NHS
Liverpool
Community Health
NHS Trust

Liverpool Community Health
Annual Report & Accounts
2017 – 2018

Liverpool Community Health NHS Trust
Annual Report and Accounts 2017/18

Presented to Parliament pursuant to Schedule 15, paragraph 8 (3) of the NHS Act 2006

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1. Performance Report

1.1 OVERVIEW

a. Welcome from Chief Executive and Chairman

Welcome to our annual report covering the financial year 2017/18. The last year has been both challenging and exciting in equal measure, with the Trust making considerable improvements in the delivery of patient-centred care for the people of Liverpool.

From 1 April 2017 as part of a process initiated by Liverpool Clinical Commissioning Group and NHS Improvement, the Trust's services began transferring to numerous new health care providers and Liverpool Community Health NHS Trust was managed on an interim basis from 1 May 2017 by Alder Hey Children's NHS Foundation Trust.

In late October 2017, as part of the NHS Improvement procurement process Mersey Care NHS Foundation Trust was successfully chosen as the preferred new provider (subject to the completion of an approvals process) to deliver the Liverpool Community Health (LCH) Liverpool Core Services. Following a request from NHS Improvement, Mersey Care was asked to enter into an interim management agreement to provide management and other support to LCH from 1 November 2017 and Mersey Care was approved and all staff and services formally transferred to the Trust on 1 April 2018.

Earlier this year the Independent Clinical Review into the Trust between 2010 - 2014 which was led by Dr Bill Kirkup was published, attracting considerable interest from the media. It was widely acknowledged that significant progress has since been made since this investigation period as we continue to develop all our processes, clinical and human resources practices to help ensure we deliver the highest standards of care for all our patients going forward.

The guiding light during this period has been the Trust's front-line and support staff, who with the right support, have continued to make a hugely positive difference to the lives of patients and their loved ones in the communities we serve.

Whilst the work to improve services for both staff and patients continues, we have already begun to make significant strides to improve our services. This is reinforced by the number of compliments relating to the excellent care and compassion our patients and their loved ones receive. This has made such a considerable difference to their quality of life that they have taken the time to write or call in to express their gratitude

Mersey Care is looking forward to working alongside Liverpool Community Health colleagues and to using the expertise and experience of both Trusts to deliver and further improve the quality of community healthcare services for the people of Liverpool. It provides an exciting opportunity to integrate community physical and mental health service which would enable us to reduce complexity of care packages and improve outcomes for the people we serve.

We are also committed to providing colleagues with a supportive work environment and will be introducing a Fair and Just Culture within the organisation, benefiting from the wisdom of world renowned expert, Professor Sidney Dekker. The premise of this ground-breaking

approach is that in the event of a problem we ask 'how can we put this right' rather than 'who did this?' We need to ensure that in our daily practice, our conduct and our dealings with colleagues is honest, supportive, kind and fosters learning at every opportunity thereby ensuring that we have the very best support and development for our colleagues across the trust who are then able to give the very best care for our patients and their families.

Joe Rafferty
Chief Executive

Beatrice Fraenkel
Chair of the Board

b. Who we are and what we do

Liverpool Community Health (LCH) is an NHS Trust established as a legal body under the National Health Service Act 2006.

LCH provides community healthcare across the city of Liverpool and Sefton (but relinquished control of Sefton Community services on 1 June 2017). Our teams deliver essential community-based medical, nursing and therapeutic care to more than 6,000 adults, children and families every day.

We employ almost 2,000 staff, the majority of whom are community clinicians including nurses, therapists, dentists and doctors.

Our teams care for patients in their own homes, health clinics, and in a range of other local community premises such as children's centres, community centres and schools. We also work closely with GPs and with other health and social care services to ensure patients are cared for with the best support, as close to their home as possible.

Wherever we work, we support our patients to help them plan, manage and adjust to changes in their health and to live as independently as possible. We recognise that each patient is an individual with their own needs and circumstances, so our clinical teams aim to deliver flexible patient-centred approaches to meet these specific individual needs.

Who we serve

Liverpool's population experiences some of the highest levels of poor health and health inequalities, compared to the rest of England. Whilst improvements in medicine mean that we are living longer, many people locally are living with multiple, long-term conditions.

Although some lifestyle improvements have been achieved, such as a reduction in smoking rates, poor lifestyles remain a significant challenge for the city region.

45% of Liverpool's population live in the top 10% most deprived areas in England.

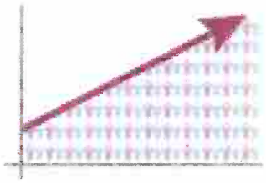
The gap in life expectancy for Liverpool compared with the England average is 3 years. The gap between different areas of the city is around 11 years

1 in 4 people in Sefton and almost 1 in 3 people in Liverpool live with one or more long-term conditions.

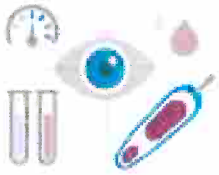
How long people can expect to live – life expectancy – is often used as a way to measure the health and wellbeing of a community and life expectancy has generally been increasing over recent years. Across Liverpool the average life expectancy for men and women is lower than

the national average and more than 25% of the population live with one or more long –term conditions.

Respiratory disease is the 3rd biggest killer in Liverpool



By 2035 Liverpool's population is expected to have increased from its current figure of 478,680 to 493,889.



There are 14,211 people in Sefton and 23,667 in Liverpool living with Diabetes. This is expected to increase by about 1% every year.

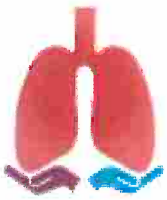
Long-term conditions that residents are living with, and which affect them every day, range from cardiovascular disease and COPD (Chronic Obstructive Pulmonary Disease) to diabetes, which is increasing at a rate of approximately 1% a year.

Liverpool adults consume 2.1 portionsof fruit per day compared with 2.5 portions nationally and consumption is falling

1 in 4 people in Sefton and almost 1 in 3 people in Liverpool live with one or more long-term conditions

Up to 25% of Adults in Liverpool and 18% in Sefton are affected by mental health issues

As national and local populations continue to grow and age, this will have a direct impact on local health and social care services. The number of people living with mental health issues and dementia will increase adding further complexity to the delivery of community health care.



By 2021 there will be a increase of 5% in Liverpool and 8.5% in Sefton of people living with Chronic Obstructive Pulmonary Disease (COPD).

A total of 6.2% adults in Liverpool and 6.6% in Sefton drink at a high risk level

1 in 4 adults in Liverpool smoke.

Lifestyle has a significant impact on long-term health and life expectancy. Health promotion initiatives play an important role in trying to improve activity within the local communities to help families maintain good quality health.

86% of people in Liverpool and 78% in Sefton are not active enough to maintain good health.

The importance of delivering care that is focused on prevention and getting health interventions right the first time is crucial to improving health outcomes for patients in the long-term. Demographics highlight that the population is ageing, and long-term conditions are occurring at a younger age than the national average, meaning that people are living longer with more long-term conditions than ever before. This can not only affect a person's life expectancy, but can also significantly impact their mental health.

LCH provides a range of health and care services to address these needs and help people to live longer healthier lives – especially children and adults with complex, on-going health conditions and frail elderly people.

Our team of dedicated staff deliver high quality care for patients from birth to end of life, and from head to toe. They made over 1.25 million patient contacts over the last year. Our staff and services are part of the local communities. The relationships we build with patients, their families and the community means that our staff help to sustain and improve people's lives.

Some of our key achievements and awards in 2017/18

- Every 20 seconds we provide care for another patient
- 9% increase in antenatal visits
- 97% of Trust KPIs rated as green or amber
- Adult Allied Health Professional waiting times at seven weeks, the lowest in five years
- Ehi Awards – Best Nursing Technology Award for the Gate Tool (with partner organisations). The accolade was in recognition of a new information gathering and patient assessment tool to help Community Care teams to deliver a more proactive model of care for vulnerable patients in Liverpool

- Public Sector Awards 2017: Best Community Relations Campaign (Community Equipment Amnesty)

- Public Sector Partnership Awards 2017: Partnership Engagement Initiative (#jabdone campaign - NHS Merseyside)

- CIPR Pride Awards 2017- Shortlisted for Best healthcare Campaign (#jabdone campaign – NHS Merseyside)

- Directorate of Community Dental Health became the largest in the country to be successful in achieving British Dental Association accreditation of good practice its for all ten dental sites
- South Liverpool Administration Team recognised as NHS Unsung Heroes - For the excellent work the team undertook in supporting health visitors in South Liverpool locality to deliver the full Healthy Child programme. The team helped to ensure thatplanned targets for this important quality marker were met

- Health Technology service (Telehealth) has put LCH at the forefront of health technology and enables patients to monitor their own health at home with the support of professionals. The Trust has so far worked with more than 5800 patients, monitoring between 800 and 1,000 patients on a day-to-day basis. The service was inspected by the Technology Enabled Care Standards Association (TSA) against their Quality Standards Framework and successfully achieved accreditation

- Staff Flu Vaccination rate was 70.7%, successfully meeting the CQUIN target

- Delivery of a Stop the Pressure Event and four Pressure Ulcer Forums

c. Our Vision and Values

OUR VISION:

To provide high quality, person and family-centred community services, as close to home as possible.

Our strategic objectives:

Better care – Improve the way we deliver care through clinically-driven change and a culture of continuous improvement and compliance with our regulators.

Better health - Improve the way we provide care by empowering clinical leaders to shape and deliver joined-up care and support with other professionals in localities and neighbourhoods.

Better life – Transform the lives of our patients and families by achieving a sustainable organisational model that invests in transformed frontline services, delivers more care and prevention closer to home, and supports people to live independently for longer.

Priorities for 2017/18:

- **Prevention:** we will empower people to self-care and improve their long term health and wellbeing. This is all about helping to ensure that people spend more of their lives in good health and that people with a long term condition are able to manage their own care

- **Supporting children:** we will support children in growing up to become healthy adults

- **Family medicine:** we will provide primary care 'step up' and community services to support families to receive care closer to home. We'll know we're succeeding in this as quality of life for people with long term conditions increases

- **Supporting winter:** we will provide admission avoidance and safe discharge services to help people stay independent during the winter. We'll know we're succeeding in this as we reduce avoidable admissions and bed days spent by people in hospital due to winter-related conditions

- **People:** we will develop, engage and support our staff to provide great care for our community. This is all about providing you with the support you need to be your best

Our values:

Care Community Collaboration Courage Commitment

Our values inspire us to design and deliver high quality services for our patients. We aim to meet their needs, deliver improved health outcomes and demonstrate best practice to our commissioners and partners. The same spirit is driving us to continue to widen partnership working, with the goal of transforming the whole health and social care system in Merseyside.

We strongly believe that as an integrated community-based organisation our services are in an ideal position to deliver this transformation, by focusing on self-care and prevention, reducing dependence on hospital care and delivering more services closer to home.

This Annual Report details our work in the 2017/18 financial year and celebrates the dedication and hard work of our staff.

d. Our services at the start of the 2017-18 year

Liverpool Community Health NHS Trust delivers a wide range of services that can help to change lives, by providing high quality care to people in their own homes, in their community or as close to home as possible.

Outlined below is the list of services the Trust provided in 2017 to 2018. Please refer to page 40 in relation to the transaction of staff and services to other health care providers.

Abacus Sexual Health	1
Adult Speech & Language Therapy	1&2
Anticoagulation Service	3
Armistead	1
Care of Next Infant (CON)	4
Children's Audiology Service	4
Children's Community Matrons	4
Children's Complex Needs	4
Children's Continence Service	4
Children's Diabetes Nurses	4
Children's Dietetic Service	4
Children's Health Information Service	5
Children's Liaison Service	5
Children's Occupational Therapy	4
Children's Physiotherapy	4
Children's Safeguarding	5
Children's Speech & Language Therapy	4
Cochlear Implants	4
Community Cardiac Diagnostic Department	3
Community Equipment Nurse Specialist (CENS) Service	1&2
Community Equipment Service & Disability Advice Service	1&2
Community Falls Team	1&2
Community Frailty	1&2
Community Food Workers	(a)
Community Heart Failure Team	6
Community Intermediate Care Sefton	2
Community Matron	1&2
Community Occupational Therapy Adult Rehabilitation Team (COTART)	1
Community Physiotherapy	1&2
Community Respiratory Service	3
Community Specialist HIV Nursing	3
Community Specialist Palliative Care	1&2
Continence Team	1
Cycle For Health	(a)
Dental Services	(b)1
Diabetes Service	7
Discharge Planning Team	2
District Nursing	1&2
Education Healthcare Team	1
Family Nurse Partnership	1&5
Food & Health Workers	(a)
Health Visiting	1&5
Healthy Communities Cancer Collective	(a)
Healthy Families	1
Infection Control Prevention & Control	1
Intermediate Community Care Team	1
Integrated Care Sefton Direct	2
Intermediate Care Ward (Ward 35)	2
Intravenous (IV) Therapy Team	1&2
Liveability	(a)
Liverpool Alcohol Service	(a)
Liverpool Manual Handling Service	1
Liverpool Out of Hospital Service (LOOHS)	1
Liverpool Stop Smoking Coordination	(a)
Liverpool Stop Smoking Specialist Midwife	(a)
Liverpool Wheelchair Service	1
Medicines Management	1
More Independence Telehealth	1
Nutrition & Dietetics Team	1
Nutrition Support Team	1
Oral Health Promotion	1
Phlebotomy Service	1&2
Podiatry	1&2
Practice Nurse Development Team	1
Psychosexual Service	1&2
Radiotherapy	3
Rehab at Home	1
SAFE Place Merseyside	8
Safeguarding Service (Adults)	1&2
School Health Team (School Nurses)	1&5
Skin Service	1
So To Speak	1
Social Inclusion Team	1
Specialist Diabetes Nurses	7
Stop Smoking Report	(c)9
Total Wound Purchasing	1
Trans Support Service	1
Treatment Rooms	1&2
Tuberculosis (TB) Service	3
Unplanned Care Direct (UCD) Liverpool	1
Urgent Care Sefton	2
Virtual Ward	2
Vaccination & Immunisation	1&2
Walk for Health	(a)
Walk In Centres	1&5
Weight Management Team	1
Willy Russell Centre	4
Windmill Hill Medical Centre	10
X-Ray	2&3

Notes:

(1) Interim Management arrangement Alder Hey Children's Hospital NHS Foundation Trust from 1 May 2017 and Mersey Care NHS Foundation Trust 1 November 2017

(2) Transferred to Mersey Care NHS Foundation Trust on 1 June 2017

(3) Transferred to Royal Liverpool & Broadgreen University Hospital NHS Foundation Trust on 1 June 2017

(4) Transferred to Alder Hey Children's Hospital NHS Foundation Trust on 1 April 2017

(5) Transferred to North West Boroughs Healthcare NHS Foundation Trust on 1 April 2017

(6) Transferred to Virgin Care on 1 May 2017

(7) Transferred to Aintree University Hospital NHS Foundation Trust on 1 April 2017

(8) Transferred to Central Manchester University Hospitals NHS Foundation Trust on 1 April 2017

(9) Transferred to Solutions 4 Health on 1 April 2017

1.2 PERFORMANCE ANALYSIS

a. Performance Overview

Monitoring our activity and performance against a range of indicators, including national, contractual and local targets, is an important part of ensuring we deliver high quality services. We summarise Trust performance in a monthly integrated performance report which is provided to the Board, published on the website and made available to localities, services and teams.

LCH currently monitors and reports against 57 indicators in the Integrated Performance and Quality Report (IPQR). These Key Performance Indicators (KPI's) are aligned to the five CQC domains of *Safe, Caring, Effective, Responsive* and *Well-led,* which enable the Trust to triangulate across all areas of performance.

As the Performance Management Framework continued to mature, we have seen evidence that locality teams increasingly solve problems at a local level and escalate to senior management when resources are insufficient or greater managerial authority for change is required.

As a result of the improvements achieved during 2016/17, the performance framework was updated and formal performance reviews for each of the localities were undertaken on a quarterly basis during 2017/18.

Clinicians, managers and corporate services colleagues are all involved in this approach, ensuring that local managers have the information and support that they require to be effective in managing local teams.

This approach continues to provide the Board with assurance that each locality is either delivering against LCH strategic objectives or receive assurance that appropriate remedial action plans are in place to ensure that any performance and quality issues are being addressed and monitor improvement against agreed trajectories to the recovery position.

Care Quality Commission

We also undertake frequent, ongoing engagement with the Care Quality Commission (CQC). As a result of the focused re-inspection in February 2016, a number of requirement notice actions that the Trust had to address within 90 days of publication of the report were identified.

The 2016 action plan detailed 30 actions including the requirement notice actions and seven actions ongoing from the 2014 inspection. Each action has a corresponding monitoring Committee, Executive and Management Lead, progress update, evidence to support progress, completion date and its current status.

This was reviewed at the monthly engagement meetings with CQC and was closed in July 2017. On-going work is undertaken to ensure sustainability via performance meetings,

meetings with action leads and utilising a Star Chamber approach involving service leads and the executive team support to explore how services can improve and achieve key performance indicators.

The CQC Action Plan overview table below highlights the position as at the end of July 2017 when all actions were closed.

Critical Services

The critical list was established to identify and monitor those services that required additional support and focus following a review by the Executive Team at that time. All of the original 29 services identified in 2015/16 have been fully peer reviewed.

This critical service review process continued during 2017/18 as LCH sought to improve areas that are critical in nature. Services that have been removed from the critical list continued to receive targeted support to ensure improvements are sustained.

Currently there are no services on the critical list.

Section 4 : CQC Action Plan Overview

Key: Requirement Notice action

As a result of the focused re-inspection in February 2016, a number of requirement notice actions that the Trust had to address 90 days of publication of the report were identified. The 2016 action plan had 30 actions including these requirement notice actions and seven actions ongoing from the 2014 inspection. Each action has a corresponding monitoring Committee, Executive and Management Lead, progress update, evidence to support progress, completion date and RAG status. This is reviewed at the monthly engagement meetings with CQC and was closed in July 2017. Continuous monitoring and reviews will be undertaken as appropriate. As a result of the transaction process, all services not within the Liverpool core bundle, have been removed and CQC will liaise with the new providers for future actions.

CQC Ref No.	Completion Date	RAG Rating January 2017	RAG Rating July 2017
MUST DO ACTIONS			
CQC1-M Governance – Improving Quality	31/10/2016	Green	Blue
CQC2-M Health Visitors	31/10/2016	Green	Blue
CQC3-M Record Keeping Risks	31/10/2016	Green	Blue
CQC4-M Duty of Candour	31/10/2016	Green	Blue
CQC5-M Safeguarding	31/08/2016	Blue	Blue
CQC6-M Staffing Levels	31/03/2017	Blue	Blue
SHOULD DO ACTIONS			
CQC7-S Healthy Child Programme	31/10/2016	Green	Blue
CQC8-S Waiting Times – Children's AHPs	31/10/2016	Yellow	Blue
CQC9-S Waiting Times – Adults AHPs	31/10/2016	Green	Blue
CQC-10S Mandatory Training / Appraisals	31/03/2017	Blue	Blue
CQC11-S New Starter Caseloads / Staff Competency	31/03/2017	Green	Blue
CQC12-S Dietetics	31/03/2017	Blue	Blue
CQC13-S Child to Adult Transition of Care	31/12/2016	Green	Blue
CQC14-S Communications and Engagement	31/03/2017	Blue	Blue
CQC15-S Clinical Supervision	31/03/2017	Green	Blue

CQC Ref No.	Completion Date	RAG Rating January 2017	RAG Rating July 2017
CQC16-S Duty of Candour – Understanding and Application	05/10/2016	Green	Blue
CQC17-S Facilities	31/12/2016	Blue	Blue
CQC18-S Cleanliness Audits	31/10/2016	Blue	Blue
CQC19-S Capacity and Demand	31/03/2017	Green	Blue
CQC20-S Duplication of collecting patient information	31/03/2017	Green	Blue
CQC21-S Clarity of Roles	31/10/2016	Green	Blue
CQC22-S Inequalities in Service Delivery	30/09/2016	Yellow	Blue
CQC23-S Lessons Learned	28/02/2017	Green	Blue
CQC24-S Communications and Engagement	Linked to CQC14-S	Blue	Blue
CQC25-S Patient Information Leaflets	31/08/2016	Blue	Blue
CQC26-S Patient Experience	31/10/2016	Blue	Blue
CQC27-S Lessons Learned – Intermediate Services	28/02/2017	Blue	Blue
CQC28-S Intermediate Care – Patient Acuity	31/03/2017	Blue	Blue
CQC29S End of Life - DNACPR	30/09/2016	Blue	Blue
CQC30S Governance	31/03/2017	Blue	Blue

Key
- Complete
- On track
- On track; risks identified
- Off track

N. B All longer term completion dates are underpinned by a number of key milestones which are included in the action plan and monitored by Executive Leads.

b. Performance Overview

Key highlights at the end of the 2017/18 year include:

- At the end of 2017/18 a total of 93% of required performance standards were rated green or amber compared to 86% at the end of 2016/17 and the number rated as red has decreased by 50% to just three
- Despite an increase in the number of the most serious (Grade 4s), the overall number of community acquired and avoidable pressure ulcers has decreased by 19% (ten) during 2017/18
- Waiting times for urgent referrals to the Wheelchair Service remain below the four week target whilst routine referrals, waits have reduced further to 13 weeks which is below the 18 week target and a significant improvement compared to the peak waiting times of 30 weeks earlier in the year
- A total of 3,005 antenatal visits were completed which is 9% more than last year and 5% higher than this year's target
- 98.4% of patients who responded to the national Family and Friends Test – where people report on whether they would be happy for their friends or family to receive care or treatment in a trust's services, positively recommended the Trust as a good place to receive treatment andcare
- The proportion of staff who would recommend LCH as a place for treatment was 84% and the proportion who would recommend it as a place to work was 72%. Both remain above the national benchmark.
- Staff flu vaccination uptake rates for clinical staff were reported at 70.7% for 2017/18 which is above the national target of 70%, successfully meeting the CQUIN target
- Mandatory training compliance rates have increased to 93.7% which is well above the Trust target set in line with the community healthcare provider benchmark
- The Trust successfully implemented a flu outbreak protocol for nursing homes across Liverpool for prescribing antiviral treatment to prevent cross-infection. The protocol was enacted by our Community Matrons during this year's flu season and was very effective across five outbreaks in care homes which prevented many admissions

Additional information is provided over the following pages regarding the Trust's performance against KPIs, which relate to each of the CQC's five domains. Trust Board meetings are held in public and visitors are welcome to attend and listen to discussions about the Trust's performance.

The key performance highlights 2017/18
Some of our key achievements:

334,084

District Nurse, Specialist Nurse and Community Matron visits' providing quality nursing care at home, maintaining and promoting health and independence

93,728

Community Intermediate Care contacts. The service assists patients in crisis situations at home, helping to avoid hospital admissions or enable earlier discharge from hospital

67,761

Community Adult Therapy contacts including Physiotherapy, Occupational Therapy, Dietetics and Speech and language therapy

53,123

Sexual Health clinic appointments and contacts. Using innovative approaches to delivering healthcare, advice and prevention in the heart of our communities

7,724

Palliative Care Nurses contacts to patients to patients in Liverpool who are on End of Life pathways

3,560

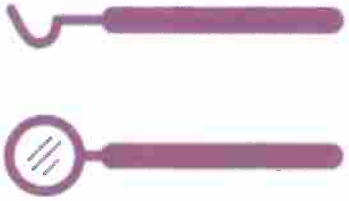
Wheelchair assessments. LCH has helped reduce waiting time for assessment

62,723

Orders received for community equipment throughout Liverpool

330,832

Blood tests delivered in community clinics and patients' homes



8,571

Units of dental activity

28,555

Vaccination and immunisation jabs were undertaken to further reduce incidence of diseases such as measles, mumps, rubella and polio

60,908

Treatment Room appointments which provided patients with flexible, local and accessible health care and treatments seven days a week though a central booking system

45,903

Podiatry treatments provided to patients. These take place in clinical settings and in patient's own home enabling patients to remain independent and mobile

150,102

Visits recorded across LCH Walk-In centres including 27,915 at Smithdown Children's Walk-In Centre. Walk-in Centres provide patients with a vital alternative to attending A&E and in reducing the burden on acute services

c. Performance Report

The Trust Board monitors performance against the achievement of key indicators that have been selected to demonstrate delivery of the Trust's strategic objectives.

Performance is measured and reported using the five domains of the Care Quality Commission's inspection regime. This regime is used to make judgements about the ability of Trusts to deliver services in compliance with the CQC's Fundamental Standards of Care for Community Health Trusts. These standards are: Safe; Responsive; Effective; Caring; and Well-led.

Key Performance Indicators in the Safe Domain

Never Events (serious incidents that are entirely preventable)	The Trust has reported one 'Never Event' which occurred in June 2017 and related to a wrong site tooth surgery in the Dental service. This was the first since August 2016 and the Trust continues to share and learn across the organisation to reduce the potential for future Never Events
Pressure Ulcers	There was a reduction in Grade 2 and Grade 3 community acquired and avoidable pressure ulcers of 38% (11) and 6% (1) respectively however an increase in Grade 4's of 33% (2) over the last 12 months Work continues in line with the collaborative pressure ulcer reduction programme which was developed in conjunction with commissioners. This includes the "PURPLE" programme (Pressure Ulcer Reduction Programme Learning and Education) which has received positive feedback from staff Also, an aggregated review has been undertaken for Grade 4 community acquired pressure ulcers and crossed referenced to the pressure ulcer reduction programme. A pressure ulcer forum was held in March 2017 to share lessons learnt and quality improvement initiatives
Safety Thermometer Harm Free Care	97.1% patients received harm free care. Further improvement compared to last year
Catheter Acquired UTIs (CAUTIs)	0 this year – 100% reduction compared to 1 last year
Medication errors causing major harm	0 this year for the second consecutive year

Work continues in line with the collaborative pressure ulcer reduction programme which was developed in conjunction with commissioners. This includes the "PURPLE" programme (Pressure Ulcer Reduction Programme Learning and Education) which has had positive feedback from staff.

An aggregated review has been undertaken for Grade 4 community acquired pressure ulcers and crossed referenced to the pressure ulcer reduction programme. A pressure ulcer forum was held in March to share lessons learnt and quality improvement initiatives. the Skin Service launched a new booklet to provide information outlining the general principles of wound management, pressure ulcer process and referral process. The booklet was designed to assist clinicians to base their decisions on with best evidence available and offer a structured approach to assessment and management of patients with wounds.

The Trust has reported one 'Never Event' which related to wrong site tooth extraction and continues to learn and share best practice across the organisation to reduce the potential for Never Events to re occur.

Key Performance Indicators in the Responsive Domain

Walk-in Centres	100% of patients seen within four hours
Allied Health Professionals	Overall Allied Health Professional (e.g. Speech and Language, Occupational Therapy) waiting times are below the eight week target at seven weeks. Individually, only Adult Speech and Language Therapy and the Falls Service are above this target whilst Dietetics, Occupational Therapy, Physiotherapy and Podiatry are all within the target
Treatment Room Waiting Times	The number of patients seen within two weeks was just below the 95% target at 94.%. Following a review of patient access to the Treatment Room Service to determine the most effective places to meet the demand, additional sessions have been implemented mainly in Central and South Liverpool localities
Community Equipment	93.4% of orders delivered within seven days
Wheelchairs	Significant improvements have been made in waiting times for routine referrals for the Wheelchair service. During this year waiting times have reduced from a peak of 30 weeks down to just 13 weeks, against the target of 18 weeks. Waiting times for urgent referrals are reported at three weeks which is within the target of four weeks
Did Not Attend (DNA) Rate	Although DNA rates for the year remain above the 8.5% target at 9.1%, this is a reduction compared to last year and there has been a significant reduction later this year with the target being achieved during Quarter 4

Cancellation Rates	The percentage of appointments cancelled by the Trust remains well below the target of 3.5% at 2.3%

The Walk-in Centres achieved the 100% target of patients being seen within the four hour period.

Significant improvements have been achieved in the waiting times for routine referrals for the Wheelchair service. During this year they have reduced from a peak of 30 weeks down to 13 weeks against the target of 18 weeks.

Waiting times for urgent referrals are reported at three weeks which is within the target of four weeks. Although the DNA rates for the year remain above the 8.5% target at 9.1%, this is a reduction compared to last year. There has been a significant reduction later this year with the target being achieved during Quarter 4.

Key Performance Indicators in the Effective Domain

Antenatal	A total of 3,005 antenatal visits were completed which is 9% more than last year
Health Visitor KPIs	Performance against all the Healthy Child Programme key performance indicators increase however the 95% targets for New Birth Visits within 14 days and 6-8 Week Follow Ups and 1 Year Reviews in 15 months remained below the target
HPV	Achieved 82.3% uptake which was below the 90% target for the last school year and a reduction compared to the previous year
Chlamydia	939 positive chlamydia tests, which is a 26% increase compared to last year and well above the target of 749

Key Performance Indicators in the Caring Domain

Friends and Family Test	98.4% of patients would recommend LCH as place of treatment which is an increase compared to last year and remains above national benchmark
Staff Friends and Family Test	84% of staff would recommend LCH as place of treatment – higher than the national benchmark

Staff Friends and Family Test	72% of staff would recommend LCH as place to work- higher than the national benchmark
Complaints	29% reduction in the number of complaints received
Compliments	1,462 compliments received about Trust services, an increase of 6% compared to last year

The percentage of staff who would positively recommend LCH as a place to work is 72% which is a significant improvement compared to last year and above the national community service provider average. The percentage of staff who would recommend LCH as a place for treatment also increased from 81% to 84%, and also remains above the national community service provider average.

Customer service and patient experience are definitive indicators in measuring the quality of services we provide. We strive to learn from every comment, compliment and complaint received from patients, relatives and carers about our services. This year the number of compliments has increased by 6% and the number of complaints has reduced by 29%. Over the last six months we have started to use social media to share compliments, this has been well received by patients and staff.

Key Performance Indicators in the Well-led Domain

Sickness absence	Sickness rates were reported at 7.3% this year, an increase against last year and above the target of 5.2%
Mandatory Training	93.7% of staff have completed all mandatory training. This is well above the national benchmark
Performance Appraisal	79.4% have had an annual performance appraisal which is a reduction compared to last year and below both the 85% target and the national benchmark
Staff Flu	Although staff flu vaccination uptake rates for total staff was reported at 69.6% clinical staff were reported at 70.7% which is above the national target of 70%

Although staff flu vaccination uptake rates for total staff was reported at 69.6% clinical staff were reported at 70.7% which is above the national target of 70% and successfully met the CQUIN target.

The sickness absence rate for the year is reported at 7.3%, and remains above the locally agreed target of 5.2%. The Trust has designed and implemented a sickness absence reduction programme, which includes use of back to work interviews, and easier access for managers to occupational health support. The Occupational Health and Staff Physiotherapy

Service proactively review data, and specifically support individuals with high levels of frequent sickness absence from work.

d. Sustainability

LCH recognises that as a major employer and consumer of goods, services and resources in the delivery of services, we have the potential to impact on the environment and our community significantly.

We are a responsible organisation and seek to reduce our impact on the environment and use resources efficiently and wisely to improve health outcomes, for the benefit of the local community.

Our Board approved a Sustainable Development Strategy, which has been developed and implemented against a backdrop of global environmental and economic pressures and uncertainties. National policy changes and demands, and major changes within the NHS and LCH itself, further emphasise the importance for the Trust of becoming more effective and efficient.

The strategy integrates the Trust's ambitions and direction with respect to sustainable development, corporate responsibility and carbon reduction.

LCH has adopted the NHS Sustainable Development Unit's Good Corporate Citizen Self-Assessment Model and utilised this to form the basis of our annual Board-approved Sustainable Development Management Plan (SDMP). The SDMP addresses the following areas:

- Travel (Staff and Patients)
- Procurement
- Work Force (Staff Health and Wellbeing and Development)
- Community Engagement
- Buildings (New Builds and Refurbishments)
- Facilities Management (Energy, Waste, Water, Hazardous Substances and Grounds)
- Adaptation (for Climate Change and Emergency Response)
- Models of Care

e. Financial Summary

The Annual Report reflects on financial performance from 1 April 2017 – 31 March 2018. The Trust delivered within all targets set within the financial plan and has delivered statutory financial duties for this period including:

- Breakeven financial performance over the three year cumulative period and delivery within the 2017/18 NHS Improvement set control total of a £1.5m deficit, inclusive of £1.3m Sustainability and Transformation Fund allocation
- Achievement of Capital Resource Limit (CRL). £0.6m capital investment against a £1.7m limit for the year
- Achievement of the External Finance Limit (EFL). £0.7m cash inflow against a £2.5m limit for the year
- Achievement of the agency spend cap. £2.6m agency spend against a £3.4m cap for the year
- Financial performance has been delivered within a sound system of financial internal control. The 2017/18 internal audit programme provided opinions of significant and high assurances across all core areas of assessment for the finance environment

Additional financial challenges that were presented by the initial stages of transaction during Quarter 1 of the financial year were responded to positively and in full by the Trust. The complex transfer of non-Liverpool Core services to successor organisations saw a £5.6m loss arising from transfers by absorption which was in line with approved plans. The service transfers also resulted in a significant reduction in income and expenditure between financial years.

The Trust received total income of £97.4m from all sources, a reduction from 2016/17 of £35.2m (25.5%). The reduction largely reflected the movement of the non-Liverpool Core Services to successor organisations.

Of the Trust's total income £89.7m (94%) was covered by block contracts with commissioners. Of this value £79.1m (88%) was received from Liverpool Clinical Commissioning Group (included Liverpool City Council's public health funding), £5.3m (6%) was from NHS England, £3.8m (4%) was from South Sefton Clinical Commissioning Group, and the remaining £1.5m (2%) was received for services provided under block contracts with other commissioners.

An allocation from the Sustainability and Transformation Fund was also received totalling £3.1m for the year. This represented the full base allocation of £1.3m allowed to the Trust with no reductions being made for none delivery of agreed targets, plus an additional £1.8m as part of the national incentive and bonus allocations.

Our operating expenditure for the year was £96.8m, which when added to finance costs resulted in a surplus of £0.5m, which represented an improvement on the Trust's financial plan. Recognising that staff are our greatest asset; £70.3m (72.5%) of the money we spent in 2017/18 was on employing staff and delivering training and development.

During 2017/18 we incurred £0.6m of capital expenditure to deliver key strands of the Estates Strategy. The investment delivered improved accommodation for the delivery of patient care services, relocation of staff into fit for purpose premises and has created the capacity for co-location of clinical and social care partners across the city.

Following delivery of the transaction that has seen all clinical services transfer to Mersey Care NHS Foundation Trust on 1 April 2018 a single consolidated financial plan for 2018/19 as been approved. The transaction has seen the transfer of all residual assets and liabilities transfer by absorption to the successor Foundation Trust.

2. Accountability Report

2.1 OVERVIEW

a. Directors Report

The Board sets the tone within the Trust, establishing values and behaviours required to deliver the organisation's strategy. It provides leadership to the Trust, setting strategic direction, ensuring management capacity and capability, monitoring performance and holding the Executive to account for performance.

The Board defines the vision of the Trust and champions and safeguards its values, keeping the safety of patients at the centre of its work and ensuring obligations to key stakeholders including our patients, commissioners, staff and partners are met. By ensuring the effective and efficient use of resources it safeguards public funds giving best value for money for the tax payer.

As a unitary Board, all Board members (Executive and Non-Executive) have joint responsibility for decisions of the Board and share the same liability. All Board members also have responsibility to constructively challenge the assumptions and options under consideration during decision making and help develop proposals for priorities, risk mitigation, values, standards and strategy.

The Non-Executive Directors have a particular duty to ensure appropriate challenges are made, and in holding the Executive Directors to account. As well as bringing their own expertise to the Board, Non-Executive Directors scrutinise the performance of management in reaching goals and objectives and monitor the reporting of performance.

Non-Executive Directors satisfy themselves as to the quality and integrity of financial, clinical and other information and to ensure that the system of internal control is well designed, consistently applied and operating effectively.

The Board delegates certain powers to its ccommittees, which exclude executive powers unless expressly authorised. The Executive team is responsible for the day-to-day running of the organisation and implementing decisions taken at a strategic level by the Board.

THE STATEMENT OF THE DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year.

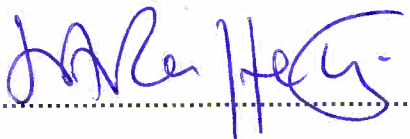
The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts

The directors are responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

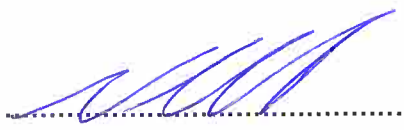
They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board



Date 24th May 2018

Joe Rafferty, Chief Executive



Date 24th May 2018

Neil Smith, Finance Director

Membership and attendance at Board and committees 2017/18

			Attendance of committee members during the year (number of meetings attended / total number of possible attendances)					
Name	Title	Board	Audit Committee*	Quality Committee	Planning & Performance Committee	HR and OD Committee**	Health & Safety Committee***	Remuneration Committee
Non-Executive Directors								
David Henshaw[1]	Chair / Non-Executive Director	5/5 (100%)						
Trevor Lake[2]	Chair / Non-Executive Director	1/1 (100%)						1/1 (100%)
Beatrice Fraenkel [3]	Chair / Non-Executive Director	5/5 (100%)						1/1 (100%)
Tony Allen	Non-Executive Director	9/11 (82%)	3/4 (75%)		6/7 (86%)	1/4(25%)	3/3 (100%)	1/2 (50%)
Val Davies [4]	Non-Executive Director	1/1 (100%)		1/1 (100%)				1/1 (100%)
Karen Fielding	Non-Executive Director	8/11 (73%)	0/4 (0%)	8/8 (100%)				2/2 (100%)
Mike Roach[5]	Non-Executive Director	1/1 (100%)						1/1 (100%)
Steve Igoe[6]	Non-Executive Director	3/5 (60%)	2/3 (66%)				3/3 (100%)	

[1] D Henshaw undertook role of chair under management agreement with Alder hey/ NHSI from 1 May – 31 October 2017
[2] T Lake (Non-Executive Director) left the organisation at the end of April 2017
[3] B Fraenkel undertook role of Chair under management agreement with Mersey Care / NHSI from 1 Nov 2017 – 31 March 2018
[4] V Davies (Non-Executive Director) left the organisation at the end of April 2017
[5] M Roach (Non-Executive Director) left the organisation at the end of April 2017
[6] S Igoe undertook role of Non-Executive Director under management agreement with Alder Hey/ NHSI from 1 May – 31 October 2017

Anita Marsland[7]	Non-Executive Director	5/5 (100%)		3/4 (75%)	5/5 (100%)			
Geoff Rossington[8]	Non-Executive Director	1/1 (100%)						1/1 (100%)
Jo Williams[9]	Non-Executive Director	2/5 (40%)				4/4 (100%)		
Gerry O'Keeffe[10]	Non-Executive Director	5/5 (100%)		1/2 (50%)	1/1 (100%)			1/1 (100%)
Pam Williams[11]	Non-Executive Director	5/5(100%)	1/1 (100%)		1/1 (100%)			1/1 (100%)
Rob Beardall[12]	Non-Executive Director	4/4 (100%)		2/2 (100%)				1/1 (100%)

[7] A Marsland undertook role of Non-Executive Director under management agreement with Alder Hey/ NHSI from 1 May – 31 October 2017
[8] G Rossington undertook role of Non-Executive Director under management agreement with Alder Hey/ NHSI from 1 May – 31 October 2017
[9] J Williams undertook role of Non-Executive Director under management agreement with Alder Hey/ NHSI from 1 May – 31 October 2017
[10] G O'Keeffe undertook role of Non-Executive Director under management agreement with Mersey Care / NHSI from 1 Nov 2017 – 31 March 18
[11] P Williams undertook role of Non-Executive Director under management agreement with Mersey Care / NHSI from 1 Nov 2017 – 31 March 18
[12] R Beardall undertook role of Non-Executive Director under management agreement with Mersey Care / NHSI from 1 Nov 2017 – 2 March 18

			Attendance of committee members during the year (number attended / total number of possible attendances)						
Name	Title	Board	Audit* Committee	Quality Committee	Planning & Performance Committee	HR and OD** Committee	Health & Safety Committee ***	Executive Committee ****	Remuneration Committee
Executive Directors									
David Fearnley[13]	Medical Director	5/5 (100%)		1/2 (50%)				1/3 (33%)	
Moira Angel[14]	Director of Nursing	0/1 (0%)		1/1(100%)					
Hilda Gwilliams[15]	Director of Nursing	4/5 (80%)		3/5 (60%)					
Trish Bennett[16]	Director of Nursing	5/5 (100%)		2/2 (100%)	1/1(100%)			2/3 (66%)	
Julie Cooper[17]	Director of Workforce	1/1 (100%)							

[13] D Fearnley undertook role of Medical Director under management agreement with Mersey Care / NHSI from 1 Nov 2017 – 31 March 18
[14] M Angel (Director of Nursing) left the organisation at the end of April 2017
[15] M Gwilliams undertook role of Director of Nursing under management agreement with Alder Hey/ NHSI from 1 May – 31 October 2017
[16] T Bennett undertook role of Director of Nursing under management agreement with Mersey Care / NHSI from 1 Nov 2017 – 31 March 18
[17] J Cooper (Director of Workforce) left the organisation at the end of April 2017

Mellissa Swindell[18]	Director of Workforce	5/5 (100%)		2/5 (40%)		3/3 (100%)	1/3 (33%)		
Amanda Oates[19]	Director of Workforce	5/5 (100%)		2/2 (100%)	1/1(100%)	1/1 (100%)		2/3 (66%)	
Non-Voting Executive Directors									
Johanna Reilly	Chief Operating Officer	10/11 (91%%)		6/7 (86%)	6/7 (86%)		3/4(75%)		

- Executives are prohibited from being members of the Audit Committee and the Remuneration Committee. Whilst the CEO regularly attends the Remuneration Committee and the Director of Finance regularly attends the Audit Committee, the attendance of officers invited to the committees is not reportable.
- ** The Governance Framework for the organisation was revised and approved in November 2017 and as a result the HR & OD Committee was removed as Board Committee (now a sub-Committee)
- *** The Governance Framework for the organisation was revised and approved in November 2017 and as a result the Health and Safety Committee was removed as Board Committee (now a sub-Committee)
- **** The Governance Framework for the organisation was revised and approved in November 2017 and as a result the Executive Committee was established as Board Committee.

[18] M Swindell undertook role of Director of Workforce under management agreement with Alder Hey/ NHSI from 1 May – 31 October 2017
[19] A Oates undertook role of Director of Workforce under management agreement with Mersey Care / NHSI from 1 Nov 2017 – 31 March 18

Division of responsibilities

The Board is satisfied that there is a clear division of responsibilities between the Chair and Chief Executive.

Conflicts of interest

The Board is satisfied that there is a clear process by which Directors are able to declare and then avoid any actual or perceived conflict of interest. All Directors are appropriately informed whenever a potential conflict of interest is declared by another. There are Standards of Business Conduct in place, supported by relevant procedures, to ensure that a Director, declaring a conflict of interest, withdraws from consideration of the matter. The Standards of Business Conduct, applicable to all staff are written in line with the revised conflict of interest guidance issued by NHS England in 2017. During the year, a register of interests was regularly reviewed and updated.

The register of Directors' Interests as at 31 March 2018 is available on the Trust website and can be found here: www.liverpoolcommunityhealth.nhs.uk/who-we-are/corporate-governance.htm

Health and Safety

The Trust is committed to ensuring the prevention of injury and ill health and to continually improve its safety performance.

Health and safety surveillance is part of the overall Risk Management Strategy, which aims to identify and manage all risks to the organisation, its people, patients and the services it provides. Health and safety activity focuses on the risks of injury and ill health that can arise from the wide range of work activities necessary to deliver health care services to the people of Liverpool and Sefton, and the surrounding areas.

In 2017/18, LCH reported six incidents under the reporting of injuries, diseases and dangerous occurrences regulations 2013 (RIDDORs).

The Health and Safety Sub-Committee and Operational Health and Safety Working Group lead a programme of activities which improve the culture and delivery of health and safety at work across the Trust.

Countering Fraud and Corruption

For 2017/18, NHS Trusts continued to be required to comply with NHS Protect Guidance and Provider Standards, which set out the requirements for countering fraud. These provisions include the requirements for a nominated Lead Counter Fraud Specialist (CFS) to be in place to undertake work across four generic areas of action.

LCH has a proactive approach to reducing the risk of fraud. Regular information is circulated to staff to raise awareness of the latest fraud alerts and how to identify and report suspected fraud. The Trust has policies in place for staff, including declarations of interests and the Anti-Fraud and Corruption Policy, which reinforce the commitment of the organisation to maintain an embedded counter fraud culture and to take robust action where allegations of fraud, bribery and corruption are proven.

The Trust contracts with Mersey Internal Audit Agency (MIAA) for the provision of this anti-fraud service. The Audit Committee approves on an annual basis, an Anti-Fraud Work Plan, receives progress reports from MIAA four times per year setting out delivery of the Plan and holds MIAA to account for the provision of the service.

Emergency Preparedness and Resilience Planning

We continue to collaborate successfully with stakeholders and other agencies to ensure emergency plans are in place, regularly reviewed, tested and updated.

Our participation includes multi-agency training and exercises; rigorously testing our service resilience plans; enabling our staff to respond effectively to different emergency scenarios.

These include maintaining continuous services when faced with disruption from local risks; resuming key services which have been disrupted by, for example severe weather, IT failure, an infectious disease outbreak, a fuel shortage or industrial action. The Trust's Accountable Emergency Officer is the Chief Operating Officer.

The Trust also has suitable, up to date service resilience plans which set out how it will maintain continuous services when faced with disruption from local risks, and resume key services which have been disrupted by, for example, severe weather or IT failure.

Cost Allocation and Charges for Information

LCH has complied with HM Treasury's guidance on setting charges for information access either through Freedom of Information Act 2000 and Data Protection Act 2003.

External Auditor's Remuneration

The cost of audit services performed by the Trust's external auditor, Grant Thornton LLP amounted to £40,784, excluding VAT. Grant Thornton have not undertaken any non-audit work for LCH during 2017/18 outside of its statutory activities, therefore their independence has not been compromised by non-audit work commitments.

Disclosure to Auditors

Each of the Directors at the date of approval of this report confirms that:

- So far as the Director is aware, there is no relevant audit information of which the Trust's auditors are unaware

- The Director has taken all the steps that he ought to have taken as a Director to make himself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information

This confirmation is given and should be interpreted in accordance with the provisions of Section 418 of the Companies Act 2006.

Details of the Trust's Exit Packages and Off-Payroll Engagements can be found in the Remuneration Report on page 59. In addition, details relating to the Better Payment Practice Code, Prompt Payment Code are outlined in the Financial Statements.

Cost Allocation and Charges for Information

LCH has complied with HM Treasury's guidance on setting charges for information access either through Freedom of Information Act 2000 and Data Protection Act 2003.

b. The Statement of the Accountable Officer's Responsibilities

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets, and assist in the implementation of corporate governance
- Value for money is achieved from the resources available to the Trust
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- Effective and sound financial management systems are in place
- Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Date:

Joe Rafferty,
Chief Executive

c. Annual Governance Statement 2017-18

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS 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 Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can, therefore, only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Liverpool Community Heath NHS 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 Liverpool Community Health NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

A systematic, reproducible process of risk assessment and horizon scanning is in place within the Trust and throughout the health economy. This activity aims to identify at an early stage all risks of failure to achieve objectives and to enable management to put in place mitigating measures to reduce the likelihood and consequences of failure where possible. Where the risk remains outside of the Board's appetite, plans can be made to avoid or transfer such risks.

From information handed over to me I assume that an effective system of internal control has been in place in Liverpool Community Health NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts. Where the system of internal control has been found to exhibit weaknesses in design or consistency of application during the year, this is explained, together with the actions, which have been or are being taken to remedy such weaknesses.

Background to Preparation of the Annual Governance Statement

2017/18

In early 2015 it became increasingly clear that many of the quality issues identified in 2014, and described in the Trust's previous annual report, were deep-seated and required thorough review.
The serious issues included, for example: the previous provision of Offender Health Services at HM Prison Liverpool; a number of complex on-going employment issues involving bullying and harassment of staff; and requests from the Nursing and Midwifery Council for information in relation to a regulatory investigation..

Consequently, it was considered that the most appropriate approach would be to commission an independent review of the events and issues that had surfaced in relation to the former management of the Trust.

Accordingly, the Trust Board agreed at its meeting in April 2015 to the appointment of Capsticks LLP, a firm of solicitors with a governance practice. Capsticks was retained to carry out a Quality, Safety and Management Assurance Review. Its purpose was to investigate a number of very serious incidents and to establish why the issues highlighted by the CQC and others had happened. The aim was that the Trust would learn from the events, enabling it to better design and consistently apply its system of internal control in order to ensure that the same or similar incidents never happened again.

Part one of the review was a 'look back exercise' into the governance, quality and safety issues within the Trust between 2010 and 2014. Part two of the review focused on the governance issues within the Trust at that time.

The report was named 'The Quality, Safety and Management Assurance Review Report Findings and Recommendations'. It was considered at a meeting of the Trust Board in March 2016, with the recommendation that the findings be accepted and the 36 recommendations of the report adopted for implementation.

The Board accepted that the review report described a series of very concerning events that had occurred in the period between 2010 and 2014. A detailed action plan was developed which was implemented in accordance with the timescales prescribed in the review report – red rated recommendations within two months and amber rated recommendations within four months. The Board monitored progress with the action plan and by July 2016, all actions had been satisfactorily implemented.

Throughout 2015/16 the Trust continued to implement and initiate a three phase Improvement Plan, established in 2014 in conjunction with the Trust's staff, commissioners and stakeholders:

Phase 1 - Fix critical operational delivery
Phase 2 – Devolve clinical leadership
Phase 3 – Service transformation

Importantly, Phase 3 of the Improvement Plan involved securing a new organisational model in line with the Trust Board's decision in January 2015, supported by the NHSI, to leave the Foundation Trust application pipeline.

The identification of a new organisational model was led by NHSI and the Trust's commissioners. Much of the Trust's work in 2015/16 was planned to progress the delivery of the new organisational model to enable this to be operational during 2017. A set of four clear gateways were established by NHSI, as shown below.

By the end of the 2016/17 year, the preferred options had largely been identified but became subject to delays and pauses created by additional due diligence requirements of stakeholders and public interest.

In February 2016, CQC undertook a re-inspection, following its visit in May 2014. The 2016 visit focussed on the areas that had been subject to review recommendations in 2014.

In the intervening period the Trust had developed an action plan and redesigned a wide range of elements of the system of internal control.

The Inspection was welcomed as an independent source of assurance that those changes were having beneficial effects. The CQC report was provided to the Trust on 8 July 2016. The Trust was rated as 'requires improvement' but also acknowledged that many improvements had been made, but that more remained to be done.

The CQC found that the Trust had recruited more front-line clinicians to ensure safer staffing levels, and delivered improvements to its intermediate care services on the Broadgreen and Aintree sites.

Inspectors also highlighted 'significant improvements' in the culture of the organisation and praised the Trust for the measures it had introduced to keep staff safe.

The findings echoed the conclusions of the separate Quality, Safety and Management Assurance Review, published in March 2016, which judged that the Trust had 'turned an important corner' following several years of deep-rooted problems.

The CQC inspectors also identified a number of new areas for the Trust's focus, including:

- Ensuring the Trust correctly documents the way it is responding to the NHS Duty of Candour

- Ensuring robust systems are implemented in all services to monitor and improve the quality of services provided

As a result of this latter CQC report, the Trust committed to further improve the system of internal control to address these weaknesses. A new action plan was developed and monitored by Quality Committee and the Board. A further visit by the CQC to review progress was made on 13 January 2017 which indicated a series of improvements in respect of quality, safety, culture and staffing. The Executive Team provided to CQC a range of evidence to substantiate the most recent progress made and this was received positively.

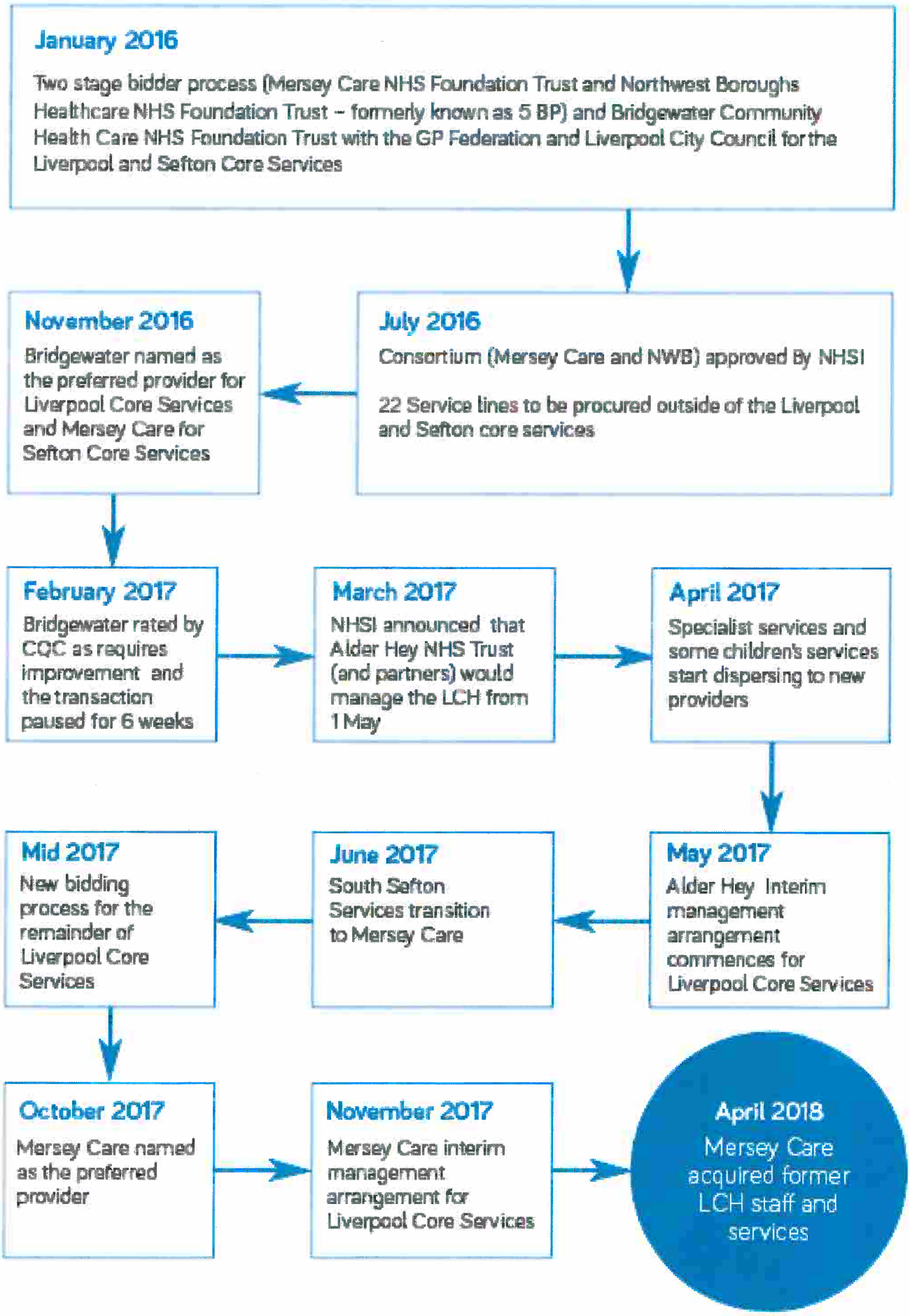
The CQC and Capsticks reports generated a level of concern about the management culture of LCH and the quality of services provided, which resulted in NHS Improvement commissioning Dr Kirkup to undertake an independent review of LCH with terms of reference to look not only at LCH but the wider health economy and the role of regulators between November 2010 and December 2014.

This independent review published its report on 8 February 2018. The report provided a succinct summary of the issues the Review found:

"Liverpool Community Health NHS Trust (LCH) was a dysfunctional organisation from the outset. The Trust acted inappropriately in pursuit of Foundation Trust (FT) status, setting infeasible financial targets that damaged patient services. The Trust managed services that it was ill-equipped to deal with, particularly prison healthcare in HMP Liverpool. Senior leadership and the Board failed to realise that the Trust was out of its depth, and did not take heed of the effects. Staff were overstretched, demoralised and, in some instances, bullied. Significant unnecessary harm occurred to patients. External NHS bodies failed to pick up the problems for four years."

Paragraph 1.1 – Kirkup Review (February 2018)

The review identified ten recommendations and although the implications of many of these recommendations will likely impact on the majority of NHS organisations, Liverpool Community Health has prepared and commenced implementation of its own Action Plan, delivery of which is, and will continue to be, overseen by the Trust Board.


January 2016
Two stage bidder process (Mersey Care NHS Foundation Trust and Northwest Boroughs Healthcare NHS Foundation Trust – formerly known as 5 BP) and Bridgewater Community Health Care NHS Foundation Trust with the GP Federation and Liverpool City Council for the Liverpool and Sefton Core Services
July 2016
Consortium (Mersey Care and NWB) approved By NHSI
22 Service lines to be procured outside of the Liverpool and Sefton core services
November 2016
Bridgewater named as the preferred provider for Liverpool Core Services and Mersey Care for Sefton Core Services
February 2017
Bridgewater rated by CQC as requires improvement and the transaction paused for 6 weeks
March 2017
NHSI announced that Alder Hey NHS Trust (and partners) would manage the LCH from 1 May
April 2017
Specialist services and some children's services start dispersing to new providers
May 2017
Alder Hey Interim management arrangement commences for Liverpool Core Services
June 2017
South Sefton Services transition to Mersey Care
Mid 2017
New bidding process for the remainder of Liverpool Core Services
October 2017
Mersey Care named as the preferred provider
November 2017
Mersey Care interim management arrangement for Liverpool Core Services
April 2018
Mersey Care acquired former LCH staff and services

The below diagram illustrates the transaction process and the timeline to move the Trust into a new organisational form.

A two-stage bidder selection process commenced in January 2016 and after reviewing Expressions of Interest from potential acquirers, a Request for Proposal (RFP) document was issued on 16 May 2016 to three NHS trusts: Mersey Care NHS Foundation Trust ("Mersey Care"), Bridgewater Community Healthcare NHS Foundation Trust ("Bridgewater") and North West Boroughs Health Care NHS Foundation Trust (formerly known as 5 Boroughs Partnership NHS Foundation Trust ("NWB").

In July 2016 NHSI approved a request from Mersey Care and NWB to establish a consortium, thereby reducing the field to two trusts bidding to acquire LCH and on 31 August 2016 proposals were received for both Lots from both bidders:

- **Mersey Care (sub-contracting some services to 5BP).**
- **Bridgewater (with an intention to develop over time consortia involving Liverpool GP Federation and Liverpool City Council).**

As part of the transfer process, commissioners also identified twenty-two service lines for re-procurement. This procurement exercise was to be effected concurrently but outside the NHSI process for Liverpool and Sefton 'core' services. Some of these services, incorporating some 280 staff, transferred to new providers on 1 April 2017.

The bidder Evaluation Process was based on a set of Evaluation Criteria agreed at the Option Appraisal stage by NHSI and subsequently developed as a more detailed set of questions shared with the bidding trusts as part of the RfP process. These reflect equal consideration of four criteria: Quality, Sustainability, Deliverability and Finance.

The outcome of a detailed evaluation process, which took place during the period of September to November 2016 confirmed Bridgewater as the preferred bidder for Liverpool core services and Mersey Care the preferred bidder for Sefton core services.

In early February 2017, Bridgewater was the subject of a CQC report which rated Bridgewater's services at the time of its mid-2016 inspection as *'requires improvement'*.

Following public and stakeholder comment and internal NHSI review of the appropriateness of transitioning LCH core services to Bridgewater, NHSI paused the transaction process to Bridgewater for a 4-week review period. This was extended by a further two weeks.

NHSI announced on 30 March that LCH would be managed from 1 May through a short- term management arrangement led by Alder Hey Children's NHS Foundation Trust, with support from Aintree University Hospitals NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

In mid-2017, NHS Improvement established a second bidding process, this time to identify an organisation which would acquire the remaining services at LCH, with the intention that the successful bidder would acquire LCH from 1 April 2018. As such, on 4 October 2017 NHS Improvement notified Mersey Care that it has been identified as the 'Preferred Acquirer' to acquire LCH from 1 April 2018. 'Preferred Acquirer' status resulted in that Mersey Care being subject to a separate process overseen by NHS Improvement, whereby NHS Improvement will determine whether Mersey Care should acquire LCH.

As part of the bidding process, Mersey Care NHS Foundation Trust confirmed that they would be prepared to enter into an Interim Management Agreement to support LCH and as such, have provided this support from 1 November 2017.

The Executive team at Mersey Care has taken on the responsibility for the day-to-day management of LCH services, providing extra capacity, and ensuring that safe and effective community services continue to be delivered to patients whilst the transaction was progressed. Services were monitored through a robust governance structure which included:

- Patient Safety Committee
- Clinical Effectiveness Committee
- Patient Experience Committee

These reported to the Quality Committee via provision of minutes and Chairs reports.

RISK AND CONTROL FRAMEWORK

The Governance Framework of the Organisation

The governance framework of the organisation is designed to manage operational and strategic risk and minimise the risk of failure to deliver the Trust's strategic objectives.

The Board is responsible for providing strategic leadership to the organisation and ensuring that the Trust exercises its functions effectively and efficiently. The Board monitors to arrangements in place to maintain the quality and safety of the Trust's services, including ensuring processes are in place for the management of risk.
The Board takes an active role in monitoring the Trust's performance in respect of serious incidents, which are reported at each formal Board meeting together with *lessons learned*.

The Board has approved Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions in place (revised and approved in November 2017) that outline the responsibilities for all members of staff on key issues such as governance and financial transactions in addition to Standards of Business Conduct, approved by the Board in February 2018.

The Board met formally in public 11 times during 2017/18. The Board and Committee membership and attendance is provided at Section 2.1.a of this annual report.

Board Committee Structure and Corporate Governance Arrangements

The law requires the Board to establish an Audit Committee and a Remuneration Committee. In addition, the Board chooses to gather its assurances regarding the effectiveness of the system of internal control by convening several other committees.

The way in which these committees work together to acquire and scrutinise the assurance, which the Board needs is frequently reviewed, the most recent occasion being November 2017.

The committee structure, to support achievement of the organisations strategic objectives, is outlined below. Any Board Committee can request that a risk be considered for inclusion in the Trust risk register and the risk escalation arrangements are set out in the Risk Management Strategy.

- **Audit Committee** – scrutinises the systems and processes in place across the Trust to provide the Board with assurance that it is effectively governed, well run, on track to achieve its objectives and complies with statutory responsibilities. It is supported in this role by Internal and External Audit, which review key areas, including the auditing of the annual accounts to ensure compliance with statutory duties

- **Remuneration Committee** – advises on the determination of the appropriate salaries and conditions of the Trust's Chief Executive and other Executive Directors. The Committee discharges its functions in accordance with legal and NHS requirements, principles of probity and the requirements of good corporate governance. Membership comprises all Non-Executive Directors, including the Chair

- **Quality Committee** – has delegated responsibility from the Board to provide assurance concerning all aspects of quality and safety relating to patient care and identifying quality improvement measures. This includes providing assurance that the Trust is compliant with all regulatory requirements

- **Planning and Performance Committee** – provides assurance to the Board on the governance arrangements supporting the delivery of the Trust's strategy, Improvement Plan and operational performance. This includes all aspects of financial and operational performance when compared to planned financial and operational performance and all risks and mitigating actions affecting the short term sustainability of the organisation. During the year it has paid particular attention to the financial and other transactional challenges facing the Trust and the Trust's consequent financial risk profile

- **Executive Committee** – established in November 2017, this Committee: supports the Trust Board in setting and delivering the organisation's strategic direction and priorities; oversees the effective operational management of the Trust and delivery of continuous improvement in quality and to assess and control risk. It also oversees and scrutinises regulatory and reputational strategically significant risks on behalf of the Trust Board, proposing new or revised risks where necessary

In November 2017, the Scheme of Reservation and Delegation was fundamentally reviewed and updated, including the Committee structure and associated Terms of Reference. As a result, the following Board Committees were amended to become sub-Committees of the Executive Committee from December 2017:

HR & Organisation Development Committee - with responsibility delegated from the Board to:

- Provide assurance to Liverpool Community Health Trust NHS Board on the development, implementation and effectiveness of the HR/ODstrategy
- Assure the Board that the implementation of the people element of the change programme to develop a clinically led, locality-based organisation is effective
- Advise on future HR governance arrangements
- Provide assurance that the Trust is compliant with all HR regulatory requirements

Health & Safety Committee - the Committee provides assurance to the Board that the system of internal control, as it relates to health and safety, is well designed, consistently applied and operates effectively. The Committee engages employee representation. In 2016/17 the Committee has particularly sought and received assurance on estate and buildings compliance as well as the sustainability and impact of the corporate Health and Safety function.

Attendance at Board and Board Committee Meetings

The Trust Board met 11 times in public in 2017/18. Attendance was monitored throughout the year and is reflected earlier in this Annual Report.

The Trust Board achieved an average attendance level of 92% by its members in 2017/18, with the various Board Committees achieving average attendance levels of between 55% and 98% by their members in 2017/18.

Board and Committee Effectiveness

NHS Trusts are not required to adhere to the Code of Governance in place for Foundation Trusts or the UK Corporate Governance Code. However, many of the conventions for good governance described within the Codes have been adopted for use within the Trust. These include:

- The Board is collectively responsible for the long term success of the Trust
- There is a clear division of responsibilities between the Chief Executive who runs the Trust on a day to day basis and the Chair of the Board
- The Board includes an appropriate combination of executive and independent non-executive directors such that no individual or small group of directors can dominate the Board's decision making
- The Board has always presented a fair, balanced and understandable assessment of the Trust's position and prospects
- The Board has maintained a constructive dialogue with stakeholders based on mutual understanding of the Trust's objectives

In addition to formal meetings of the Trust Board there have been regular Board development sessions which have provided the opportunity for exploration of key strategic, operational and performance matters in more detail than would otherwise be possible at a formal Board meeting. The Board has consistently considered and prioritised the requirement to support the Transaction process led by NHSI and commissioners.

Each of the Board's committees provides a set of approved minutes for each of its meetings. In addition, the Chair of each committee provides a verbal summary report at the following Board meeting of the main issues discussed, any identified risks, specific matters of escalation or board decisions required. This forms an integral part of the Trust's escalation mechanisms.

At the conclusion of each Board meeting the opportunity is also taken to review the effectiveness of the meeting.

The Trust has in place arrangements for the discharge of its statutory functions. These have been checked for any irregularities and found to be legally compliant.

Capacity to Handle Risk

The Trust Board is ultimately accountable for the management of all risks in the organisation. The Chief Executive, supported by Board Members, has responsibility for the implementation of the Risk Management Strategy. These responsibilities are met in a variety of ways, with the advice of the Executive Lead for risk management (Executive Director of Nursing) who is

supported by the Executive Committee.

I, as Chief Executive, with overall responsibility for risk within Liverpool Community Health NHS Trust, ensure the work of the Executive Committee and other specialist sub-committees is reviewed by the Board. The Chief Executive has overall responsibility for having effective risk management systems in place within the Trust, and for meeting all statutory requirements and adhering to guidance issued by NHS Improvement and other regulatory bodies in respect of risk and governance.

The Trust Board has overall responsibility for consideration of the Board Assurance Framework and resource allocation relating to the 'significant risks' of the Trust. The recommendations from Board committees, taking account of advice from relevant sub-committees, are made to the Board where competing priorities are debated and agreed or accepted.

The capacity of the Trust to handle risk is achieved through delegated responsibilities in place as defined in the Scheme of Reservation and Delegation and the Risk Management Strategy, both documents being approved by the Trust Board. The Strategy outlines the Trust's approach to risk, accountability arrangements and the risk management process including identification, analysis, evaluation and approval of the risk appetite.

The accountability arrangements for risk management in 2017/18 involved the following:

- The Trust Board has overall responsibility for ensuring robust systems of internal control, encouraging a culture of risk management, routinely considering risks and defining its appetite for risk

- The Executive Committee, the Planning & Performance Committee and the Quality Committee undertake the detailed scrutiny of those risks that fall within their terms of reference on behalf of the Board, recommending new or revised risks to the Board as appropriate

- The Audit Committee on behalf of the Board ensures that the trust's risk management systems and processes are robust

- Identification, scrutiny and escalation of risks through the Locality Governance Meetings and Locality Performance Meetings

- The Chief Executive, as the Trust's Accountable Officer, has overall responsibility for the risks management processes and Risk Management Strategy

- The lead Executive Director, the Executive Director of Nursing, has responsibility, on behalf of the Chief Executive, for managing the trust's risk management processes

- Each member of the Executive Team has responsibility for the identification and management of risks within their executive portfolios

- The Executive Director of Finance (Deputy Chief Executive) has responsibility for ensuring that the Trust had sound financial arrangements that were controlled and monitored through financial regulations and policies

The Board Assurance Framework and Risk Register have been regularly scrutinised and reviewed through the Trust's governance structure and have been subject to various internal and external reviews. The Trust's strategic intentions, policies, procedures, Board Assurance Framework and supporting documentation are openly accessible via the Liverpool Community Health website to internal and external stakeholders for comment, scrutiny and reference.

Managers and staff have been encouraged to ensure that risk management is embedded into daily working practices at a local level, through staff training in risk and safety management.

Trust policies are available on the intranet and relevant staff are encouraged to participate in the consultation of new and updated policies. Newly approved policies are published through a network of policy leads and also in the regular communications update issued to staff.

To ensure that the Trust's approach to risk management is successfully implemented and maintained, staff of all levels, are appropriately trained in key elements of risk management. All staff are required to regularly update their knowledge and skills and maintain their personal awareness of their responsibilities for risk management via an on-going training Health and Safety (including risk assessment). This training is mandatory for all staff.

All new employees of the Trust are required to attend a corporate induction programme that covers Health and Safety (including risk management). Emergency resilience training is also delivered to all senior managers who undertake on call duties and table top exercises are conducted to test robustness of the Trust's major incident plans.

Compliance with mandatory training is reported to the Trust Board of Directors (in addition to the Quality committee, Executive Committee and Planning and Performance Committee) through an integrated performance report.

The Trust Board has also received risk management training through their respective organisations under the management contracts in place in 2017/18.

Risk Assessment

In accordance with the Risk Management Strategy, risks are identified by staff, reviewed, and entered onto the Datix system for managing risks. Risks are managed and escalated through the governance structure. The Board reserves ratification of the Risk Management Strategy to itself. It was most recently reviewed in January 2018.

The clinical quality escalation procedure provides a process through the locality governance structures to the Executive Committee and Quality Committee and onwards to the Board.

The Trust's Risk Management Strategy provides a framework for managing risk within the Trust and outlined the objectives of risk management; the structure in place to support the

management of risk across the organisations; and the systems and processes to ensure identification, management and control of risk. The current Risk Management Strategy includes a number of key components including:

- A system of risk classification and risk stratification that makes clear who and where risks are to be escalated and reviewed
- The Trust's appetite for risk, which is reviewed by the Board on an annual basis
- A Trust wide Risk Register
- A combined risk report and Board Assurance Framework
- A process to moderate and standardise the approach to assessing risk (overseen by the Executive Committee)
- The requirement for all risks to have three risks scores – an initial score, a current score and a target risk score
- Greater alignment between risks and the assurance in respect of the controls / mitigation that has been put in place

The Risk Management Strategy describes the levels at which risks are reviewed and managed. In practical terms, risks are scored for likelihood and impact, each on a 1-5 scoring system, to generate an overall score between 1-25. This allows management to direct resources more effectively at those risks which pose the greatest threats. Risks rated five and below are managed locally; risks rated six and above are managed by the service lead and reviewed at Locality Governance meetings. The Quality Committee reviews all red rated risks which score 15 and above on a monthly basis.

The Risk Management Strategy sets out the overall governance structure for managing risks at a corporate level through the three related mechanisms:

- The Board Assurance Framework (BAF) which sets out the strategic objectives, identifies key risks in relation to each strategic objective along with the controls in place and assurances available on the design and operation of those controls
- A Strategic Risk Register which contains the high level risks to the organisation, which cannot be managed at a local level and requires corporate management
- The Annual Governance Statement signed off by the Accountable Officer and which describes the organisation's approach to internal control

The Trust Board has reviewed the Strategic Risk Register, together with the Board Assurance Framework, frequently. It has also had available to it directly and through

escalation via the Quality Committee, the Operational Risk Register of risks scored 15+.

The development of the Board Assurance Framework has enabled the organisation to systematically identify, record and action the key risks faced by the organisation in relation to the achievement of our overarching strategic aims.

In-Year and On-Going Risks

Significant strategic risks which the organisation has identified and which it has continued to mitigate through its management actions are set out below. During the 2017-2018 year the risks facing the Trust in relation to the dispersal of services and dissolution of the Trust in connection with the planned transaction increased.

On an annual basis, as part of the Trust's risk management process, the strategically significant risks facing the Trust are comprehensively reviewed, also taking into account the trust's risk appetite statement. A revised and updated Board Assurance Framework, in its new format, was approved by the Board of Directors in January 2018.

As the approach to risk management is dynamic, it is not uncommon for risks to be regarded as strategically significant for a short time, which means that strategically significant risks may be included in the Board Assurance Framework at the request of an Executive Director outside of the usual Board / Board Committee reporting cycles.

The table below highlights the strategically significant risks the Board considered in March 2018, listed against the Trust's strategic objectives.

Board Assurance Framework - March 2018

Strategic Objective: To deliver high quality community services driven by a culture of continuous improvement and compliance with regulatory standards

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Assessments of risk Jul 17 – Jan 18)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
SR1.1	Quality	Improve care quality in an uncertain environment - There is a risk that the Trust is unable to continue to deliver high quality services and ensure quality improvements due to uncertainty regarding the future of LCH and the impact of this uncertainty on services.	Trish Bennett / David Fearnley	3	27-Jun-2017	9	9	6		-	31 Mar-2019	N/A	15 Mar 2018	No
SR1.2	Quality	Managing the Trust in Transition - If the Trust does not ensure sufficient capacity and staff engagement within corporate services during the transaction period then service delivery may be negatively impacted.	Neil Smith	4	24-Oct-2017	9	16	8		-	1-Apr-2018	N/A	15 Mar 2018	No
SR1.3	Reputational	Kirkup Review - There is a risk that the published Kirkup Report could impact negatively on staff morale and the Trusts reputation which may destabilise the	Joe Rafferty	3	01-Dec-2018	12	12	6	N/A	N/A	31 Mar-2018	N/A	15 Mar 2018	No

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Assessments of risk Jul 17 – Jan 18)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
		Trust.												
SR1.4	Quality	Quality Improvement - If there are limited resources dedicated to quality improvement in the organisation then quality improvement activity will be reactive and learning from safety incidents will be impaired. This may impact on the organisations ability to achieve a Good CQC rating	D Fearnley	4	27 Jan 18	12	12	4		-	Dec 18	Dec 18	31 Mar 18	No
SR1.5	Quality/ reputational	Kirkup Review - Failure of the Trust to deliver its Action Plan in response to the Kirkup Review recommendations may impact on the quality of the services provided by the Trust, resulting in harm to patients. This would lead to potential further regulatory actions against the Trust, resulting in damage to the Trust's reputation. [SR 1.5]	T Bennett	4	27 Feb 18	16	16	5	NEW	N/A	Dec 18	Dec 18	31 Mar 18	No

Strategic Objective: Prevention - We will empower people to self-care and improve their long term health and wellbeing

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Last 6 Assessments)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
SR2.1	Quality	Adding years to life and life to years – If the Trust is unable to engage with prevention agenda this will impact on delivery of the health promotion strategy of adding years to life and life to years	Trish Bennett / David Fearnley	3	27-Jun-2017	9	9	6			31 Mar-2019	N/A	15 Mar 2018	No

Strategic Objective: Supporting children - We will support children in growing up to become healthy adults

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Last 6 Assessments)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
SR3.1	Quality	The first 1000 days - If the Trust is unable to accelerate collaborative working, then children's services will not improve.	Trish Bennett / David Fearnley	4	27-Jun-2017	12	16	9			31 Mar-2019	N/A	15 Mar 2018	No

Strategic Objective: Family medicine - We will provide primary care "step up" and community services to support families to receive care closer to home

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Last 6 Assessments)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
SR4.1	Quality	Moving services closer to home - there is a risk that not appropriately caring for "at risk" populations in the most appropriate setting will compromise agenda of moving services closer to home.	Johanna Reilly	4	27-Jun-2017	12	12	8		-	31 Mar-2019	N/A	15 Mar 2018	No

Strategic Objective: To develop, engage and support our staff to provide great care for our community

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Last 6 Assessments)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
SR5.1	Quality	Workforce capability & resilience - If the Trust is unable to retain and engage the skilled workforce due to uncertainty regarding future workforce requirements then service improvements will not be delivered	Amanda Oates	4	27-Jun-2017	12	12	8		-	1-Apri-2018	N/A	15 Mar 2018	No
SR5.2	Quality / Financial	Workforce Culture & OD - There is a risk that inadequate resources in place to support staff wellbeing and OD	Amanda Oates	4	4	12	16	6		↑	31 Dec 18	N/A	31 Mar 2018	No

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Last 6 Assessments)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
		mechanisms will negatively impact staff wellbeing and morale which in turn, will impact on both individual and team performance and inadvertently impact on patient experience and outcomes												

Strategic Objective: To develop and deliver a sustainable strategic and operational plan

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Last 6 Assessments)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
SR6.1	Quality	Sustainable community services for Liverpool - If the Trust fails to deliver is operational and financial plan then there is a risk that sustainable community services may not be in place long term for the residents of Liverpool.	Neil Smith / Johanna Reilly	4	27-Jun-2017	16	12	12			1-Apri-2018	N/A	15 Mar 2018	No

Strategic Objective: Supporting winter - We will provide admission avoidance and safe discharge services to help people stay independent during the winter

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Last 6 Assessments)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
SR7.1	Quality/ Reputational	System wide winter plan - If the Trust fails to implement an effective winter plan across the system then it may be unable to meet the increased demand on services.	Johanna Reilly	3	27-Jun-2017	9	9	6		-	28-Feb-2018	N/A	15 Mar 2018	No

Strategic Objective: To develop with our key partners a patient and family centered model of care that integrates services along pathways

Reference	Risk Type	Title	Executive Owner	Impact	Date Identified	Initial Risk Rating	Current Risk Rating	Target Score	Spark Chart (Last 6 Assessments)	Current Trend	Target Date	Initial Target Date	Next Review Date	Tolerable Risk
SR8.1	Quality	Future service models - If the organisations' strategic options are not progressed in partnership with other appropriate organisations, then opportunities for improvement and future growth may be lost.	Joe Rafferty	5	27-Jun-2017	15	15	5		-	1-Apri-2018	N/A	15 Mar 2018	No

The control framework in place in Liverpool Community Health NHS Trust has a number of elements, including a Board Assurance Framework. In addition, there are a wide range of strategies, policies and procedures for all staff with training at all levels, including risk management training available for the Board, senior managers and staff.

The development of effective risk management across the organisation is underpinned by clear processes and procedures which include:

- Overarching strategic aims for risk management
- The Trust's Risk Management Strategy
- Organisational risk management objectives
- The organisational process for risk identification and analysis
- A definition of significant risk and acceptable risk within the organisation
- Organisational risk management structures
- The development and application of risk registers within the organisation
- Incident reporting
- The accountability and responsibility arrangements for risk management
- The Board Assurance Framework

The Board Assurance Framework (BAF) is a high level document used to inform and give assurance to the Board that the risks to the achievement of the Trust's principal organisational objectives have been identified, and that controls and assurances are in place to manage these risks. In 2017/18 the BAF has been reviewed, updated and discussed by the Trust Board frequently and was fundamentally re-written in December 2017 at the request of the Board.

All risks are logged within an online database (Datix) and moderated by responsible managers prior to reporting to appropriate audiences in teams, services and localities. Risks are escalated to responsible individuals and reported to management.

The Trust has a dynamic process of identifying risk in place with six new risks being identified each month and added into the risk register and a similar number being de-escalated and closed. At any single time there are approximately 80 'open' risks within the risk register.

Key components of mandatory training include infection control, fire safety, health and safety and information governance. These are delivered both via face-to-face training and e-learning packages and an overall improvement in mandatory training was achieved. All incidents are reported on the Datix system with all members of staff being able to access the system. Datix is supported with on-line training with the system being generally well understood by staff.

All incidents are rated for their severity with the opportunity for managers to adjust the severity score upon review. Through a 'Daily Datix' alert, all incidents from the previous day are sent to Care Managers for review. Care Managers occupy senior roles within the operational management. The incident reporting system is also used as a trigger to enable the Trust to meet its duty of candour duty through the identification and review of all moderate and above category of harm incidents.

The Trust's Incident Reporting Policy includes the management and investigation of serious incidents. Through Locality 'Being Open' meetings, all 'moderate +' incidents are reviewed. Serious incidents are identified and categorised in accordance with NHS guidance. In accordance with national requirements, every Serious Incident (which is reported on the STEIS system) is subjected to a root cause analysis.

The Trust has a cohort of staff trained in carrying out RCAs. A Serious Incident/Never Event Panel was established in 2015, which meets monthly to review all incidents and quality assure all RCAs. In addition a 'Weekly Meeting of Harm' reviews current incidents and is used to agree appropriate management action. All Serious Incidents and Never Events are reviewed by the Quality Committee and the Trust Board. In the last financial year, the Trust reported one 'Never Event' which occurred in June 2017. This related to a wrong site surgery (wrong tooth extraction).

Quality Governance

All three of the Trust's operating localities became further established during 2017/18 with clinical and management teams in place and services delivered in line with the Trust's governance and performance processes. The progress made towards integrated working and the formation of Community Care Teams (CCTs) will continue in 2017/18.

The provision of high quality patient care continues to be our main focus. LCH has reviewed all the data available on the quality of care in these services. The performance and quality of our services are reviewed through our performance and governance processes.

In addition, we have continued to hold 'Peer Review' sessions for those 'critical list' services that were identified as needing additional support in 2014/15 and 2015/16. These 'Peer Review' sessions involve Clinical Leads from the three localities work with service leads to gain confirmation of progress against service plans and identify services which are ready to return to normal monitoring within localities.

At locality level, governance and performance against quality domains are embedded with reporting arrangements in place up to the Board via the Quality Committee and monthly performance meetings.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by LCH in 2017/18.

Head of Internal Audit Opinion

In accordance with the Public Sector Internal Audit Standards, the Director of Internal Audit provided an annual opinion to the Board, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control).

This was achieved via a risk-based plan of work, agreed with management and approved by the Audit Committee. The programme provides a reasonable level of assurance, subject to the inherent limitations of internal audit (covering both the control environment and the assurance over controls). The opinion does not imply Internal Audit has reviewed all risks relating to the Trust. The findings are based upon and limited to the results of the internal audit work as set out in the 2017/18 Annual Audit Risk Assessment and Plan approved by the Audit Committee.

The internal audit reviews undertaken led to the Chief Internal Auditor providing a Moderate Assurance Opinion on the system of internal control in the Trust.

During the year, the focus of the internal audit programme was adjusted to ensure appropriate priority was allocated to issues of locality governance thereby better enabling management to ready services for safe, effective handover to other providers.

Specific attention will be required to ensure improvements are noted at service level given that a number of reviews in year (3) resulted in limited assurance, although it was also noted that the audit plan was directed towards these areas by management.

Other Regulatory Requirements

The Trust is fully compliant with the registration requirements of the Care Quality Commission. As part of the most recent Care Quality Commission inspection of Liverpool Community Health NHS Trust, an assessment of compliance with the well-led was undertaken. In addition, a series of key performance indicators are in place to monitor compliance with CQC domains including the well-led framework, performance against which is reported monthly to the Trust Board.

Whilst NHS Trusts are exempt from the requirement to apply for and hold the NHS Provider Licence, directions from the Secretary of State require the TDA (via NHSI) to ensure that NHS Trusts comply with conditions equivalent to the licence as the TDA

deems appropriate. The Board approved in May 2017, the necessary self-certifications as required by NHS Improvement and confirmed compliance with General condition 6 (G6) and condition FT4.

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

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

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

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

The Board, on a monthly basis, reviews the Trust's use of resources through the integrated performance report in addition to the monthly financial performance report which allows the Board to understand and scrutinise financial performance and cost effectiveness.

Where the Board identifies key risks and issues in relation to the Trust's use of resources, it will instruct the Planning and Performance Committee to undertake an in-depth review to ensure that a sufficient degree of assurance can be obtained.

The Planning and Performance Committee and the Executive Committee scrutinise financial performance at each meeting which includes key financial statements and operating performance.

The oversight role of the Board and its committees is supplemented by the annual internal audit programme which includes a comprehensive review of the Trust's financial systems and controls.

Processes have been implemented to ensure that resources are used economically, efficiently and effectively. At the beginning of the year budgets are scrutinised to ensure they represent an effective use of public funds and are signed off by the Trust Board. The budget setting processes are reviewed by Internal Audit and reported through the Audit Committee.

Information governance

Information Governance is the term used to describe the standards and processes for ensuring that organisations comply with the laws and regulations regarding handling and dealing with personal information.

Within the organisation there are clear procedures and processes to ensure that information, including patient information, is handled in a confidential and secure manner.

The individual within the Trust who is responsible for ensuring confidentiality of personal information is the Caldicott Guardian. In 2017/18 this designated individual was the Medical Director as follows:

- Dr Ann Hoskins (1 April 2017 to 30 April 2017)
- Dr Steve Ryan (1 May 2017 to 31 October 2017)
- Dr David Fearnley (1 November 2017 to 31 March 2018)

The Trust also has a Senior Information Risk Owner (SIRO) who is responsible for reviewing and reporting on identifying any information and providing assurance on the management of information risk to the Board. In 2017/18 this role was held by the Director of Finance as follows:

- Mrs Nora-Anne Heery [1 April 2017 to 30 April 2017]
- Mr John Grinnell [1 May 2017 to 31 October 2017]
- Mr Neil Smith [1 November 2017 to 31 March 2018]

Each year the Trust submits compliance scores to the Health and Social Care Information Centre using the NHS Information Governance Toolkit. The toolkit is an online system, which allows NHS organisations and partners to assess themselves against Department of Health information governance policies and standards.

It also allows members of the public to view progress on improving information governance standards. The Trust's Information Governance Toolkit overall score for 2017/18 was 66% and graded as an overall green rating.

The Trust reported 193 information governance incidents during 2017/18, three of which were graded with a high risk rating. There were two incidents which required to be reported to the Information Commissioner's Office (ICO). These are currently under investigation by the Trust. The Trust takes all data breaches and near-misses seriously and takes immediate action to mitigate the risk of high risk incidents reoccurring.

The Trust received 222 requests under the provisions of the Freedom of Information Act and 724 requests for health records under the Data Protection Act 1998 and Access to Health Records Act 1990.

Internal Audit undertook a review of the Trust IG Toolkit arrangements in February 2018. This review concluded with a significant assurance on the Trust's IG Toolkit submission.

The Trust utilises the Information Governance Toolkit to identify and manage information risks and reports incidents regularly to the Trust Board and its Committees. Data Security risks are managed through the risk register as part of a comprehensive framework of risk management concerning IM&T and Information Governance within the Trust.

Specific issues and risks are also raised through the Technology and Information Sub-Committee which reports to the Planning and Performance Committee, which in turn reports to the Trust Board. Assurance is also provided through a comprehensive programme of internal and external audit which provides assurance on the effectiveness of security controls. Data security risks are further managed through close working with the Informatics Merseyside Service, hosted by Mersey Care NHS Foundation Trust and through regular Information Security reviews.

Annual quality account

The Trust publishes a separate document called a Quality Account each year. It can be found on the Mersey Care website and is also available on request from: communications@merseycare.nhs.uk

The content of the Quality Account is taken from a wide range of data sources. The quality of each item of data is verified via internal performance monitoring systems and signed off by relevant service leads.

Data quality is assured by a regular review by Mersey Internal Audit Agency. The Trust's commissioners, local authority Health Overview and Scrutiny committees and local Healthwatch organisations also provide a statement about their own satisfaction with quality reporting and performance.

Update on Trust Quality Priorities 2017/18

Priorities for 17/18 were:

- Locality development and implementation of our clinical strategy delivery plan: 'Community care teams for joined up patient care implementation plan'
- Smooth organisational transition of staff and services to new organisations

- Update of the Trust's Strategic Operational Plan and associated plans following receipt of CQC report to address any issues identified

The following progress has been made in the last 12 months:

Locality working and the delivery of safe and effective services through an established locality model remain a priority for 2018/19. Significant progress has been made during 17/18:

- The three localities (North, Central & South Liverpool) have firmly embedded leadership and management teams in place. They are fully established with robust governance processes embedded

- All 12 neighbourhoods are facilitating community proactive care via their Community Care Teams to help reduce avoidable hospital admissions

- The Trust has continued to effectively respond to support the whole health system across the year. Additionally, Liverpool Clinical Commissioning Group (LCCG) is currently undertaking work on evaluating proactive care. It is of particular note that in October 2017, 1,500 patients had been supported on the proactive pathway as part of avoiding admission to hospital, and as a result of this admission levels to hospital have also reduced
- The Trust has supported the Liverpool City Council and Liverpool CCG Care Homes Strategy including training, facilitating proof of concept of the neighbourhood model, and also supporting the roll out of remote tele-med

The Trust's well-established Clinical Strategy Group oversees the implementation of the strategy and progress against key clinical quality initiatives.

From 1 April 2018, LCH will no longer exist as a stand alone organisation. All staff will be employed by Mersey Care NHS Foundation Trust and as such will work to associated strategies, priorities, policies and procedures.

To facilitate this, the Trust has agreed the following priorities:

- To support staff post transition on from the 1 April 2018

- To maintain business as usual post transition

- To work towards integration with Mersey Care services in relation to physical and mental health services

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the systems 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 we 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 the management letter and other report.

I have been advised on the implication of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality assurance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. Board committees and the managers and clinical leads within the Trust that have responsibility for the development and maintenance of the internal control framework.

The BAF provides the Board with summarised information about the effectiveness of controls that mitigate the risks to the organisation in achieving its strategic objective. In addition, the Director of Internal Audit provided me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the internal audit work.

The Internal Audit Review of the Board Assurance Framework for 2017/8 confirms that *"the organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board".*

The Board's view of the system of internal control is also informed by:

- Care Quality Commission Inspections
- Opinion and reports by Internal Audit, who work to a risk-based annual plan with topics that cover governance and risk management, and control, human resources, operational and other reviews
- Opinion and reports from our external auditors
- Delivery of audit plans External and Internal Auditors
- Department of Health performance requirements/indicators
- Monthly performance management reports to regulators
- Health & Safety Executive

- Results of national patient and staff surveys
- Information governance assurance framework including Information Governance Toolkit compliance
- Investigation reports and action plans following serious incidents requiring investigation
- Clinical audit reports
- Local Healthwatch engagement

The Trust retains the services of Mersey Internal Audit Agency (MIAA) to act as its Internal Auditors. During 2017/18, a total of eleven internal audit reports were issued of which one provided high assurance, nine provided significant assurance and one provided limited assurance.

The Audit Committee sought assurance from the Internal Auditor that all recommendations resulting from internal audit reviews were graded according to importance. All recommendations graded as 'high risk' were tracked and reviewed subsequently to confirm that remedial actions to address weaknesses in the design or operation of controls had been addressed.

There were no reviews, which received an assessment of 'No Assurance' in the reporting period.

Significant control issues

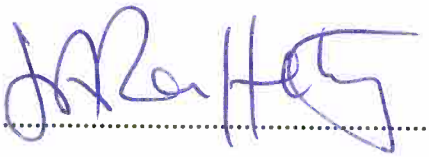
Kirkup Review:

The Kirkup Review, commissioned by NHS Improvement, was published on 8 February 2018 and sets out a series of recommendations. Publication of this report could undermine the integrity or reputation of Liverpool Community Health NHS Trust and as such, this has been reported in this annual report as a significant control issue.

Although the implications of many of these recommendations will likely impact on the majority of NHS organisations, LCH Board had approved (February 2018) its own Action Plan. In addition, given the serious nature of the findings of the Kirkup Review, the Trust's Chairman has requested that assurance on LCH's response to the review and delivery of the Trust's Action Plan be reported directly to the Trust Board, and not via any Board Committee. As such this Action Plan and the Trust's response to the Kirkup Review will be a standing agenda item for the Public Trust Board meetings.

A risk has also been added to the Board Assurance Framework as follows: "Failure of the Trust to deliver its Action Plan in response to the Kirkup Review recommendations may impact on the quality of the services provided by the Trust, resulting to harm to patients.

This would lead to potential further regulatory action against the Trust, resulting in damage to the Trust's reputation."



Date 24th May 2018

Joe Rafferty, CEO and Accountable Officer

2.2 REMUNERATION AND STAFF REPORT

Remuneration Report 2017/18

The organisation is required, under guidelines issued by the Department of Health and Social Care, to include in its Annual Report a Remuneration Report. The tables contained within the report together with the pay multiples paragraph are subject to External Audit opinion. There are some general points that need to be discussed, and more specific items that relate to individual officers and members. All officers and members who are named have given their permission for their details to be disclosed.

Remuneration Committee

This Committee's role is to review and approve the terms of service of Executive Directors, including the pay of the Chief Executive. However, given the requirements at various stages of the transaction process NHS Improvement has made a number of interim director appointments during the year.

The Committee consists of all Non-Executive Directors including the Chair of the Trust. The Chief Executive and the Interim Director of Human Resources attend the Committee by invitation. The Chief Executive or Executive Directors do not however attend where matters under discussion pertain to their personal conditions of service. The Committee met on four occasions throughout 2017/18.

Further details concerning the Remuneration Committee and its membership can be found within the Annual Governance Statement.

Remuneration Policy

The remuneration of the Chairman and Non-Executive Directors is set in accordance with the levels provided by NHS Improvement. The Remuneration Committee sits to review all changes to pay and conditions of Executive Directors. The Chairman's remuneration is based on the banding relating to the relative size of the Trust's annual turnover.
The remuneration of senior managers is based on guidance from the Department of Health for Very Senior Managers (VSM) and where relevant the NHS Improvement

The current contracts do not require any performance related elements which would impact on the remuneration packages.

Organisation Transaction – Management Contracts

During the 2017/18 financial year there were a number of changes to those holding executive and non-executive roles in the Trust which followed the three discrete stages of transaction delivery. They were:

- April 2017. Interim Executive and Non-Executives remained in post during April 2017

- May 2017 - October 2017. Following the decision to retract the decision made regarding the original preferred bidder a management contract was introduced by NHS Improvement involving Chairman and Non-Executives from Alder Hey Children's NHS Foundation Trust fulfilling roles at the Trust. The management contract also saw Chief Executive, Director of Nursing, Medical Director, Director of Workforce and Director of Finance from Alder Hey Children's NHS Foundation Trust taking up equivalent roles at the Trust. During this transition the Chief Operating Officer remained in post at the Trust along with two Non-Executive Directors. The previous interim Director of Nursing, interim Medical Director and interim Director of Finance remained employed by the Trust in advisory roles (i.e. no longer holding a director role) during May and June 2018, at which point they were no longer employed by the Trust

- October 2017 – March 2018. Following the identification of preferred bidder a second management contract was introduced by NHS Improvement involving Chairman and Non-Executives from Mersey Care NHS Foundation Trust at the Trust. The management contract also saw Chief Executive, Director of Nursing, Medical Director, Director of Workforce and Director of Finance from Mersey Care NHS Foundation Trust taking up equivalent roles at the Trust. During this transition the Chief Operating Officer remained in post at the Trust along with two Non-Executive Directors

The terms of both management contracts saw Chairman and Non-Executives appointments reflect remunerated roles. Executive Director roles in both management contracts were not remunerated roles as reflected in the tables below. Information regarding the remuneration of all Executives employed under the terms of both management contracts can be seen in the Annual Report and Accounts for each of the respective Foundation Trusts.

Remuneration of Executive and Non-Executive Directors

The following table summarises the key terms in contracts for Executive Directors in post at 31 March 2018:

Name	Position	Contract date (or date of appointment)	Contract	End Date	Unexpired term	Notice period	Early termination provision
Joe Rafferty	Chief Executive	01/11/2017	Interim – Management Contract	31/03/2018	Nil	N/A	N/A
Johanna Reilly	Chief Operating Officer	31/03/2016	Permanent	N/A	N/A	3 months	None
Amanda Oates	Executive Director of Workforce	01/11/2017	Interim – Management Contract	31/03/2018	Nil	N/A	N/A
Trish Bennett	Executive Director of Nursing	01/11/2017	Interim – Management Contract	31/03/2018	Nil	N/A	N/A
David Fearnley	Medical Director	01/11/2017	Interim – Management Contract	31/03/2018	Nil	N/A	N/A
Neil Smith	Executive Director of Finance	01/11/2017	Interim – Management Contract	31/03/2018	Nil	N/A	N/A

Notes
With the exception of the Chief Operating Officer who is a permanent appointment with the Trust all other Executive Directors contract end dates reflect the terms of the management contract with Mersey Care NHS Foundation Trust. From the 1 April 2018 Executive leadership for those services previously provided by the Trust transferred to the current Mersey Care NHS Foundation Trust Executive Team.

The following table summarises the key terms in contracts for non-Executive Directors in post at 31 March 2018:

Name	Position	Term of office	Unexpired term	Early termination provision
Beatrice Fraenkel	Chairman	01/11/2017 – 31/03/2018 (Management Contract)	Nil	None
Tony Allen	Non-Executive Director	01/05/2016 – 31/03/2018	Nil	None
Karen Fielding	Non-Executive Director	01/11/2015 – 31/03/2018	Nil	None
Gerry O'Keeffe	Non-Executive Director (Senior Independent Director)	01/11/2017 – 31/03/2018 (Management Contract)	Nil	None
Pamela Williams	Non-Executive Director	01/11/2017 – 31/03/2018 (Management Contract)	Nil	None

Notes
All Non-Executive Directors contract end dates reflect the terms of the management contract with Mersey Care NHS Foundation Trust or the contracts in place for individual. From the 1 April 2018 Board

responsibility and accountability for those services previously provided by the Trust transferred to the current Mersey Care NHS Foundation Trust Board of Directors.

Remuneration Report: Executive & Non-Executive Directors

The following three tables, together with the pay multiple disclosure, have been subject to audit.

a. Executive and Non-Executive Director Salaries and Allowances 1 April 2017 to 31 March 2018.

Name	Title	Salary Bands (bands of £5k)	Expense payments (taxable payments to the nearest hundred)	Performance pay and bonuses (bands of £5k)	Longer term performance and pay bonuses (bands of £5k)	All pension related benefits (bands of £2500)'	Total remuneration (bands of £5k)
		£000	£00	£000	£000	£000	£000
Trevor Lake (from 1 April 17 – 30 April 17)	Chair	0 - 5	6	0	0	0	0 - 5
Sir David Henshaw (from 1 May 17 – 31 October 17) (1)	Chair (Alder Hey Management Contract)	10 - 15	5	0	0	0	10 - 15
Beatrice Fraenkel (from 1 November 17 – 31 March 18) (2)	Chair (Mersey Care Management Contract)	5 - 10	0	0	0	0	5 - 10
Michael Roach (from 1 April 17 – 30 April 17)	Non-Executive Director	0 - 5	8	0	0	0	0 - 5
Geoffrey Rossington (from 1 April 17 – 30 April 17)	Non-Executive Director	0 - 5	2	0	0	0	0 - 5
Valerie Davies (from 1 April 17 – 30 April 17)	Non-Executive Director	0 - 5	3	0	0	0	0 - 5
Anthony Allen	Non-Executive Director	5 - 10	5	0	0	0	5 - 10
Karen Fielding	Non-Executive Director	5 - 10	2	0	0	0	5 - 10
Steve Igoe (from 1 May 17 – 31 October 17) (1)	Non-Executive Director (Alder Hey Management Contract)	0 - 5	0	0	0	0	0 - 5

Anita Marsland (from 1 May 17 – 31 October 17) (1)	Non-Executive Director (Alder Hey Management Contract)	0 - 5	0	0	0	0	0 - 5
Dame Jo Williams (from 1 May 17 – 31 October 17) (1)	Non-Executive Director (Alder Hey Management Contract)	0 - 5	0	0	0	0	0 - 5
Robert Beardall (from 1 October 17 – 5 March 18) (2) (3)	Non-Executive Director (Mersey Care Management Contract)	0 - 5	0	0	0	0	0 - 5
Gerald O'Keeffe (from 1st October 17 – 31st March 18) (2)	Non-Executive Director (Mersey Care Management Contract)	0 - 5	0	0	0	0	0 - 5
Pamela Williams (from 1 October 17 – 31 March 18) (2)	Non-Executive Director (Mersey Care Management Contract)	0 - 5	0	0	0	0	0 - 5
Sue Page (from 1 April 17 – 30 April 17) (4)	Interim Chief Executive	10 - 15	0	0	0	0	10 - 15
Louise Shepherd (from 1 May 17 – 31 October 17) (1)	Chief Executive (Alder Hey Management Contract)						
Joe Rafferty (from 1st November 17 – 31st March 18) (2)	Chief Executive (Mersey Care Management Contract)						
Johanna Reilly	Chief Operating Officer	110 - 115	0	0	0	0	110 - 115
Nora-Ann Heery (from 1 April 17 – 31 May 17) (5)	Interim Director of Finance	155 - 160	0	0	0	0	155 - 160
John Grinnell (from 1 May 17 – 31 October 17) (1)	Director of Finance (Alder Hey Management Contract)						
Neil Smith (from 1 November 17 – 31 March 18) (2)	Executive Director of Finance (Mersey Care Management Contract)						
Melissa Swindell (from 1 May 17 – 31 October 17) (1)	Director of Human Resources (Alder Hey Management Contract)						

Amanda Oates (from 1 November 17 – 31 March 18) (2)	Executive Director of Workforce (Mersey Care Management Contract)						
Moira Angel (from 1 April 17 – 30 April 17 as Director) (6)	Interim Director of Nursing	20 - 25	0	0	0	0	20 - 25
Hilda Gwilliams (from 1 May 17 – 31 October 17) (1)	Director of Nursing (Alder Hey Management Contract)						
Trish Bennett (from 1 November 17 – 31 March 18) (2)	Executive Director of Nursing (Mersey Care management Contract)						
Dr Ann Hoskins (from 1 April 17 – 30 April 17 as Director) (7)	Interim Medical Director	10 - 15	0	0	0	0	10 - 15
Dr Steve Ryan (from 1 May 17 – 31 October 17) (1)	Medical Director (Alder Hey Management Contract)						
Dr David Fearnley (from 1 November 17 – 31 March 18) (2)	Medical Director (Mersey Care Management Contract)						
Mark Graham (from 1 April 17 – 14 April 17) (8)	Director of Communications	55 – 60	0	0	0	0	55 - 60
Paul Lehmann (from 15 April 17 – 30 November 17) (9)	Director of Communications	105 - 110	0	0	0	0	105 - 110

Notes:

1. Executive and non-Executive Directors holding role under the terms of the Alder Hey Children's NHS Foundation Trust Management Contract between 1 May 2017 – 31 October 2017. . Information regarding the remuneration of all executives and non-executives employed under the terms of this management contract can be seen in the Annual Report and Accounts for Alder Hey Children's NHS Foundation Trust.
2. Executive and non-Executive Directors holding role under the terms of the Mersey Care NHS Foundation Trust Management Contract between 1 October 2017 – 31 March 2018. Information regarding the remuneration of all executives and non-executives employed under the terms of this management contract can be seen in the Annual Report and Accounts for Mersey Care NHS Foundation Trust.
3. Rob Beardall left his role as non-Executive Director with the Trust ahead of the Management Contract end date with Mersey Care NHS Foundation Trust.
4. Sue Page left the Trust on 30 April 2017 and received a payment to reflect annual leave that had not been taken ahead of her leave date. This is reflected in the salary figures above.
5. Nora Ann Heery received additional payments to reflect 26.25 additional hours worked during 2017/18 that were additional to her contracted three days per week. The Director of Finance role ceased on 30 April but she subsequently acted as an advisor to the Board until 31 May 2017. She also received a redundancy payment of

£144,000 (within the £100,001 - £150,000 payment range) which is reported in the Exit Packages disclosure within the Staff Report. Both additional hours payments and redundancy payment are reflected in the salary figures above.

6. Moira Angel received additional payments to reflect 114 additional hours worked during 2017/18 that were additional to her contracted three days per week. The Director of Nursing role ceased on 30 April however she subsequently acted as an advisor to the Board until 30 June 2017. This is reflected in the salary figures above.
7. Ann Hoskins received additional payments to reflect 22 additional hours worked during 2017/18 that were additional to her contracted two days per week. This is reflected in the salary figures above.
8. Mark Graham received a redundancy payment of £52,419 (within the £50,001 - £100,000 payment range) which is reported in the Exit Packages disclosure within the Staff Report. This is reflected in the salary figures above.
9. Paul Lehmann was contracted as the Director of Communications employed through an Agency, Gatenby Sanderson. His invoiced costs are included in the table above.
10. Expenses payments made to Trevor Lake, Michael Roach, Geoffrey Rossington, Valerie Davies, Tony Allen and Karen Fielding include travel and car parking costs incurred when attending meetings on behalf of the Trust.
11. The Director of Workforce role remained vacant during April 2017. The post was filled by Melissa Swindell upon the commencement of the management contract with Alder Hey Children's NHS Foundation Trust.

b. Executive and Non-Executive Director Prior Year Comparators of Salaries and Allowances 1 April 2016 to 31 March 2017

Name	Title	Salary (Bands of £5,000)	Expense payments (taxable) total to nearest £hundred)	Performance pay and bonuses (Bands of £5,000)	Long term performance pay and bonuses (Bands of £5,000)	All pension-related benefits (Bands of £2,500)	Total remuneration (Bands of £5,000)
		£000	£00	£000	£000	£000	£000
Trevor Lake	Chair	20-25	5100	0	0	0	25-30
Tony Allen (from 1 May 2017)	Non-Executive Director	5-10	600	0	0	0	5-10
Farath Arshad (from 22 March 16 to 30 September 2016) (1)	Non-Executive Director	0-5	400	0	0	0	0-5
Valerie Davies	Non-Executive Director	5-10	1100	0	0	0	5-10
Karen Fielding	Non-Executive Director	5-10	0	0	0	0	5-10
Michael Roach	Non-Executive Director	5-10	0	0	0	0	5-10
Geoffrey Rossington (from 1 October 2016)	Non-Executive Director	5-10	1300	0	0	0	5-10
Sally Anne Watkiss (to 31 May 2016)	Non-Executive Director	0-5	0	0	0	0	0-5
Sue Page (2)	Interim Chief Executive	135-140	0	0	0	0	135-140
Johanna Reilly (3)	Chief Operating	110-115	0	0	0	37.5-40	150-155

	Officer						
Nora Ann Heery (4)	Interim Director of Finance	80-85	0	0	0	0	80-85
Therese Harvey (to 14 July 2016) (5)	Interim Director of Human Resources	40-45	0	0	0	7.5-10	45-50
Julie Cooper (from 14 August 2016) (6)	Interim Director of Human Resources	105-110	0	0	0	0	105-110
Carole Panteli (to 2 August 2016)	Interim Director of Nursing	30-35	0	0	0	0	30-35
Moira Angel (from 1 August 2016) (7)	Interim Director of Nursing	50-55	0	0	0	0	50-55
Ann Hoskins (from 1 August 2016) (8)	Interim Medical Director	25-30	0	0	0	0	25-30
Mark Graham	Director of Communication	80-85	0	0	0	15-17.5	95-100

Notes

1. Farath Arshad received remuneration to reflect arrears in 2016/17 of £165 in relation to the period 22 March 2016 – 31 March 2016.
2. Sue Page had a period of unpaid leave between 7 January and 22 February 2017 inclusive.
3. Johanna Reilly became an employee of the Trust on 1 April 2016. Johanna Reilly received acting up pay for the 5-week period while Sue Page was on leave during January and February 2017.
4. Nora Ann Heery received additional payments to reflect 20.5 additional days worked during 2016/17 that were additional to her contracted three days per week.
5. Therese Harvey left the Trust on 14 July 2016 and received a payment in lieu of notice to reflect four weeks salary. This payment in lieu of notice is reflected as one of the six cases reported within the Exit Packages disclosure on page 67 of this report.
6. Julie Cooper was engaged by the Trust in advance of moving into the role of Interim Director of Human Resources on 14 August 2016. The Trust engaged Julie initially through an agency and later through JSC Consultancy Ltd.
7. Moira Angel was contracted to work three days per week. Moira received additional payments to reflect 12 additional days worked during 2016/17 that were additional to her contracted three days per week.
8. Ann Hoskins was contracted to work two days per week.
9. Expenses payments made to Trevor Lake, Tony Allen, Fareth Arshad, Valerie Davies and Geoffrey Rossington include travel and car parking costs incurred when attending meetings on behalf of the Trust.

c. Pensions Benefits: Executive Directors - 1 April 2017 to 31 March 2018

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
Sue Page	Interim Chief Executive	0	0	0	0	0	0	0	0
Louise Shepherd (1)	Chief Executive (Alder Hey Management Contract)								
Joe Rafferty (2)	Chief Executive (Mersey Care Management Contract)								
Johanna Reilly	Chief Operating Officer	0 - 2.5	0 - 2.5	30 - 35	95 - 100	655 – 660	40 – 45	695 - 700	0
Nora-Ann Heery	Interim Director of Finance	0	0	30 - 35	100 - 105	1155 - 1160	0	745 - 750	0
John Grinnell (1)	Director of Finance (Alder Hey Management Contract)								
Neil Smith (2)	Executive Director of Finance (Mersey Care Management Contract)								
Melissa Swindell (1)	Director of Human Resources (Alder Hey Management Contract)								
Amanda Oates (2)	Executive Director of Workforce (Mersey Care NHS Foundation Trust)								
Moira Angel	Interim Director of Nursing	0	0	0	0	0	0	0	0
Hilda Gwilliams (1)	Director of Nursing (Alder Hey Management Contract)								

Trish Bennett (2)	Executive Director of Nursing (Mersey Care NHS Foundation Trust)								
Ann Hoskins	Interim Medical Director	0	0	0	0	0	0	0	0
Steve Ryan (1)	Medical Director (Alder Hey Management Contract)								
David Fearnley (2)	Medical Director (Mersey Care Management Contract)								
Mark Graham	Director of Communications	0	0	15 - 20	0	180 - 185	10 - 15	195 - 200	0
Paul Lehmann	Director of Communications	0	0	0	0	0	0	0	0

Notes

1. Executive Directors holding role under the terms of the Alder Hey Children's NHS Foundation Trust Management Contract between 1 May 2017 – 3 October 2017. Information regarding the Pension Benefits of Executive Directors employed under the terms of this management contract can be seen in the Annual Report and Accounts for Alder Hey Children's NHS Foundation Trust.
2. Executive Directors holding role under the terms of the Mersey Care NHS Foundation Trust Management Contract between 1 October 2017 – 31 March 2018. Information regarding the Pension Benefits of Executive Directors employed under the terms of this management contract can be seen in the Annual Report and Accounts for Mersey Care NHS Foundation Trust.

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members. No other pensions' contributions have been made where employees have opted out of the NHS Pension scheme.

Pension Related Benefits

Pension related benefits, includes increases in benefits arising in the year from participating in pension schemes. These are the aggregate input amounts, calculated using the method set out in Section 229 of the Finance Act 2004(1). Any contributions by the employee in the period, or transferred in amounts, are excluded from this figure.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 200824.

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

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement, which the individual has transferred to the NHS Pension Scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Pay Multiples

Reporting bodies are required to disclose the relationship between the total remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The mid-point of the banded remuneration of the highest paid Director of Liverpool Community Health NHS Trust in the financial year 2017/18 was £112,500 (2016/17, £142,500). This was 3.9 times (2016/17, 5.01) the median remuneration of the workforce, which was £28,746 (2016/17, £28,462).

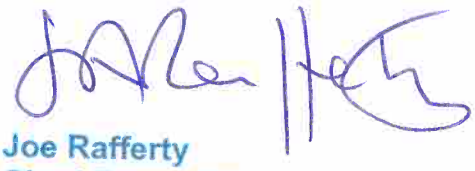
In 2017/18, nil (2016/17, nil) employees received remuneration in excess of the highest-paid Director. Remuneration ranged from £15,404 to £111,000 (2016/17 £6,096-£142,400).

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.

The 2017/18 Pay Multiple has reduced significantly. This is as a consequence of the midpoint of the banded remuneration of the highest paid employee reducing whilst the

median salary has marginally increased in line with nationally agreed pay award and incremental progression. The reduction in the remuneration of the highest paid director reflects the executive arrangements described earlier in the Remuneration Report and the fact that a number of the executive roles carried no salary cost to the Trust

Signed:



Joe Rafferty
Chief Executive

2.3 STAFF REPORT

Supporting our staff Trust Workforce Plan

Transaction

During the year 2017/18 we have seen a huge amount of change to the services and the workforce. Following the initial decisions from NHS Improvement and the Liverpool Clinical Commissioning Group the Trust was advised it would be broken up and staff would TUPE across to 13 different providers. However as this exercise was being undertaken a revised decision was made to retender the remaining bulk of services to a revised provider with a set of criteria which included being an NHS Entity and local to the Liverpool region.

During April 2017 through to June 2017 a number of services were transacted to eight providers as detailed in the table below:

Transfer of Services Table

Service	Staff WTE	Date of Transfer	New Provider
Children's Services	167	01/04/2017	North West Boroughs Healthcare Foundation Trust (0-19)
Diabetes Service	8	01/04/2017	Aintree University Hospital NHS Foundation Trust
Paediatric SALT & Community Matrons	138	01/04/2017	Alder Hey Children's NHS Foundation Trust
Anticoagulation Service	23	01/04/2017	Royal Liverpool and Broadgreen University Hospitals NHS Trust
Stop Smoking	10	01/04/2017	Solutions 4 Health
SARC (Sexual Abuse Referral Centre)	2	01/05/2017	Central Manchester NHS Foundation Trust
Heart Failure Service	2	01/05/2017	Virgin Care
Paediatric Therapies	57	01/06/2017	North West Boroughs Healthcare Foundation Trust (MC)
South Sefton Core Services	415	01/06/2017	Mersey Care NHS Foundation Trust
Radiology, HIV & TB Services	62	01/06/2017	Royal Liverpool and Broadgreen University Hospitals NHS Trust

During October 2017 it was announced that a decision had been reached to transfer the remainder of the organisation to Mersey Care NHS Foundation Trust. The transfer is due to take place on the 1 April 2018 and Liverpool Community Health NHS Trust will no longer exist as of 1 April 2018.
A total of 2051 staff remain in LCH currently working across three Liverpool Localities will move under the interim management of Mersey Care NHS Foundation Trust. It is hoped that this amalgamation of NHS Services being Community and Mental Health will enhance the patient experience across the community setting.

Care Quality Commission

The workforce has continued to engage with the Care Quality Commission and a further visit took place during February 2018. It is hoped it will continue to recognise the hard work and improvements staff have continued to make throughout 2017/18.

Continuation of the growth of the Community Intensive Care Team

During 2016 /17 the Trust supported the transformation of its bed based model into a multi -disciplinary team of health care professionals working in a community based setting. Initially there were a number of challenges, but due to the dedication and commitment of the staff working very closely with various partners including GPs and acute hospitals the delivery has become very successful and has assisted in the prevention of a number of patients being admitted to hospital.

As the success continues the Trust has seized the opportunity to work with other groups of internal staff from its out of hours and discharge planning services, to further enhance a smoother patient journey for the different packages of care available to patients.

In order to ensure this is fully achieved, further workforce modelling is currently taking place looking into skill mix requirements, shifts patterns and working hours..

The following table outlines the key changes to the Trust's workforce over the year:

Staff in Post by Locality - March 2018	FTE	Headcount
Staff In Post		
830 LCH Central Locality	518.42	613
830 LCH Corporate Services	120.58	145
830 LCH North Locality	612.21	714
830 LCH Nurse-Led Services	36.27	41

830 LCH South Locality	454.89	538
Grand Total	**1,742.37**	**2,051**

Ethnic Split	Headcount
Ethnicity	
Asian or Asian British	24
Black or Black British	28
Mixed	27
Not Stated/Undefined	58
Other Ethnic Groups	15
White	1899
Grand Total	**2,051**

Gender Split	Headcount by Month		2018 / 01
Gender	**Female**	**Male**	**Grand Total**
All other Staff	1732	204	1936
Senior Manager	89	19	108
VSM	5	2	7
Grand Total	**1826**	**225**	**2051**

*This includes any VSMs that were employed by the Trust during 2017/18.

Partnership working

During the last 12 months many services and staff have continued to transfer to different providers. The last 12 months has presented a significant period of change for the Trust, during which it has remained firmly committed to sustaining good employee relations and maintaining a constructive relationship with Staffside/Trade Unions. Work has continued

during the year with Staffside over the review of the effectiveness of relationships and adherence with the core principles agreed in 2015/16.

Staffside and management worked collaboratively to co-ordinate activities associated to the 2015/16 staff survey action plan. These activities included engagement events with staff and the development of team charters.

Staff Survey

The NHS Staff Survey was launched in September 2017 and by the end of the return date on 1 December 2017, the Trust response rate was 40.3%.

The survey provided staff with an opportunity to continue to feedback on what we do, how we do it and how we can do it better. This feedback is very important and will help us to refine our focus.

The strategic ambition is for staff to recommend the Trust as:

- An employer of choice: and/or
- Treatment to friends and family

Highlights from the report include:

- A significant improvement in the number of staff who would recommend Liverpool Community Health as a place to work or receive treatment
- An 11% increase in the number of staff who agree that care of patients/service users is the organisation's top priority
- Whilst the Trust acknowledges the challenges faced in relation to sickness absence, the survey results highlight that the number of staff feeling unwell due to work related stress in the last 12 months is significantly lower than the national average for Community Trusts

The results of the 2017 LCH staff survey will feed in to the wider Mersey Care action planning processes to ensure a consistent approach across all staff groups. Robust action plans will be developed and cascaded within all divisions as part of Mersey Care's strategic People Plan.

A 2017/18 Staff Survey Action Plan is being developed in line with the existing plans and strategies in place in Mersey Care, including the Organisational Effectiveness Plan, Staff Engagement Plan, Health and Wellbeing Plan and Leadership Plan. Localities will develop their own locality action plans.

Staff Health & Wellbeing

Liverpool Community Health is fully committed to ensuring a range of opportunities exist to support staff in maintaining their health and wellbeing. A motivated, happy and healthy workforce underpins positive service delivery and patient experience.

Throughout the last year the Trust has continued to ensure its health and wellbeing strategy has been implemented across the services and staff. It is also acknowledged that whilst sickness has remained higher than the set target, recognition has to be given to the ongoing journey of transition in to another NHS trust and the change impact felt by staff.

A Health and Wellbeing group has been operating on a regular basis under the sickness absence strategy and has reviewed and improved both processes and systems. Local working groups have been striving to improve support and positive working relations across wider staff groups facing similar personal and work base challenges in difficult situations.

Stress Packs – detailing guidance and advice for managers to work with employees to support them at such times.

Following steady improvements in response through the staff survey on the health and wellbeing section. Below are some of the achievements reached this year:

- Continued delivery of the organisational workforce Health and Wellbeing Strategy which enables the Trust to support a healthier workforce by creating the right conditions and environment for staff to deliver services and do their job to a high standard

- Achieved the flu vaccination target of 70% of all employed staff being vaccinated. This means a safer environment for patients receiving treatment and protection for staff as they deliver care in the community. The Trust hasalso achieved the 70% CQUIN target set locally from the commissioners

- Following on from the previous year 90% of staff who accessed the Staff Physiotherapy Service remained in work and did not result in absence

- The majority of staff who have accessed the long-standing Staff Support Counselling Service have remained in work, though throughout the year demand increased

- Investment in (EAP) the Employment Assistance Programme was implemented based on the demand for staff support services, and proved to be very successful. The programme offers a vast range of support on various issues

Safer Staffing

Liverpool Community Health NHS Trust takes the quality and care of our patients very seriously and already use a number of mechanisms and professional judgements to ensure that services are safely staffed and are able to escalate any issues.

The approach to safer staffing takes into consideration the evolving national guidance and also the daily fluctuating demand for services.

The Trust will move into alignment with Mersey Care staffing reviews after transfer and report findings through governance and performance routes.

Throughout 2017/18 LCH has not been able to maintain engaging solely with agency workers within the agreed rates, also not maintaining engagement with framework agencies only. This is due to demand for disciplines in short supply across the country. The need to engage with these workers/agencies is to maintain safer staffing levels across all disciplines.

Medical Appraisal and Revalidation

As a Designated Body, the Trust has a trained and registered a Responsible Officer (RO) who oversees Medical Appraisal and Revalidation; this is a statutory role. There is identified Human Resources and Governance support to enable the RO to fulfil their duties.

The Trust is classed as a 'small' Designated Body with less than 30 doctors directly linked to LCH as their Designated Body. All of these doctors undergo an annual appraisal, and all have a defined date for revalidation. All other doctors who work for, or are employed by, LCH but are not directly linked to it as their Designated Body (there is a prescribed hierarchy for doctors being linked to a Designated Body that is determined by the General Medical Council – GMC), including all locums, have their appraisal and revalidation details logged with the Trust before they undertake any work on behalf of the Trust.

Any concerns about doctors who undertake work for LCH but are linked to another Designated Body, e.g. GPs, are shared with the RO for their Designated Body. This ensures that concerns about any doctor are appropriately shared and acted upon.

The Annual Organisational Audit (for Medical Appraisal and Revalidation) collates all the necessary information regarding all doctors who work for the Trust, and this forms the main part of the assurance for the Board in the new annual Board report on Medical Appraisal and Revalidation.

Fit and Proper Person

In January 2018 the CQC has issued revised guidance for providers and CQC inspectors in respect of regulation 5 of the 2014 regulations. The guidance places ultimate responsibility on the Chairman to discharge the fit and proper person responsibilities of the Trust, for both existing and new directors, and confirms how the CQC expects these matters to be handled. The systems and processes used by the Trust ensure that we follow the regulations and guidance.

Specifically, the CQC has made a minor change to its guidance to make it explicit that they expect providers to undertake an 'enhanced DBS for Directors to check that they are not on the children's and/or safeguarding barred list' where they meet the eligibility criteria. Directors are eligible for such an enhanced DBS if the role they fulfil falls in to the definition of 'regulated activity' as defined by the Safeguarding Vulnerable Groups Act 2006.

In early 2015 LCH board agreed the scope for those persons it would regard as being subject to the fit and proper person test as:

- Applicable to all directors and 'equivalents'. This will include **Executive and Non-Executive Directors** of NHS Trusts and any member of staff who sits on the Board regardless of their voting rights

It is proposed that following the new guidance and on acquisition that any new arrangements agreed by Mersey Care will include the LCH division. FPPT will include:

- The Chief Executive, Executive Directors and non-voting board members
- Trust Secretary
- Associate Medical Directors and Chief Operating Officers of the clinical divisions

Liverpool Community Health continues to conform with FPPR, although new processes will be implemented to support the new CQC guidance.

Sickness Absence Rates

The Trust's revised sickness absence target for 2017/18 was revised and increased to 5.2% following the previous annual Trust's average of 6.9%.

The Sickness Absence reduction strategy was reviewed and updated during 2017/18. The strategy continues to focus on prevention of absence by the various measures available for staff to utilise.

During the last year the Trust has seen a focus on mental health and stress and as part of the support, the Human Resources Team has produced a stress-related support pack for staff and managers to work through, as well as setting up an Employee Assistance

Programme for staff to access. The programme offers a range of support including guidance and advice on a variety of matters as well as instant access to counselling and other therapies.

Programmes continue for staff across the Trust and up take has been good. As a result staff have continued to feel a marked improvement in team working environments and it has empowered individuals to use the skills learnt to deal with difficult situations and support colleagues, not only within their immediate team, but across the organisation.

Off Payroll Engagements

There were nil off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months.

Exit Packages

The table below, which is subject to external audit, provides details about payments on termination of employment for 2017/18:

Exit package cost band (including any special payment element)	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
	No.	£000	No.	£000	No.	£000	No.	£000
<£10,000	3	17	13	35	16	52	0	0
£10,000 - £25,000	4	85			4	85	0	0
£25,001 - 50,000	2	89			2	89	0	0
£50,001 - £100,000	1	52			1	52	0	0
£100,001 - £150,000	1	144			1	144	0	0
£150,001 - £200,000					0	0	0	0
>£200,000					0	0	0	0
Total	11	387	13	35	24	422	0	0

Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS

Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

The table below provides an additional breakdown of the total exit package payment made following non-compulsory departures of staff. The table reports the number and value of exit packages agreed to the year.

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	No.	£000	No.	£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 *	13	35	6	27
Exit payments following employment tribunals or court orders	0	0	1	2
Non-contractual payments requiring HMT approval **	0	0	0	0
Total**	13	35	7	29

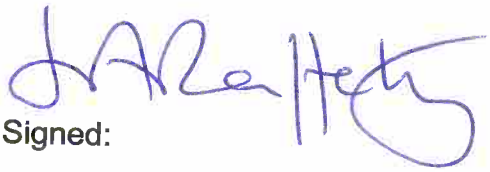
* any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" below.
**includes any non-contractual severance payment made following judicial mediation,.

None of the non-contractual payments made to individuals exceeded 12 months' of their annual salary.

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total number of individuals.

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note xx which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

Signed: 

Joe Rafferty
Chief Executive

3. Parliamentary accountability and audit report

Independent auditor's report to the Directors of Mersey Care NHS Foundation Trust in relation to Liverpool Community Healthcare NHS Trust

Report on the Audit of the Financial Statements of Liverpool Community Healthcare NHS Trust

Opinion

We have audited the financial statements of Liverpool Community Healthcare NHS Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including the accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Who we are reporting to

This report is made solely to the Directors of Mersey Care NHS Foundation Trust, as a body, in respect of Liverpool Community Healthcare NHS Trust, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of Mersey Care NHS Foundation Trust those matters we are required to state to them in an auditor's report in respect of Liverpool Community Healthcare NHS Trust and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than Mersey Care NHS Foundation Trust and the Directors of Mersey Care NHS Foundation Trust as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- 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.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, , which is not modified, we draw attention to note 1.1.2 in the financial statements, which indicates that Mersey Care NHS Foundation Trust took over Liverpool Community Healthcare NHS Trust's services and that Liverpool Community Healthcare NHS Trust ceased to exist on 1 April 2018.[LHC1]

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report of Liverpool Community Healthcare NHS Trust, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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 course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements 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 in this regard.

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

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement of Liverpool Community Healthcare NHS Trust does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report of Liverpool Community Healthcare NHS Trust to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report of Liverpool Community Healthcare NHS Trust for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters for Liverpool Community Healthcare NHS Trust**.**

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors of Mersey Care NHS Foundation Trust are responsible for the preparation of the financial statements of Liverpool Community Healthcare NHS Trust in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors 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 Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

Report on other legal and regulatory requirements – Conclusion on Liverpool Community Healthcare NHS Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

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

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that Liverpool Community Healthcare NHS Trust has made 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 in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report 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 review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Liverpool Community Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Smith

Andrew Smith, Director

for and on behalf of Grant Thornton UK LLP

4 Hardman Square

Manchester

M3 3EB

25 May 2018

4. Financial statements and notes to the annual accounts

Liverpool Community Health NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	93,193	127,303
Other operating income	4	4,178	3,473
Operating expenses	5, 7	(96,779)	(131,794)
Operating surplus/(deficit) from continuing operations		**592**	**(1,018)**
Finance income	10	39	37
Finance expenses	11	(2)	(1)
PDC dividends payable		(97)	(114)
Net finance costs		**(60)**	**(78)**
[1]Gains / (losses) arising from transfers by absorption		(5,643)	-
Surplus / (deficit) for the year from continuing operations		**(5,111)**	**(1,096)**
Surplus / (deficit) for the year		**(5,111)**	**(1,096)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(893)	-
Revaluations	15	846	612
Total comprehensive income / (expense) for the period		**(5,158)**	**(484)**

[1] During 2017/18 a number of services have been transferred from Liverpool Community Health NHS Trust to other NHS Providers. Where functions transfer between public sector bodies, the GAM requires the application of 'absorption accounting'. The assets and liabilities associated with the services have been transferred, which has resulted in a loss recognised in the Statement of Comprehensive Income of £5.643m and is required to be disclosed separately from operating costs. Further detail is provided in note 33.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Property, plant and equipment	14	10,140	16,100
Total non-current assets		**10,140**	**16,100**
Current assets			
Inventories	17	68	67
Trade and other receivables	18	6,251	4,757
Cash and cash equivalents	19	11,637	11,148
Total current assets		**17,956**	**15,972**
Current liabilities			
Trade and other payables	20	(8,599)	(6,433)
Provisions	25	(230)	(540)
Other liabilities	22	-	(485)
Total current liabilities		**(8,829)**	**(7,458)**
Total assets less current liabilities		**19,267**	**24,614**
Non-current liabilities			
Provisions	25	(1,172)	(1,361)
Total non-current liabilities		**(1,172)**	**(1,361)**
Total assets employed		**18,095**	**23,253**
Financed by			
Public dividend capital		229	229
Revaluation reserve		3,179	6,549
Income and expenditure reserve		14,687	16,475
Total taxpayers' equity		**18,095**	**23,253**

The notes on pages 6 to 50 form part of these accounts.

Name	Joseph Rafferty
Position	Chief Executive Officer
Date	**24 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**229**	**6,549**	**16,475**	**23,253**
Surplus/(deficit) for the year	-	-	(5,111)	**(5,111)**
Transfers by absorption: transfers between reserves	-	(3,323)	3,323	**-**
Impairments	-	(893)	-	**(893)**
Revaluations	-	846	-	**846**
Taxpayers' equity at 31 March 2018	**229**	**3,179**	**14,687**	**18,095**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**229**	**5,937**	**17,571**	**23,737**
Surplus/(deficit) for the year	-	-	(1,096)	**(1,096)**
Revaluations	-	612	-	**612**
Taxpayers' equity at 31 March 2017	**229**	**6,549**	**16,475**	**23,253**

Information on reserves

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.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		592	(1,018)
Non-cash income and expense:			
Depreciation and amortisation	5.1	762	2,230
Net impairments	6	171	-
(Increase) / decrease in receivables and other assets		(1,769)	1,853
(Increase) / decrease in inventories		(1)	(15)
Increase / (decrease) in payables and other liabilties		1,972	(949)
Increase / (decrease) in provisions		(310)	(1,131)
Net cash generated from / (used in) operating activities		**1,417**	**970**
Cash flows from investing activities			
Interest received		39	37
Purchase of property, plant, equipment and investment property		(807)	(1,042)
Net cash generated from / (used in) investing activities		**(768)**	**(1,005)**
Cash flows from financing activities			
Other interest paid		(2)	(1)
PDC dividend (paid) / refunded		26	(311)
Net cash generated from / (used in) financing activities		**24**	**(312)**
Increase / (decrease) in cash and cash equivalents		**673**	**(347)**
Cash and cash equivalents at 1 April - brought forward		**11,148**	**11,495**
Prior period adjustments			**-**
Cash and cash equivalents at 1 April - restated		**11,148**	**11,495**
Cash and cash equivalents transferred under absorption accounting	33	**(184)**	**-**
Cash and cash equivalents at 31 March	19.1	**11,637**	**11,148**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements 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 financial statements 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 that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
These accounts have been prepared on a going concern basis.

Going Concern: IAS1 Presentation of Financial statements requires management to consider whether the financial accounts are prepared on a going concern basis.
In considering the going concern basis, the Board considered in its assessment the following three factors:

• Financial Conditions;
• Operating Conditions;
• Other Conditions;

The evidence used to satisfy the Boards view that the accounts should be presented on a going concern basis across the above factors include:

Forecasts and Budgets - The 2018/19 financial plan, which has been completed and approved by Directors and draft operating plans have been submitted to NHS Improvement. A detailed, independent due diligence and working capital review has been undertaken as part of the Liverpool Community Health Transaction.

Medium and long-term plans - The Trust has an agreed long term financial model and estates strategy, underpinned by an agreed financial strategy, which is regularly reviewed and updated;

Timing of cashflows - The Care at a Glance board report details a twelve month rolling cashflow forecast;

Financial and operational risk - The Trust risk register is regularly reviewed by the Quality Assurance Committee;

Systems Controls - Internal Audit reviews have consistently delivered a significant assurance opinion.
In reviewing the conditions above and assessing going concern, the Directors have concluded that there are no material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, and the going concern basis remains appropriate.

From 1 April 2018, Mersey Care NHS Foundation Trust will take over the services of Liverpool Community Health NHS Trust. This process has been subject to a tendering process and an independent due diligence process has been undertaken as part of the transaction.

Further detail is provided in note 35 and 36 in respect of events after the reporting date and the final period of operation of Liverpool Community NHS Trust

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Segmental Reporting: The Trust engages in its activities as a single operating segment, as set out in Note 2 to these accounts.

Note 1.3 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Provisions: The amount recognised as a provision is the best estimate at the end of the reporting period of the expenditure required to settle a present obligation or constructive obligation, taking into account risks and uncertainties. Further clarification of the provisions accounting policy is set out in note 1.13.

PPE Leased Properties: A proportion of the Trust's building estate is made available through lease agreements. When the Trust commits to capital investment within such properties the value carried within the capital asset register is reflected at investment cost depreciate over the lease term. This is deemed the most appropriate way to depreciated the cost of the investment over its useful life and to reflect the current value of the investment over the life of the lease. The value of associated assets is £2.6m at 31 March 2018 (31 March 2017 £3.7m).

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. Revenue related to podiatry services under "Any Qualified Provider" is received in full at the commencement of the course of treatment and apportioned across the financial years based on the expected length of treatment.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

The NHS Trust receives income under the NHS Injury Cost Recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives payment from the Department of Work and Pension's Compensation Recovery Unit. The income is measured at the agreed tariff for the treatments provided to the individual.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

The cost to Liverpool Community NHS Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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 the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Note 1.6 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 consideration paid. Therefore, expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

Revaluations of property, plant and equipment 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. Current values in existing use are determined as follows:

• Land and non-specialised buildings - market value for existing use.

• Specialised buildings - depreciated replacement cost, modern equivalent asset basis. All assets are measured subsequently at valuation.

• Properties in the course of construction for services or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.
Individual items of IT equipment over £5,000 in value, furniture and fittings, and pant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

A proportion of the Trust's building estate is made available through lease agreements. When the Trust commits to capital investment within such properties the value carried within the capital asset register is reflected at investment cost depreciated over the lease term. This is deemed the most appropriate way to depreciate the cost of the investment over its useful life and to reflect the current value of the investment over the life of the lease. The value of associated assets is £2.6m at 31 March 2018 (31st March 2017 £3.7m).

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost it capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item is replaced and written out and charged to operating expenses.

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.

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

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

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

Impairments
At each financial year end, Liverpool Community Health NHS Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

Note 1.7.3 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 are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	4	58
Plant & machinery	1	9
Information technology	-	-
Furniture & fittings	1	4

Subsequent expenditure on leased properties is capitalised and is depreciated over the shorter of the useful economic life or the lease term.

Note 1.8 Intangible assets

Note 1.8.1 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

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of 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.

Note 1.8.3 Useful economic lives of intangible assets

The Trust is not currently carrying any intangible assets

Note 1.9 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents

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 that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Carbon Reduction Commitment scheme (CRC)
The Trust does not currently fall under the requirements of the CRC scheme.

Note 1.12 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, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.12.

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

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

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

Classification and measurement
Financial instruments are initially measured at fair value and subsequently measured according to their classification as described below.

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

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

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

Note 1.13 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

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

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 0.10% (2016/17 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timings of cashflows from the Statement of Financial Position date:

A short term rate of 2.42% (2016/17 -2.70%) for expected cashflows up to and including 5 years.

A medium term rate of -1.85% (2016/17 -1.95%) for expected cashflows over 5 years up to and including 10 years.

A long term rate of -1.56% (2016/17 -0.80%) for expected cashflows over 10 years.

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 25.2 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.

Note 1.15 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 26 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance which represents the Department of Health and Social Care's investment in the trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, 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
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health 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 the audit of the annual accounts.

Note 1.17 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.

Note 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 note 19 to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 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 that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Transfers of functions to other NHS bodies

In April and May 2017, an element of the Liverpool Community Health services were transferred to Other NHS bodies. The transfers reflect the agreed position and are shown in note 33.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

The functions that the trust transferred to other NHS bodies, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss corresponding to the net assets transferred is recognised within expenses, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted
The following new standards will be adopted by the NHS in 2018/19, however the impact for the successor organisation to Liverpool Community Health NHS Trust will be minimal.
IFRS 9 - Financial Instruments: recognition and measurement; the changes relate to classificaiton and measurement of financial assets, including a new impairment model and changes to hedge accounting. Therefore there will a minimal impact for 2018/19.
IFRS 15 - Revenue from contracts with customers
IFRS 16 - Leases, this will change the current treatment of leased buildings from operating leases to finance leases, therefore the lease obligations will need to be reclassified accordingly.

Note 2 Operating Segments

The Trust engages in its activities as a single operating segment i.e. provision of healthcare. The main source of revenue for the Trust is from commissioners of healthcare which are principally NHS England (NHSE) and Clinical Commissioning Groups (CCG's). The Department of Health has deemed that as NHSE and CCG's are under common control they are classified as a single customer for the purposes of segmental analysis. No other customer generates in excess of 10% total revenue.

The basis for Internal reporting is a single operating segment, for which the operating results are reviewed by the chief operating decision maker.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18	2016/17
	£000	£000
Community services		
Community services income from CCGs and NHS England	88,529	117,239
Income from other sources (e.g. local authorities)	4,664	10,064
All services		
Private patient income	-	-
Other clinical income	-	-
Total income from activities	**93,193**	**127,303**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	5,386	6,168
Clinical commissioning groups	83,143	111,071
Other NHS providers	3,227	2,737
NHS other	-	25
Local authorities	677	6,720
NHS injury scheme	371	432
Non NHS: other	389	150
Total income from activities	**93,193**	**127,303**
Of which:		
Related to continuing operations	93,193	127,303
Related to discontinued operations	-	-

There has been an overall reduction in income from activities of £34.110m between 2016/17 and 2017/18.

Clinical commissioning groups income has seen the largest reduction of £27.928m, the most significant changes are:

Transfer of non core services and associated activity to successor organisaitons (Alder Hey NHS Foundation Trust and Royal Liverpool and Broadgreen Hospitals NHS Trust) from 1st April 2017 £7.397m.
Transfer of Sefton services and associated activity to successor organisation (Mersey Care NHS Foundation Trust) from 1st June 2017 £16.628m.
Transfer of Southport services and associated activity to successor organisations £2.777m on 1st June 2017.
Cessation of services at Windmill Hill £0.472m.

Local Authority income has reduced by £6.043m and relates to the transfer of services to North West Boroughs NHS Foundation Trust on 1st June 2017.

NHS injury scheme income has reduced by £0.061m as a result of the transfer of Sefton services and associated activity to successor organisations on 1st June 2017

Non NHS: other income has increased by £0.239m. The transfer of SAFE place services to Central Manchester NHS Foundation Trust is offset by deferred income relating to Podiatry from 2016/17.

Income reported above has been reported as all relating to continuing operations. Services have continued to be provided, despite some services being transferred to other NHS Providers during 2017/18. Services are only deemed to be discontinued if they are transferred outside of the public sector.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The Trust had no overseas visitors income in 2017/18 (2016/17 £nil)

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Education and training	808	1,190
Non-patient care services to other bodies	4	123
Sustainability and transformation fund income	3,087	1,894
Other income	279	266
Total other operating income	**4,178**	**3,473**
Of which:		
Related to continuing operations	4,178	3,473
Related to discontinued operations	-	-

Other opertaing income has increase in total by £0.705m between 2016/17 and 2017/18. The main movements include:

Education and Training income has reduced by £0.382m in 2017/18 following the transfer of non Liverpool core services and associated activity during the year on 1st April and 1st June 2017.

Non Patient Care Services income has reduced by £0.119m. Domestic services provided by the Trust in respect of the South Sefton service and recharged to Community Health Partnership and NHS Property Services has transferred alongside the non core service transfer.

The Trust received £3.1m directly from NHS England as part of the **Sustainability and Transformation Fund** (STF) in 2017/18 (£1.9m in 2016/17). The 2017/18 value includes £1.296m core STF, £0.416m Incentive STF (finance), £0.475m Incentive STF (general distribution) and £0.900m Incentive STF (bonus).

Other Revenue includes property rental income.

Income reported above has been reported as all relating to continuing operations. Services have continued to be provided, despite some services being transferred to other NHS Providers during 2017/18. Services are only deemed to be discontinued if they are transferred outside of the public sector.

Note 5.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,581	5,440
Purchase of healthcare from non-NHS and non-DHSC bodies	349	1,405
Staff and executive directors costs	70,160	97,365
Remuneration of non-executive directors	54	59
Supplies and services - clinical (excluding drugs costs)	8,349	9,670
Supplies and services - general	654	813
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	604	610
Consultancy costs	189	382
Establishment	3,028	3,968
Premises	5,169	3,981
Transport (including patient travel)	149	168
Depreciation on property, plant and equipment	762	2,173
Amortisation on intangible assets	-	57
Net impairments	171	-
Increase/(decrease) in provision for impairment of receivables	14	238
Increase/(decrease) in other provisions	(35)	-
Audit fees payable to the external auditor		
[1]audit services- statutory audit	49	49
other auditor remuneration (external auditor only)	-	-
Internal audit costs	77	99
Clinical negligence	231	93
Legal fees	185	215
Insurance	64	107
Education and training	425	451
Rentals under operating leases	2,772	3,799
Early retirements	-	-
Redundancy	104	(57)
Car parking & security	325	373
Hospitality	6	6
Losses, ex gratia & special payments	25	-
Other	318	330
Total	**96,779**	**131,794**
Of which:		
Related to continuing operations	96,779	131,794
Related to discontinued operations	-	-

Overall, operating expenses have reduced by £35.015m between 2016/17 and 2017/18. This is largely in relation to the transfer of non-core service bundles to other NHS Providers between April 2017 and June 2017, as part of the organisation transfer process.

The largest reduction has been within **Staffing** costs, which have reduced by £27.205m due largely to the transfer of non core services, actitivty and associated spend transferred to successor organisations in line with the organisation transaction process. Further detail is provided in Note 7.

Supplies and services clinical - reduction of £1.321m relates to the transfer of sefton services, activity and associated spend to successor organisations (Mersey Care NHS Foundation Trust) in line with the organisational transaction process on 1st June 2017.

Suppies and services general - reduction of £0.159m relates to the transfer of sefton services, activity and associated spend to successor organisations on 1st June 2017, cessation of services provided to Wards 9 and 11, transfer of X ray services, and the cessation of Windmill Hill services.

Establishment expenses - reduction of £0.940m largely associated with the transfer of sefton services, activity and associated spend £0.702m to successor organisations on 1st June 2017. A reduction in legal services in relation to prisons £0.068m and reductions in travel and insurance associated with service transfers.

Purchase of healthcare from Non-NHS bodies expenses have reduced by £1.056m. Transfer of sefton services, activity and spend relates to £0.478m, transfer of non core SARC services relates to £0.174m and Childrens speech and language therapy £0.217m. Therapy service no longer provided by LCC £0.061m.

Purchase of healthcare from NHS bodies expenses have reduced by £2.859m. Transfer of sefton services, activity and spend relates to £0.950m on 1st June, transfer ot X Ray services £0.251m, cessation of wards 9 & 11 £0.360m, transfer of anti coagulation and SALT services £0.321m. Also the transfer of Mersey Care informatics associated with Sefton services £0.786m.

Depreciation costs have reduced by £1.411m following the transfer by absorption of the non current assets (totalling £5.643m) associated with the services that have transferred. In addition, Cushman & Wakefield valuers were commissioned to undertake a revaluation exercise on 31 March 2018. The impact has been a net downward revaluation of £0.218m, which has also resulted in an impairment charged to operating expenses (whereby there is no revaluation reserve remaining on the assets) of £0.171m.

Expenditure reported above has been reported as all relating to continuing operations. Services have continued to be provided, despite some services being transferred to other NHS Providers during 2017/18. Services are only deemed to be discontinued if they are transferred outside of the public sector.

[1]Audit Fees are stated gross of VAT

Note 5.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**-**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: N/A).

Note 6 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	171	-
Total net impairments charged to operating surplus / deficit	**171**	**-**
Impairments charged to the revaluation reserve	893	-
Total net impairments	**1,064**	**-**

Following a revaluation exercise undertaken by valuers Cushman & Wakefield at 31 March 2018, there has been an overall reduction in the valuation of non current assets of £218k. This can be broken down as:

○ Buildings (excluding dwellings) £188k
○ Land £30k

Some properties and land have increased in value. The total impact of the valuation (gain taken directly to the revaluation reserve) is £846k and can be broken down as follows:

○ Buildings (excluding dwellings) £821k
○ Land £25k

Conversely some properties and land have reduced in value. The total impact of the impairments (taken to the revaluation reserve to the extent there is a balance available, with the remainder being charged to expenses) is £1,571k and can be broken down as follows:

○ Buildings (excluding dwellings) £1,516k (of which £838k has been taken to the revaluation reserve and £171k charged to SoCI

○ Land £55k (all of which has been taken to the revaluation reserve)

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	54,399	76,970
Social security costs	6,040	7,244
Apprenticeship levy	262	-
Employer's contributions to NHS pensions	6,826	9,685
Pension cost - other	14	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	104	(57)
Temporary staff (including agency)	2,619	3,466
Total gross staff costs	**70,264**	**97,308**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**70,264**	**97,308**
Of which		
Costs capitalised as part of assets	-	-

Staffing costs have reduced by £27.044m between 2016/17 and 2017/18, this largely relates to the transfer of services to other NHS providers. The following list providers detail of the main movements:

•Transfer of Sefton services and associated activity to successor organisations (Mersey Care NHS FT) £19.641m on 1st June 2017. This also includes transfer of indirect and operational costs linked to the transfer.
•Transfer of non-core services and associated activity to successor organisations (Royal Liverpool & Broadgreen Hospitals University NHS Trust) £2.614m on 1st April and 1st June 2017.
•Transfer of non-core services and associated activity to successor organisations (Alder Hey Childrens Hospital NHS FT) £2.095m on 1st April 2017.
•Transfer of non-core services and associated activity to successor organisations (Aintree Hospitals NHS FT) £0.255m on 1st April 2017.
•Transfer of non-core services and associated activity to successor organisations in relation to Corporate areas £1.529m.
•Cessation of Windmill Hill services £0.333m by Halton Clinical Commissioning Group
•Full year effect of the 2016/17 cessation of Public Health services in Liverpool £0.487m

Note 7.1 Retirements due to ill-health

Ill health retirements from the Trust agreed no the ground of ill-health	**2017/18**	**2016/17**
• Number	3	1
• Estimated additional pension liabilities of these ill health retirements (£000's)	255	156

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 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 that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The 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 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 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The trust does not operate any material defined benefit pension schemes other than the statutory NHS Pension Scheme.

Note 9 Operating leases

Note 9.1 Liverpool Community Health NHS Trust as a lessor

The Trust had no leasing arrangements as a lessor in 2017/18 (2016/17 none)

Note 9.2 Liverpool Community Health NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Liverpool Community Health NHS Trust is the lessee.

The Trust has entered into four 10 year property leases since establishment, the impact of which is reflected in the analysis below. Minimum lease payments reduced by £1.0m in 2017/18 as a result of the transfer of services to other organisations. Other property leases are renewed on an annual basis.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	2,772	3,799
Contingent rents	-	-
Less sublease payments received	-	-
Total	**2,772**	**3,799**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,537	3,667
- later than one year and not later than five years;	4,750	5,342
- later than five years.	120	528
Total	**7,407**	**9,537**
Future minimum sublease payments to be received	-	-

The operating lease commitments will transfer to the successor organisation (Mersey Care NHS Foundation Trust from 1st April 2018. Further detail is provided in note 35.

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	39	37
Total	**39**	**37**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	2	1
Total interest expense	**2**	**1**
Total finance costs	**2**	**1**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	2	1

Note 12 Other gains / (losses)

During 2017/18 there were no gains or losses arising from the disposal of assets, foreign exchange or change in fair value of financial assets or financial liabilities (2016/17 £nil)

Note 13.1 Intangible assets - 2017/18

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**-**	**-**
Gross cost at 31 March 2018	**-**	**-**
Amortisation at 1 April 2017 - brought forward	**-**	**-**
Amortisation at 31 March 2018	**-**	**-**
Net book value at 31 March 2018	**-**	**-**
Net book value at 1 April 2017	**-**	**-**

Note 13.2 Intangible assets - 2016/17

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**90**	**90**
Valuation / gross cost at 1 April 2016 - restated	**90**	**90**
Disposals / derecognition	(90)	**(90)**
Valuation / gross cost at 31 March 2017	**-**	**-**
Amortisation at 1 April 2016 - as previously stated	**33**	**33**
Amortisation at 1 April 2016 - restated	**33**	**33**
Provided during the year	**57**	**57**
Disposals / derecognition	(90)	**(90)**
Amortisation at 31 March 2017	**-**	**-**
Net book value at 31 March 2017	**-**	**-**
Net book value at 1 April 2016	**57**	**57**

Intangible non-current assets at 31 March 2016 comprised computer licences that were originally recognised at cost and amortised over the life of the associated information technology asset.

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**2,190**	**14,269**	**-**	**1,736**	**-**	**342**	**18,537**
Transfers by absorption	(1,120)	(4,006)	-	(989)	-	(33)	**(6,148)**
Additions	-	317	174	96	-	76	**663**
Impairments	(55)	(1,099)	-	-	-	-	**(1,154)**
Revaluations	25	748	-	-	-	-	**773**
Valuation/gross cost at 31 March 2018	**1,040**	**10,229**	**174**	**843**	**-**	**385**	**12,671**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**1,487**	**-**	**788**	**-**	**162**	**2,437**
Transfers by absorption	**-**	**(74)**	**-**	**(429)**	**-**	**(2)**	**(505)**
Provided during the year	**-**	**623**	**-**	**105**	**-**	**34**	**762**
Impairments	-	(90)	-	-	-	-	**(90)**
Revaluations	-	(73)	-	-	-	-	**(73)**
Accumulated depreciation at 31 March 2018	**-**	**1,873**	**-**	**464**	**-**	**194**	**2,531**
Net book value at 31 March 2018	**1,040**	**8,356**	**174**	**379**	**-**	**191**	**10,140**
Net book value at 1 April 2017	**2,190**	**12,782**	**-**	**948**	**-**	**180**	**16,100**

The transfer by absorption reflects the transfer of non core services to other NHS organisations during 2017/18. Further details of the transfers are reflected in note 33.

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**2,190**	**13,160**	**273**	**1,482**	**2,651**	**296**	**20,052**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	684	31	255	-	46	**1,016**
Revaluations	-	331	-	-	-	-	**331**
Reclassifications	-	304	(304)	-	-	-	**-**
Disposals / derecognition	-	(210)	-	(1)	(2,651)	-	**(2,862)**
Valuation/gross cost at 31 March 2017	**2,190**	**14,269**	**-**	**1,736**	**-**	**342**	**18,537**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**1,023**	**-**	**571**	**1,686**	**127**	**3,407**
Provided during the year	**-**	**955**	**-**	**218**	**965**	**35**	**2,173**
Revaluations	-	(281)	-	-	-	-	**(281)**
Disposals/ derecognition	-	(210)	-	(1)	(2,651)	-	**(2,862)**
Accumulated depreciation at 31 March 2017	**-**	**1,487**	**-**	**788**	**-**	**162**	**2,437**
Net book value at 31 March 2017	**2,190**	**12,782**	**-**	**948**	**-**	**180**	**16,100**
Net book value at 1 April 2016	**2,190**	**12,137**	**273**	**911**	**965**	**169**	**16,645**

During 2016/17 the Trust treated expenditure on IT equipment (iPads, laptops and desk tops) as revenue in nature due to the low unit cost of such items and frequent replacement due to technological advances. In line with this change in classification, the Trust also in 2016/17 fully depreciated the opening net book value of previously capitalised IT equipment and wrote out the gross replacement cost and accumulated depreciation of IT equipment from the Trust's Capital Asset Register. Likewise, associated capitalised computer licences were also fully depreciated in year and written out of the Trust's Capital Asset Register.

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018						
Owned - purchased	1,040	8,356	379	-	191	**10,140**
NBV total at 31 March 2018	**1,040**	**8,356**	**379**	**-**	**191**	**10,140**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017						
Owned - purchased	2,190	12,782	948	-	180	**16,100**
NBV total at 31 March 2017	**2,190**	**12,782**	**948**	**-**	**180**	**16,100**

Note 15 Revaluations of property, plant and equipment

The Trust's land and buildings were revalued on 31 March 2018 by Gian Wong (MRICS), a professionally qualified valuer of Cushman & Wakefield. The values of the assets subject to the revaluation were updated on 31 March 2018 in line with values provided by the valuer.

The valuation, and subsequent update, was undertaken in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards - Global and UK, 7th Edition, insofar as these terms are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health.

The valuation of all specialist property assets is on a Modern Equivalent Asset basis taking into account functional and economic obsolescence. Non-specialist assets valued based on market value for existing use.

The carrying value of the trust estate (subject to the revaluation) has decreased by £0.218m from £7.044m to £6.826m. This resulted in an impairment of £1.064m which can be seen at note 6 and an upward revaluation of £0.846m.

A proportion of the Trust's building estate is made available through lease agreements. When the Trust commits to capital investment within such properties the value carried within the capital asset register is reflected at investment cost depreciated over the lease term. This is deemed the most appropriate way to depreciate the cost of the investment over its useful life and to reflect the current value of the investment over the life of the lease. The value of associated assets is £2.6m at 31 March 2018 (31 March 2017 £3.7m).

Note 16.1 Investment Property

The Trust holds no Investment property at 31 March 2018 (2016/17 None)

Note 17 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	68	67
Total inventories	**68**	**67**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £609k (2016/17: £682k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 18.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	2,963	1,472
Accrued income	2,380	1,349
Provision for impaired receivables	(195)	(533)
Prepayments (non-PFI)	292	550
PDC dividend receivable	56	179
VAT receivable	463	1,122
Other receivables	292	618
Total current trade and other receivables	**6,251**	**4,757**
Non-current		
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	4,905	2,419
Non-current	-	-

The majority of trade is with Clinical Commissioning Groups and NHS England. These bodies are funded by Government to purchase NHS patient care services, therefore no credit scoring of them is considered necessary.

Trade receivables have increased by £1.491m between 2016/17 and 2017/18, however payments have been received in relation to these balances in April totalling £1.3m.

Accrued Income has increased by £1.031m betweeen 2016/17 and 2017/18. This relates to the quarter 4 STF payment and the Incentive/bonus payments notified all of which total £1.953m.

VAT - has reduced by £0.659m. The balance in 2016/17 had approximately six months of outstanding VAT reclaims, which has reduced in 2017/18.

From 1st April 2018, current assets will transfer to the successor organisation (Mersey Care NHS Foundation Trust), further detail is provided in note 35.

Note 18.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**533**	**303**
Increase in provision	14	193
Amounts utilised	(352)	(8)
Unused amounts reversed	-	45
At 31 March	**195**	**533**

The provision for impairment of receivables includes an assessment of all the Trust's receivables, inclusive of invoiced debt.

Note 18.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	148	-
30-60 Days	-	-	-	-
60-90 days	1	-	5	-
90- 180 days	8	-	6	-
Over 180 days	186	-	374	-
Total	**195**	**-**	**533**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	335	-	503	-
30-60 Days	26	-	156	-
60-90 days	241	-	50	-
90- 180 days	871	-	12	-
Over 180 days	324	-	289	-
Total	**1,797**	**-**	**1,010**	**-**

The majority of receivables past due, but not impaired relates to debt with other NHS Organisations. Therefore the credit risk against such debt is deemed low.

Note 19.1 Cash and cash equivalents movements

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	2016/17
	£000	£000
At 1 April	**11,148**	**11,495**
Transfers by absorption	(184)	-
Net change in year	673	(347)
At 31 March	**11,637**	**11,148**
Broken down into:		
Cash at commercial banks and in hand	1	1
Cash with the Government Banking Service	11,636	11,147
Total cash and cash equivalents as in SoFP	**11,637**	**11,148**
Total cash and cash equivalents as in SoCF	**11,637**	**11,148**

From 1st April 2018, current assets will transfer to the successor organisation (Mersey Care NHS Foundation Trust), further detail is provided in note 35.

Note 19.2 Third party assets held by the trust

The Trust does not hold any cash or cash equivalents on behalf of patients or other third parties

Note 20.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	3,062	2,454
Capital payables	7	151
Accruals	4,563	3,821
Social security costs	767	-
Other taxes payable	200	-
Other payables	-	7
Total current trade and other payables	**8,599**	**6,433**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	1,746	2,098
Non-current	-	-

Social security costs and other taxes - have increased between 2016/17 and 2017/18. This relates to National Insurance payments relating to March payable in April. In 2016/17 the March liability was settled in March.

From 1st April 2018, current liabilities will transfer to the successor organisation (Mersey Care NHS Foundation Trust), further detail is provided in note 35.

Note 20.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	-		1	

Note 21 Other financial liabilities

The Trust does not have any other financial liabilities as at 31 March 2018 (31 March 2017 nil)

Note 22 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	-	485
Total other current liabilities	**-**	**485**
Non-current		
Total other non-current liabilities	**-**	**-**

Deferred Income includes revenue received from Clincial Commissioning Groups for Podiatry services under 'any qualified provider'. Payments are received in full on commencement of a course of treatment, which typically lasts twelve months.

Note 23 Borrowings

The Trust does not have any other borrowings as at 31 March 2018 (31 March 2017 nil)

Note 24 Finance leases

Note 24.1 Liverpool Community Health NHS Trust as a lessor

The Trust has no finance lease obligations as at 31 March 2018 (31March 2017 nil)

Note 24.2 Liverpool Community Health NHS Trust as a lessee

The Trust has no finance lease receivables as at 31 March 2018 (31 March 2017 nil)

Note 25.1 Provisions for liabilities and charges analysis

	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**304**	**236**	**1,361**	**1,901**
Transfers by absorption	-	-	(189)	**(189)**
Utilised during the year	(39)	(236)	-	**(275)**
Reversed unused	(35)	-	-	**(35)**
At 31 March 2018	**230**	**-**	**1,172**	**1,402**
Expected timing of cash flows:				
- not later than one year;	230	-	-	**230**
- later than one year and not later than five years;	-	-	1,172	**1,172**
- later than five years.	-	-	-	**-**
Total	**230**	**-**	**1,172**	**1,402**

Legal Claims - provisions comprise of a £208k in respect of a repudiatory breach of contract claim. In addition to £22k clinical negligence claims notified by NHS Resolution as part of the Liability to Third Parties (LTPS).
Other provisions - comprise dilapidations clauses contained within property leases to return the property to its original state on vacation.

Note 25.2 Clinical negligence liabilities

At 31 March 2018, £419k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Liverpool Community Health NHS Trust (31 March 2017: £494k).

Note 26 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(3)	(28)
Gross value of contingent liabilities	**(3)**	**(28)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(3)**	**(28)**
Net value of contingent assets	-	-

Note 27 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	109	15
Total	**109**	**15**

Note 28 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	1,784	1,782
after 1 year and not later than 5 years	33	158
paid thereafter	-	-
Total	**1,817**	**1,940**

From 1st April 2018, financial commitments will transfer to the successor organisation (Mersey Care NHS Foundation Trust), further detail is provided in note 35.

Note 29 On-SoFP PFI, LIFT or other service concession arrangements

The Trust does not have any PFI or LIFT arrangements (2016/17 nil)

Note 30 Financial instruments

Note 30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with whole of government commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of 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 NHS 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 NHS 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. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majoriy 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

NHS Trust's borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust has no government borrowing for capital expenditure.

NHS Trust's may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken. The Trust has no government borrowing for revenue financing.

Credit risk

The majority of the Trust's revenue derives from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures at 31 March are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with other public sector funded bodies, which are financed from resources voted annually by Parliament. The Trust funds it's capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity at £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	5,353	-	-	-	**5,353**
Cash and cash equivalents at bank and in hand	11,637	-	-	-	**11,637**
Total at 31 March 2018	**16,990**	**-**	**-**	**-**	**16,990**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	3,000	-	-	-	**3,000**
Cash and cash equivalents at bank and in hand	11,148	-	-	-	**11,148**
Total at 31 March 2017	**14,148**	**-**	**-**	**-**	**14,148**

Note 30.3 Carrying value of financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Trade and other payables excluding non financial liabilities	7,545	-	**7,545**
Total at 31 March 2018	**7,545**	**-**	**7,545**

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017			
Trade and other payables excluding non financial liabilities	6,433	-	**6,433**
Total at 31 March 2017	**6,433**	**-**	**6,433**

Note 30.4 Fair values of financial assets and liabilities

The carrying values of fianancial assets and liabilities are deemed to be a reasonable approximation of fair value.

Note 31 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Cash losses	2	0	11	3
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	66	14	90	5
Stores losses and damage to property	56	11	51	9
Total losses	**124**	**25**	**152**	**17**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	1	0	2	1
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**1**	**0**	**2**	**1**
Total losses and special payments	**125**	**25**	**154**	**18**
Compensation payments received		-		-

There are no individual cases over £300,000 in value to report

Note 32 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Liverpool Community Health NHS Trust.

Details of related party transactions with individuals or their companies are as follows:

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Deparmtent, and with other entities for which the Department is regarded as the parent Department. For example:

- Clinical Commissioning Groups and NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority

The directors below reflect the transactions with Mersey Care NHS Foundation Trust, and details the Directors associated with the management agreement with Mersey Care from 1 November 2017. Further detail is provided in the remuneration report section of the Annual Report.

	Income £000	Expenditure £000	Receivables £000	Payables £000
Mersey Care NHS Foundation Trust	1,316	2,003	578	50
Beatrice Fraenkel (Chairman)				
Robert Beardall (Non Executive Director)				
Gerry O'Keeffe (Non Executive Director)				
Pamela Williams (Non Executive Director)				
Joseph Rafferty (Chief Executive)				
David Fearnley (Medical Director)				
Neil Smith (Executive Director of Finance & Deputy Chief Executive)				
Amanda Oates (Executive Director of Workforce)				
Patricia Bennett (Executive Director of Nursing)				

The directors below reflect the transactions with Alder Hey NHS Foundation Trust, and details the Directors associated with the management agreement with Alder Hey between 1 May 2017 - 31 October 2017. Further detail is provided in the remuneration report section of the Annual Report.

	Income £000	Expenditure £000	Receivables £000	Payables £000
Alder Hey NHS Foundation Trust	194	186	172	1
Sir David Henshaw (Chairman)				
Steve Igoe (Non Executive Director)				
Anita Marsland (Non Executive Director)				
Dame Jo Williams (Non Executive Director)				
Louise Shepherd (Chief Executive)				
John Grinnell (Director of Finance)				
Melissa Swindell (Director of Human Resources)				
Hilda Gwilliams (Director of Nursing)				
Dr Steve Ryan (Medical Director)				

Other Related Parties:	Income £000	Expenditure £000	Receivables £000	Payables £000
Health Education England	733	9	0	0
NHS Knowsley Clinical Commissioning Group	186	0	0	33
NHS Liverpool Clinical Commissioning Group	79,406	0	126	138
NHS South Sefton Clinical Commissioning Group	3,239	0	200	13
NHS Southport and Formby Clinical Commissioning Group	295	11	0	20

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Local Authorities following the transfer on 1 April 2013 of Public Health commissioning responsibilities under the Health and Social Care Act 2012.

Note 33 Transfers by absorption

As public sector bodies are deemed to operate under common control, business reconfigurations withing the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income and is disclosed separately from operating costs.

Following a tendering exercise for the non-core service bundles. There has been a transfer of the services during 2017/18 to other NHS providers. The transfer has resulted in a loss on transfers by absorption reported as £5.643m. The services have transferred to the following organisations.

	Absorption Loss (£000's)	**Date of Transfer**
Mersey Care NHS Foundation Trust	(3,554)	01/06/2017
North West Boroughs Partnership NHS Foundation Trust	(960)	01/04/2017
Royal Liverpool and Broadgreen University Hospitals NHS Trust	(1,129)	01/06/2017
Alder Hey Childrens Hospital NHS Foundation Trust	0	01/04/2017
Total calculated absorption loss	**(5,643)**	

Note 34 Prior period adjustments

There have been no prior period adjustments reported at 31 March 2018

Note 35 Events after the reporting date

Following a successful bid, Mersey Care NHS Foundation Trust will take over the remaining services at Liverpool Community Health NHS Trust from 1 April 2018, following approval of the Full Business Case by NHS Improvement and subquent approval from Mersey Care NHS Foundation Trust Board on 28 March 2018. The key risks relate to agreeing contract values with Commissioners and the completion of the due diligence process. This will be transacted as a transfer by absorption to transfer the remaining assets of Liverpool Community Health NHS Trust to the successor organisation. Notes 9.2, 18, 19, 20 and 28 provide further detail in terms of the balances that will transfer to the successor organisation as of 1st April 2018.

Note 36 Final period of operation as a trust of NHS healthcare

Liverpool Community Health NHS Trust will cease to exist from 31 March 2018. The services, including all assets and liabilities will transfer to Mersey Care NHS Foundation Trust from 1 April 2018.

Note 37 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	19,454	24,349	24,847	25,635
Total non-NHS trade invoices paid within target	15,776	20,393	23,238	24,660
Percentage of non-NHS trade invoices paid within target	**81.09%**	**83.75%**	**93.52%**	**96.20%**
NHS Payables				
Total NHS trade invoices paid in the year	509	4,488	804	5,941
Total NHS trade invoices paid within target	424	3,997	719	5,461
Percentage of NHS trade invoices paid within target	**83.30%**	**89.06%**	**89.43%**	**91.92%**

The Better Payment Practice Code (BPPC) requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later. Performance against BPPC has reduced in 2017/18, which reflects the temporary staffing arrangements in Finance, required as part of the transaction. In addition there have been challenges around approval due to changes in senior management also associated with the transaction. However, despite these challenges, the Trust has maintained a significant assurance opinion from Mersey Internal Audit Agency in respect of the internal systems and controls.

Note 38 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	-673	347
External financing requirement	**(673)**	**347**
External financing limit (EFL)	2,499	5,372
Under / (over) spend against EFL	**3,172**	**5,025**

Note 39 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	663	1,016
Charge against Capital Resource Limit	663	1,016
Capital Resource Limit	1,752	2,500
Under / (over) spend against CRL	**1,089**	**1,484**

Note 40 Breakeven duty financial performance

NHS Improvement has provided guidance that the first year for consideration for the breakeven duty should be 2009/10. Liverpool Community Health NHS Trust is subject to a five year period for recovery of any deficit incurred. As can be seen in Note 41, the Trust hasn't been in a cumulative deficit position during the reported periods.

Breakeven duty financial performance 2017/18

Breakeven duty financial performance is determined as guided by NHS Improvement, in a manner to be consistent with previous years in this note

Breakeven duty financial performance	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	703
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**703**

Note 41 Breakeven duty rolling assessment

The application of breakeven duty means that if a cumulative surplus or deficit is reported (greater than a materiality threshold of 0.5% of operating income), it should be recovered within the next two financial years. The table below shows that Liverpool Community NHS Trust has not incurred a cumulative deficit.

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		-	2,654	3,530	3,123	3,008	8	(1,768)	(1,096)	703
Breakeven duty cumulative position	-	-	2,654	6,184	9,307	12,315	12,323	10,555	9,459	10,162
Operating income		-	111,406	143,021	146,648	139,252	135,747	134,929	130,776	97,371
Cumulative breakeven position as a percentage of operating income		0.00%	2.38%	4.32%	6.35%	8.84%	9.08%	7.82%	7.23%	10.44%