds Annual Report and Accounts for 2016/17.

Fraud

- The Trust's counter fraud service is provided by KPMG. The counter fraud annual plan was agreed at the April 2017 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 the plan were provided to each meeting.
- A number of counter fraud investigations were instigated during 2017/18. 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 2018.

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 2017/18.

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. A further agreement to retain PricewaterhouseCoopers for a further year was agreed at the Audit Committee on 2 August 2017 and the Council of Governors on 15 November 2017; this period is to allow for competitive procurement for the contract. The agreed fee for the audit work for 2017/18 was £58,000 excluding VAT (£56,800 in 2016/17).

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 confirm that, in our professional judgement, as at the date of this document, we are independent accountants with respect to the Foundation Trust, within the meaning of UK regulatory and professional requirements and that the objectivity of the audit engagement leader and the audit staff is not impaired.

1.8. Additional director responsibilities

Our Chief Nurse and Executive Director for Operational Clinical Services has a non-executive director role and is the Vice Chair for 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.nwbh.uk/trust-board
- Council of Governors: www.nwbh.nhs.uk/governor-meetings

Neither of our chairmen had any 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 2017/18, our nominated lead governor was Chris Whittle.

During the reporting year, 12 governors claimed a total of £2,192.45 in expenses. In the previous reporting year, 14 governors claimed a total of £1,586.55 in expenses.

Our Council of Governors met four times during the period 1 April 2017 to 31 March 2018.

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)	3/05/17	6/09/17	15/11/17	21/02/18
Bernard Pilkington, Chairman	✓	N/A	N/A	N/A
Helen Bellairs, Chairman	N/A	✓	✓	
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	✓	✓	×	✓
Reverend Lyn Cavell McIver – Public, Halton, Elected	✓	✓	×	×
Chris Coffey – Public, St Helens, Elected	×	✓	✓	✓
Ann Cunliffe – Staff Side Chair, Appointed	×	×	×	×
Amber Dickinson – Staff, Nursing, Elected	×	N/A	N/A	N/A
Councillor Damian Edwardson – Wigan Council, Appointed	×	×	N/A	N/A
Alan Griffiths – Public, St Helens, Elected	✓	✓	✓	N/A
Hazel Hendriksen – Staff, Allied Health Professional, Elected	✓	✓	×	×
Chris Hugo – Public, Warrington, Elected	×	×	×	×
Andy Jones – Public, Halton, Elected	✓	✓	✓	✓
Councillor John Kelly, Sefton Council, Appointed	N/A	✓	×	×
Charlie Leonard – Staff, Supporting Services, Elected	✓	×	×	×
Denis McFarland – Public, Other, Elected	✓	✓	✓	✓
Jacqui McGloin – Public, Halton, Elected	×	×	×	×
Chris Molyneux – Public, Warrington, Elected	✓	✓	×	✓
Councillor Jim Moodie, Wigan Council, Appointed	N/A	✓	×	×
Chris Peake – Staff, Supporting Services, Elected	✓	×	✓	✓
Councillor Marlene Quinn – St Helens Council, Appointed	×	×	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	×	×	×	×

The following governors were appointed from 1 March 2018, and as at 31 March 2018 have yet to attend their first Council of Governors' meeting:

- Paul Davies – Public, Knowsley, Elected
- Richard Short – Public, Wigan, Elected
- Innes Arnold – Public, St Helens, Elected
- Gerald O'Connell – Public, St Helens, Elected
- Colin Pearson – Public, St Helens, Elected
- Lisa Martin – Staff, Allied Health Professional, Elected
- Jane Neve – Staff, Managers, Elected
- Narender Dhillon – Staff, Medical, Elected
- Mike Crawford – Staff, Support Services, Elected
- Jason O'Flaherty – Staff, Nursing, Elected

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.

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

3 May 2017

- Simon Barber, Chief Executive
- Helen Bellairs, Non-Executive Director, Vice Chair
- Brian Marshall, Non-Executive Director

6 September 2017

- Simon Barber, Chief Executive
- Alison Tumilty, Non-Executive Director

15 November 2017

- Sam Proffitt, Chief Finance Officer
- Brian Marshall, Non-Executive Director

21 February 2017

- Sam Proffitt, Chief Finance Officer
- Philippa Tubb, 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 three times during the period 1 April 2017 to 31 March 2018. 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).

Governor	03/07/17	10/10/17	12/12/17
Trevor Barton	×	✓	✓
Dr Marian Catalan	×	×	×
Chris Coffey	×	×	×
Andy Jones	✓	×	✓
Denis McFarland	✓	✓	✓
Chris Molyneux	N/A	✓	✓
Sheila Ratcliffe	×	×	×
John Richards	×	×	×
Jim Sinnott	✓	✓	✓
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 three times during the period 1 April 2017 to 31 March 2018. The membership is made up of the Chairman, Helen Bellairs, 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:

Governor	28/07/17	16/10/17	10/01/18
Michael Ashley	×	×	×
Trevor Barton	✓	✓	×
Andy Jones	N/A	N/A	✓
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.

The Trust does not use an external search consultancy for advertising non-executive appointments, it does use a recruitment consultant to carry out preliminary interviews as part of the 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 director 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	20/06/17	10/10/17	19/12/17	21/03/18
Chris Coffey	✓	✓	✓	✓
Alan Griffiths	✓	✓	N/A	N/A
Andy Jones	✓	×	✓	✓
Denis McFarland	✓	✓	✓	×
Jackie McGloin	✓	N/A	N/A	N/A
Chris Molyneux	✓	✓	✓	✓
Gerald O'Connell	N/A	N/A	N/A	✓
Chris Peake	✓	×	✓	×
Sheila Ratcliffe	×	✓	✓	✓
John Richards	✓	×	×	×
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 2018 are shown below.

Constituency	Number of members
Halton	751
Knowsley	656
Sefton	334
St Helens	897
Warrington	1,294
Wigan	1,066
Other	889
Total	**5,887**

Trust staff are automatically members, but may opt out if they wish. On 31 March 2018, there were 4,169 staff members.

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

- Allied health professionals (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.

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

- Trust website – www.nwbh.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.

In addition, in September 2017, 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 and Trust Strategy for 2018-2021.

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 ongoing 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 local community events. This enables our governors to share views about areas of particular interest and new developments at the Trust.

Foundation trust members can find out who their governor is on the membership section of our website: www.nwbh.nhs.uk/our-council-of-governors

Members can contact their governor by calling the Membership Office on 01925 664869 or emailing ftmembership@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 of 2016/17 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 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

		2017/18				2016/17	
Area	**Metric**	**Q4**	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**
Financial sustainability	Capital service capacity	3	4	4	4	2	3
	Liquidity	3	3	3	3	3	2
Financial efficiency	I and E margin	2	2	3	4	3	3
Financial controls	Distance from financial plan	1	1	1	1	2	1
	Agency spend	1	2	2	1	2	2
Overall scoring		**2**	**3**	**3**	**3**	**2**	**2**

Statement of the Chief Executive's responsibilities as the accounting officer of North West Boroughs Healthcare 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 North West Boroughs Healthcare 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 North West Boroughs Healthcare 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 responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
25 May 2018

Annual Governance Statement

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control which supports the achievement of North West Borough Healthcare 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 Accountable 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 ongoing 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 North West Boroughs Healthcare NHS Foundation Trust for the year ended 31 March 2018 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 Chief Nurse and Executive Director of Operational Clinical Services.

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 policy. To enable this, the committee receives regular monitoring reports about the management of strategic risks. 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.

At each of its 10 meetings during the year, the Board receives an update on all serious incidents and inquests which have occurred.

The Trust's Quality and Safety Meeting is chaired by the Chief Nurse and Executive Director of Operational Clinical Services. 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 to the Trust Board through the Chief Executive's report and quarterly to the Quality Committee. Additionally exception reports are made 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 Accountable 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 Chief Nurse and Executive Director of Operational Clinical Services, who is supported by the Medical Director, Chief Finance Officer and Director of Strategy and Organisational Effectiveness, who are responsible for overseeing risk management activities within their individual areas of responsibility.

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

Within the period 1 April 2017 to 31 March 2018, there have been five changes in personnel of non-executive directors, as follows:

- Bernard Pilkington retired as Chairman on 16 May 2017
- Helen Bellairs (previously vice-chair) was appointed Chairman on 17 May 2017
- Tricia Kalloo was appointed as Non-Executive Director on 2 June 2017
- Richard Sear left the role as Non-Executive Director on 22 September 2017
- Jonathan Berry was appointed as Non-Executive Director on 16 November 2017

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 2017/18, as follows:

- Process for new business wins – significant assurance with minor improvement opportunities
- Atherleigh Park project – deferred into 2018/19
- Corporate governance – significant assurance with minor improvement opportunities
- Risk management and Board Assurance Framework – significant assurance with minor improvement opportunities

Work undertaken for the corporate governance, and risk management and Board Assurance Framework was combined within the well-led review, which remains ongoing at year-end. Our internal auditors have therefore not issued separate reports with recommendations on these areas. However, internal auditors have completed fieldwork to conclude on these areas early within the well-led review, with assurance levels based on their understanding of processes and how they have operated throughout the year.

3.3 Risk management accountability

The Trust's Risk Management Policy and Procedure 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 Policy and Procedure 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 2017/18, we have continued to improve our serious incident process, which included additional scrutiny of our reports by the Patient Safety Panel, chaired by the Medical Director, to ensure quality of reporting.

In 2017/18, we reviewed our Incident Reporting (serious incidents) Policy and Procedure to give assurance to the Trust and our commissioners on our reporting in line with the NHS England Serious Incident Framework (March 2016), and how we conduct investigations.

Following engagement across our stakeholders, one of the quality priorities for 2017/18 was to review the implementation and monitoring of Duty of Candour processes; this priority was fully met. The achievement of this quality priority included a review of the Being Open Policy and Procedure, education sessions in support of statutory Duty of Candour requirements, and undertaking a Duty of Candour audit.

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, and safeguarding. A system is in place to ensure due process has been followed before policies are ratified by the Audit Committee.

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 Clinical Operational Services, the Director of Integrated Governance, the Assistant Director of Integrated Governance, the Assistant Director of Nursing and Quality, and the Assistant Clinical Directors from each borough meets on a weekly basis. They discuss any serious incidents which have occurred in the preceding week, together with any 72-hour reviews which have been undertaken, to determine actions needed and next steps. The Patient Safety Panel approves any serious incident investigation reports.

A communications plan for the sharing of lessons from incidents is in place with regular updates shared through Trust-wide channels on a weekly basis. Internally, it is reported by the executive and non-executive directors from 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 ensure lessons are learned.

4. Risk and control framework

4.1. Risk management strategy

Our Risk Management Policy 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 Risk Management Policy 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 axis – 'stable and known' through to 'changing and new' and also '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 Policy and Procedure is the overarching process for managing all risk within a single framework. The Risk Management Policy and Procedure detail the strategic 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 2.

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 Operational Performance Meeting. The Audit Committee scrutinises these risks further. The Audit Committee receives, at each meeting, reports on the current status and management of all risks within the Trust. 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 borough quality and safety meetings, involving Trust assistant clinical directors.

Risk movement and control is monitored monthly at the Trust and borough quality and safety meetings, 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 change inevitably brings.

At the January 2018 Trust Board meeting, a decision was taken to review the rating of risks escalated to the Trust Board. The Board Assurance Framework presented to the Trust Board on a bi-monthly basis contained details of all significant risks scored 12 and above. From January 2018 onwards, all risks rated 15 and above, with limited or fair

controls, are escalated to the 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 its programme of inspections.

The Trust continually assesses itself against the fundamental standards, reporting monthly as part of the performance report. Assurances are provided through the clinical quality assurance cycle which incorporates the following three areas:

- **Collaborative quality visits** – 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** – visits undertaken by executive and non-executive directors. A total of 31 have taken place between April 2017 and March 2018. 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 identify 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.

During 2017/18, there have been a total of 22 inspections of the Trust by the Care Quality Commission. Of these, 18 were unannounced Mental Health Act monitoring inspections.

In addition, there was a focused inspection around absent without leave (AWOL) incidents at Atherleigh Park during July 2017. A Trust action plan is in place and good progress continues to be made. Monitoring of the progress against the action plan is through the Quality Committee on behalf of the Trust Board.

There was a focused inspection around the use of Section 136 in Merseyside, of which the Trust formed part of a wider project. An action plan has been implemented as part of a joint health providers' action plan, and the Trust remains on target with actions.

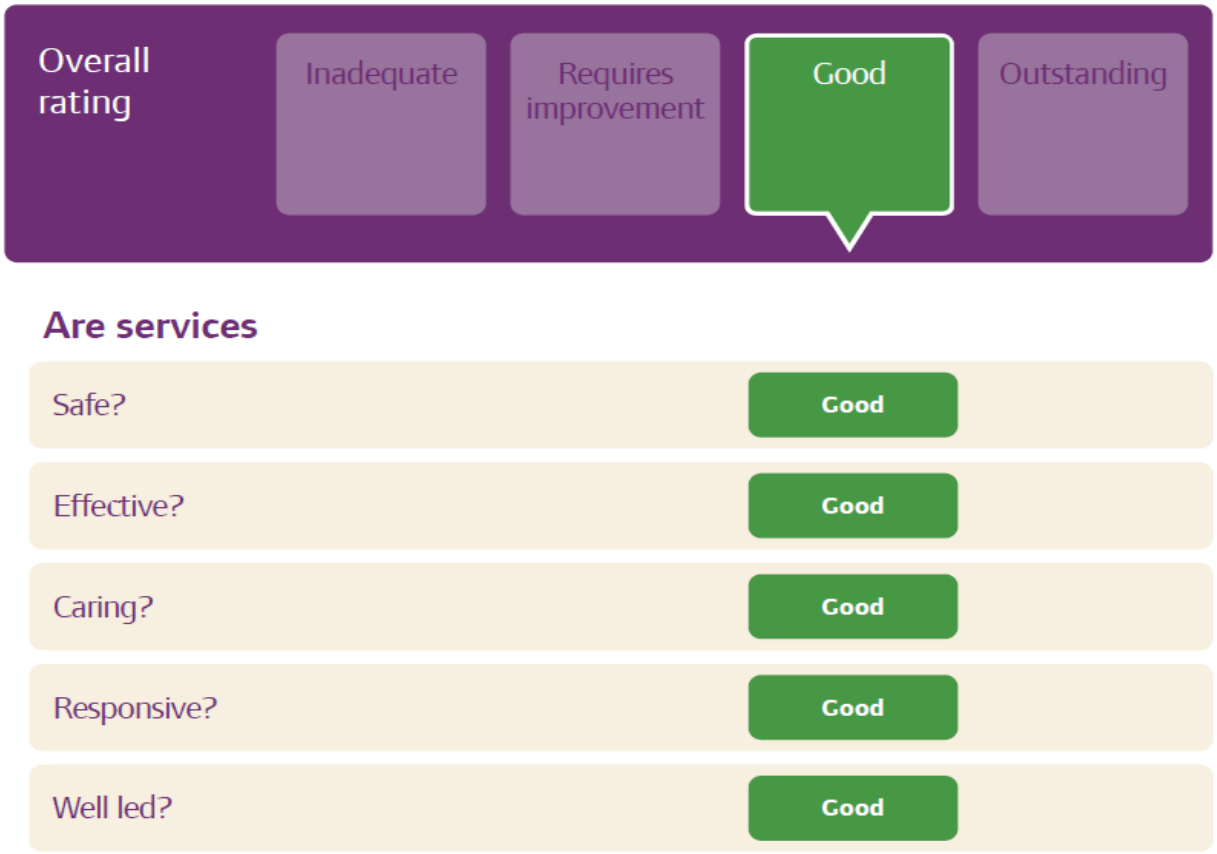
A focused inspection of Fairhaven Unit took place during December 2017 to look at the 'safe' domain in relation to specific concerns highlighted from information received. A Trust action plan has been developed, and monitoring takes place through the Quality and Safety Meeting.

There was also a CQC review of services for Looked after Children and Safeguarding in St Helens during November 2017. An action plan has been implemented as part of a joint health providers' action plan, and the Trust remains on target with actions. Updates are submitted to St Helens commissioners through the Designated Nurse for Safeguarding Children and the St Helens borough leadership team.
The table below details the inspections undertaken by the Care Quality Commission during 2017/18.

Month of visit	Ward/area visited and borough	Type of visit	Areas covered
May 2017	Bridge Ward, Halton	Routine unannounced	**Domain 2** Detention in hospital
May 2017	Golborne Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
July 2017	Westleigh Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
July 2017	Atherleigh Park, Wigan	Focused inspection	Atherleigh Park – Westleigh Unit and Sovereign Unit inspection focusing on the 'safe' domain in relation to absent without leave (AWOL) incidents
August 2017	Knowsley	Focused inspection	The Trust formed part of a larger project to undertake a thematic review of the use of Section 136 Mental Health Act 1983 (MHA) across Merseyside
August 2017	Kingsley Ward, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
September 2017	Parsonage Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
October 2017	Priestner's Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
October 2017	Sheridan Ward, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
October 2017	Austen Ward, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
October 2017	Weaver Ward, Halton	Routine unannounced	**Domain 2:** Detention in hospital
November 2017	St Helens	Review of CLAS (Children Looked After and Safeguarding)	Looked after children and safeguarding
November 2017	Iris Ward, St Helens	Routine unannounced	**Domain 2:** Detention in hospital
November 2017	Sovereign Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
November 2017	Taylor Ward, St Helens	Routine unannounced	**Domain 2:** Detention in hospital
December 2017	Fairhaven Unit, Warrington	Focused inspection	Inspection focusing on the 'safe' domain
December 2017	Fairhaven Unit, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
January 2018	Grasmere Ward,	Routine unannounced	**Domain 2:** Detention in hospital

Month of visit	Ward/area visited and borough	Type of visit	Areas covered
	Knowsley		
January 2018	Coniston Ward, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
February 2018	Auden Unit, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
March 2018	Rydal Ward, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
March 2018	Byron Ward, Warrington	Routine unannounced	**Domain 2:** Detention in hospital

The Trust has maintained a Care Quality Commission rating of '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.



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

4.4.2. NHS Improvement'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 Policy and Procedure and has three schemes in place which are contributing to data quality improvements across the Trust:

- Rollout of an electronic patient record / clinical information system to all services across all boroughs
- Data quality improvement plan
- Information management platform

The data quality improvement plan was initiated in 2015/16. During 2017/18, the following key deliverables were achieved:

- Rollout of the information management platform which enables the combination of a wide range of information in one central, robust system; supporting greater insight into Trust services.
- Rollout of RiO clinical information system to adult community physical health services and children's community physical health services in Knowsley and St Helens. 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.

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 and procedures are stored on the Trust's intranet and are available to all staff members.

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 2017/18, 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 2017/18 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:

- 99.9% for admitted patient care
- 100% for outpatient care
- 97.3% 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
- 99.9% for accident and emergency care

The percentage of records in the published data which included the patient's valid Ethnic Category Code was:

- 97% for admitted patient care
- 91% for outpatient care
- 99.7% for accident and emergency care

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.

Information governance incidents are reported through the DATIX risk management system as per the Trust's Incident Management Policy. A bespoke reporting system is in use to ensure specific information is captured. Two reports are in use – the Information Governance Incident Report and the Caldicott Issues Log – enabling a proactive approach towards managing information governance incidents. These incidents are regularly reported through local and strategic aggregated incident reports, allowing broader analysis and a Trust-wide approach to improvement and learning. Incident themes and serious incidents are reviewed bi-monthly by the Information Governance Executive Committee.

The Trust continues to submit its Information Governance Toolkit self-assessment and declared 80 per cent (satisfactory) for 2017/18 (version 14.1). The Trust provides comprehensive information governance training, through e-learning and face-to-face sessions, with ad-hoc training provided as required. This is coupled with extensive awareness raising and communications throughout the Trust.

The annual audit of the Trust's Information Governance Toolkit submission was undertaken by KPMG in December 2017, with a follow-up review in March 2018. 'Significant Assurance with Minor Improvement Opportunities' was achieved.
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 and the Information Governance and Security Manager is the Data Protection Officer.

4.6. Information governance incidents

The Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation (HSCIC, 2015, v5.1) 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 no Level 2 incidents in 2017/18.
- Level 1 incidents are other personal data-related incidents and the numbers are aggregated. The Trust's figures for 2017/18 are shown in the table below.
- Level 0 incidents are not required to be included in the Trust's Annual Report.

The Level 1 incidents in the following table occurred between 1 April 2017 and 31 March 2018 inclusive.

Category	Breach type	Total
A	Corruption or inability to recover electronic data	5
B	Disclosed in error	76
C	Lost in transit	7
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	22
F	Non-secure disposal of hardware	0
G	Non-secure disposal of paperwork	2
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access or disclosure	10
K	Other	0

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 15 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 2017/18

Below is a summary of risks as at 31 March 2018.

There are a total of 93 open risks, 11 of which have been mapped against the Board Assurance Framework.
There are nine open risks identified which may impact on the Trust's achievement of the 2017/18 high-level objectives.

At the end of March 2018, 11 risks remained open on the Board Assurance Framework. Of these, there are no risks with limited controls. Four have fair limited controls and one of these is rated as 16, therefore making this the top risk for the Trust.

The Trust's top Board Assurance Framework risk as at year end 2017/18 is shown below.

Theme: Is the organisation and its services well led?
Risk: There is a risk that clinical supervision is not recognised as a fundamental process for patient safety and professional support, due to the organisation struggling to implement this fully, which will lead to a quality and safety risk for service delivery.

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 four Clinical Quality and Safety Commissioning Groups across the six clinical commissioning groups within the Trust's footprint. Two groups meet monthly, one bi-monthly, and one quarterly, 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.

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 2017/18, the Trust further embedded the systems and assurances which underpin the Provider Licence, the Risk Assessment Framework and the Code of Governance.

4.9. Governance structures

The Trust Board recognises that robust governance processes should give leaders of organisations, those who work in them and those who regulate them, confidence about their capability to maintain and continuously improve services.

To support the Trust's review of its effectiveness, an in-depth and externally facilitated developmental review of leadership and governance commenced in December 2017, using NHS Improvement's Well-Led Framework Guidance published in June 2017.

The initial work was a self-review questionnaire, individually undertaken by the Trust Board members and senior leaders, against a questionnaire based on both the eight key lines of enquiry and the characteristics of 'Good'.

The Trust Board and senior leaders devoted a full Trust Board development day on 24 January 2018 to the effectiveness review, where analysis and comments were reviewed, assurance was gained from presentations given, and actions for improvement were determined.

The Trust Board agreed to commission the independent arm of the Trust's internal auditors KPMG as the external reviewers to undertake the further aspects of the developmental review for the Trust. The review is currently ongoing and includes a review of Trust documentation, attendance at meetings and interviewing leaders. The Trust expects to receive the external report in June 2018.

In addition to the well-led review, during 2017/18, both the Audit Committee and Quality Committee have reviewed their effectiveness using best practice tools.

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

4.10. Corporate governance statement

The Chief Nurse and Executive Director of Operational Clinical Services 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 2018.

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 led by an equality, diversity and inclusion member of staff from the Integrated Governance 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 the organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

The Trust has undertaken a climate change risk assessment. Mitigation and adaptation plans are in place in accordance with the planning and reporting requirements of the Civil Contingencies Act 2004 and the Climate Change Act 2008.

The Trust recognises, monitors and reports on its environmental impacts. Energy and carbon management plans are in place to reduce carbon emissions. 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 and disruption to road fuel supplies, and chemical, biological, radiological and nuclear threats.

The Trust's emergency preparedness, resilience and response arrangements were self-assessed 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 both mental health and learning disability and community physical health services. This is supported by Estates on-call and Trust strategic on-call, comprising executive directors and deputy directors.

The Chief Nurse and Executive Director of Operational Clinical Services has lead responsibility for emergency preparedness, resilience and response, and she 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 account

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 Chief Nurse and Executive Director of Operational Clinical Services is the identified Board member responsible for the Provider Licence and 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 Healthwatch organisations, local authorities, and 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 2017/18 quality priorities and final status are listed below. Full details are included within the Quality Report starting on page 110.

Safety – Always events
This quality priority was partially met during 2017/18, and continues to be a quality priority for 2018/19.

Effectiveness – Complaints, concerns and compliments
The Trust met this quality priority during 2017/18.

Experience – Duty of Candour
The Trust met this quality priority during 2017/18.

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 Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in 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 a minimum of 10 times per year. The Quality Committee routinely receives reports on patient safety, complaints and clinical processes. The Quality Committee provides any relevant updates to the Audit Committee and reports directly to the Trust Board.

The Quality and Safety Meeting meets monthly and is chaired by the Chief Nurse and Executive Director of Operational Clinical Services. 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 December)	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. 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 Annual Governance Statement • 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 Board Assurance Framework, to provide external assurances to the Audit Committee and then the Trust Board • Reports to Trust Board
Quality Committee (Minimum of 10 meetings a year)	Non-executive director	• Receives Quality Account and Quality Priority updates • Development and implementation of the Trust's Quality Strategy • Receives assurance on the quality and safety of services provided, including Care Quality Commission reports and progress of actions • Receives assurance on the effectiveness of Trust systems for quality, safety and risk systems and processes • Receives patient experience information which includes complaints and concerns • Receives reports and thematic analysis of

Group	Chaired by	Functions
		serious incidents, investigations, complaints and claims and how lessons learned are disseminated • Receives reports from other groups and meetings within the Trust, supported by a robust work plan • Reports to Trust Board
Executive Quality and Performance Meeting (monthly)	Chief Executive	• Receives reports on quality, performance and financial risk
Quality and Safety Meeting (monthly)	Chief Nurse and Executive Director of Operational Clinical Services	• 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 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 • Receives updates from the borough quality and safety meetings • Dissemination of topics for discussion at borough quality and safety meetings • Discuss operational issues relating to Care Quality Commission inspections
Operations and Integration Meeting (monthly)	Chief Nurse and Executive Director of Operational Clinical Services	• Receives updates from the borough operational meetings • Discuss impact of risks and agree programmes of work to manage risk
Clinical Leadership Group (monthly)	Medical Director	• Monthly review and discussion of clinical risks • Considers relevant guidance from the National Institute for Health and Care Excellence. • Reviews clinical strategies, clinical innovations and the clinical impact of large scale transformational change • Receives reports in relation to the development of clinical services, clinical models and clinical pathways in order to ensure compliance with national standards • Receives quality impact assessments carried out by clinical leads for cost improvement

Group	Chaired by	Functions
		programme schemes
Borough Quality and Safety Meetings (monthly)	Assistant Clinical Director	• Terms of reference for borough quality and safety meetings are standardised; reporting directly into the Trust Quality and Safety Meeting • 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
Clinical Audit Committee	Deputy Medical Director	• Stimulates and supports national and local quality improvement interventions and, through re-auditing, assesses the impact of such interventions • Approves the Clinical Audit Forward Plan identifying the areas for audit, and reports the progress against this to the Quality and Safety Meeting • Reports outcomes from clinical audit internally 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 2017 to 31 March 2018 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 2017 to 31 March 2018 inclusive, and is based on the 11 audits that 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 'limited assurance' or 'no assurance' opinions in respect of our 11 assignments. We raised five high-risk recommendations in respect of our 11 assignments. The high-risk recommendations were in relation to the advisory review of the Knowsley Centre for Independent Living and the Information Governance Toolkit Audit.

None of our 11 assignments prevent us from issuing significant assurance.

During 2017/18, 11 audits were conducted, assurance ratings were given in eight cases and an overall assurance rating was not given for three reviews due to the nature of the work; which the above audit opinion was based upon. Below details these reviews and the outcomes:

- Data quality – significant assurance with minor improvement opportunities
- Nurse revalidation – significant assurance
- Process for new business wins – significant assurance with minor improvement opportunities
- Atherleigh Park project – deferred into 2018/19
- Core financial controls – significant assurance with minor improvement opportunities
- 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 with minor improvement opportunities
- Cost improvement programmes – advisory report
- RiO informatics – deferred into 2018/19
- Knowsley Centre for Independent Living review – advisory report

Work undertaken for the corporate governance and risk management and Board Assurance Framework was combined within the well-led review, which remains ongoing at year-end. The internal auditors have therefore not issued separate reports with recommendations on these areas; however, they have completed fieldwork to conclude on these areas early within the well-led review, with assurance levels based on their understanding of processes and how they have operated throughout the year.

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 received external reports from organisations which have assessed the Trust and provide assurance, these include:

- Ofsted
- NHS England
- Care Quality Commission

8. Conclusion

My review confirms North West Boroughs Healthcare 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 2017/18 have worked well and delivered a continuous learning, evaluation and improvement cycle. During 2017/18, the Trust has been successful in acquiring new business and the coming year will see the Trust's 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
25 May 2018

Appendices

Appendix 1 – High-level objectives 2017/18

Accountable Executive Director	Trust high-level objectives – 2017/18		Owner
	Are we delivering safely?		
Chief Nurse and Executive Director of Operational Clinical Services	1	By October 2017, we will have rolled out for full implementation the following care pathways: personality disorder, schizophrenia, and dementia. During the rollout we will carry out auditing and checking to promote consistency and standardisation.	Clinical Network Director (Strategic) and Clinical Network Director (Operations)
	Do we have sufficiently, highly motivated and skilled staff?		
Director of Strategy and Organisational Effectiveness	2	By September 2017, we will have a Workforce Plan that will ensure we have the right number of staff, with the right skills, focusing on the development, retention and attraction of a flexible and skilled workforce capable of delivering care in line with year two of our transformational programmes of change.	Director of Strategy and Organisational Effectiveness
	Are we delivering to our patients and service users?		
Chief Nurse and Executive Director of Operational Clinical Services	3	During 2017/18, we will deliver our programmes of clinical transformation to ensure that the resources we have available are used in the most efficient way to deliver safe and effective care to our population.	Director of Operations and Integration and Clinical Director of Operations and Integration

Chief Finance Officer and Chief Nurse and Executive Director of Operational Clinical Services	4	By September 2017, we will have developed market-ready solutions outlining the benefits of whole person care to promote the benefits of aligning physical and mental health services.	Director of Business Development and Clinical Director of Operations and Integration
	Are we financially viable?		
Chief Finance Officer	5	During 2017/18, we will ensure the delivery of £7.1 million cost improvement plans, which will be monitored through the Cost Improvement Group and reported by exception to the Trust Board.	Lead for the individual cost improvement plan and Deputy Director of Finance and Performance
	Are we delivering our strategy?		
Chief Executive	6	During 2017/18, we will try to ensure that the principles of whole person care and the role that an integrated community health provider can play are prominent in the implementation of plans in our sustainability and planning regions.	Chief Executive
Chief Executive	7	During 2017/18, we will lead agreed programmes of work within the Cheshire and Mersey Mental Health Plan. We will also fully participate in Greater Manchester's Mental Health Implementation Board and lead on children and young people's mental health across Greater Manchester.	Chief Executive
Chief Finance Officer	8	During 2017/18, a new clinical information system will be deployed to the existing community services, and business cases for system connectivity will be developed to support any opportunities to access the required funding through the wider system investment opportunities.	Chief Information Officer

	Do our stakeholders support what we do?		
Chief Finance Officer	9	By September 2017, we will have evaluated our partnership arrangements in order to ensure lessons learned are used to continue to strengthen our processes.	Director of Business Development
Chief Finance Officer	10	During 2017/18, we will work with our commissioners to develop an outcomes-based contract in line with the new National Tariff Guidance.	Director of Finance and Performance
	Is the organisation and its services well led?		
Chief Executive	11	During 2017/2018, we will achieve our statutory duties and meet all our targets and obligations within our Terms of Authorisation.	Chief Executive
Director of Strategy and Organisational Effectiveness	12	During 2017/18, we will continue to develop our organisational culture and focus on the behaviours we aspire to at the Trust. As part of this, we will support the implementation of our 'Maximising your Potential' approach to performance and development reviews for all staff.	Director of Strategy and Organisational Effectiveness

Appendix 2 – 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>0.5 m	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 that may potentially arise as the result of the assessed risk.

Quality Report

Contents

1. Our commitment to quality

1.1. Our Quality Report / Quality Account 2017/18

This is the ninth Quality Report produced by North West Boroughs Healthcare 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 – a sub-committee of our Trust Board – members have been engaged with the work in relation to our quality priorities. The chair of the Quality Committee provides a statement in support of our commitment to improving quality and safety.
- Council of Governors and its sub-committee, the Governors' Assurance Committee, have overseen the development of our quality priorities, have attended engagement events, and identified a governors' local indicator for audit
- Service users and carers from across our organisation supported our Quality Account and quality priority engagement events.

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 Annex 1 of this report.

Throughout 2017/18, I have overseen continued challenge and improvement in the way the Trust delivers on quality and safety. During 2017/18, 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 2017/18 quality priorities:

- **Safety: Always events**
  It has never been more important for organisations to ensure a culture wherein there is a commitment to determining what events should always happen to ensure quality and safety levels and standards are consistently achieved. Over the past year, always events have been introduced, which have included:
    - Determining the ‘always events’ and an ‘always event’ approach to support patient safety across inpatient units.
    - Creating a robust system to record and track ‘always events’ to identify areas of focus, and reviewing outcomes to determine the impact from actions.
    - Developing a communications strategy to define and launch ‘always events’ across the Trust.

  ‘Always events’ is now accepted as the cultural framework on which services must perform consistently for every patient, every time.

- **Effectiveness: Complaints, concerns and compliments**
  The Trust approach to responding to complaints and concerns is respectful and efficient, and is central to developing an open learning culture which values the patient and their family by listening to their experience. Achievement of this quality priority includes:
    - Development of robust system to capture feedback from complainants.
    - Reviewing complaint letter templates.
    - Implementing a framework for capturing evaluation from complainants.
    - Analysing whether protected characteristic groups are under or over represented in voicing their concerns.
    - Improving complaints investigations by providing high-quality training to staff.
    - Reviewing promotional literature will ensure information is inclusive and accessible.

- **Experience: Duty of Candour**
  Being open is a long-standing commitment of the Trust, supporting a culture of truthfulness and transparency to our patients and service users, our colleagues and ourselves. Achievement of this quality priority is demonstrated by the implementation of the principles of statutory Duty of Candour into everyday work and in to all elements of care. Achievement of this quality priority includes:
    - Raising awareness Duty of Candour notifiable incidents and actions.
    - Developing systems to record Duty of Candour conversations and correspondence.
    - Reviewing Duty of Candour letter templates in consultation with staff, service users and carers.
    - Revising Trust policies and procedures.
    - A suite of lessons learned communications have been developed and cascaded for discussions at team level.

The Trust has maintained a Care Quality Commission rating of '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 2017/18 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.

Our Trust has expanded in line with its overall strategic intention to deliver whole person care. As such, it was no longer relevant to describe the Trust as 5 Boroughs Partnership NHS Foundation Trust due to the geography that we cover. As a result, 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

The quality of care and safety for the people who use our services are the most important things to the Board.

We strive to support every member of staff to contribute in their own way to the delivery of effective, high-quality and safe services.

One of the most rewarding, nevertheless challenging ways of hearing about the care we provide is to receive a patient story at the beginning of each Board meeting. Over the past 12 months, we have heard about the positive experiences of people using our services, and experiences where we didn't do so well. These stories provide an increased understanding at Board-level of the work we do and the care we provide; contributing to our commitment to improve and learn.

This year saw the continuation and further development of safety walkabouts undertaken by executive and non-executive directors. 31 were undertaken during 2017/18, 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.

Simon Barber, our Chief Executive, has reflected on the progress made on achieving our 2017/18 quality priorities, and a key area for development this is year is supporting service users, carers and those with lived experience to be even more involved in developing quality and safety.

The quality priorities for 2018/19 have been agreed by our Council of Governors, following engagement with our stakeholder organisations. All four quality priorities are linked to each other and to the Trust objectives, and we look forward to making progress throughout the year.

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, alongside Ignite your Life (an event which celebrates the activity of the involvement scheme), with regular service user and carer forums throughout the year. All of these opportunities enhance our ability to obtain information about services and help us to communicate with the wider community.

Helen Bellairs
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. Our 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 Annex 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 Annex 1.

1.9. Chief Executive's written statement and signature

I confirm that to the best of my knowledge the information in the 2017/18 Quality Account is accurate in all material respects.

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
25 May 2018

2. Priorities for improvements

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 Improvement Plan, and includes reporting and monitoring of the Trust's quality goals and quality priorities.

2.1. Trust quality and safety priorities 2017/18

We start this section by reporting on our achievement against the Trust quality priorities we set ourselves for 2017/18.

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.

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

Rationale	Outcome	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	**Partially met**	**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 rollout to remaining wards • Monitoring of 'always events' for safety carried out • Monitoring processes for 'always events' for quality defined

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.		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

Partially met

This initiative was partially met due to not fully achieving the quarter 4 indictors and measures set against this quality priority. Whereas the Trust successfully defined and launched 'always events' for safety and quality in inpatient wards, we were unable to fully evaluate. An overview of the reporting and monitoring arrangements, for each 'always event' is described below.

Inpatient units will always approve rosters six weeks in advance – Reporting, monitoring and evaluation is undertaken on a monthly basis in line with the Trust operational performance meeting discussions.

There will always be an experienced Trust substantively employed registered nurse in charge of every shift – Reporting, monitoring and evaluation is undertaken on a monthly basis in line with the Trust operational performance meeting discussions.

Units will always operate to 85% occupancy – Reporting, monitoring and evaluation is undertaken on a monthly basis in line with the Trust operational performance meeting discussions.

A discharge plan containing an estimated date of discharge will always be developed and agreed with the service user within 72 hours of admission – The Trust found it difficult to fully evaluate the impact of this 'always event' due to a limited reporting structure being in place.

Prescribed medicines will always be received by the patient within one hour of the prescribed interval – The Trust found it difficult to fully evaluate the impact of this 'always

event' due to a limited reporting structure being in place.

The Trust plans to implement electronic prescribing in line with its Informatics Strategy which will enable the reporting structure to be in place.

The limitations in respect of reporting and monitoring identified during 2017/18 are being further explored and considered alongside the development of monitoring and evaluation arrangements for the 2018/19 'always events' year two priority.

How we partially achieved this quality priority

- The Trust defined and launched 'always events for safety' across inpatient units.
- A report is provided on a monthly basis to the Trust Quality and Performance Meeting and Trust Board which examines patterns and trends from relevant performance data to record and track progress against each 'always event for safety'.
- The development of 'always events for safety' has contributed towards the development of safety huddles.
- An evaluation of the actions from 'always events for safety' has been carried out, which has contributed towards the development of 'always events' as a 2018/19 quality priority.
- The introduction of 'always events' has supported escalation processes for identifying safe staffing levels to provide therapeutic environments and delivery of care for our service users.

Our achievements in respect of 'always events' have included:

- The completion of staffing rotas 42 days in advance; with the average of 41.9 days being achieved by January 2018.
- A significant and consistent reduction from 95 occasions in January 2017, compared with 12 in January 2018, when a substantive registered nurse was not on duty and a significant reduction in the use of agency staffing on our wards.

2017/18 quality priority two – effectiveness
Complaints, concerns and compliments

Rationale	Outcome	Indicator / measure
While the NHS strives to provide a quality service, it is recognised that things can and do go wrong. Responding to complaints and concerns in a respectful and efficient manner is a key	**Met**	Quarter 1 • A system to capture feedback from complainants will be piloted. • Processes to ensure data from concerns is captured in line with complaints will be introduced. • Capture of data to identify demographic makeup of complainants will be rolled out.

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.		• 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 groups 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 groups 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.

How we achieved this quality priority

- A system to monitor actions from complaints has been developed.
- A review of complaint template letters was carried out, with a full launch of the

updated templates in line with the Complaints and Concerns Policy and Procedure.

- An analysis of whether protected characteristic groups are under or over represented in voicing their concerns was carried out, leading to the production of a video to help others with learning disabilities understand the complaints process.

- A framework for capturing evaluation from complainants was implemented to capture feedback as to the quality of response received from the Trust to support learning from feedback from complaints.

- An evaluation of the feedback from complainants was carried out, with outcomes reported to the Trust Quality and Safety Meeting and themes reported to the Lessons Learned Forum.

2017/18 quality priority three – experience
Duty of Candour

Rationale	Outcome	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.	**Met**	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

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.		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.

How we achieved this quality priority

- An awareness-raising campaign was developed and implemented for staff service users and carers; this included an emphasis on Duty of Candour notifiable incidents and actions within incident reporting training and education.
- A system to record Duty of Candour conversations and correspondence was developed, reporting in to the Patient Safety Panel.
- Duty of Candour letter templates were reviewed and relaunched to staff for their use; these were developed in consultation with staff, service users and carers.
- A Duty of Candour audit tool was developed to identify areas for focus. A deep dive into Duty of Candour notifiable incidents was undertaken and reported to the Trust Quality Committee.
- The Trust revised the Being Open Policy and Procedure to incorporate learning from an audit of the Duty of Candour process.
- A number of lessons learned communications in relation to Duty of Candour were issued to enhance staff understanding of the implementation of statutory Duty of Candour following notifiable safety incidents.

2.2. Improving on 2017/18 quality measures

Two of the Trust's quality and safety priorities for 2017/18 have been met, and one quality and safety priority for 2017/18 has been partially met. These continue to be quality initiatives for the Trust, but have been replaced with new quality priorities for 2018/19 as agreed with our stakeholder organisations.

2.3. Quality and safety priorities for improvement 2018/19

In order to make sure the views of service users, carers, staff and the wider public have been taken into account, the Trust held its annual quality account stakeholder event on 12 February 2018, with representatives from our stakeholder organisations invited to attend. This included local authorities, Healthwatch groups and commissioners from Knowsley, Halton, Sefton, St Helens, Warrington and Wigan, representatives from our Council of

Governors, and staff. The event provided an progress update on the 2018/19 priorities and the opportunity to engage and discuss any suggested areas or themes for the 2018/19 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 2018/19 from the annual event and approved the final quality priorities along with the Quality Committee.

The 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.

Four quality and safety priorities have been chosen 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 2018/19 and will be quality targets agreed with our commissioners.

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

Safety: Always events (two-year priority)
This remains one of the main areas of the Trust's Quality Strategy 2018-2021, with a focus on ensuring those events which should 'always' be adopted to ensure quality and safety levels and standards are achieved. The governance arrangements now in place for 'always events' will continue, including the recording of 'always events' within the Trust Quality and Performance Meeting. 'Always events' will continue to be developed to incorporate 'always events' for quality and safety in Community Teams.

Safety: Safety huddles
Safety huddles support our Quality Strategy 2018-2021 and our Trust values in relation to sustaining safe, high-quality and effective care. The Trust will work with service users and carers to determine an approach to reducing harm, supporting staff, improving communication in teams and improving quality, safety and effectiveness.

Effectiveness: Team clinical supervision
Team clinical supervision will bring practitioners and skilled supervisors together to reflect on practice, identify problems, improve practice and increase understanding of professional issues. The governance arrangements will continue to be in place, evaluating team clinical supervision as a key component of the Quality Strategy 2018-2021.

Experience: Service user and carer involvement
Service users, carers and those with lived experience will continue to be involved and integrated into the development of services, planning the delivery of services, and monitoring quality of services.

It supports and is supported by our Trust Strategy and our Trust values in relation to our patients and service users, carers and those with lived experience.

2018/19 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 to determine what 'always events' should be adopted 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 that can highlight developing or potential safety issues • To establish an 'always event' approach to support patient safety 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.	Quarter 1 • Finalisation of set of 'always events' for safety and quality of community teams (mental health and physical health), in line with the Quality Strategy • Monitoring and reporting processes for 'always events' defined and agreed at Clinical Leadership Group • Communications strategy for rollout Quarter 2 • Short test of 'always events' for safety and quality in community teams • Phased approach to implementation in community teams of 'always events' for safety and quality Quarter 3 • Phased approach to implementation in community teams of 'always events' for safety and quality • Monitoring and evaluation of 'always events' for safety and quality carried out Quarter 4 • Monitoring and evaluation of 'always events' for safety and quality carried out

2018/19 quality priority for safety
Safety huddles

Rationale	Indicator / measure
Safety huddles can be described as an approach to reducing harm and improving safety culture. We have undertaken a piece of work to develop and implement	Quarter 1 • Establish safety huddles as a key component of the Trust Quality Assurance Framework • Develop a framework to support implementation of safety huddles, including arrangements for monitoring and evaluating

safety huddles as an approach to reducing harm, supporting staff, improving communication in teams and improving quality, safety and effectiveness. The aims of rolling out safety huddles are: • To create an environment where staff regularly communicate and feel safe to raise concerns about patient safety • To monitor and recognise cues to increase staff awareness of what is happening around them • To integrate information to develop a comprehensive picture of the current status of patients The anticipated outcome of this quality initiative is to evidence improvements in the delivery of sustained safe, high-quality and effective care. In addition, we want to see a reduction in incidents and harm.	• Develop a communications strategy for rollout of safety huddles Quarter 2 • Launch safety huddles as a phased rollout across all teams in all boroughs Quarter 3 • Monitoring and evaluation of safety huddles to be carried out Quarter 4 • Develop a policy and procedure to support implementation of safety huddles, including arrangements for monitoring and evaluating, taking into account learning and feedback
2018/19 quality priority for effectiveness Team Clinical Supervision	
Rationale	**Indicator / measure**
Clinical supervision brings practitioners and skilled supervisors together to reflect on practice. Supervision aims to identify problems, improve practice and increase understanding of professional issues. We are committed to reviewing the current team clinicial supervision arrangements to ensure there is an effective, efficient and high-quality multidisciplinary team clinical supervision model in place. This quality priority will support the development of safe, effective and innovative practice across Trust services.	Quarter 1 • Establish clinical supervision as a key component of the Trust Quality Assurance Framework and 'happy teams' • Carry out a review of the current Clinical Supervision Policy and Procedure, including arrangements for monitoring and evaluating • Review all associated clinical supervision paperwork and templates • Ensure staff engagement takes place as part of the review of the current Clinical Supervision Policy and Procedure • Ensure clinical supervision is linked to the Trust performance development review (PDR) process • Engage and consult with staff on what they feel would support them most Quarter 2

The aims of this initiative are: • To use the collective multidisciplinary expertise to review the current clinical supervision arrangements • To further enhance the robust framework, policy and procedure for undertaking clinical supervision The anticipated outcome of this quality initiative is evidence of sustained safe and high-quality clinical supervision conversations between practitioners and skilled supervisors.	• Review the training needs analysis and support model in place for staff undertaking a supervisor role • Develop a training plan to support staff undertaking a supervisor role • Deliver training and education in support if staff undertaking a supervisor role • Identify clinical supervision performance measures Quarter 3 • Launch the updated Clinical Supervision Policy and Procedure • Monitoring and evaluation of clinical supervision • Undertake further engagement and consultation with staff in relation to the current Clinical Supervision Policy and Procedure • Undertake a clinical supervision audit Quarter 4 • Monitoring and evaluation of clinical supervision • Review the results, analysis and findings of the clinical supervision audit
2018/19 quality priority for experience Service user/ carer involvement	
Rationale	**Indicator / measure**
The Trust believes the involvement and integration of service users, carers and those with lived experience has a lot to contribute to our services. These experts by experience are key to supporting the Trust develop services, plan the delivery of services, and monitor quality of services. We have undertaken a piece of work to identify the most effective way to support service users, carers and those with lived experience to work with the Trust to enhance quality, safety and effectiveness. The aims of this initiative are: • To enhance the involvement and integration of service users, carers and those with lived experience • To review the existing	Quarter 1 • Undertake engagement with service users, carers and those with lived experience who are currently working alongside the Trust • Carry out a review of the current Involvement Scheme Policy and Procedure, including arrangements for monitoring and evaluating • Identify any policy and procedure gaps in respect of all service users, carers and those with lived experience groups and communities • Carry out a review of the networks for engaging, consulting and involving service users, carers and those with lived experience Quarter 2 • Develop a communications strategy for rollout • Launch the updated policy and procedure(s) • Review the training needs analysis and support model in place for those providing support and supervisory role to service users, carers and those with lived experience • Explore the use of national and best practice

framework for supporting service users, carers and those with lived experience • To ensure service users, carers and those with lived experience have a voice within the Trust The anticipated outcome of this quality initiative is evidence of a positive working relationship with service users, carers and those with lived experience, to enhance quality, safety and the effectiveness of services within the Trust.	models for working alongside service users, carers and those with lived experience Quarter 3 • Develop a plan for the further development of supporting service users, carers and those with lived experience to enhance and develop Trust services Quarter 4 Monitoring and evaluation of framework for supporting service users, carers and those with lived experience

2.4. Quality Strategy and Improvement Plan

During 2017/18, the quality review process within the Quality Strategy – previously known as the Internal Quality Review – has been developed to create a more collaborative approach to review, and thus renamed the Collaborative Quality Framework. This way of reviewing has been beneficial in terms of looking at aggregated themes across the same service types in different parts of the Trust. The success of this approach informs the refreshed Quality Strategy for 2018-21 and the required quality assurance framework.

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. It 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.nwbh.nhs.uk/key-documents

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 2017/18, the 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 these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2017/18.

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 2017/18 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 2017/18, providing evidence and assurance that agreed actions have been successful in improving the quality of care provided.

Other, locally agreed clinical audit activity during 2017/18 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 2017/18 have continued to show improvements in the care we provide.

During 2017/18, 12 national clinical audits and one national confidential inquiry covered relevant health services North West Boroughs Healthcare NHS Foundation Trust provides.

During that period, the Trust participated in 100 per cent of national clinical audits and 100 per cent of national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries the Trust participated in during 2017/18 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) 17/18
- National Learning Disability Mortality (LeDeR)
- National Audit of Psychosis
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Organisational)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Clinical)
- National Audit of Intermediate Care
- National Audit of Anxiety and Depression
- Sentinel Stroke National Audit Programme (SSNAP) (Clinical) 17/18
- POMH – Topic 7: Monitoring of patients prescribed lithium
- POMH – Topic 16a: Rapid tranquillisation
- POMH – Topic 1 and 3: Prescribing high dose and combination psychotics
- POMH – Topic 17a: Use of depot/LA antipsychotic injections for relapse prevention
- POMH – Topic 15b: Prescribing Valproate for Bipolar Disorder

The national clinical audits and national confidential inquiry the Trust participated in, and for which data collection was completed during 2017/18, 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
NCAPOP – National Clinical Audit and Patient Outcomes Programme Audit: National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH) 17/18	19 2 0	70% 100% 0%
National Learning Disability Mortality (LeDeR)	19	100%
National Audit of Psychosis	250	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	187	100%
National Audit of Intermediate Care	Inpatients: 20 Community: 85	100% 100%
Sentinel Stroke National Audit Programme (SSNAP) (Clinical) 17/18	147	100%
POMH – Topic 7e: Monitoring of patients prescribed lithium	100	100%
POMH – Topic 16a: Rapid tranquillisation	51	100%
POMH – Topic 1g and 3d: Prescribing high dose and combination psychotics	152	100%
POMH – Topic 17a: Use of depot/LA antipsychotic injections for relapse prevention	78	100%
POMH – Topic 15b: Prescribing Valproate for Bi-polar Disorder	90	100%

Reports have been received for the following national audits in 2017/18:

- POMH – Topic 7: Monitoring of patients prescribed lithium
- POMH – Topic 16a: Rapid tranquillisation
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
- National Audit of Intermediate Care

The reports of four national clinical audits were reviewed by the provider in 2017/18 and the 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 47 local clinical audits were reviewed by the provider in 2017/18 and the 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 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 the Trust in 2017/18 who were recruited during that period to participate in research approved by a research ethics committee was 219.

The Trust was involved in 49 research studies in mental health, learning disabilities and community health services in 2017/18, 32 of which were new studies opened to recruitment at the Trust during this time. The studies have included UK Clinical Research Network (UK CRN) 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 or 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 base studies. They have been across all ages, in areas such as dementia, schizophrenia, psychosis, bipolar disorder, autism, perinatal mental health, eating disorder, self-harm and back or 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 2017/18.

During 2017/18, 11 publications were produced by Trust employees.

2.5.4. Commissioning for Quality and Innovation Payment Framework

A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation Payment Framework.

Knowsley Clinical Commissioning Group acts as the coordinating commissioner for St Helens and Knowsley through the Commissioning for Quality and Innovation Payment Framework. Targets are agreed separately with Wigan, Halton and Warrington clinical commissioning groups and NHS England. Targets are also agreed within our sub-contracted services via St Helens and Knowsley Teaching Hospitals NHS Trust and Mersey Care NHS Foundation Trust with St Helens and Sefton clinical commissioning groups.

Section 3.1 of this report includes progress against Commissioning for Quality and Innovation targets for 2017/18.

During 2017/18, the Trust attracted 2.4 per cent of our contract value as Commissioning for Quality and Innovation (CQUIN) payments. The total available within the CQUIN framework during that period was £3.4 million.

During 2016/17, the Trust attracted 2.4 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

North West Boroughs Healthcare 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 the Trust during 2017/18.

The Trust's rating remains as 'Good' overall for the five domains of safe, effective, caring, responsive and well-led.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

2.5.6. Quality of our data

The Trust submitted records during 2017/18 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:

- 99.9% for admitted patient care
- 100% for outpatient care
- 97.3% 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
- 99.9% for accident and emergency care

The percentage of records in the published data which included the patient's valid Ethnic Category Code was:

- 97% for admitted patient care
- 91% for outpatient care
- 99.7% for accident and emergency care

2.5.7. Information Governance Toolkit

The Trust's Information Governance Toolkit Self-Assessment Report overall score for 2016/17 was 80 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 December 2017 and reviewed in March 2018. The Trust obtained an overall level of assurance of 'significant assurance with minor improvement opportunities'.

2.5.8. Clinical coding

The 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 December 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 96%
- Secondary diagnosis 83.47%

Coding is now performed on the Trust's new electronic patient record system, RiO. RiO does not support the coding of procedures. As a result, no procedures were audited as the internal auditors could not confirm the accuracy of the codes. However, the auditing of procedures is not mandatory; therefore this did not affect the audit's overall outcome.

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 2017. The results should not be extrapolated further than the actual sample audited.

The 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 2017/18 Quality Account. The following tables show the Trust's performance compared with the NHS Digital data representing all of England.

Table 1	**Health and Social Care Information Centre benchmarking data** (quarter 3 2017/18)			**Trust percentage**		
	National average	**Highest reported**	**Lowest reported**	**Full year 2015/16**	**Full year 2016/17**	**Full year 2017/18**
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	95.4%	100%	69.2%	96%	96.5%	97.3%

The Trust considers 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.

The 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	**NHS Digital data** (quarter 3 2017/18)			**Trust percentage**		
	National average	**Highest reported**	**Lowest reported**	**Full year 2015/16**	**Full year 2016/17**	**Full year 2017/18**
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	98.5%	100%	84.3%	99.2%	98.3%	99%

The Trust considers 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.

The 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	NHS Digital 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	Full year 2017/18
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%	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%	12.74%

The Trust considers this data is as described for the following reasons: A review of the calculation of the readmission measure was completed in April 2017 against robust guidelines which comply with NHS Improvement guidance. This has led to an increase in the number of readmissions being reported in 2017/18.

The Trust has taken 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. The Trust is committed to reviewing and reporting this information on a monthly basis. Exceptions are reported internally at borough and Trust-level within the monthly Quality and Performance Meetings and report to Trust Board.

Table 4	Health and Social Care Information Centre benchmarking data		Trust percentage	
	National 2017	2015	2016	2017
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	67%	62%	65%	71%

The Trust considers 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.

The Trust has taken the following actions to improve this percentage, and so the quality of its services, by providing further investment in the Organisational Development function. This has allowed the introduction of Organisational Development 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 Trust has been committed to providing visible leadership across our services including a range of initiatives. These have included: afternoon with the Chief Executive, patient safety visits, supported clinical initiatives (for example participation in food and nutrition afternoon teas), presentation of awards to staff and teams, and attendance at borough leadership meetings.

During 2017/18, in line with the development of our workforce strategy, the Trust has reviewed the career development framework for staff, including the introduction of apprenticeships, assistant practitioners, associate nurses and advanced practitioner initiatives. A framework of talent spotting through an improved staff appraisal personal development plan is now in place, and we now utilise a values-based recruitment system.

The data in table five and six is the latest available from the CQC NHS Patient Survey Programme and NRLS data.

Table 5	CQC NHS Patient Survey Programme data	Trust percentage	National
	National 2016	2017	2017
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	7.8/10	7.6/10	About the same

The Trust considers 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.

The 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	NHS Improvement – National Reporting and Learning System (NRLS) data				
	Reporting period latest available	National average	Lowest reported	Highest reported	Trust performance
Number of patient safety incidents reported	1 Mar 2017 to 28 Feb 2018	8,180	59	38,506	5,879
Number of patient safety incidents that resulted in severe harm or death	1 Mar 2017 to 28 Feb 2018	47	0	481	75
Percentage of patient safety incidents that resulted in severe harm or death	1 Mar 2017 to 28 Feb 2018	0.58%	0%	1.44%	1.28%

The Trust considers this data is as described for the following reasons: the information in table six shows we have reported an increased number of patient severe harm safety incidents during 2017/18. 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 2017/18
For the full reporting period for 2017/18, the Trust percentage of National Patient Safety Agency reported patient safety incidents which resulted in severe harm or death is 1.05 per cent.

The Trust has taken the following actions 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.

2.6. Learning from deaths

In September 2017, the Trust implemented the requirements outlined in the Learning from Deaths Framework (National Guidance on Learning from Deaths: A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care, March 2017) as part of the Trust's existing policies to learn and continually improve the quality of care provided to patients.

This supported the Trust to ensure all staff have a clear understanding and follow a standardised, consistent approach to learning from mortality.

2.6.1. Mortality reporting

During April 2017 to March 2018, 315 deaths were reported within the Trust. This number relates to the number of deaths reported to the Datix system.

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 50 in the first quarter
- 46 in the second quarter
- 65 in the third quarter
- 154 in the fourth quarter

The number of deaths reported significantly increases from January 2018 onwards due to a change in the reporting requirements for services to report each death, regardless of cause, to the Datix system. This change in the reporting requirements relates to the reporting of both expected and unexpected deaths, regardless of cause, to ensure all deaths are reported through the Datix system.

Of the deaths reported in the first three quarters of the year, the majority have progressed forward to a further level of investigation in comparison to a lesser amount in quarter four.

This evidences that, although more deaths have been reported, the number which require a further investigation due to significant gaps or lapses in care identified has remained static. Quarter three identifies the majority of the deaths reported moved on to a further level of investigation.

During this quarter, the new systems and processes on mortality reporting devised from the National Quality Board and the recommendations from this were being embedded across the organisation which has seen an increase in the number of 72 hour reviews being requested for deaths. Of the 315 deaths reported within the financial year, 57 were categorised as suicide – either proven or suspected, 73 deaths were identified as unexpected, and the remaining185 were identified as expected deaths or deaths due to natural causes.

By 31 March 2018, 15 case record reviews and 194 investigations had been carried out in relation to 315 of the deaths referred to above. It can be noted that an investigation can be

described as a 72-hour review, a concise or a comprehensive investigation. Where the service user was under the care and treatment of learning disability services, details of the incident and any internal investigation are shared with the Learning Disabilities Mortality Review (LeDeR) programme.

In 15 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation as described above was carried out was:

- 42 in the first quarter
- 36 in the second quarter
- 61 in the third quarter
- 55 in the fourth quarter

2.6.2. Structured judgement reviews

The development and use of the structured judgement review tool began in December 2017 and has seen the delivery of three workshops where a group of medical staff and senior members of the Trust were invited to learn and become reviewers with the tool. From January 2018, structured judgement reviews have been allocated to death incidents which have occurred for patients identified as having a severe and enduring mental illness or learning disability. There have been a total of 15 structured judgement reviews allocated from January to April 2018, with a total of eight being completed. However, these had not been through a robust governance process for the reports to be signed off as completed. Therefore, at present, the learning identified from the competed reviews has not yet been validated. Following a discussion of this process at the Mortality Review Group in April 2018, it was agreed that completed structured judgement reviews would be fed through the Patient Safety Panel governance process to allow for the reports to have peer review and ensure the findings are appropriately managed if further investigation is required.

Looking forward to 2018/19, the Trust has recently been approached by the Royal College of Psychiatry to participate in a pilot for Structured Judgement Reviews. At this stage, it has been agreed the Trust would take part in this pilot following provisional conversations taking place with regional counterparts to ensure the process for completing the pilot is consistent. This would be a good opportunity for the Trust to engage and incorporate into the development of this tool.

No cases, representing zero per cent of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the structured judgement review and/or root cause analysis methodology to conclude, analyse and determine whether a patient's death was due to problems in the care.

In relation to each quarter, this consisted of:

- 0 in the first quarter
- 0 in the second quarter
- 0 in the third quarter
- 0 in the fourth quarter

No case record reviews and no investigations completed after 31 March 2017 related to deaths which took place before the start of the reporting period.

Of the 15 case record reviews and 194 investigations carried out between 1 April 2017 and 31 March 2018, none of the deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient. The number has been estimated using the root cause analysis and structured judgement review methodology as described within the Trust Incident Investigation (Serious Incidents) Policy and Procedure, and Learning from Deaths Policy and Procedure.

2.6.3. Thematic analysis

Thematic analysis has been carried out on the 65 deaths reported in quarter three 2017/18 in line with the implementation of the Learning from Deaths Policy and Procedure.

Of all the contributory factors identified across each incident, the main themes identified are as follows: communication and information sharing with external agencies involved with the patients care; lack of use of evidence-based assessment tools; telephone triage assessment not completed within the identified timeframe; and lack of adherence to care pathways and clinical guidance. Analysis of the key actions to address the gaps identified evidences boroughs continue to work in silos and actions remain similar despite the reoccurring themes.

In response to these identified themes, the following actions have been taken:

- **Evidence-based assessment tools** – the Trust has continued to develop evidence-based clinical pathways through the relaunched clinical networks, working with service users, carers and partners. We continue to further build on how we utilise and embed NICE guidance and standards as part of clinical pathways to enhance the use of evidence-based assessment tools.

- **Information sharing with external providers** – the Trust has introduced a new Information Technology Strategy and implemented a new electronic clinical records system – RiO. This has supported information sharing with external providers.

- **Completion of telephone triage assessment within allocated timeframe** – to further build on our successes of introducing telephone triage to provide enhanced safe and effective care, we are continuously evaluating for quality and efficiency. Where we identified areas of learning in respect of telephone triage, we delivered a workshop to review the telephone triage standard operating procedure to clarify use at each stage of the triage process.

- **Adherence to care pathways and clinical guidance** – the Trust has successfully implemented new care pathways and clinical guidance through a range of transformation projects across our start well, live well and age well work streams. These are being further developed in response to learning from incident investigations.

In addition, the Trust has shared lessons learned communications with staff in support of each of the above areas.

3. Other Information

Over the past 12 months, we have seen changes in borough leadership teams, strengthening quality and safety leadership with the appointment of assistant clinical directors within all boroughs. Assistant clinical directors and matrons of quality have worked together with borough leadership teams to improve quality and safety for the people who use our services at a local level.

During 2017/18, we further developed and enhanced clinical operational services, building on the implementation of a 'future fit' programme in 2016/17. We moved from pan-borough specialist services into local borough-based services under a dedicated multi-professional leadership team, supported by corporate service business partners. This strengthened partnership working with commissioners and stakeholders.

We have worked closely with Advancing Quality Alliance (AQuA) on a wide range of quality, safety and effectiveness programmes to enhance and transform quality and safety. This includes further rollout of the REsTRAIN programme, demonstrating a reduction in the use of restrictive practices; supporting the development of service improvement plans; and supporting a culture for safety, focusing on human factors approach to improve outcomes for those who use our services.

Throughout 2017/18, the Trust has utilised a triangulated approach to improving patient safety through a range of improvement initiatives in support of safe systems and ways of working. Changes include review of the serious incident framework with refreshed policies and procedures having been implemented, specifically implementing a 72-hour review process in conjunction with discussions with clinical commissioning groups. Learning from incidents and deaths occurs through the Mortality Review Group in addition to structured judgements reviews and the Trust Patient Safety Panel; which has been strengthened with membership of the borough assistant clinical directors to improve local ownership and embedding of learning with local services.

Lessons are learned and shared through local Quality and Safety Meetings and borough-specific collaborative events, strengthening the borough-based leadership and delivery of learning, improving and reducing harm to patients.

From September 2017, Specialist Services became independent of the Warrington borough. Establishment of a robust leadership team and governance structure has been a key focus in-year, along with developing relationships with commissioning colleagues within NHS England and a diverse range of partner organisations.

A revised framework of oversight by local leadership teams through Quality and Safety Meetings is in place across the Trust which includes clinical environment self-assessments and programme of local safety checks, ligature risk assessments and local triangulation of information; with an escalation and exception reporting structure to the Trust Quality and Safety Meeting on a monthly basis and through the local borough stories as part of monthly quality and performance reports to Trust Board.

The Trust has invested and introduced a range of staff development initiatives including the purchase of the Clinical Skills Net training for staff which links clinical 'back to basics' policies with competency training at the point of practice within operational services which are based on National Institute and Care Excellence (NICE) guidance and best practice standards.

The 2015-2018 Quality Strategy and Quality Improvement Plan have driven a number of work programmes within the Trust, and led to a cultural shift towards a collaborative approach to quality and safety improvement. Acknowledging this is a three-year strategy, the Trust has taken the opportunity to review and update the Quality Strategy in 2018 to ensure there is a culture of continuous focus on quality embedded in all work streams

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 2017/18, 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 the Trust's Our Stars staff recognition awards, including the monthly employee and team of the month.

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.

The clinical quality improvement cycle has been reviewed and our programme of internal collaborative quality visits continued during 2017/18, supporting local services in benchmarking and improving local standards of practice complimented by the safety walkabouts undertaken by executive and non-executive directors. The programme of visits included inpatient wards and community teams across the Trust. 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.

We have successfully implemented new ways of integrated working, care pathways and therapeutic interventions through a range of transformation and overage, Commissioning for Quality and Innovation (CQUIN) projects across our start well, live well and age well work streams which improves physical, emotional, mental health and learning disability, podiatry, therapies, forensic and across community and inpatient services.

Gail Briers
Chief Nurse and Executive Director of Operational Clinical Services

3.1. Trust quality measures

In addition to the achievement of our quality priorities during 2017/18 and establishing our quality priorities for 2018/19 (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 2017/18.

Domain	Indicator to be measured	Detailed definition	2017/18 in-year movement against previous year	2016/17 full year position	2017/18 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		77.4%	**69.8%**	Internal reporting of National Patient Safety Agency definition	There has been a decrease in incidents reported that had an outcome of no harm. Further analysis illustrates there are no themes or trends
	Medicines reconciliation	Proportion of harm identified during medicines reconciliation reviews		0.25%	**0.75%**	Internal reporting of reconciliation reviews undertaken	The low level of harm identified during medicines reconciliation review has slightly increased resulting in an overall increase of harm identified during medicines reconciliation reviews
	Number of falls	Proportion of harm as percentage of falls		34%	**31.64%**	Internal reporting of National Patient Safety Agency and NICE guidance	There has been an decrease in the proportion of falls that have resulted in harm during 2017/18; this is attributed to the positive improvements carried out in line with the sign up to safety campaign

Domain	Indicator to be measured	Detailed definition	2017/18 in-year movement against previous year	2016/17 full year position	2017/18 full year position	Data source	Comments
Patient experience	Number of compliments (Trust)	Expression of satisfaction received verbally or written in year		2,072	**1,886**	Internal reporting	The number of compliments has decreased during the 2017/18 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		180	**151**	Internal reporting of Scottish Office; Citizens Charter definition	The number of complaints received by the Trust has decreased
	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		479	**479**	Internal reporting	The number of concerns has stayed the same in 2017/18. The Trust continues to adopt a local approach to capturing issues of concern

Domain	Indicator to be measured	Detailed definition	2017/18 in-year movement against previous year	2016/17 full year position	2017/18 full year position	Data source	Comments
Effectiveness	Readmissions	The percentage of patients who have been readmitted to hospital within 28 days of discharge	 Target 9%	6.3%	**12.74%**	Internal reporting of Department of Health definition	There was an increase in the percentage of patients who have been readmitted to hospital within 28 days of discharge in 2017/18 against a target of 9% A review of the calculation of the readmission measure was completed in April 2017 against robust guidelines which comply with NHS Improvement guidance. This has led to an increase in the number of readmissions being reported in 2017/18
	Self-harm	The proportion of harm as percentage of self-harm		33.7%	**52.01%**	Internal reporting of National Patient Safety Agency and NICE guidance	There was an increase in the percentage of self-harm incidents causing patient harm in 2017/18. The Trust continues to implement the self-injury pathway to support a reduction in harm as percentage of self-harm going forward

Domain	Indicator to be measured	Detailed definition	2017/18 in-year movement against previous year	2016/17 full year position	2017/18 full year position	Data source	Comments
	Violence and aggression	The proportion of harm as percentage of violence and aggression		22.5%	**35.7%**	Internal reporting of National Patient Safety Agency and NICE guidance	There has been an increase in the proportion of violence and aggression incidents that have resulted in harm during 2017/18. The Trust has prioritised Least Restrictive Practice within inpatient services and as such the Least Restrictive Practice Group, and is working closely with Advancing Quality Alliance (AQuA) for the REsTRAIN programme, demonstrating a reduction in the use of least restrictive practices and harm from violence and aggression for both patients and staff.

Quality measures – Commissioning for Quality and Innovation targets 2017/18

Domain	Indicator name	Definition/goal	Q1-Q3 actual and Q4 forecast
Trust-wide mental health and community	NHS staff health and wellbeing	• Improvement in two of the three NHS annual staff survey questions on health and wellbeing – MSK and stress	**Indicator met in Q1** **Forecast not to be met in Q4**
		• a) 70% of drinks lines stocked must be sugar-free • b) 60% of confectionery and sweets do not exceed 250 calories • c) At least 60% of pre-packed sandwiches and other savoury pre-packed meals available contain 400 calories (1680 kJ) or less per serving	**Forecast to be met in Q4**
		• Achieving an uptake of flu vaccinations by frontline clinical staff of 70%	**Forecast to be met in Q4**
Trust-wide mental health only	Physical health of mental health patients	Cardio metabolic assessment for patients with schizophrenia	**Indicator met in Q1** **Forecast to be partially met in Q4**
		Communication with primary care clinicians – alignment of SMI QOF and CPA registers	**Indicator met in Q2 and Q3** **Forecast to be met in Q4**
Trust-wide mental health only	Improving services for people with mental health needs who present to A&E	Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable	**Indicator met in Q1, Q2 and Q3** **Forecast to be met in Q4**

Domain	Indicator name	Definition/goal	Q1-Q3 actual and Q4 forecast
Trust-wide mental health only	Transitions out of Children and Young People's Mental Health Services (CYPMHS)	This Commissioning for Quality and Innovation (CQUIN) is constructed so as to encourage greater collaboration between providers spanning the care pathway. There are three components of this CQUIN: • A case note audit in order to assess the extent of joint-agency transition planning • A survey of young people's transition experiences ahead of the point of transition (pre-transition / discharge readiness) • A survey of young people's transition experiences after the point of transition (post-transition experience)	**Indicator met in Q1 and Q2** **Forecast to be met in Q4**
Trust-wide mental health only	Preventing ill-health by risky behaviours – alcohol and tobacco	To undertake tobacco screening, brief advice, referral and medication offer. Alcohol screening, brief advice or referral to all adult admissions. Baseline assessment in Q1 followed by incremental improvements Q2-Q4	**Indicator met in Q1, Q2 and Q3** **Forecast to be met in Q4**
Community services only	Supporting proactive and safe discharge	• Actions to map existing discharge pathways, rollout new protocols, collect baseline/trajectories • Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within seven days of admission by 2.5% points from baseline (Q3 and Q4). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.	**Indicator met in Q2** **Forecast to be met in Q4**
Community services only	Improving the assessment of wounds	The indicator aims to increase the number of wounds which have failed to heal after four weeks that receive a full wound assessment.	**Indicator met in Q2, forecast to be met in Q4**

Domain	Indicator name	Definition/goal	Q1-Q3 actual and Q4 forecast
Community services only	Personalised care and support planning	Activity will be focused on agreeing and putting in place systems and processes to ensure the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers.	**Indicator met in Q2 and Q3 Forecast to be met in Q4**
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, Q2 and Q3 Forecast to be met in Q4**
	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, Q2 and Q3 Forecast to be met in Q4**
	Discharge and resettlement	To fund initiatives to remove hold-ups in discharge when patients are clinically ready to be resettled into the community. To include implementation of CUR for mental health at pilot sites.	**Indicator met in Q1, Q2 and Q3 Forecast to be met in Q4**
Fairhaven (tier 4)	CAMHS transition pathway	To improve transition or discharge for young people reaching adulthood to achieve continuity of care through systematic client-centred robust and timely multiagency planning and coordination.	**Indicator met in Q1, Q2 and Q3 Forecast to be met in Q4**

3.2. Achievements against Single Oversight Framework 2017/18

On a monthly basis throughout 2017/18, the Trust reported progress against the Risk Assessment Framework and the Single Oversight Framework. Our performance is as follows:

Single Oversight Framework 2017/18	Threshold	Full year 2017/18
Monitor mental health and learning disability targets reported throughout the year		
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	88% Ⓐ
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	90% 90% 65%	This will be measured by the CQUIN audit
Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	75% 50%	99.72% 52.26%
Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days	95%	97%
Admissions to adult facilities of patients under 16 years old		0%
Inappropriate out-of-area placements for adult mental health services		2017/18 – 656 days / monthly average 54.7 days Ⓐ

Ⓐ This indicator has been audited.

3.2.1. How we are Implementing Duty of Candour

The care across the Trust has always aimed to be open, honest and transparent and the importance to apologise when harm has occurred is understood. In order to meet Statutory 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.

During the past year we have reviewed and improved on our delivery of our Duty of Candour requirements, including a review of the Being Open Policy and Procedure, education sessions through incident reviewer training, patient safety alerts, lessons learned theme of the week, Duty of Candour audit and monitoring of when statutory Duty of Candour is applied.

Discussions at Patient Safety Panel throughout 2017/18 have put an emphasis on increasing support for frontline staff to implement statutory Duty of Candour. All incidents reported which result in moderate harm, severe harm or death are discussed with the Trust's Risk Team to review whether appropriate measures have taken place to apply Duty of Candour and guidance on how to apply it if required. 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 statutory Duty of Candour requirements; however will continue to strive to improve our processes to ensure this requirement remains embedded within the delivery of quality care.

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 over a three-year period, 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:

- The implementation on three female wards of an evidence-based self-injury pathway.
- A reduction in the number of incidents of self-injury on inpatient wards.
- A fluctuating pattern of falls, but overall reduction in falls and harm from falls continues.
- Local ownership of incidents of falls, with the introduction of local fall prevention groups.
- Working with Advancing Quality Alliance (AQuA) for the REsTRAIN programme, demonstrating a reduction in the use of least restrictive practices and harm from violence and aggression for both patients and staff.
- A decreasing trend of patient violent and aggressive incidents which correlates with the Trust's least restrictive practices and therapeutic interventions.
- A relaunch of the Trust Suicide Strategy.

With the support of Advancing Quality Alliance (AQuA), we have successfully implemented improvement plans for reducing restrictive practices and have introduced positive behaviour support approaches within our specialist forensic service (Auden Unit).

The Trust has completed the final year of the Sign Up to Safety campaign, and commitment to maintaining the pledges are now part of business as usual activity, in line with the Quality Strategy.

3.3. Trust-wide achievements

This section represents quality and safety achievements for the Trust realised throughout 2017/18.

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 through the Quality Strategy and clinical assurance cycle and incorporate the following three areas:

- **Collaborative quality visits** – 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** – visits undertaken by executive and non-executive directors. A total of 31 have taken place between April 2017 and March 2018. 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 2017/18 against each of the Fundamental Standards which were introduced in April 2015.

Fundamental Standard Regulations		
Regulation	**Accountable director**	**March 2018**
5 – Fit and proper person – directors	Simon Barber	**Green**
9 – Person-centred care	Gail Briers	**Green**
10 – Dignity and respect	Gail Briers	**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	Gail Briers	**Green**
17 – Good governance	Gail Briers	**Green**

18 – Staffing	Tracy Hill	**Green**
19 – Fit and proper persons employed	Tracy Hill	**Green**
20 – Duty of Candour	Gail Briers	**Green**

The Trust uses a three point rating scale of red, amber, green to show the level of compliance with each of the 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 (ie 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 (ie 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 2017/18, there have been a total of 22 inspections to the Trust from the Care Quality Commission. These were as follows:

- 18 unannounced Mental Health Act monitoring inspections.
- A focused inspection around absent without leave (AWOL) incidents at Atherleigh Park during July 2017.
- A focused inspection around the use of Section 136 in Merseyside, of which the Trust formed part of a wider project.
- A focused inspection at Fairhaven Unit during December 2017 to look at the 'safe' domain in relation to specific concerns highlighted from information received.
- A review of services for looked after children and safeguarding in St Helens during November 2017.

The table below details the inspections undertaken by Care Quality Commission during 2017/18.

Month of visit	Ward/area visited and borough	Type of visit	Areas covered
May 2017	Bridge Ward, Halton	Routine unannounced	**Domain 2** Detention in hospital
May 2017	Golborne Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
July 2017	Westleigh Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
July 2017	Atherleigh Park, Wigan	Focused inspection	Atherleigh Park – Westleigh Unit and Sovereign Unit inspection focusing on the 'safe' domain in relation to absent without leave (AWOL) incidents
August 2017	Knowsley	Focused inspection	The Trust formed part of a larger project to undertake a thematic review of the use of Section 136 Mental Health Act 1983 (MHA) across Merseyside
August 2017	Kingsley Ward, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
September 2017	Parsonage Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
October 2017	Priestner's Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
October 2017	Sheridan Ward, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
October 2017	Austen Ward, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
October 2017	Weaver Ward, Halton	Routine unannounced	**Domain 2:** Detention in hospital
November 2017	St Helens	Review of CLAS (Children Looked After and Safeguarding)	Looked after children and safeguarding
November 2017	Iris Ward, St Helens	Routine unannounced	**Domain 2:** Detention in hospital
November 2017	Sovereign Unit, Wigan	Routine unannounced	**Domain 2:** Detention in hospital
November 2017	Taylor Ward, St Helens	Routine unannounced	**Domain 2:** Detention in hospital
December 2017	Fairhaven Unit, Warrington	Focused inspection	Inspection focusing on the 'safe' domain
December 2017	Fairhaven Unit, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
January 2018	Grasmere Ward, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital

Month of visit	Ward/area visited and borough	Type of visit	Areas covered
January 2018	Coniston Ward, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
February 2018	Auden Unit, Warrington	Routine unannounced	**Domain 2:** Detention in hospital
March 2018	Rydal Ward, Knowsley	Routine unannounced	**Domain 2:** Detention in hospital
March 2018	Byron Ward, Warrington	Routine unannounced	**Domain 2:** Detention in hospital

The Care Quality Commission undertook a focused unannounced inspection at Fairhaven Unit to follow up concerns from information received specifically in relation to administration of medicines and potential use of restrictive practices on the unit.

Following the inspection and receipt of the formal report, the Trust received three requirement notices:

One requirement notice in relation to a breach of regulation 9 (1) (a):

- The language used in records was not consistently person-centred. Care plans did not in all instances demonstrate the individualised care required by each patient and were not always written to the highest of professional standards.

One requirement notice in relation to a breach of regulation 12 (2) (a):

- Staff did not always document all risks associated with each patient within the appropriate section of the care record.

One requirement notice in relation to a breach of regulation 18 (1):

- Staff did not complete all mandatory training within the intended timeframe.

Actions have been taken to address the issues and continual monitoring of compliance has been implemented.

The Care Quality Commission undertook a focused unannounced inspection at Atherleigh Park to follow up on information received from the police in relation to an increase in incidents of patients going absent without leave (AWOL).

Following the inspection and receipt of the formal report, the Trust received two requirement notices:

One requirement notice in relation to a breach of regulation 12 (1) (2) (a) and (b):

- Care and treatment was not provided in a safe way for service users. Staff were not doing all that was reasonably practicable to mitigate risks to the health and safety of service users when patients went on leave and following incidents of service users going absent without leave.

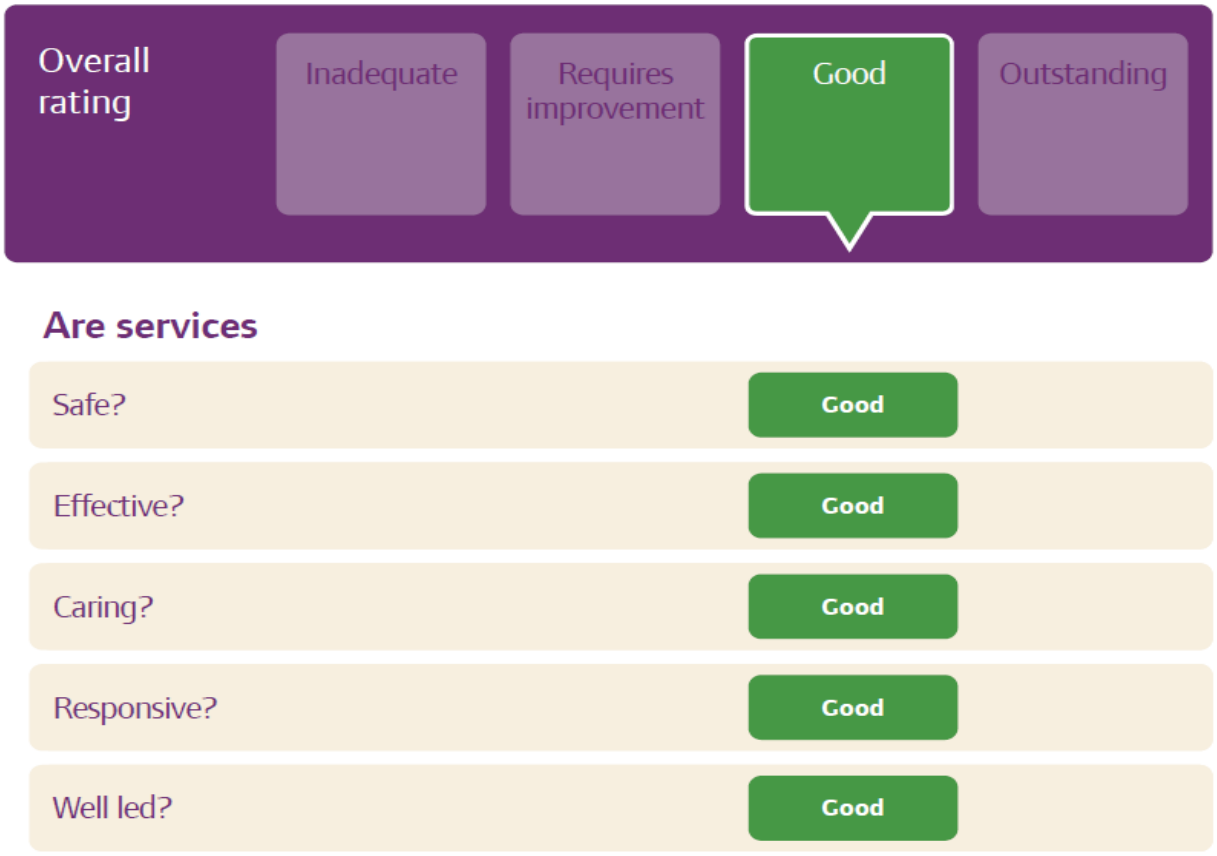
One requirement notice in relation to a breach of regulation 17 (1) (2) (b) and (c):

- Systems and processes were not effective. The systems and processes were not established to guide staff following incidents of service users going absent without

leave and mitigate the risks. There was no current written guidance on missing patients, as required by the Mental Health Act Code of Practice.

Actions have been taken to address the issues and continual monitoring of compliance has been implemented. An action plan has been provided to the Care Quality Commission.

The table below shows the Care Quality Commission overall ratings.



The table at Annex 6 shows the Care Quality Commission ratings for each of the core services provided by the Trust.

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

A number of other visits also took place during 2017/18. These are detailed in the table below, along with a summary of the positive practice and any immediate actions identified:

Month of visit	Ward/area visited and borough	Visiting organisation	Positive practice	Immediate actions
May 2017	Children's services – Knowsley Special Educational Needs and Disabilities (SEND)	Ofsted	Willingness and commitment to move forward at pace with SEND Children's community nursing and specialist nurses are making a very positive contribution towards health needs Positive contribution of 'early help'	An action plan is in place to address the learning identified as part of the visit, however it can be noted that there were no immediate areas of concern raised immediately following the visit
June 2017 and November 2017	CAMHS Services Wigan	Wigan Borough Clinical Commissioning Group	Positive relationships between children and young people, and their therapists Provision of a range of therapeutic interventions and flexibility specific to individual needs Strong sense of the child or young person within the records Promotion of systems and processes for staff to raise concerns	An action plan is in place to address the learning identified as part of the visit, however it can be noted that there were no immediate areas of concern raised immediately following the visit

Month of visit	Ward/area visited and borough	Visiting organisation	Positive practice	Immediate actions
June 2017	Byron Ward, Warrington	Knowsley Clinical Commissioning Group	Overall calm and therapeutic environment Monitoring of environmental risks and responding to changes in identified risks to individual patients Care plans were detailed, person centred and produced in collaboration with patients, carers and family members Therapy and activity areas were being utilised with patients engaging in activities as per individualised care plans Staff understood how to support people in a way that protected them and others from danger, harm and abuse Treatment plans had a strong emphasis on monitoring and treating any physical health needs identified Patients, carers and family members were involved in the decisions about the care and treatment	An action plan is in place to address the learning identified as part of the visit, however it can be noted that there were no immediate areas of concern raised immediately following the visit

Month of visit	Ward/ area visited and borough	Visiting organisation	Positive practice	Immediate actions
September 2017	Knowsley Resource and Recovery	NHS England and Knowsley Clinical Commissioning Group	Passionate, committed and professional staff Staff would recommend the team as a provider of care to their family or friends	An action plan is in place, however it can be noted that any immediate actions in relation to the staff photo board were addressed at the time of the visit
October 2017	Assessment Team, Warrington	Warrington Clinical Commissioning Group	Team is well-led, and staff are well informed Telephone triage process appeared to be a comprehensive process Practitioners contribute to child protection plans via a written report and attendance at meeting	An action plan is in place, however it can be noted that any immediate actions in relation to the work relating to the telephony system were addressed at the time of the visit

Month of visit	Ward/ area visited and borough	Visiting organisation	Positive practice	Immediate actions
January 2018	Children's Services – St Helens Special Educational Needs and Disabilities)	Ofsted	Leaders have a deep and accurate understanding of the local area's strengths and weaknesses Staff have embraced the spirit of the reforms, putting children, young people and families at the heart of their plans, identifying needs and addressing concerns The local area has responded swiftly to the recommendations from the recent children looked after and safeguarding inspection Staff take their safeguarding responsibilities seriously Robust systems and procedures are in place A wide range of programmes offered by speech and language therapy (SALT) and occupational therapy promote early identification of need	An action plan is in place to address the learning identified as part of the visit, however it can be noted that there were no immediate areas of concern raised immediately following the visit

Month of visit	Ward/ area visited and borough	Visiting organisation	Positive practice	Immediate actions
January 2018 and February 2018	Secure and specialised services: Marlowe Unit, Warrington Chesterton Unit, Warrington Auden Unit, Warrington Tennyson Unit, Warrington	NHS England	Actions and recommendations from previous visits have been completed	An action plan is in place, however it can be noted that any immediate actions in relation to the environment were addressed at the time of the visit
February 2018	Children and Young People's Eating Disorder Service, Knowsley	Knowsley Clinical Commissioning Group	Transparency of families available for interview who have had issues with service Care received by Service Users was of a high standard and service users had made progress	An action plan is in place, however it can be noted that any immediate actions in relation to rearranging cancelled appointments at the earliest convenience were implemented immediately following the visit

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.

From 1 February 2018, the Trust received 32 doctors in training under the 2016 contract.

The Trust has four 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 2017 to 31 March 2018, there have been 31 safety walkabouts across the Trust. The visits have taken place across a variety of community teams and inpatient wards. 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 continues to be reviewed in line with Trust priorities and this year, as a result of the information governance staff survey, an additional question has been added which asks about awareness of data security issues.

The outcome of the safety walkabouts has been used within the heat mapping process of the collaborative quality framework and highlighted where a more in-depth review may be required.

The safety walkabouts will continue under the refreshed Quality Strategy for 2018-2021.

3.3.5. REsTRAIN project

During 2017/18, the Trust has prioritised least restrictive practice within inpatient services and, as such, a Least Restrictive Practice Group has been launched with wide representation from across the Trust. The group has established a work plan to take this practice forward.

The Trust has continued to work with Advancing Quality Alliance (AQuA) and has focused on the REsTRAIN programme within Trust inpatient wards.

All wards engaged within the programme have shown a reduction in restraint; a reduction in harm to patients from restraint; and a reduction in harm to staff from restraint.

The Least Restrictive Practice Group will take forward the development of the Trust strategy and policy framework for restrictive practices used within the trust.

In December 2017, the Trust was recognised in the Care Quality Commission publication ‘A focus on restrictive intervention reduction programmes in inpatient mental health services’ for effective approaches to reducing restrictive practice.

3.3.6. National award winners

We have enjoyed another year of awards success, having won and been shortlisted for a number of national awards.

In May 2017, our Estates Project Manager Paul Jackson won the Design Champion Award at the Design in Mental Health Awards.

Paul led the development of Atherleigh Park, our £40 million hospital which opened in Leigh, Wigan, in March 2017. He championed the design from the outset, continually demonstrating and promoting the importance of service users' needs throughout to ensure it achieved its potential to bring improvements to patient care and wellbeing.

The Trust was also shortlisted in three other categories:

- Service User Engagement – for the positive way we worked with service users in the development of Atherleigh Park
- Project of the Year – for Atherleigh Park mental health hospital
- Collaborative Estates and Facilities Team – for the way our Estates and Facilities Team works with operational services to enhance patient environments

In June 2017, Dr Phil Cooper, Nurse Consultant in Dual Diagnosis, was awarded a Member of the Order of the British Empire (MBE) as part of the Queen's Birthday Honours 2017 for his outstanding contribution to raising mental health awareness and advocating for vulnerable people in the local community.

In his role, Dr Cooper works with vulnerable adults who have mental health and substance misuse problems, passionately advocating for the service users he works with and working tirelessly to improve access to support. Dr Cooper cofounded the State of Mind rugby league campaign to raise awareness of mental health in the rugby league community. Six years on, State of Mind is still going strong and has made a huge impact on the rugby league community and beyond.

In July 2017, our Trust's 'Shabby Chic' furniture restoration project within mental health inpatient wards won an award for waste prevention at the National Recycling Awards 2017. 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.

In January 2018, the Knowsley Parent Infant Mental Health Service received national recognition for the work they do in supporting parents to build secure attachments and loving bonds with their babies, whilst breaking negative life cycles. The service won the Outreach to Vulnerable Groups Award, at the National Children and Young People's Mental Health Awards.

The Knowsley Parent Infant Mental Health Service offers a collaborative multi-disciplinary team approach to support vulnerable families, which is one of its key strengths. Clinical psychologists and specialist public health midwives work jointly to support families during the antenatal and postnatal period to ensure much-needed therapeutic attachment-based interventions are offered at the earliest opportunity.

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.

The organisational framework for the oversight for delivery of infection prevention and control is through the Trust Infection Prevention and Control Committee and the approved annual work plan. This includes education, audit and a monitoring programme to prevent healthcare associated infections within the Trust.

The Infection Prevention and Control Team has worked hard to increase education opportunities for staff. The team has undertaken a number of education and awareness activities around the blood-borne human immunodeficiency virus (HIV). This was in response to a number of reported incidents and requests for advice demonstrating a lack of knowledge in staff around HIV transmission. The education events were supported by Sahir House (a local HIV charity) and evaluated as being excellent. Additionally, staff showed their support by wearing a red ribbon which is the symbol for World Aids Day.

The Infection Prevention and Control Team has recently acquired responsibility to lead on sepsis work for the organisation. The aim is to promote awareness and early recognition of this life-threatening condition to ensure the best outcome for patients. The team will continue to review the sepsis campaign and hopes to build on previous successes and hard work within this area.

The team has continued to deliver the responsibilities under our service level agreement with Knowsley Clinical Commissioning Group and Knowsley Council. This has included the provision and delivery of providing support, advice, auditing and education to Knowsley GPs, dentists, schools, care homes, nurseries and the general public. Knowsley Clinical Commissioning Group has requested a further extension to this contract for 2018/19.

A new award system has been introduced over the last year linked to the infection prevention and control audit programme to highlight the achievements of our staff and in particular the infection prevention and control link practitioners within operational services. 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 delivery of this important agenda. Wards that achieve an extremely high score in their first unannounced infection control audit are awarded a gold, silver or bronze award for excellent in infection prevention and control. During the past year, five wards have been awarded gold awards, three wards were awarded silver and seven were presented with bronze awards.

The Infection Prevention and Control Team has supported Occupational Health with the influenza campaign for the third year running which has been a great success and has increased the Trust workforce resilience and health and, in turn, protected many of our patients and families.

Weekly surveillance continues to be undertaken by the Infection Prevention and Control Team, enabling quick identification of infections occurring on wards within the Trust. Further enhanced surveillance is now being collected to allow a more detailed analysis of diagnosis and prescribing patterns regarding urine infections which will further assist in the Trust's antimicrobial resistance agenda and newly introduced bloodstream infections reduction requirements.

The Infection Prevention and Control Team remains vigilant in the surveillance and monitoring of emerging multi-drug resistant organisms such as Carbapenemase Resistant Enterobacteraciae. The antimicrobial resistance agenda continues to be of upmost importance and is one of the biggest threats to the public's health in recent times. The team is working closely with local partners and the medicines management team to deal with the rising concerns over anti-microbial prescribing and emerging multi-drug resistant organisms.

The Trust continues to report on healthcare associated infections as part of the national mandatory return which currently includes Clostridium Difficile Infection, bloodstream infections due to Methicillin-Resistant Staphylococcus Aureus, Methicillin Sensitive Staphylococcus Aureus and Escherichia Coli. There have been no reported cases of Methicillin-Resistant Staphylococcus Aureus, Methicillin Sensitive Staphylococcus Aureus and Escherichia Coli bloodstream infections.

There has been one reported case of Clostridium Difficile Infection attributable to the Trust in April 2017. In line with the NHS Serious Incident Framework, a full root cause analysis was undertaken. This identified the infection was avoidable. In conjunction with the ward, attributing factors were identified and changes to practice agreed to ensure implementation of extra safety precautions to prevent reoccurrence of issues. This work has now been completed.

The Infection Prevention and Control Team continues to respond to all reports of infectious diseases and conditions both in community and inpatient areas. The team also monitors local epidemiology and surveillance reports to predict areas of risk and level of responses required. The team works closely with Public Health England, clinical commissioning groups and the respective local authorities to ensure information, advice and support is readily available for staff and public.

The Infection Control and Prevention Team is now finalising plans for delivery of the service during 2018/19 to provide assurance that the Trust's high standards around infection prevention and control are maintained across existing services and attained within newly acquired areas of business.

3.3.8. Coaching programme

During 2017/18, the Trust continued to develop the Trust's coaching capacity with 13 senior leaders holding professional coaching qualifications to support the delivery of the Trust's coaching strategy, and six coach supervisors.

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.

A range of coaching sessions have been facilitated by members of our executive and non-executive directors to support development of leadership within the organisation.

3.3.9. Business development

The Trust has expanded its portfolio of commissioned services across a widened geographical footprint in a number of key areas to support and enhance delivery of whole person care. These areas include community out-of-hospital services, children's services, criminal justice liaison, eating disorder services, and perinatal mental health; in addition to a number of smaller specialist services. This work has enabled the Trust to deliver its strategy of growth to provide person-centred therapeutic recovery-based services.

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 2017 session, they further explored the Trust's 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.

During 2017/18, the Trust has been successful in winning new business across the Trust footprint, including within Greater Manchester. 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 further 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 has been working in partnership across Cheshire and Merseyside to deliver new care models for child and adolescent mental health services, taking a whole system approach to enable local accountability for local children and young people and seamless provision of integrated mental health services which meet individual needs and those of their families.

We continue to work with partners to deliver new care models across the Trust footprint, combining the knowledge, experience and expertise of the partnership to ensure needs-led and personalised care for children and young people, inclusive of the Trust's tier four (inpatient) child and adolescent mental health service provision at Fairhaven Unit.

The Trust's new children and young people's eating disorder services across Wigan and Bolton, and a service for Warrington, St Helens, Knowsley and Halton, successfully went live from February 2017 and from April 2017 respectively; supporting delivery of whole person physical and mental health care.

In April 2017, the Trust welcomed community nursing services in St Helens. This saw the transition of more than 120 staff into our Trust, consisting of district nurses, community matrons, phlebotomists and many other staff.

Throughout 2017/18, within St Helens, we transformed musculoskeletal service pathways and provision demonstrating a system approach to designing service provision amongst the partners to deliver whole person care.

From April 2017, the Trust began to deliver parent and infant mental health services in Knowsley. The service aims to improve the attachment of mother and baby during the early stages of life, which ultimately improves the child's outcomes later on.

In April 2017, the Trust began delivering the healthy child programme to children and families in Sefton, aimed at improving health and wellbeing outcomes, building resilience and reducing health inequalities. In addition, from June 2017, we entered into a sub-contract arrangement with Mersey Care NHS Foundation Trust to deliver further community-based services in Sefton. These include the Sefton Integrated Community Equipment Service, Litherland Walk-in Centre, the phlebotomy service, safeguarding service and health provision to youth offending and looked after children services.

In January 2017, we launched our new way of working within our psychological therapies service in Wigan – Think Wellbeing. This increases opportunities for our population to access psychological therapies in a wider range of ways, allowing more people to be helped by this service.

In February 2018, the Trust, alongside Cheshire and Wirral NHS Foundation Trust and MITIE (providers of forensic medical services), secured the Cheshire Integrated Healthcare, Liaison and Diversion Service, which will be mobilised by May 2018.

In March 2018, the Trust, in partnership with Cheshire Police, saw the Halton and Warrington anti-stalking unit go live. This is one of three sites within the country.

The Trust has successful bid, in partnership with Greater Manchester Mental Health NHS Foundation Trust, to deliver child and adolescent mental health community services in Bolton from April 2018.

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 within Cheshire and Merseyside Health and Care Partnership, 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.

3.3.10. Launch of new medicines supply service with Rowlands Pharmacy

In 2017, the Trust launched a new medicines supply service, with Rowland's Pharmacy as the sole provider of medicines. The new service delivery model focused on strengthening the medicines management infrastructure to further improve the accessibility of medicines for our service users and carers.

3.3.11. Health and wellbeing

The Trust's Health and Wellbeing Strategy has been implemented. The Trust has an established yearly calendar of health and wellbeing events and initiatives such as Nutrition and Hydration Week, Stress Awareness Month, Dry January, the NHS Games, Work Out at Work Day, Sport Relief and World Mental Health Day. The Trust is proud to continue support of the national State of Mind charity and campaign to improve mental health and wellbeing within sports and leisure.

Staff have 24-hour access to free health and wellbeing centres within Knowsley, Warrington and Wigan, containing a fully equipped gym and a virtual exercise class facilities, enabling staff to choose and perform a wide variety of exercise classes. In addition, free weekly instructor-led classes are offered including Pilates, circuit training and yoga.

The Health and Wellbeing Strategy aims to improve the opportunity for both staff and service users to increase their physical activity and consequently improve their health and wellbeing. The Trust understands that promoting a healthy lifestyle and encouraging physical activity benefits both the physical and mental health of our service users.

Mental health and emotional wellbeing remains a top priority in terms of staff health and wellbeing. As such, the Trust offers staff an eight-week mindfulness programme which has demonstrated positive results. The stress management programme devised and delivered by Occupational Health has also produced very positive outcomes, resulting in a case study being published in a national occupational health journal.

A fitness facilitator's course was developed and introduced in 2017 which enables our staff to facilitate gym sessions with service users. This has seen an increase in both staff and service user use of the gym facilities across the various gyms throughout the Trust and will positively impact on service user experience.

3.3.12. NHS Improvement reporting requirements 2017/18

NHS Improvement is the sector regulator for health services in England. Its role is to protect and promote the interests of patients and ensure 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 Annex 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. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral
    2. Inappropriate out-of-area placements for adult mental health services

Details of the criteria for indicators 1 and 2 are included within Annex 9.

PricewaterhouseCoopers LLP undertook the audit on the above elements. Their external assurance statement is included at Annex 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 (Annex 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

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 Halton child and adolescent mental health service showcases the offer of animal therapy to the SHOUT group – which focuses on 'caring for yourself' – demonstrating innovative ways to support young people in a therapeutic and caring way.

The Trust sponsored and jointly led the organisation of the first national Children and Young People's Mental Health Awards held at Manchester Town Hall in January 2018. Young people from the Trust's child and adolescent mental health service, supported by our Chief Executive and Director of Clinical Networks, judged the Contribution to Services category for an individual or group whose efforts in contributing to improving the quality of their local children and young people's mental health services has been exemplary and inspiring to professionals and children and young people. The young people from the judging panel were supported to attend the event and reported they had a wonderful time.

The Trust's Parent and Infant Mental Health Service won the Outreach to Vulnerable Groups Award for an individual young person or group which helps encourage individuals from groups who have had poor access to traditional services to seek support.

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 quality visit review teams
- Patient-led assessments of the care environment inspection teams
- Safeguarding Panel

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 and Chairman.

During 2017/18, 24 service user and carer forums have taken place across the Trust. Our service user and carer forums and events have been successfully held over the past year which included 'take it to the top' sessions led by our Chief Executive and Chairman, and benefit from the consistent support of foundation trust governors.

The Trust runs monthly service user and carer forums across the Trust designed to:

- Increase engagement with the wider community
- Increase knowledge of our activity within a locality
- Promote North West Boroughs NHS Foundation Trust

- Enable local people to ask questions directly to senior leaders within the Trust

Our key partners all have robust connections within their communities and they support the forums by attending and publicising across their membership. This includes all our local Healthwatch organisations and carers centres, plus local service user representative and peer support groups.

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 includes:

- 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:

- Face Forward – service users deliver a wide range of activities covering health, art, and social activities to service users, carers and members of the community in Knowsley.
- Swapping Seats – a group of 18 service users and carers have been trained to provide mentoring to University of Liverpool trainee clinical psychologists.
- Ward activities – volunteers visit wards across Halton, Knowsley, Warrington and Wigan and carry out a range of activities with inpatients. This includes tea and biscuits, reading newspapers and general social interaction. Volunteers for St Helens wards have been identified and are currently being trained.
- Specialist Services Recovery College – volunteers have been recruited and trained to deliver a range of sessions including, cooking, dance, health and fitness, gambling awareness and relaxation. These have been run on both the male and female secure services inpatient wards and are currently underway on Fairhaven Unit – our child and adolescent inpatient unit.
- Criminal Justice Liaison Team – volunteers with lived experience of the criminal justice system and mental health services work alongside staff in peer support groups.

- Gardening project in St Helens inpatient site – volunteers work with inpatients tending an area of raised beds and a copse.
- Walking basketball sessions at Atherleigh Park – volunteers deliver weekly inpatient sessions accessible to people of all abilities.
- Smokefree – volunteers visit inpatient wards to promote the benefits of going smokefree and support service users to access community-based smokefree resources.
- Involvement Scheme representation on each collaborative quality visit.
- Membership on editorial committee to produce Reflect magazine.

Two members of the Involvement Scheme have used their experience of volunteering to gain paid employment within the Trust. One is now employed in the Criminal Justice Liaison Team providing peer support and the other is an activity worker at Atherleigh Park.

3.4.6. Annual involvement events

The Trust's annual involvement scheme event – Ignite Your Life – was held on 12 July 2017 and was attended by more than 150 patients, service users, carers, volunteers, staff and representatives from local third sector organisations.

The celebration of the past year's involvement began with joint presentations from service users, carers and staff describing the involvement opportunities carried out over the last 12 months and the difference they have made.

The event also included the presentation of 100 Hours Recognition Awards to 42 volunteers.

The Harry Blackman Memorial Trophy for 2017 was presented to Bahman Aghatabay. Mr Aghatabay strongly believes activity has a positive impact on both the physical and mental health of service users. He has, with input from former professional players, developed weekly walking basketball sessions which he runs for inpatients in Atherleigh Park. He ensures the sessions are accessible to everyone regardless of ability or disability and feedback from both staff and service users shows how highly the sessions are valued.

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', journal therapy with creative stitching and furniture painting. Other sessions included, song writing, Samba Band 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 six 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.

The Trust worked closely with Sefton Healthwatch utilising their links within local communities to drive foundation trust membership.

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
- Care Opinion postings
- Service user and carer forums
- Patient Advice Liaison Services (PALS)
- Compliments, complaints and incidents
- Other feedback (Healthwatch, National Patient Survey)

The outcomes from concerns identified and actions taken are reported through 'You said, together we did' posters which are displayed locally.

3.4.9. Friends and Family Test

Over the past 12 months, feedback from service users and their carers has shown that they are more likely to recommend the care we provide to their friends and family if they needed similar care or treatment.

The NHS Friends and Family Test provides every patient with an opportunity to feed back on the care provided to them, supporting us as a Trust to understand where people accessing our services are happy with the care provided or whether there are improvements needed.

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.

Between April 2017 and March 2018, the Trust received 11,584 responses to the first question. See Annex 4 for tables highlighting results from Friends and Family Test for April 2017 and March 2018.

End of life care has been recognised as delivering high-quality services within the Halton and Knowsley Admiral Nursing Service. The team has worked collaboratively with colleagues, partners and service users to develop and provide a service for families and carers of people living with dementia which has resulted in a nomination for a Parliamentary Award for the NHS at 70 for the care and compassion category.

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. Training has been given to senior managers conducting equality impact assessments as part of the process to identify cost improvement plans.

The Accessible Information Standard has continued to be embedded within the Trust's electronic systems and practice and is supported through a contract with a translation and interpretation service.

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 has agreed to focus on inclusive leadership outcomes, as follows:

4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.
4.2 Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed.
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.

The focus is about finding evidence to support these for the EDS 2 assessment.

Our EDS2 event is being held in May and will see a large group of service users, carers, staff, third sector organisations and Healthwatch representatives brought together from across the Trust footprint to assess the evidence provided. We hope to maintain or improve on the previous score for 2016/17, when 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

Annex 1 – Supporting statements from NHS England or relevant clinical commissioning groups, local Healthwatch organisations and Overview and Scrutiny Committees

North West Boroughs Healthcare 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 Trust's Quality Strategy for 2018-2021 has been reviewed by the Quality Committee in December 2017 and is scheduled for approval in April 2018.

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.

Tricia Kalloo
Quality Committee Chair, Non-Executive Director

Statement on behalf of the Council of Governors on the Trust's Quality Report

During 2017/18, 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 2017/18 this has been demonstrated by:

- The Council of Governors and the Governors' Assurance Committee received updates on progress to achieve the Trust's quality priorities during 2017/18.
- Attendance and involvement at the Quality Account stakeholder event on 12 February 2018, both reviewed progress of 2017/18 quality priorities and development of 2018/19 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 21 February 2018, the governors reviewed feedback and responses from the stakeholder event and agreed themes for the 2018/19 quality priorities.
- Governors' Assurance Committee meeting on 21 March 2018 – agreed the detailed quality priorities for 2018/19 and will continue to monitor progress against the quality priorities for the coming year.
- This year, the Council of Governors chose 'delayed transfers of care' as the quality indicator to be audited as part of the assurance processes for the Quality Report 2017/18.
- The Council of Governors received the external assurance on the Trust's Quality Report (Governors' Report) from the external auditors for 2016/17

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 2017/18 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 2018/19 quality and safety agenda as set out in the Trust's Quality Report.

Andy Jones
Chair of Governors' Assurance Committee / Governor

Clinical Commissioning Groups/ Borough Council/ Healthwatch

Halton Borough Council

HALTON BOROUGH COUNCIL

Kerstin Roberts
Assistant Director of Integrated Governance (Interim)
North West Boroughs Partnership
NHS Foundation Trust
Hollins Park House
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Warrington
WA3 8WA

Our Ref	DD/NWB
If you telephone please ask for	Debbie Downer
Your ref	
Date	11th May 2018
E-mail address	Debbie.Downer@halton.gov.uk

Dear Kerstin,

Quality Accounts 2017 - 2018

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 10th May that you and your colleagues Jan Snodden and Lyndsey Maloney 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 2017/18 the Board were pleased to note that the Trust made progress on all three of their priorities. The Board noted in particular, the following:

- **Safety: Always Events** is a commitment to determining events which should 'always' happen to ensure quality and safety levels and standards are consistently achieved. The Trust partially met this objective and the Board are interested to hear about ongoing work being carried out to evaluate 'always' events.
- **Effectiveness: Complaints, Concerns and Compliments** is key in developing an open learning culture which values the patient and their family by listening to their experience. The Board were interested to note that a video to help those with Learning Disabilities understand the complaints process had been produced and a review of complaint template letters had taken place.
- **Experience: Duty of Candour** is a long-standing commitment of the Trust supporting a culture of transparency and honesty. The Board noted that an awareness raising campaign had taken place for staff, service users and carers.

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BOROUGH COUNCIL

The Board were pleased to note the following:

- The Trust were awarded a Care Quality Commission rating of 'Good' overall, with 'Good' achieved in all five domains of safe, effective, caring, responsive and well-led.
- That the Contact and Referral Team (CART) were piloting a scheme whereby staff from a centralised location in St Helens, were moving to a locality based CAMHS which aims to speed up processes and reduce referral waiting times.
- The move to Vine Street ensuring place-based provision was progressing with the Trust working alongside HBC and Halton NHS CCG.

The Board are pleased to note the following Improvement Priorities for 2018 – 2019:

- **Priority 1 Safety:**
  - Always Events (year two). The governance arrangements now in place for 'always events' will continue, including the recording of 'always events' within the Trust Quality and Performance Meeting. 'Always events' will continue to be developed to incorporate 'always events' for quality and safety in Community Teams.
  - Safety huddles. The Trust will work with service users and carers to determine an approach to reducing harm, supporting staff, improve communication in teams and improving quality, safety and effectiveness.
- **Priority 2 Effectiveness:**
  - Team Clinical Supervision. Bringing practitioners and skilled supervisors together to reflect on practice; identify problems, improve practice and increase understanding of professional issues.
- **Priority 3 Experience:** Service User/ Carer Involvement. Service users, carers and those with lived experience will continue to be involved and integrated into the development of services, planning the delivery of services, and monitoring quality of services.

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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Mr S Barber
Chief Executive
North West Boroughs Partnership NHS Foundation Trust
Hollins Park House
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21st May 2018

Dear Simon,

Quality Accounts 2017 - 2018

I am writing to express my thanks for the submission of North West Boroughs Partnership NHS Foundation Trust Quality Report for 2017-2018 and for the presentation given by Jan Snoddon, Interim Director of Governance, Lindsey Maloney, Assistant Director for Halton and Kerstin Roberts, Assistant Director Integrated Governance to local stakeholders on 8th May 2017. This letter provides the response from NHS Halton Clinical Commissioning Group.

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.

There is evidence of engagement of a wide group of stakeholders in producing the Quality Account 2017-18 and in developing the priorities for 2018-19 including service users and carers.

NHS Halton CCG noted the progress against the identified priorities in 2017 – 2018 which where:

1. Safety: Always Events
   - Determining the 'always events' and an 'always event' approach to support patient safety across inpatient units.
   - Developing a communications strategy to define and launch 'always events' across the Trust.
   - Creating a robust system to record and track 'always events' to identify areas of focus, and reviewing outcomes to determine the impact from actions.
   - 'Always events' is now accepted as the cultural framework on which services must perform consistently for every patient, every time.

It was note this was partially met due to not fully achieving the quarter 4 indictors and measures set against this quality priority. However, the limitations in respect of reporting and monitoring that were identified during 2017/18 are being further explored and considered in the development of monitoring and evaluation arrangements for the 2018-19.

The implementation of the the requirements outlined in the Learning from Deaths framework has been achieved.

2. Effectiveness: Complaints, Concerns and Compliments
Achievement of this quality priority includes:
- Development of robust system to capture feedback from complainants.
- Reviewing complaint letter templates.
- Implementing a framework for capturing evaluation from complainants.
- Analysing whether protected characteristic group(s) are under or over represented in voicing their concerns.
- Improving complaints investigations, by providing high quality training to staff.
- Reviewing of promotional literature will begin to ensure information is inclusive and accessible

It was noted this priority was met evidenced by the implementation of a system to monitor actions from complaints has been developed. The development of a video for people with learning disabilities to enable them to understand the complaints process was felt an area of good practice, alongside using the trend information at Quality and Safety Meetings as part of lessons learned.

3. Experience: Duty of Candour
- Raising awareness Duty of Candour notifiable incidents and actions
- Developing systems to record Duty of Candour conversations and correspondence.
- Reviewing Duty of Candour letter templates in consultation with staff, service users and carers.
- Revising Trust policies and procedures.
- A suite of lessons learned communications have been developed and cascaded for discussions at team level.

It was noted this priority was met evidenced by the Duty of candour awareness raising campaign, training and education for staff in regard to notifiable incidents. The development of an audit tool, a Being Open policy and lessons learned communications were seen to be positive steps for both staff and patients.

The Trust has maintained a Care Quality Commission rating of '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 staff work together to jointly address tangible issues for patients, carers and families.

Given the national issues in regard to workforce recruitment and retention the development of the trust workforce strategy was highlighted. It was encouraging to see the Trusts review of the career development framework for staff including the introduction of apprenticeships, assistant practitioners, associate nurses and advanced practitioner initiatives. A framework of talent spotting through an improved staff appraisal personal development plan is now in place, and we now utilise a values based recruitment system. It is clear that there is board oversight and that there is Executive visibility at ward level evidenced in the safety walkabouts.

The Trusts involvement in both National and local audit is evident, however stakeholders noted that the learning and embedding of new practice as a result of audit is not evident. It was also felt that mental health services are well represented within the quality account however, community services provision i.e. district nursing, therapies for example and key performance indicators and outcomes are not.

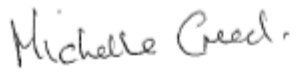
NHS Halton CCG noted the Trusts Improvement Priorities for 2018 – 2019:

- **Safety:** Always Events (Two Year Priority)
- **Safety:** Safety Huddles
- **Effectiveness:** Team Clinical Supervision
- **Experience:** Service User/ Carer Involvement

NHS Halton CCG recognises the challenges for providers in the coming year but we look forward to working with the Trust during 2018-2019 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 2017/2018.

Yours sincerely,



Michelle Creed
Chief Nurse

Commentary on the Quality Account of North West Boroughs Healthcare NHS Foundation Trust by Healthwatch Knowsley.

Healthwatch Knowsley welcomes the opportunity to provide this commentary in support of the North West Boroughs Healthcare (NWB) Quality Account for 2017/18. A draft copy of the Account was provided to Healthwatch Knowsley in a timely manner to allow for a response to be produced.

Healthwatch Knowsley would like to thank the Trust for their willingness to work with Healthwatch throughout the year across the community and mental health services provided to Knowsley residents. Healthwatch members have contributed to work streams for Podiatry and End of Life Care and also to the CQUIN work linked to Hospital Discharge. This collaborative working has been a consistent theme over many years now and is very much appreciated.

North West Boroughs currently holds a patient experience rating of 4.6 out of 5 stars (good/excellent) based on the 239 comments for community services and 4 stars (Good) based on 150 comments for Mental Health services. This information is held on the Healthwatch Knowsley online feedback centre. Each rating has been collated through patient experience provided by patients and family members via feedback online or direct contact in the local community. Listening Events and surveying activities have also been undertaken with patients attending clinic appointments. Healthwatch Knowsley also visits the mental health inpatient units in Knowsley to capture patient feedback. The Trust has proactively supported this work and it is felt that the ratings closely correlate with the reported Patient Experience for Mental Health with the Quality Account.

The opportunity to be able to contribute to the shaping of priorities as part of the Quality Account process is welcomed and levels of transparency and honest dialogue provides scope for meaningful engagement. With regard to

aspects of the detail presented in the report Healthwatch Knowsley would ask that staff are commended for the performance around Early Intervention in Psychosis and in the later stages of the reporting year around IAPT.

We would encourage the Trust to continue to closely monitor the percentage of patients readmitted to hospital and review and respond to any emerging themes. We welcome the involvement in the LeDer programme and recognise the opportunity to ensure that where themes and learning are available to the Trust that they are influencing the day to day practice and strategic thinking.

Moving forward, Healthwatch Knowsley would ask that thought is continually given to how levels of quality are maintained and the focus on the needs of local communities is retained during this period of significant expansion for the organisation.

It is also clear to see the significant amount of achievement that has been detailed throughout the Quality Account for 2017-18 and the staff at the Trust must be commended for this. Healthwatch Knowsley wishes to place on record their appreciation of the Trust's work on behalf of our local community.

Healthwatch Watch Warrington's Response to North West Boroughs Healthcare NHS Foundation Trust's Quality Account Document 2017 - 2018 (May 2018)

As a people's champion for health and social care, Healthwatch Warrington is here to act as a 'critical friend'; offering constructive criticism to partners, alongside celebrating areas of good practice - from the perspective of local service users.

As such, we are pleased to offer our response to North West Boroughs Healthcare NHS Foundation Trust's (NWB) Draft Quality Account (2017/18). Mainly, we see this as an opportunity to consider whether the lived experiences of local people using the Trust's services are properly reflected in this year's report. Furthermore, we have looked for evidence of a tangible learning culture being in place and that those priorities identified by the Trust are clearly measurable and challenging enough to drive quality improvements forward (i.e. that areas of good practice have been highlighted and areas requiring further attention have been adequately flagged).

Regarding the report's structure, we were pleased to see that the report began with a clear focus on the importance of organisational values in driving quality improvements. This authenticity of this emphasis was shown by the Trust's reference to embedding a values-based staff recruitment system into its cultural practices.

As Healthwatch Warrington received a draft version of the report, some data was not included at this stage, which has limited our ability to comment on certain aspects of the Trust's performance (for example, the outcome of the Mortality Review Group Meeting in relation to learning from patient deaths).

In general though, we felt that this report was comprehensive and included a range of supporting datasets and clear definitions were include where necessary (for example, a succinct definition of what constitutes a 'complaint'). It was especially useful to have indicator arrows to give a snapshot impression of performance and to have side-by-side datasets from different years included; making comparative appraisals easier to carry out.

However, we would still recommend that future reports contain a key terms glossary; helping the public to better understand any clinical terminology used and access further detail about engagement campaigns, initiative or programmes referred to in the document (for example, AQuA and the 'Sign up to Safety' campaign). Also, while the report has clearly referenced the Trust's recent name change (from 5 Boroughs Partnership) due to its geographic expansion, which was a positive development, it would have been useful to include an up-to-date map showing the scope of the Trust's enlarged service footprint.

Healthwatch Warrington did note a number of positive developments relating to patient experience, and in particular, the 'whole system' regional partnership approach adopted by the Trust to enable local accountability for children and young people, and integrated mental health service delivery to meet families' needs. We also recognise the value of the Trust's new Children and Young Person's Eating Disorder service, which is available to Warrington residents. We were also satisfied to read that staff had received additional training to boost their skills (such as the Trust's investment in Clinical Skills Net Training).

In relation to patient safety and effectiveness, Healthwatch Warrington was pleased to read that the Trust is continuing to prioritise the achievement of 'Always events', with a proactive focus on securing positive outcomes for patients. However, there were some areas of concern evident in the report that we believe need further attention. For instance, there was a reported increase in the percentage of patients re-admitted to hospital within 28 days of discharge; the proportion of self-harm incidents and an increase in the proportion of violence and aggression incidents causing harm.

Similarly, the number of patient safety incidents resulting in severe harm or death were relatively high in comparison to the national average figures for 2017/18. Coupled with these trends, it was also concerning to read that there had been a high number of Absent Without Leave incidents at Atherleigh Park in 2017, which had led to a targeted inspection.

Healthwatch Warrington would urge the Trust to focus on learning from these trends and incorporating robust actions plans in its priorities to address them effectively.

Regarding the Trust's use of patient feedback, Healthwatch Warrington found it very useful to have an overview and analysis of themes from patient complaints and concerns included within the report. In terms of the patient and partner organisation feedback that Healthwatch Warrington has received about the Trust in this period, clear areas of concern have been identified that overlap with those identified in this thematic analysis.

For example, patients and carers have encountered difficulties accessing the Trust's services (especially during telephone system based assessments), which has been particularly distressing to those patients requiring urgent help. Similarly, patients have reported general issues with communication; particularly around a lack of timely follow up calls, disjointed discharge processes and instances of poor staff attitudes (such as a lack of compassion in conversations with patients in crisis).

We would strongly encourage the Trust to continue working with patients, carers and local partners to address these issues and applaud the clear focus on improving the collection and harnessing of patient feedback data in the near future. As such, we have shared this feedback with the Trust and continue to have a constructive relationship with its patient experience contacts.

We also feel that the Trust's local Patient and Carer Forums provide an excellent venue to have open discussions around patient and partner experiences of using its services. In next year's report, it would be beneficial to include more detail with respect to how the feedback gathered at these forums has been used by the Trust to make a difference (for example, a 'You Said, We Did' section). This would fit in line with the Trust's stated aim of improving its effectiveness by enhancing its 'complaints, concerns and compliments' mechanisms in order to strengthen its learning-culture.

In the year ahead, Healthwatch Warrington will continue to work closely with the Trust in order to better support patients and help to improve quality outcomes (such as sharing good practice ideas for achieving greater support for family and carers). For example, we look forward to welcoming Trust representatives at our Quality Accounts Involvement Day in May 2018, where they will be able to discuss this year's report with stakeholders and members of the public.

Kind regards

Lydia Thompson

Chief Executive Officer

Healthwatch Warrington

Knowsley Clinical Commissioning Group and St Helens Clinical Commissioning Group joint response

St Helens Clinical Commissioning Group

NHS
Knowsley
Clinical Commissioning Group

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0151 244 4126

21st May 2018

Simon Barber
Chief Executive
North West Boroughs Healthcare NHS Foundation Trust
Hollins Park House, Hollins Lane
Winwick, Warrington
WA2 8WA

Dear Simon

North West Boroughs Healthcare NHS Foundation Trust Quality Account 2017/18

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 2017/18.

The CCGs acknowledge the progress made against the 2017/18 quality priorities:

Priority 1: Always Events
Priority 2: Complaints, Concerns and Compliments
Priority 3: Duty of Candour

The CCG notes, in particularly, the work with service users and involvement scheme members to shape these priorities.

Looking forward to 2018/19 the priorities have continued to show commitment to safety, effectiveness and experience.

Safety Priorities: Always Events and Safety Huddles
Effectiveness Priority: Team Clinical Supervision
Experience Priority: Service User / Carer Involvement

The safety focus around expanding always events within the community services and the implementation of safety huddles has been viewed positively. Likewise the commitment to effectiveness, through a review of the team clinical supervision processes, and experience through, further development of the service user / carer involvement within the Trust, are commended.

In response to the Quality Account 2016/17, the CCGs noted the challenge to quality within the Trust due to the growth geographically and through acquisition of new services. When reviewing the Quality Account 2017/18, it has been noted that there is little in relation to how the Trust has managed these challenges.

In addition the CCGs are aware of the challenge the Trust has faced in relation to learning from Serious Incidents. During 2017/18 the Trust has worked in collaboration with several stakeholders to make improvements in this area and reference to this within the Quality Accounts could demonstrate the commitment to learning.

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 Quality, Safety and Safeguarding (QSSG) 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
CLINICAL ACCOUNTABLE OFFICER
NHS ST HELENS CLINICAL COMMISSIONING GROUP

Wigan Borough Clinical Commissioning Group

NHS
Wigan Borough
Clinical Commissioning Group

Wigan Borough Clinical Commissioning Group Response the North West Boroughs Healthcare NHS Foundation Trust Quality Account 2017/18

Wigan Borough Clinical Commissioning Group (the CCG) welcomes the opportunity to comment on the ninth Quality Account for North West Boroughs Healthcare NHS Foundation Trust.

Successes in relation the 2017/18 quality priorities have included:

- The introduction of 'Always Events' for safety across inpatient units
- Improvements to the complaints process, particularly the introduction of a framework for capturing evaluation from complainants
- Implementation of the principles of statutory Duty of Candour into everyday work and in to all elements of care

The CCG is pleased to note the Trust has maintained a Care Quality Commission (CQC) rating of 'Good' overall, with 'Good' achieved in all five domains of 'Safe, Effective, Caring, Responsive and Well-led'. There was a good response from the Trust in year to the CQC focussed inspection of Atherleigh Park.

Whilst we recognise that the Trust has made considerable improvements across a number of areas during 2017/18 there have also been challenges in the Wigan Borough. Examples include the performance of the Wigan Assessment Team and an increase in inpatient readmission rates. The CCG requires the Trust to continue to focus on improving the quality and safety in these areas during 2018/19.

The CCG was pleased to have the opportunity to contribute to development of the 2018/19 quality priorities at the Quality Account Stakeholder Event held in February 2018 and welcomes the Trusts plans to focus on:

- The further roll out of Always Events to community teams
- Safety huddles
- Team clinical supervision
- The involvement of service users, carers and those with lived experience into the development of services, planning the delivery of services, and monitoring quality of services.

During 2018/19 the CCG looks forward to the publication of the Trusts Quality Strategy 2018/21 and Suicide Prevention Strategy and work plan.

The CCG will continue work in partnership with the Trust and other stakeholders during 2018/19 to ensure the continuous focus upon improvement in order to provide the best possible care for our patients.

Dr Tim Dalton, Chairman, Wigan Borough Clinical Commissioning Group
18 May 2018

Wigan Life Centre • College Avenue • Wigan WN1 1NJ • www.wiganboroughccg.nhs.uk
Chairman: Dr Tim Dalton • Chief Officer: Trish Anderson

Healthy People, Healthy Place.

Annex 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 2017/18 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes for the period April 2017 to April 2018
    - Papers relating to quality reported to the Board over the period April 2017 to April 2018
    - Feedback from the commissioners – joint response from Knowsley and St Helens Clinical Commissioning Groups dated 21 May 2018 and Wigan Borough Clinical Commissioning Group dated 18 May 2018
    - Feedback from Governors dated 20 April 2018
    - Feedback from local Healthwatch organisations – Warrington dated 16 May 2018, Knowsley dated 22 May 2018
    - Feedback from Overview and Scrutiny Committee – Halton Borough Council dated 11 May 2018
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, published April 2017 – March 2018
    - The 2016 national patient survey published November 2017
    - The 2017 national staff survey published March 2018
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2018
    - Care Quality Commission inspection report dated 15 November 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.
- 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.

Helen Bellairs, **Chairman**
24 May 2018

Simon Barber, **Chief Executive**
North West Boroughs Healthcare NHS Foundation Trust
24 May 2018

Annex 3 – National Patient Survey results 2017

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 end of 2016, 824 randomly selected service users who had been in contact with our Trust were contacted. A total of 191 service users from the Trust responded, representing 23 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 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	7.6 / 10	Average
Organising care	8.2 / 10	Average
Planning care	6.7 / 10	Average
Reviewing care	7.6 / 10	Average
Changes in who people see	4.9 / 10	Average
Crisis care	5.9 / 10	Average
Treatments	6.9 / 10	Average
Support and wellbeing	4.8 / 10	Average
Overall views and experiences	7.1 / 10	Average

Annex 4 – Friends and Family Test

Monthly responses as a percentage who said they were ‘extremely likely’ or ‘likely’ to recommend our services.

Metrics	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Total responses	440	711	773	775	535	665	430	995	897	1175	1335	2853
% recommended (extremely likely and likely)	97%	97%	96%	97%	96%	96%	94%	96%	98%	98%	96%	90%
% non-recommended (unlikely and extremely unlikely)	1%	1%	2%	1%	1%	1%	2%	1%	1%	1%	1%	1%

Annex 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.

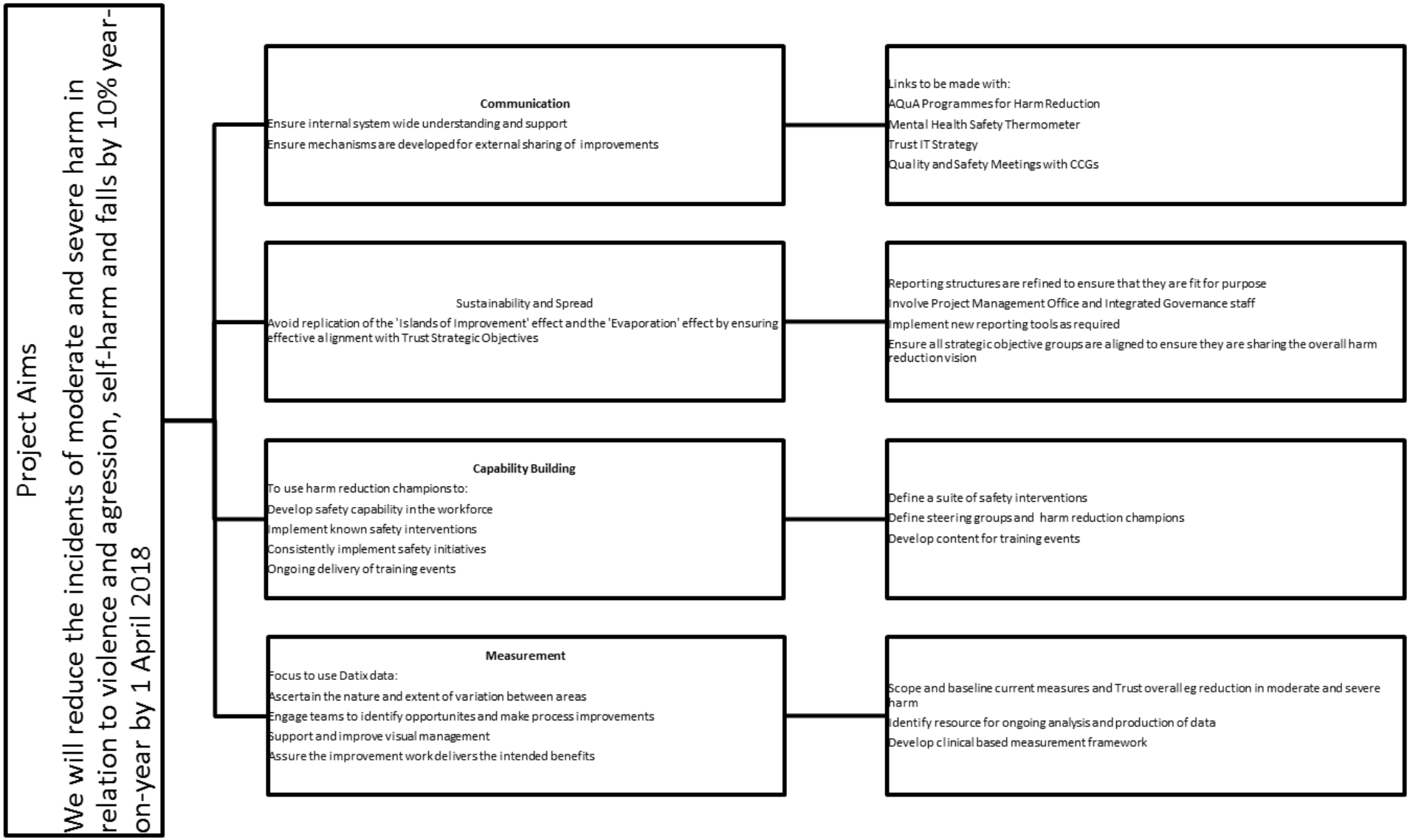
Reduction of harm in relation to falls, violence and aggression and self-harm are the Trust's quality priorities for safety. The Trust continues to concentrate on the reduction of moderate and severe harm, as it is these incidents which have the most impact on our patients. This reflects the Duty of 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 2018/19. 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 2018/19. 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 2018/19.

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 2018/19 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 2017. 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.

Annex 6 – Care Quality Commission ratings table

Annex 7 – Complaints Report 2017/18

Compliant with Regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

During the period 1 April 2017 to 31 March 2018:

- We received 151 complaints

Of the 151 complaints received:

- We closed 136 complaints; some were carried forward from the previous year

Of the 136 closed complaints:

- 130 (96%) complaints were acknowledged in three days or under following receipt
- Six (4%) complaints were acknowledged over three days following receipt

Of these 136 closed complaints:

- 51 (38%) had none of the issues complained about upheld.
- 80 (59%) were well-founded (some or all of the issues complained about upheld).
- Five (3%) were withdrawn or not progressed by the complainant.

During the reporting period, we were informed of 10 complaints which were referred to the Parliamentary and Health Service Ombudsman.

In total, the Ombudsman investigated three complaints, one was upheld with recommendations and two were not upheld and no further action considered necessary by the Ombudsman. Of the remaining seven complaints, three were not investigated and the Ombudsman requested further information for the remaining four, and has made no further contact with the Trust regarding these complaints.

The Ombudsman also concluded their investigation of one complaint which was carried forward from the previous year, this was not upheld.

Breakdown of themes of complaints (top five):

Previous year (2016/17):		**2017/18:**	
Communication	35%	Care issues	42%
Care issues	30%	Staff attitude	29%
Staff attitude	25%	Communication	25%
Clinical treatment	10%	Medication	11%
Medication	10%	Appointments/referrals/discharge	10%

Please note, complaints can have more than one theme, consequently, the breakdown of themes can equate to more than 100 per cent. During 2017/18:

- We received **1,871** compliments
- We received **31** Members of Parliament enquiries
- We received **479** concerns

Annex 8 – NHS Improvement's external assurance statement

Independent Auditors' Limited Assurance Report to the Council of Governors of North West Boroughs Healthcare NHS Foundation Trust on the Annual Quality Account

We have been engaged by the Council of Governors of North West Boroughs Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of North West Boroughs Healthcare NHS Foundation Trust's Quality Account for the year ended 31 March 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 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*** (exact page number where criteria can be found)
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral	In line with the definition included within NHS Improvement's "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18" Annex C (page 26)
Inappropriate out-of-area placements for adult mental health services	In line with the definition included within NHS Improvement's "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18" Annex C (page 28)

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 2017/18" 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 2017/18";
- 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 2017/18".

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 2017/18"; 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 period, April 2017 to April 2018;
- Papers relating to quality report reported to the Board over the period April 2017 to April 2018;

- Feedback from the Commissioners - joint response from Knowsley and St Helens Clinical Commissioning Groups dated 21/05/2018 and Wigan Clinical Commissioning Group dated 18/05/2018;
- Feedback from Governors dated 20/04/2018;
- Feedback from Local Healthwatch organisations - Warrington dated 16/05/2018;
- Feedback from Local Healthwatch organisations – Knowsley dated 22/05/2018
- Feedback from Overview and Scrutiny Committee - Halton Borough Council dated 11/05/2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, published April 2017 – March 2018;
- The 2016 national patient survey published November 2017;
- The 2017 national staff survey published dated March 2018;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2018; and
- Care Quality Commission inspection, 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) 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 North West Boroughs Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting North West Boroughs Healthcare 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 2018, 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 North West Boroughs Healthcare 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 2017/18";
- 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 2017/18"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 North West Boroughs Healthcare 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 2018:

- 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 2017/18";
- 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 2017/18".

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Manchester
25 May 2018

The maintenance and integrity of the North West Boroughs Healthcare 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.

Annex 9 – Criteria for mandated indicators tested

1) Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

Detailed descriptor
The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE-recommended package of care.

Numerator
The number of referrals to and within the Trust with suspected first episode psychosis or 'at risk mental state' that start a NICE-recommended care package in the reporting period within two weeks of referral.

Denominator
The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start NICE-recommended care package in the reporting period.

Accountability
Achieving at least a 50 per cent rate of people with first episode psychosis treated with a NICE-approved package of care within two weeks of referral.

More detail about this indicator and the data can be found within the mental health community teams' activity section of the NHS England website.

2) Inappropriate out-of-area placements for adult mental health services

Detailed descriptor
Total number of bed days patients have spent inappropriately out-of-area. In *Detailed requirements of quality reports* we have specified that the indicator should be stated as a monthly average.

Data definition
An out-of-area placement for acute mental health inpatient care happens when:
A person with assessed acute mental health needs who requires adult mental health acute inpatient care is admitted to a unit that does not form part of the usual local network of services.

Numerator
The number of out-of-area placements to the Trust's acute wards during the reporting period.

Denominator
The number of out-of-area placements to the Trust's acute wards during the reporting period.

Detailed guidance
More detail about this indicator and the data can be found in the out-of-area placements in mental health services for adults in acute inpatient care guidance on the governance services and information website gov.uk.

Auditor's Report

Independent auditors' report to the Council of Governors of North West Boroughs Healthcare NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, North West Boroughs Healthcare NHS Foundation Trust's financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of the Trust's income and expenditure and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2018; 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 description of the significant accounting policies.

Basis for opinion

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"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Our audit approach

Context

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged.

Overview

- Overall materiality: £3,625,000 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.

Our principal risks and key audit matters were:

- Management override of controls and fraud in revenue recognition;
- Financial performance and economic uncertainty; and
- Valuation of property, plant and equipment.

The scope of our audit

As part of designing our audit, we determined materiality and assessed 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.

We found management override of controls and fraud in revenue recognition to be a key audit matter, and this is discussed further below. 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.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified by our audit.

Key audit matter	***How our audit addressed the Key audit matter***
Management override of controls and risk of fraud in revenue 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. 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 transactions in such a way as to lead to material misstatement in the reported surplus position. Given these incentives, we considered the risk of management manipulation in each of the key areas of focus, which are: • Recognition of revenue; • 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 2017/18. 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 ("CCGs") and NHS England, traced them to contract and to correspondence between the Trust and the CCG regarding over/under performance. We tested income back to invoices and cash receipts. Our testing did not identify any items incorrectly recorded. 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. *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 £300,000 (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 income and expenditure recognised in 2017/18 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 revenue, focusing in particular on those with unusual characteristics. We performed other journal tests focussed on identifying unusual account combinations. 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.

Key audit matter	How our audit addressed the Key audit matter
	Management estimates We evaluated and tested management's accounting estimates, focussing on accruals, provisions, deferred income and valuation of property, plant and equipment (see specific area of focus below). We tested reasonableness of 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 2018 are discussed in detail in the Performance Report within the Annual Report.*** The Trust achieved a surplus of £3.5m in the year ended 31 March 2018. The Trust's annual plan for 2018/19, 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 2018/19. We examined the Trust's cash flow forecast for 2018/19 and the subsequent period to May 2019 (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 2018/19 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 checking a sample of CIP schemes to supporting documentation and where possible, evidence of delivery to date; • Checked 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 2018/19, 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 and estimates relating to property, plant and equipment and note 13 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 2018. 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.	As part of our work around valuation of property, plant and equipment we: • Engaged our in-house valuation experts to consider the assumptions and estimates applied by management's expert during the course of the valuation. This exercise considered whether key assumptions, and the valuation methodology used was reasonable and appropriate; • Tested a sample of the assets by verifying that the input data used by the valuer was consistent with the underlying estates and property asset information held by the Trust; • Recalculated the revaluation/impairment arising from the valuation exercise for a sample of assets and checked that these had been appropriately reflected in the financial statements; and • Physically inspected a sample of assets across land, buildings to check existence and to confirm they were in use. Our testing identified no matters that required amendment within the financial statements.

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 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	£3,625,000 (2017: £3,107,000)
How we determined it	% of revenue (2017: 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 £181,000 (2017: £155,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which ISAs (UK) require us to report to you when:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism

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.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of North West Boroughs Healthcare 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.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, 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 2017/18.

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 2018. 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:

- the statement given by the directors within the Statement of the Chief Executive's responsibilities as the accounting officer, 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, 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 2017/18 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 not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

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
25 May 2018

Annual Accounts

Foreword to the accounts

These accounts for the year ended 31 March 2018 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**
25 May 2018

Statement of Comprehensive Income
1 April 2017 – 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	**173,527**	147,357
Other operating income	4	**7,861**	8,004
Operating expenses	5, 7	**(176,846)**	(167,759)
Operating surplus / (deficit) from continuing operations		**4,542**	(12,398)
Finance income	10	**22**	20
Finance expenses	11	**(687)**	(683)
PDC dividends payable		**(1,338)**	(1,547)
Net finance costs		**(2,003)**	(2,210)
Other gains	12	**40**	5
Gains arising from transfers by absorption		**960**	-
Surplus / (deficit) for the year from continuing operations		**3,539**	(14,603)
Surplus / (deficit) for the year		**3,539**	(14,603)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	13	**(2,058)**	(2,080)
Revaluations		**1,184**	-
Total comprehensive income / (expense) for the year		**2,665**	(16,683)

The surplus / (deficit) and total comprehensive income / (expense) recorded above is all attributable to the owners of the parent.

Memorandum information:			
Surplus / (deficit) for the year		**3,539**	(14,603)
Net impairments of property, plant and equipment [1]	5	**(352)**	14,548
Gains arising from transfers by absorption		**(960)**	-
Surplus / (deficit) before impairments and transfers		**2,227**	(55)

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.

[1] 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.

Statement of Financial Position
31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets:			
Intangible assets	14	**1,541**	481
Property, plant and equipment	15	**82,282**	82,253
Total non-current assets		**83,823**	82,734
Current assets:			
Inventories	16	**1,003**	80
Trade and other receivables	17	**4,955**	4,281
Non-current assets for sale	18	**294**	275
Cash and cash equivalents	19	**5,909**	4,883
Total current assets		**12,161**	9,519
Current liabilities:			
Trade and other payables	21	**(12,309)**	(10,374)
Borrowings	23	**(1,621)**	(1,621)
Provisions	24	**(983)**	(246)
Other liabilities	22	**(264)**	(202)
Total current liabilities		**(15,177)**	(12,443)
Total assets less current liabilities		**80,807**	79,810
Non-current liabilities:			
Trade and other payables	21	**(7)**	(7)
Borrowings	23	**(29,389)**	(31,010)
Provisions	24	**(1,894)**	(1,991)
Total non-current liabilities		**(31,290)**	(33,008)
Total assets employed		**49,517**	46,802
Financed by:			
Public dividend capital		**45,629**	45,579
Revaluation reserve		**11,653**	11,755
Other reserves		**10**	10
Merger reserve		**130**	130
Income and expenditure reserve		**(7,905)**	(10,672)
Total taxpayers' equity		**49,517**	46,802

The Statement of Financial Position provides a snapshot of the Trust's financial position at a specific date – 31 March 2018. In simple terms, it lists the assets (what the Trust owns or is owed), liabilities (what the Trust owes) and taxpayers' equity (public funds invested in the Trust). At any given time, the Trust's total assets less total liabilities must equal taxpayers' equity. The notes starting on page 214 form part of these accounts.

Simon Barber, **Chief Executive**
25 May 2018

Statement of Changes in Equity
1 April 2017 – 31 March 2018

	Public dividend capital	Revaluation reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 – brought forward	**45,579**	**11,755**	**10**	**130**	**(10,672)**	**46,802**
Surplus for the year	**-**	**-**	**-**	**-**	**3,539**	**3,539**
Transfers by absorption: transfers between reserves	**-**	**772**	**-**	**-**	**(772)**	**-**
Impairments	**-**	**(2,058)**	**-**	**-**	**-**	**(2,058)**
Revaluations	**-**	**1,184**	**-**	**-**	**-**	**1,184**
Public dividend capital received	**50**	**-**	**-**	**-**	**-**	**50**
Taxpayers' equity at 31 March 2018	**45,629**	**11,653**	**10**	**130**	**(7,905)**	**49,517**

Statement of Changes in Equity
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' equity at 1 April 2016 – brought forward	45,579	13,835	10	130	3,931	63,485
Prior period adjustment	-	-	-	-	-	-
Taxpayers' equity at 1 April 2016 – restated	45,579	13,835	10	130	3,931	63,485
Deficit for the year	-	-	-	-	(14,603)	(14,603)
Impairments	-	(2,080)	-	-	-	(2,080)
Taxpayers' equity at 31 March 2017	45,579	11,755	10	130	(10,672)	46,802

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 organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. 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.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows
1 April 2017 – 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities:			
Operating surplus / (deficit)		**4,542**	(12,398)
Non-cash income and expense:			
Depreciation and amortisation	5.1	**1,691**	1,232
Net impairments	13	**(352)**	14,548
Increase in receivables and other assets		**(502)**	(260)
(Increase) / decrease in inventories		**(923)**	5
Increase / (decrease) in payables and other liabilities		**2,824**	(776)
Increase / (decrease) in provisions		**640**	(338)
Other movements in operating cash flows		**(4)**	-
Net cash generated from operating activities		**7,916**	2,013
Cash flows from investing activities:			
Interest received		**19**	22
Purchase of intangible assets		**(1,104)**	(425)
Purchase of property, plant and equipment		**(2,350)**	(14,390)
Sales of property, plant and equipment		**320**	1,399
Net cash used in investing activities		**(3,115)**	(13,394)
Cash flows from financing activities:			
Public dividend capital received		**50**	-
Movement on loans from the Department of Health and Social Care		**(1,622)**	6,705
Other interest paid		**(696)**	(605)
PDC dividend paid		**(1,495)**	(1,416)
Net cash (used in) / generated from financing activities		**(3,763)**	4,684
Increase / (decrease) in cash and cash equivalents		**1,038**	(6,697)
Cash and cash equivalents at 1 April – brought forward		**4,883**	11,580
Prior period adjustments		**-**	-
Cash and cash equivalents at 1 April – restated		**4,883**	11,580
Cash and cash equivalents transferred under absorption accounting	19	**(12)**	-
Cash and cash equivalents at 31 March	19	**5,909**	**4,883**

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

1.1. Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the accounts of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the GAM permits a choice of accounting policy, the accounting policy judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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 plan submitted to NHS Improvement and reviewed by them for the financial year 2018/19 and also contracts agreed with commissioners for this period.

1.2. Critical judgements in applying accounting policies and sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors 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.

1.3. Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare 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.

Within other operating income, the Trust accounted for £2.2 million sustainability and transformation fund income. £1 million of this was attributable to the Trust signing up to and achieving the control total allocated by NHS Improvement and was accounted for

quarterly in arrears. A further £1.2 million was allocated at the financial year-end as a bonus and general distribution fund.

Revenue grants and other contributions to expenditure

The value of the benefit received when accessing funds from the Government's apprenticeship scheme is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4. Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme which covers NHS employers, general practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The scheme is not designed in a way which would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is 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.

1.5. 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.

1.6. 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 a cost of at least £5,000

- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- 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, for example plant and equipment, 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 Cushman & Wakefield (independent professional valuer) to undertake a full valuation of all owned land and buildings as at 31 March 2018. The impact of this exercise has been reflected in the accounts for 2017/18.

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.

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 which 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 which has previously been recognised in operating expenses, in which case they are recognised in operating income.

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

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

Impairments
In accordance with the GAM, impairments which 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 operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments 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'
    - 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

1.7. 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 – usefulness of the asset
- Adequate financial, technical and other resources are available to the Trust to complete the development and use the asset
- The Trust can measure reliably the expenses attributable to the asset during development

Software
Software which is integral to the operation of hardware (such as 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 (such as 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.

Useful economic lives of intangible assets
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 below.

	Minimum life (years)	Maximum life (years)
Software licences	1	5

1.8. 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.

1.9. Financial instruments and financial liabilities
Cash is cash-in-hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments which mature in three months or less from the date of acquisition and which are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts which are repayable on demand and which form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.10. 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 – 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 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.

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

1.11. Leases

Operating leases

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

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.

1.12. Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable 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

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 23, 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 NHS Resolution 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.

1.13. Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events, but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

1.14. 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.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

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:

- Donated assets (including lottery funded assets)
- Average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts which relate to a short-term working capital facility
- Any PDC dividend balance receivable or payable

In accordance with the requirements laid down by the Department of Health and Social Care (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.

1.15. Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is

charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16. Corporation tax

North West Boroughs Healthcare 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.

1.17. Foreign exchange

The functional and presentational currency of the Trust is 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.

1.18. 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.

1.19. Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature, they are items which 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 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.

1.20. Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.21. 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 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, IFRS 16 in 2019/20 and IFRS 17 in 2021/22.

- IFRS 9 – Financial instruments
- IFRS 15 – Revenue from contracts with customers
- IFRS 16 – Leases
- IFRS 17 – Insurance contracts
- IFRIC 22 – Foreign currency transactions and advance consideration
- IFRIC 23 – Uncertainty over income tax treatments

1.22. Comparative figures for 2016/17

The detail in which figures are analysed in some of the notes within the Trust Accounts Consolidation (TAC) schedules 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. Refer to note 32 for details of prior year adjustment in respect to property, plant and equipment.

1.23. Charitable funds

Charitable Funds have not been consolidated within the 2017/18 accounts on the grounds of materiality in accordance with the Foundation Trust Annual Reporting Manual.

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 accounts 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 94% of healthcare revenues, are:

- NHS Knowsley Clinical Commissioning Group (24%)
- NHS St Helens Clinical Commissioning Group (14%)
- NHS Wigan Borough Clinical Commissioning Group (15%)
- NHS Warrington Clinical Commissioning Group (10%)
- NHS Halton CCG (9%)
- NHS England (6%)
- Knowsley Council (4%)
- St Helens Council (2%)
- Sefton Council (3%)
- St Helens and Knowsley Hospitals NHS Trust (5%)
- Mersey Care NHS Foundation Trust (2%)

3. Operating income from patient care activities

3.1. Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Acute services		
Other NHS clinical income	**14,667**	2,593
Mental health services		
Cost and volume contract income	**767**	727
Block contract income	**112,565**	106,401
Other clinical income from mandatory services	**1,328**	920
Community services		
Community services income from CCGs and NHS England	**27,908**	27,014
Income from other sources (eg local authorities)	**16,073**	9,462
All services		
Other clinical income	**219**	240
Total income from activities	**173,527**	147,357

3.2. Income from patient care activities (by source)

	2017/18 £000	2016/17 £000
Income from patient care activities received from:		
NHS England	**11,055**	10,172
Clinical commissioning groups	**128,148**	123,763
Other NHS providers	**15,357**	2,739
NHS other	**16**	-
Local authorities	**17,181**	9,991
NHS injury scheme	**218**	144
Non-NHS: other	**1,552**	548
Total income from activities	**173,527**	147,357
Of which:		
Related to continuing operations	**173,527**	147,357
Related to discontinued operations	**-**	-

4. Other operating income

	2017/18 £000	2016/17 £000
Research and development	**142**	108
Education and training	**3,628**	3,023
Non-patient care services to other bodies	**179**	859
Sustainability and transformation fund income	**2,227**	1,616
Income in respect of staff costs where accounted on gross basis	**273**	191
Other income	**1,412**	2,207
Total other operating income	**7,861**	8,004
Of which:		
Related to continuing operations	**7,861**	8,004
Related to discontinued operations	**-**	-
Total income from patient care activities	**173,527**	147,357
Total operating income	**181,388**	155,361

4.1. Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that have arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below.

	2017/18 £000	2016/17 £000
Income from services designated as commissioner requested services	**173,308**	147,116
Income from services not designated as commissioner requested services	**219**	241
Total	**173,527**	147,357

4.2. Profits and losses on disposal of property, plant and equipment

During 2017/18, The Elms was sold for £320,000 realising a net profit after selling costs of £40,000. This asset had previously been held at a book value of £275,000 within Assets Held for Sale. This property had been surplus to requirements for some years.

5. Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	**194**	293
Purchase of healthcare from non-NHS and non-DHSC bodies	**1,720**	959
Staff and executive directors costs	**142,805**	124,526
Remuneration of non-executive directors	**119**	122
Supplies and services – clinical (excluding drugs costs)	**3,809**	3,649
Supplies and services – general	**2,584**	3,023
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**1,662**	1,606
Consultancy costs	**178**	259
Establishment	**1,958**	1,663
Premises	**11,022**	8,660
Transport (including patient travel)	**2,358**	2,036
Depreciation on property, plant and equipment	**1,647**	1,188
Amortisation on intangible assets	**44**	44
Net impairments	**(352)**	14,548
Increase / (decrease) in provision for impairment of receivables	**22**	(32)
Decrease in other provisions	**-**	(62)
Audit fees payable to the external auditors		
Audit services – statutory audit	**70**	68
Internal audit costs	**127**	118
Clinical negligence	**700**	510
Legal fees	**225**	172
Insurance	**185**	131
Education and training	**466**	654
Rentals under operating leases	**2,472**	2,525
Redundancy	**1,240**	170
Car parking and security	**79**	40
Hospitality	**12**	3
Losses, ex gratia and special payments	**126**	121
Other services, eg external payroll	**507**	461
Other	**867**	304
Total	**176,846**	167,759
Of which:		
Related to continuing operations	**176,846**	167,759
Related to discontinued operations	**-**	-

6. Limitation on auditors' liability

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.

7. Employee benefits

7.1. Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	**114,401**	97,754
Social security costs	**10,156**	8,693
Apprenticeship levy	**544**	-
Employer's contributions to NHS pensions	**13,522**	11,394
Termination benefits	**1,157**	170
Temporary staff (including agency)	**4,236**	6,776
Total gross staff costs	**144,016**	124,787
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**144,016**	124,787
Of which:		
Costs capitalised as part of assets	**54**	91
Operating expenditure analysed as:		
Employee expenses – staff and executive directors	**142,805**	124,526
Redundancy	**1,157**	170
Total employee benefits excluding capitalised costs	**143,962**	124,696

7.2. Average number of employees (WTE basis)

	2017/18 Total number	2016/17 Total number
Medical and dental	**148**	147
Administration and estates	**825**	765
Healthcare assistants and other support staff	**238**	225
Nursing, midwifery and health visiting staff	**1,932**	1,547
Nursing, midwifery and health visiting learners	**9**	12
Scientific, therapeutic and technical staff	**624**	566
Other	**6**	6
Total	**3,782**	3,268
Of which:		
Number engaged on capital projects	**1**	2

7.3. Early retirements due to ill-health

During 2017/18, there were four early retirements from the Trust agreed on the grounds of ill-health (four in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £252,000 (£81,000 in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

Other staff and pension disclosures have been included within the Remuneration Report, starting on page 37.

7.4. Staff exit packages

Exit packages 2017/18

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	9	20	-	-	9	20	-	-
£10,000 - £25,000	11	180	-	-	11	180	-	-
£25,001 - £50,000	12	477	-	-	12	477	-	-
£50,001 - £100,000	4	268	-	-	4	268	-	-
£100,001 - £150,000	2	212	-	-	2	212	-	-
Total	**38**	**1,157**	**-**	**-**	**38**	**1,157**	**-**	**-**

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**	**-**	**-**

8. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes which 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 accounts do not differ materially from those which 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 is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2018 is based on valuation data as at 31 March 2017, updated to 31 March 2018 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 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 as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme 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 scheme changes by more than two per cent 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 the relevant stakeholders.

9. Operating leases

9.1. North West Boroughs Healthcare NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	**2,472**	2,525
Contingent rents	**-**	-
Less sublease payments received	**-**	-
Total	**2,472**	2,525

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
On building leases:		
Not later than one year	2,397	1,907
Later than one year and not later than five years	7,651	7,395
Later than five years	20,174	22,192
Total	30,222	31,494
On other leases:		
Not later than one year	127	96
Later than one year and not later than five years	292	89
Later than five years	-	-
Total	419	185
On all leases:		
Not later than one year	2,524	2,003
Later than one year and not later than five years	7,943	7,484
Later than five years	20,174	22,192
Total	**30,641**	**31,679**

The majority of the leases are property leases with Community Health Partnerships and NHS Property Services.

10. Finance income

Finance income represents interest received on assets and investments in the year.

	2017/18 £000	2016/17 £000
Interest on bank accounts	**22**	20
Total	**22**	20

11. Finance expenses

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	**687**	683
Total interest expense	**687**	683
Other finance costs	**-**	-
Total finance costs	**687**	683

12. Other gains

	2017/18 £000	2016/17 £000
Gains on disposal of assets	**40**	5
Total gains on disposal of assets	**40**	5
Total other gains	**40**	5

13. Impairments

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / (deficit) resulting from:		
Unforeseen obsolescence	**-**	3,119
Other	**(352)**	11,429
Total net impairments charged to operating surplus / (deficit)	**(352)**	14,548
Impairments charged to the revaluation reserve	**2,058**	2,080
Total net impairments	**1,706**	16,628

Cushman & Wakefield (independent professional valuer) conducted a full valuation of the Trust's owned land and buildings as at 31 March 2018. The impairments recorded in the table above are a consequence of this exercise.

14. Intangible assets

14.1. Intangible assets 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2017 – brought forward	233	425	658
Additions	-	1,104	1,104
Gross cost at 31 March 2018	233	1,529	1,762
Amortisation at 1 April 2017 – brought forward	177	-	177
Provided during the year	44	-	44
Amortisation at 31 March 2018	221	-	221
Net book value at 31 March 2018	12	1,529	1,541
Net book value at 31 March 2017	56	425	481

Intangible assets under construction relates to the implementation of the Trust's new clinical information system (RiO) and implementation of the Trust's information management platform.

14.2. Intangible assets 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2016 – as previously stated	233	-	233
Prior period adjustments	-	-	-
Valuation/gross cost at 1 April 2016 – restated	233	-	233
Additions	-	425	425
Valuation/gross cost at 31 March 2017	233	425	658
Accumulated amortisation at 1 April 2016 – as previously stated	133	-	133
Prior period adjustments	-	-	-
Accumulated amortisation at 1 April 2016 – restated	133	-	133
Provided during the year	44	-	44
Accumulated amortisation at 31 March 2017	177	-	177
Net book value at 31 March 2017	56	425	481
Net book value at 31 March 2016	100	-	100

15. Property, plant and equipment

15.1. Property, plant and equipment 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 – brought forward	5,486	108,421	804	435	25	3,477	2,895	**121,543**
Transfers by absorption	220	740	-	-	-	-	-	**960**
Additions	-	435	136	164	-	797	-	**1,532**
Impairments	-	(2,058)	-	-	-	-	-	**(2,058)**
Reversals of impairments	552	(552)	-	-	-	-	-	**-**
Revaluations	46	1,138	-	-	-	-	-	**1,184**
Reclassifications	-	-	(804)	804	-	-	-	**-**
Transfers to assets held for sale	(8)	(286)	-	-	-	-	-	**(294)**
Valuation/gross cost at 31 March 2018	**6,296**	**107,838**	**136**	**1,403**	**25**	**4,274**	**2,895**	**122,867**
Accumulated depreciation at 1 April 2017 – brought forward	212	34,287	-	373	25	2,159	2,234	**39,290**
Provided during the year	-	1,347	-	48	-	177	75	**1,647**
Impairments	-	1,083	-	-	-	-	-	**1,083**
Reversals of impairments	-	(1,435)	-	-	-	-	-	**(1,435)**
Accumulated depreciation at 31 March 2018	**212**	**35,282**	**-**	**421**	**25**	**2,336**	**2,309**	**40,585**
Net book value at 31 March 2018	6,084	72,556	136	982	-	1,938	586	**82,282**
Net book value at 31 March 2017	5,274	74,134	804	62	-	1,318	661	**82,253**

15.2. Property, plant and equipment 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 – as previously stated	5,486	72,626	26,707	396	25	2,735	2,289	**110,264**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2016 – restated	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	-	26,678	(26,678)	-	-	-	-	**-**
Disposals / derecognition	(50)	-	-	-	-	-	-	**(50)**
Valuation/gross cost at 31 March 2017	**5,486**	**108,421**	**804**	**435**	**25**	**3,477**	**2,895**	**121,543**
Accumulated depreciation at 1 April 2016 – as previously stated	212	18,710	-	358	25	2,036	2,213	**23,554**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 – restated	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	5,274	74,134	804	62	-	1,318	661	**82,253**
Net book value at 31 March 2016	5,274	53,916	26,707	38	-	699	76	**86,710**

15.3. Property, plant and equipment financing – 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned – purchased	6,084	72,556	136	982	-	1,938	586	**82,282**
NBV total at 31 March 2018	**6,084**	**72,556**	**136**	**982**	**-**	**1,938**	**586**	**82,282**

15.4. Property, plant and equipment financing – 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned – purchased	5,274	74,134	804	62	-	1,318	661	**82,253**
NBV total at 31 March 2017	**5,274**	**74,134**	**804**	**62**	**-**	**1,318**	**661**	**82,253**

As at 31 March 2018 there were no land and buildings valued at open market value.

Cushman & Wakefield (independent professional valuer) conducted a full valuation of the Trust's land and buildings as at 31 March 2018. The output from this valuation exercise has been reflected in these accounts to ensure land and buildings are reported at fair value as at 31 March 2018.

For all other items of property, plant and equipment, depreciated historic cost is considered to be a reasonable indicator of fair value.

16. Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	-	-
Work In progress	-	-
Consumables	97	80
Energy	-	-
Other	906	-
Total inventories	**1,003**	80
Of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £2,352,000 (£1,594,000 in 2016/17). Write-down of inventories recognised as expenses for the year were £0 (£0 in 2016/17).

17. Trade and other receivables

17.1. Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	1,734	1,837
Accrued income	2,263	714
Provision for impaired receivables	(26)	(6)
Prepayments (non-PFI)	105	307
Interest receivable	4	1
PDC dividend receivable	190	33
VAT receivable	255	358
Other receivables	430	1,037
Total current trade and other receivables	**4,955**	4,281
Of which receivables from NHS and DHSC group bodies:		
Current	2,447	1,622

17.2. Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April as previously stated	**6**	123
Prior period adjustments	**-**	-
At 1 April – restated	**6**	123
Increase in provision	**24**	-
Amounts utilised	**(2)**	(85)
Unused amounts reversed	**(2)**	(32)
At 31 March	**26**	6

At the reporting year-end, receivables are evaluated on an individual basis to determine the level of impairment required.

17.3. Credit quality of financial assets

	31 March 2018 Trade and other receivables £000	31 March 2017 Trade and other receivables £000
Ageing of impaired financial assets		
0-30 days	**7**	-
30-60 days	**1**	-
60-90 days	**2**	-
90-180 days	**5**	-
Over 180 days	**11**	6
Total	**26**	6
Ageing of non-impaired financial assets past their due date		
0-30 days	**938**	1,548
30-60 days	**36**	61
60-90 days	**94**	85
90-180 days	**137**	97
Over 180 days	**500**	451
Total	**1,705**	2,242

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 the 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.

18. Non-current assets held for sale

	2017/18 £000	2016/17 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**275**	1,625
Prior period adjustment	**-**	-
NBV of non-current assets for sale and assets in disposal groups at 1 April – restated	**275**	1,625
Assets classified as available for sale in the year	**294**	-
Assets sold in year	**(275)**	(1,350)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**294**	275

During the year, the sale of The Elms was completed. The balance of £294,000 relates to Dudley Wallis which was transferred to Assets Held for Sale in February. This property is surplus to requirements following the reorganisation of teams in Knowsley.

19. Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18 £000	2016/17 £000
At 1 April	**4,883**	11,580
Prior period adjustments	**-**	-
At 1 April – restated	**4,883**	11,580
Transfers by absorption	**(12)**	-
Net change in year	**1,038**	(6,697)
At 31 March	**5,909**	4,883
Broken down into:		
Cash at commercial banks and in hand	**78**	96
Cash with the Government Banking Service	**5,831**	4,787
Total cash and cash equivalents as in Statement of Financial Position	**5,909**	4,883
Total cash and cash equivalents as in Statement of Cash Flows	**5,909**	4,883

20. Third party assets held by the NHS foundation trust

The Trust held cash and cash equivalents which relate to monies held on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018 £000	31 March 2017 £000
Bank balances	**109**	97
Total third party assets	**109**	97

21. Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	**5,035**	4,543
Capital payables	**707**	1,525
Accruals	**3,516**	1,550
Social security costs	**1,588**	1,403
Other taxes payable	**1,136**	1,070
Accrued interest on loans	**144**	153
Other payables	**183**	130
Total current trade and other payables	**12,309**	10,374
Non-current		
Accruals	**7**	7
Total non-current trade and other payables	**7**	7

22. Other liabilities

	2018 £000	2017 £000
Current		
Deferred income	**264**	202
Total other current liabilities	**264**	202

23. Borrowings

	2018 £000	2017 £000
Current		
Loans from the Department of Health and Social Care	**1,621**	1,621
Total current borrowings	**1,621**	**1,621**
Non-current		
Loans from the Department of Health and Social Care	**29,389**	31,010
Total non-current borrowings	**29,389**	**31,010**

Analysis of Department of Health and Social Care loans

	Original value	Agreement date	Interest rate	Term (years)
Loan 1 – Atherleigh Park phase1	£19,000,000	19/12/2014	2.28%	25
Loan 2 – Atherleigh Park phase 2	£11,900,000	25/09/2015	2.18%	25
Loan 3 – Informatics schemes	£3,500,000	25/09/2015	1.42%	10

24. Provisions

24.1. Provisions for liabilities and charges

	Current 31 March 2018 £000	Non-current 31 March 2018 £000	Current 31 March 2017 £000	Non-current 31 March 2017 £000
Pensions – early departure costs	**22**	**115**	22	133
Other legal claims	**286**	**1,779**	224	1,858
Restructurings	**675**	**-**	-	-
Other	**-**	**-**	-	-
Total	**983**	**1,894**	246	1,991

24.2. Provision for liabilities and charges analysis

	Pensions – early departure costs	Legal claims	Restructurings	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2017	155	2,082	-	-	-	**2,237**
Arising during the year	-	185	675	-	-	**860**
Utilised during the year	(18)	(136)	-	-	-	**(154)**
Reversed unused	-	(66)	-	-	-	**(66)**
At 31 March 2018	**137**	**2,065**	**675**	**-**	**-**	**2,877**
Expected timing of cash flows:						
Not later than one year	22	286	675	-	-	**983**
Later than one year and not later than five years	87	453	-	-	-	**540**
Later than five years	28	1,326	-	-	-	**1,354**
Total	**137**	**2,065**	**675**	**-**	**-**	**2,877**

Pensions relating to early departure costs

These are based on figures provided by the Benefits Agency.

Other legal claims

£1,794,000 relates to permanent injury benefits and £196,000 for pre-retirement benefits, both as advised by NHS Resolution. There is also a further £75,000 relating to employment tribunals.

At 31 March 2018, £4,457,000 was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of North West Boroughs Healthcare NHS Foundation Trust (£2,215,000 at 31 March 2017).

25. Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution 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	-	-

26. Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	**13**	-
Intangible assets	**609**	-
Total	**622**	-

27. Financial instruments

27.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role 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 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 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 2018 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 Social Care and internally generated funds. The Trust stringently monitors its liquidity position on a routine basis.

27.2. Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP at 31 March 2018					
Trade and other receivables excluding non-financial assets	**4,401**	**-**	**-**	**-**	**4,401**
Cash and cash equivalents at bank and in hand	**5,909**	**-**	**-**	**-**	**5,909**
Total at 31 March 2018	**10,310**	**-**	**-**	**-**	**10,310**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available -for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP 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

27.3. Carrying value of financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	**31,010**	**-**	**31,010**
Trade and other payables excluding non-financial liabilities	**9,592**	**-**	**9,592**
Provisions under contract	**2,065**	**-**	**2,065**
Total at 31 March 2018	**42,667**	**-**	**42,667**

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	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

27.4. Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

27.5. Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	**11,492**	9,746
In more than one year but not more than two years	**1,736**	1,729
In more than two years but not more than five years	**5,209**	5,188
In more than five years	**24,230**	25,958
Total	**42,667**	42,621

28. Losses and special payments

	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses				
Fruitless payments	**-**	**-**	1	38
Bad debts and claims abandoned	**7**	**3**	14	4
Total losses	**7**	**3**	15	42
Special payments				
Compensation under court order or legally binding arbitration award	**-**	**-**	1	1
Ex-gratia payments	**17**	**9**	14	4
Total special payments	**17**	**9**	15	5
Total losses and special payments	**24**	**12**	30	47
Compensation payments received	**-**	**-**	-	-

The above amounts are reported on an accruals basis but exclude provisions for future losses.

29. Related parties

The Department of Health and Social Care is the parent body of the Trust. The main entities within the public sector the Trust has had dealings with are:

- Aintree University Hospitals NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- St Helens and Knowsley Hospitals NHS Trust
- NHS Halton Clinical Commissioning Group
- NHS Knowsley Clinical Commissioning Group
- NHS St Helens Clinical Commissioning Group
- NHS Warrington Clinical Commissioning Group
- NHS Wigan Borough Clinical Commissioning Group
- NHS England
- NHS Property Services
- Community Health Partnerships
- HM Revenue and Customs
- NHS Pension Scheme
- Knowsley Council
- Sefton Council
- St Helens Council

Transactions with these bodies are in the normal course of business and are conducted on an arm's length basis.

29.1. Related party transactions

	2017/18		2016/17	
	Revenue	**Expenditure**	Revenue	Expenditure
	£000	**£000**	£000	£000
Charitable funds	**8**	**-**	8	-
Other bodies or persons outside of the whole of government accounting boundary	**1,109**	**60**	177	52
Total	**1,117**	**60**	185	52

29.2. Related party balances

	2017/18		2016/17	
	Receivables	**Payables**	Receivables	Payables
	£000	**£000**	£000	£000
Charitable funds	**78**	**-**	71	-
Other bodies or persons outside of the whole of government accounting boundary	**224**	**0**	177	0
Total	**302**	**0**	248	0

30. Transfers by absorption

Two properties were transferred from Liverpool Community Healthcare NHS Trust as at 1 April 2017 as part of the Sefton 0-19 services. These have been recorded on the Trust's Statement of Financial Position and recognised as a gain of £960,000 in the Statement of Comprehensive Income.

31. Events after the reporting date

There are no events which require disclosure after the reporting date.

32. Prior period adjustments

Prior period figures have been adjusted as per below due to a material classification error. £2.5 million had originally been reclassified from assets under construction to land. This should have been reclassified to buildings. There has been no adjustment to the overall net book value as at 31 March 2017.

32.1. Property, plant and equipment 2016/17 – as previously stated

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 – previously stated	5,486	72,626	26,707	396	25	2,735	2,289	**110,264**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2016 – restated	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 – as previously stated	212	18,710	-	358	25	2,036	2,213	**23,554**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 – restated	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 31 March 2016	5,274	53,916	26,707	38	-	699	76	**86,710**

32.2. Property, plant and equipment 2016/17 – restated

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 – previously stated	5,486	72,626	26,707	396	25	2,735	2,289	**110,264**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2016 – restated	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	-	26,678	(26,678)	-	-	-	-	**-**
Disposals / derecognition	(50)	-	-	-	-	-	-	**(50)**
Valuation/gross cost at 31 March 2017	**5,486**	**108,421**	**804**	**435**	**25**	**3,477**	**2,895**	**121,543**
Accumulated depreciation at 1 April 2016 – as previously stated	212	18,710	-	358	25	2,036	2,213	**23,554**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 – restated	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	5,274	74,134	804	62	-	1,318	661	**82,253**
Net book value at 31 March 2016	5,274	53,916	26,707	38	-	699	76	**86,710**

Contact us

To find out more about North West Boroughs Healthcare NHS Foundation Trust, visit our website at: www.nwbh.nhs.uk

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