NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Mersey Care NHS Foundation Trust

Annual Report 2017/18
Quality Report 2017/18
Annual Accounts 2017/18

Striving for perfect care and a just culture

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Annual Report and Accounts 2017/18

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

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FOREWORD

Welcome to our annual report covering the financial year 2017/18. As ever, this is a great opportunity to celebrate our achievements, activity and performance across the Trust in what has been yet another momentous year in Mersey Care's history as we ***strive for perfect care delivered through a just and learning culture***.

During 2017/18 Mersey Care has changed from being solely a provider of mental health, learning disabilities and addictions services to an organisation that now also provides a wide range of community physical health services. This means we now provide community physical health services for South Sefton (from July 2017) and Liverpool (from April 2018) following the Trust acquiring the majority of services previously provided by Liverpool Community Health NHS Trust. As a result Mersey Care is now the leading provider of ***community health services*** across Liverpool and Sefton and is in a perfect place to begin the work of developing truly integrated care pathways for the people we serve.

As well as welcoming community colleagues to the Mersey Care family, this also gives us a fantastic opportunity to improve community health services for the people of Liverpool and Sefton through systematic, high quality and sustainable integration. For our services users and carers this will mean we will increasingly be able to treat the whole person by bringing the expertise and skills of these two services together, providing seamless care for everyone we serve. This is especially important for our mental health and learning disability services users, who often have a range physical health care needs which have not always been effectively addressed when these services are provided separately. From April 2018 we will also be providing mental health services to HM Prison Liverpool, which will mean we will be able to improve the continuity of care for those who leave prison.

Another excellent piece of news this year has been the approval to build a new 123-bed state-of-the-art Medium Secure Unit at Maghull Health Park, replacing the mental health service at Scott Clinic in Rainhill and the learning disability service at Woodview in Whalley. This is something we have awaited for a number of years and it is good to see building work starting at last. Together with the new 44-bed mental health facility and community hub being built in Southport, we are well on the way to improving the environments from which we can provide great care to our service users.

We have also opened a second Life Rooms in Southport and are building a third Life Rooms at Hugh Baird Further Education College in Bootle This latest addition to our Life Rooms services will mean that we can work with Hugh Baird's 14-25 student population to build knowledge and learning of mental and physical health care for themselves and their families. Our apprenticeship centre of excellence which will sit alongside the Life Rooms at the College will also develop the very best training, development and employment opportunities for the young people of Sefton giving them a wider choice of career options for the future. It was nice to see our approach to the development of the Life Rooms model of learning, recovery, health and wellbeing endorsed by Life Rooms Walton being officially opened by HRH the Duke of Cambridge in September 2017.

It was also great to welcome Professor Sidney Dekker to the Trust for a week long visit as we continue the development of our ***just culture*** journey. Sidney's film mapping the Trust's progress can be found at http://sidneydekker.com/just-culture/. It presents a powerful story of

how, with the right support and development, a learning culture in an organisation can improve safety, staff and patient satisfaction and attract the very best people to work at Mersey Care in the future

As part of our ***zero suicide*** goal we are delighted to have launched the Zero Suicide Alliance whose aim is to ensure that the NHS works together to prevent the 6000 deaths that we see annually in this country from suicide. The Alliance is an exciting partnership between NHS Trusts and a wide range of partner and stakeholder organisations who want to share learning and best practice in suicide prevention. If you only take one thing from this report please take just 20 minutes to ***save a life and take the training*** at www.zerosuicidealliance.com.

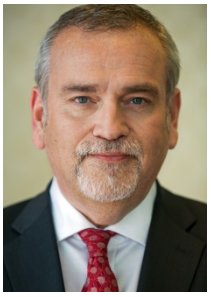
The Trust had its second CQC Inspection in 2017 which resulted in an overall 'good' rating, with services within the Specialist Learning Disabilities Division achieving an 'outstanding' rating. Although this is welcome news we continue to have a 'requires improvement' rating for being safe, which will be a focus of the work we will be doing in the coming year and we will work tirelessly as a Trust to ensure that the quality of the services that we offer continually improves

Despite the fine work going on across the Trust we face a range of other challenges in the coming year:

- those services previously provided by Liverpool Community Health in Liverpool, Sefton and HMP Liverpool have been subject to a critical external review by Dr Bill Kirkup due to concerns about the delivery of services[1]. As the new provider Mersey Care will need to support these services to be as safe and effective as possible over the coming years;

- the future of services at the Whalley site in light of NHS England's decision in 2016/17 to no longer commission learning disability services from this site. Although we are making progress in developing the community forensic teams supporting the new model of care, together with developing the new Medium Secure Service at Maghull, we and our commissioners have still to finalise plans about the future of low secure services and to facilitate the discharge of other inpatients from Whalley. The safety and dignity of these vulnerable patients is a key priority for the Trust.

Beatrice Fraenkel
Chairman



Joe Rafferty
Chief Executive

[1] See paragraphs 357 – 360 for further information

PART A – OVERVIEW

CHAPTER 1 - INTRODUCTION

1. Mersey Care is a community mental health and physical health provider which provides a wide range of community health services across Liverpool, Sefton and Kirkby together with specialist mental health services across North West England and beyond. Our vision is be an organisation that is ***striving for perfect care and a just culture*** to the people we provide services to, their carers and our staff.

2. For the people of Liverpool, Sefton and Kirkby we provide specialist mental health inpatient services and community physical health, mental health, learning disabilities, addiction services together with acquired brain injury services. We also provide secure mental health services for the North West of England, the West Midlands and Wales and specialist learning disability services across Lancashire, Greater Manchester, Cheshire and Merseyside. We are one of only three trusts in the country that provide high secure mental health services.

3. Following our acquisition of community services for South Sefton and Liverpool from Liverpool Community Health NHS Trust, from 1 April 2018 we now provide clinical services are provided from 65 sites across the North West. Our teams are supported by a corporate team based at our offices in Prescot, Merseyside and Liverpool Innovation Park. Around 8,000 staff serve a population of almost 11 million people.

4. The Trust is ***striving to provide perfect care and a just culture*** for the people we serve and make a positive difference to the lives of service users and carers. We also aim to play a full part in the local health and social care economies we serve by promoting and driving greater integration between mental and physical health and social care. Our ongoing plans are based around four aims and underpinning objectives of our strategy:

    a) ***Our services*** – we will improve the quality of our services, and strive to provide safe, timely, effective, equitable and person-centred care every time, for every service user. As we strive for continuous improvement in quality, we will also strive to find ways to save time and money;

    b) ***Our people*** – we will have a productive and high performing workforce that work in great teams, and we will work side by side with service users and carers;

    c) ***Our resources*** – we will make full use of our resources, ensuring our buildings work for us, and using technology to help improve our care;

    d) ***Our future*** – we will create opportunities for improvement and grow in the future, by working more closely with primary care and other organisations, delivering the benefits of research, development and innovation, and by growing our services.

5. The Trust is delivering a programme of organisational and service transformation in order to significantly improve the quality of the services we provide and safely reduce cost as we do so. We call this continuous improvement in quality and cost, striving for perfect care. We also aim to play a full part in the health and social care economies we serve by promoting and driving greater integration between mental and physical health and social care.

6. We will deliver our objectives through our transformation programmes throughout the organisation through both our quality improvement work and through continuing to support business development, research and innovation. Achieving our vision of striving for perfect care at a time of unprecedented demand for NHS services and financial constraints on all NHS organisations requires a clear strategy based on clear aims and objectives, and effective implementation across all of our services.

7. In 2017/18 we have set five key priorities as we *strive to provide perfect care and a just culture*, namely

   a) Priority 1 – Reducing Restrictive Practice (No Force First);

   b) Priority 2 – Towards Zero Suicide;

   c) Priority 3 – Improving the Physical Health of our Service Users

   d) Priority 4 – A Just and Learning Culture

   e) Priority 5 – Zero Community Acquired Pressure Ulcers

   Details about the Trust's progress against these priorities can be found in the Quality Report for 2017/18.

8. As we make necessary improvements to our services, we support our clinical teams to maintain quality and safety during a period of increased demand on all NHS Trusts. The task of balancing this need for service continuity and safety with the need to deliver necessary transformation of our services is never underestimated.

9. A key component of our Strategy is the development of a *Just and Learning Culture*, where we put equal emphasis on accountability and learning. When things don't go as expected we try and find out 'what was responsible, not who is responsible'. For further information in this new approach please see paragraphs 214 - 218 below

10. On 1 June 2017 we acquired a wide range of community physical health services for South Sefton and a rehabilitation ward at Aintree University Hospitals from Liverpool Community Health NHS Trust, as part of a bidding process leading to their acquisition. This lead to the creation of a new clinical division within the Trust – the South Sefton Community Services Division. We have been working with these new teams to use their experience and skills to help improve Mersey Care and use our skills and experience to help improve the services they provide to local people. The acquisition of these services has also had a huge impact on Mersey Care, no longer are we just and mental health, learning disability and addictions provider, we are now a provider of both physical and mental health community services

11. After a protracted and extended bidding process we were notified in October 2017 that Mersey Care had been identified as the 'Preferred Acquirer' to acquire a wide range of community physical healthcare services for Liverpool from Liverpool Community Health NHS Trust (LCH). Being identified as 'Preferred Acquirer' meant that:

    a) under an Interim Management Agreement members of Mersey Care's Board, including the Chairman and Chief Executive, would join LCH's Board to help run LCH (although LCH still remained a separate legal body)[2];

    b) Mersey Care would be subject to an assessment process undertaken by NHS Improvement which, if successful, would mean Mersey Care would acquire the whole of LCH (i.e., the services provided to Liverpool) from 1 April 2018.

12. Following the support of Mersey Care's Board of Directors and its Council of Governors, and following the completion of the assessment process by NHS Improvement by the end of March 2018, from 1 April 2018 Mersey Care legally acquired LCH and LCH was disbanded. Mersey Care as such now provides a wide range of community physical health services to the people of Liverpool and South Sefton. To reflect this from 1 April 2018 a new clinical division has been formed – the Liverpool & South Sefton Community Division (including the South Sefton Community Services Division).

13. A key component of our bids for both the South Sefton and Liverpool physical health services was that it allowed for the integration of our existing community mental health services with these community physical health services. Many of our mental health, learning disability and additions service users also have physical health problems so the opportunity to integrate these community services over the next two years. The acquisition of the Liverpool and South Sefton now makes Mersey Care the leading provider of ***community healthcare services*** in these areas.

14. In addition from 1 April 2018, we will be providing mental health services at HM Prison Liverpool under a sub contract with Spectrum Healthcare Community Interest Company which is contracted by NHS England to provide the whole range of healthcare services at HM Prison Liverpool.

15. We are also continuing to embed the services we acquired from Calderstones Partnership NHS Foundation Trust on 1 July 2016, which now form the Specialist Learning Disabilities Division. This clinical division is working increasing closely with the Secure Division given that they are both primarily involved in the provision of secure forensic services, indeed a single Associate Medical Director now leads both of these clinical divisions.

[2] Details of those members of Mersey Care's Board who became members of LCH's Board can be found at paragraph 104 below (Table 3)

16. Some of the other Trust highlights for 2017/18 are outlined below:

a) we were subject to our second Care Quality Commission (CQC) inspection. In June 2017 CQC reported that Trust was 'good' for being effective, caring, responsive and well-led and 'requires improvement' for safety – with an overall rating of 'good'. The Specialist Learning Disability Division was rated as 'outstanding';

b) we obtained approval for the business case to build a new mental health and learning disability Medium Secure Unit at the Maghull Health Campus to replace the mental health secure unit at Scott Clinic, Rainhill, and the learning disability secure unit at Woodview, Whalley. The ground-breaking ceremony took place in April and we hope that this new unit will be open in 2020;

c) in May 2017 we officially opened the second Life Rooms at Southport and announced plans in September 2017, in conjunction with Hugh Baird College, to build a third Life Rooms in Bootle which is expected to be open in 2018. The first Life Rooms in Walton was also officially opened by HRH the Duke of Cambridge on 14 September 2017. The Life Rooms provide centres for learning, recovery, health and wellbeing, as well as the base for our Recovery College. Over the last 12 months Life Rooms Walton has been visited by 23,184 people and Life Rooms Southport has been visited by 11,682 people for advice support and college activity;

d) in August 2017 the Trust approved the business case to build a new mental health facility in Southport adjacent to our Boothroyd Unit (on the former Southport General Infirmary site). Building work started in November 2017 and it is expected that this new 44-bed mental health facility and integrated community mental health hub. Services are expected to move to this new unit from April 2019;

e) building on the Trust's work in respect of its priority of working towards zero suicide, in August 2017 Mersey Care entered into a formal partnership with Stanford University Medical Network Risk Authority LLC for a Limited Liability Company called *Innocence Augmented Intelligence Medical Systems – Psychiatry* (or *AIMS Psychiatry* for short) to design two 'apps' – *SWiM* and *SMiLE* – which are designed to reduce self-harm and suicide as part of a rigorously evaluated and ethically approved research study;

f) in September 2017 the Board approved the Funding Agreement with NHS England which meant that Mersey Care became a Global Digital Exemplar (GDE), one of seven such mental health trusts in the country. The GDE means the Trust is recognised as one of the most advanced NHS IT organisations who are committed to becoming world class exemplars for the harnessing of technology and innovation from which other organisations can learn;

g) Mersey Care is committed to reducing the number of deaths by suicide of people in our care to zero by 2020. As part of this initiative, together with bereaved families, charities, politician and over 90 NHS organisations, in

November 2017 we launched the Zero Suicide Alliance at the Houses of Parliament. The aim of the Alliance is to ensure suicide is taken seriously and use of the best prevention evidence to reduce the number of suicides across the country. One of the Alliance objectives is to encourage one million people to take a 20-minutes free online training course on suicide prevention. Since its launch in November over 7,300 people have taken the training. ***Save a life and take the training*** at www.zerosuicidealliance.com

h) In January 2018 as part of our approach to a Just and Learning Culture, Professor Sidney Dekker (who is leading authority on the Just Culture approach), visited a range of Trust services and met with service users, carers and staff over a week. He produced a film of his experiences and the Trust's progress on its Just and Learning Culture journey which is available at http://sidneydekker.com/just-culture/;

i) we are delighted that our progress has been recognised by others as in 2017/18, amongst other recognition, Mersey Care's Primary Care Mental Health Liaison Team won the Best Nursing Technology Award at the EHI Awards for the GATE Assessment Tool and the 'No Force First' team winning the Improving Patient Safety Award at the Nursing Times Award.

CHAPTER 2 – RISK MANAGEMENT

17. Risk management enables individuals and the Trust as a whole to deal competently with all key risks, clinical and non-clinical, providing confidence that the Trust will achieve its objectives. Mersey Care's Board of Directors has overall responsibility for:

    a) ensuring robust systems of internal control are in place and are appropriately resourced;

    b) encouraging a culture whereby risk management is embedded across the Trust;

    c) routinely considering risks and collectively being assured that risks are being effectively managed;

    d) through its plans, set out its appetite and priorities in respect of the mitigation of risk when delivering a safe and high quality service.

18. The Board of Directors and its supporting Board committees are detailed in the Annual Governance Statement (see Chapter 15).

19. During the majority of 2017/18 the Executive Director of Nursing had responsibility for overseeing the Trust's risk management arrangements. In March 2018 the Medical Director took over responsibility for the Trust's risk management arrangements. The Executive Lead is supported by the Director of Patient Safety and a dedicated risk manager who are responsible for implementing effective systems and processes of risk management across the organisation including the identification, management and monitoring of risks; and providing reports, information and training as appropriate.

20. As well as the Board of Directors, other senior Trust staff, managers and individual staff members, clinical leads and other senior managers, are responsible for ensuring that they engage with risk management objectives in order to ensure that their clinical and managerial responsibilities for risk management are met.

21. Risks that were listed in the Board Assurance Framework as at March 2018 are shown in the following table and the Board Assurance Framework (March 2018) in the Annual Governance Statement further on in this document. Embedding risk management as a core activity within the organisation is achieved through multiple systems and processes and 2017/18 has seen:

    a) the risk assessment-reviewing template amended to include specific actions to be taken for each risk;

    b) initial and new target dates of risks now clearly stated in reports, along with an explanation of the reasons target dates are changed;

    c) risk management systems for Mersey Care and the South Sefton Community Services Division (part of Liverpool Community Health NHS Trust until June 2017) now fully integrated;

    d) risk register system and risk management training and development sessions taken place for Board, managers, risk leads and relevant administration staff;

    e) the Risk Management Group continuing to meet on a monthly basis, considering risks from teams / divisions, liaising with them and reporting to the Board Committees on these risks (and through these Board Committees to the Board of Directors);

    f) further risk management development sessions organised;

    g) risk management included in essential skills training package for managers.

22. The development of the Board Assurance Framework has enabled the Trust to systematically identify, record and action the key risks it faces in relation to the achievement of its overarching strategic objectives. An opinion on the assurance framework has been provided by Mersey Internal Audit Agency. The opinion (review) states that: "*The organisation's Assurance Framework meets the NHS requirements, is visibly used by the Board and reflects the risks discussed by the Board*".

23. The Board Assurance Framework discussed by the Board of Directors at its meeting in March 2018 can be found in Table 15 (see paragraph 266 of Chapter 15 – Annual Governance Statement.

PART B – PERFORMANCE REPORT

CHAPTER 3 – EXECUTIVE PERFORMANCE REPORT (previously Care at a Glance)

24. The Executive Performance Report (previously called 'Care at a Glance') provides the Board of Directors and Board Committees with high level information relating to Trust performance across a number of key areas.

25. The Trust's Strategic Priorities for 2017/18 are related to the underpinning objectives linked to the strategy which are to improve the quality of our services, and strive to provide safe, timely, effective, equitable and person-centred care every time, for every service user.

26. The breakdown of the key areas is:

    a) Regulatory – this includes information relating to the Trust's compliance with Care Quality Commission requirements and performance against indicators in the NHS Improvement Single Oversight Framework;

    b) Our services – this looks at saving time and money and improving quality (safe, timely, effective, equitable, efficient and patient centred);

    c) Our people – this looks at whether we have great managers and teams, a productive workforce with the right skills and the extent to which we are working side by side with service users and carers

    d) Our resources – this looks at our investment in technology to help us provide better care and ensure that we have buildings that work for us;

    e) Our future – this includes measures that show the benefits of research and innovation, our progress in growing our services and how we work effectively with primary care and other organisations.

27. The high level Executive Performance Report is supported by a number of detailed documents that provide the Board of Directors and Board Committee members with further information about the Trust's performance. The Executive Performance Report is also a standing item on the agenda of the Performance, Investment and Finance Committee, a Non Executive Director chaired committee of the Board of Directors. Performance is regularly reviewed at the Operational Management Boards (which oversee the delivery of the Trust's clinical services) that report to the Executive Committee, a committee of the Board. This includes identifying areas of performance improvement and the actions required/being undertaken to achieve this. Information is also provided from this performance process to the Council of Governors.

28. During 2017/18 Mersey Care provided care, treatment and support to 33,726 service users, broken down as follows for each of the four clinical divisions:

Clinical Division	No. of Service Users
Local Services Division	22,068
Secure Division	245
Specialist Learning Disability Division	1,119
South Sefton Community Division	10,294

29. During 2017/18 Mersey Care provided services from 53 sites (freehold - 29, Leasehold - 24) and, as at 31 March 2018, had 766 inpatient beds. The Trust also had 568,951 outpatient attendances, community contacts or domiciliary visits. A breakdown of this activity by service line is provided in the table below:

Service line	Activity Type	2017/2018
Adult mental health services	Outpatient	23,305
	Community	153,172
Assessment services	Outpatient	1,273
	Community	25,393
Complex care services	Outpatient	8,252
	Community	61,268
Specialist services	Outpatient	2,702
	Community	37,625
Low secure services	Outpatient	2
	Community	3,888
Medium secure services	Outpatient	94
	Community	5,455
		Continued
Offender health	Outpatient	41
	Community	4,848
South Sefton Community Division	Outpatient	48,018
	Domiciliary	177,764
Other service lines	Outpatient	107
	Community	15,744
Total		568,951

CHAPTER 4 – ENVIRONMENT & SUSTAINABILITY

Sustainability and Carbon Management

30. In response to the NHS Sustainability Development Unit (SDU) objectives to embed sustainability into all areas of the NHS, the Trust has a Carbon Management Plan but has developed a sustainability framework, based on the SDU's model referred to as a Sustainable Development Management Plan (SDMP) and delivery plan that has been approved by the Board of Directors.

31. The development of an SDMP will enable a more holistic view of the Trust's carbon footprint in order to extend carbon reductions beyond energy consumption and into areas such as procurement and travel, in order to meet national NHS carbon reduction targets.

32. This will require a more strategic board level driven approach to sustainability and will lead to embedding sustainability objectives across all departments within the organisation.

33. This year has seen a decrease in carbon emissions relating to Scope 1 and Scope 2 emissions from previous, this being attributed to the Trust disposing of a number of properties, the most significant being the closure of HM Prison Kennet at the Maghull Health Campus.

34. Nonetheless, it is recognised that there is a need for significant capital investment in carbon reduction projects going forward if the Trust is to maintain the momentum needed to achieve the increasingly tough targets within the carbon management elements of the sustainability framework.

35. A summary of the carbon emissions for the past 5 years as compared to the base line year is provided below:

Carbon Emissions (electricity & gas) - CO_2e tonnes						
2009/10 (Base Year)	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
11,222	10,787	10,028	9,748	9,835	8,684	6,894

36. The energy consumption and carbon emission figures for the current year along with a comparison of the previous year are detailed in the table below.

Greenhouse Gas Emissions Indicator	Consumption *(MWh)*		Emissions *(CO_2e tonnes)*	
	2016/17	2017/18	2016/17	2017/18
Scope 1 (Direct) Emissions - gas consumption	24,897	20,164	4,096	3,075
Scope 2 (Indirect) Emissions - electricity consumption	9,132	8,003	4,572	3,819
	Distance Travelled *(Miles)*		Emissions *(CO_2e tonnes)*	
	2016/17	2017/18	2016/17	2017/18

Scope 3 – official business travel emissions	Air travel	94,145	46,365	8.21	7.33
	Road travel	2,192,710	2,551,769	644.16	747.98
	Rail travel	193,470	217,187	14.75	16.61

37. A number of objectives and targets will need to be set during the coming year to address these increases and it is advised that this could be achieved through the implementation of the Trusts Sustainable Development Management Plan (SDMP).

Financial Indicator for Energy	2016/17	2017/18
Cost of Scope 1 & Scope 2 consumption (£)	1,302,916	2,607,750

38. Capital Projects successfully implemented in the current year have included the refurbishment of a ward in the Secure Division which included a variety of energy efficient measures, (including; LED lighting, boilers, pipe insulation and double glazed windows) achieving a BREEAM 'Good' standard. The ward refurbishment programme continues into 2018.

Water Consumption & Management

39. As a major user of water for domestic purposes the Trust aims to manage its water consumption responsibly through its environmental management system.

40. Water consumption is being continually monitoring across all Trust sites and night usage baselines established and wherever practical reduced or removed in order to eliminate unnecessary water usage. A number of new water meters have been installed at various Trust sites in order to replace inefficient meters which will help improve monitoring in the future.

41. Water consumption for the current year has shown an increase on the previous year. Costs have also increased due to higher usage charges being levied by the water supplier.

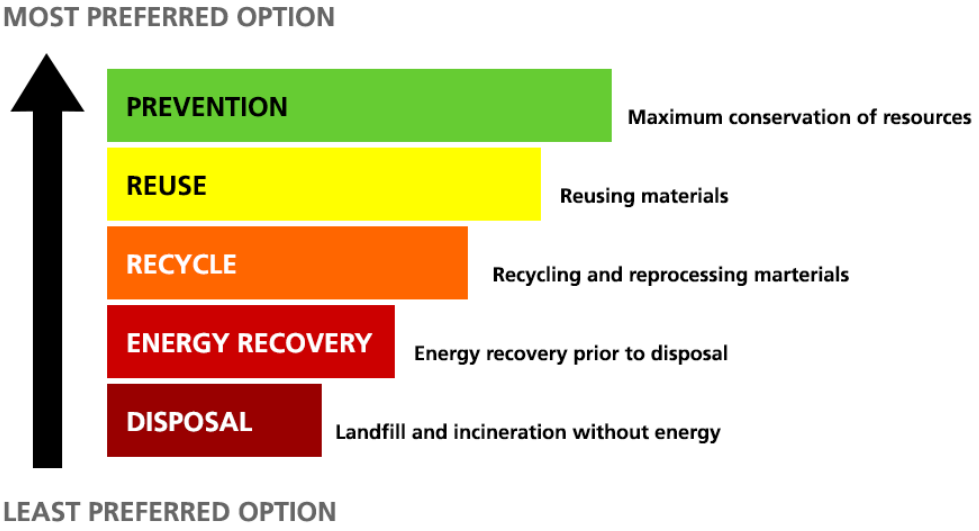
Finite Resource Consumption Indicator	2015/16	2016/17	2017/18
Water consumption (m^3)	110,487	85,805	153,986
Total expenditure – Water (£)	468,861	414,659	738,401

Waste Management

42. The Trust currently has an integrated waste and recycling contract across all of its sites, operated by independent waste contractors. The general waste stream is separated out into recyclable fractions at an off-site material recovery facility (MRF). By placing all non-clinical waste streams into a single general waste bin, it is easier to engage both service users and staff in recycling activity. Over 93% of general waste collected from Trust sites is now sent for recycling or energy recovery (via incineration). As a result of this service, the Trust has seen significant increases in

the levels of waste recycled year-on-year and proportionately less waste sent to landfill.

43. The generation of clinical and hazardous wastes by the Trust necessitates the commitment of significant financial resources to ensure statutory responsibilities are met. As a result we are working towards moving wastes up the waste hierarchy and placing more emphasis on the prevention of waste and increasing reuse and recycling. Where it is not possible to recover resources, landfill and incineration without energy recovery are viewed as a last resort option. By considering the life cycle of materials in such a way, the Trust will in turn reduce its carbon footprint and maximise cost savings.



Waste minimisation and management indicators (tonnes)	2015/16		2016/17		2017/18	
	Tonnes	%	Tonnes	%	Tonnes	%
Waste recycled/reused	477	48	357	54	213	32
Waste incinerated (clinical waste)/energy from waste	447	45	261	40	430	65
Waste to landfill	73	7	39	6	16	3
Total waste arising (tonnes)	997	100	657	100	659	100

Financial indicators on waste	2015/16	2016/17	2017/18
Cost of waste incinerated/energy from waste (clinical waste) £	22,768.33	20,975.27	33,285.30
Total expenditure on waste arising £	191,695.79	163,997.67	168,858.09

44. Challenges remain in minimising the overall production of waste at source and reducing the amount of non-clinical waste being disposed of through clinical waste receptacles. Audits covering all aspects of waste are periodically undertaken across the Trust to ensure the appropriate segregation is happening and suitable receptacles are in place.

45. Adopting a life cycle approach is enabling the Trust to look beyond the direct costs of generating waste. For example, in the last year emphasis has been placed on the

sorting of waste at source where possible. This has reduced the volumes of residual waste greatly and tonnages landfilled are kept to a minimum.

CHAPTER 5 – EQUALITY, DIVERSITY AND HUMAN RIGHTS

46. Equality and Human Rights continue to be an important element for Mersey Care in its provision of services to the people we serve and for the people it employs.

47. Mersey Care has been an NHS Diversity Partner in 2017/18; we also worked with NHS Employers as a member of the stakeholder group for the development of the Sexual Orientation Monitoring Standard. The Trust has been effectively monitoring, analysing, evaluating and developing services for people who have identified as Lesbian, gay or bisexual for over 7 years and following the standard have adapted its monitoring process to ensure we mirror that which is now expected across the NHS.

48. We continue to have a system across all divisions to ensure it is within the work of our colleagues, our clinical areas, our corporate departments and committees.

49. The Trust has made the assurance of EQUITY within its key standards of Quality. This is assessed at the Board of Directors, The Quality Assurance Committee and within Perfect Care.

50. The Trust has an Equality and Human Rights Sub Committee chaired by a Non Executive Director, which reports via the Executive Committee to the Board of Directors. This provides governance, assurance and support for equality and human rights developments across the Trust. It includes the monitoring of the Trust wide equality and human rights action plan and the divisional plans which seek to pull together and monitor the numerous actions across each division, within the governance structures, service delivery and direct clinical areas.

51. The Board of Directors receives a number of key equality driven performance reports within its routine business alongside the equality or human rights specific reports.

52. The Trust has introduced a reasonable adjustment audit across all clinical divisions which support the delivery of accessible services. This also includes the requirements within the Accessible Information Standard. The Clinical Divisions have this within their equality and human rights action plans to ensure it is monitored internally and reported to the Equality and Human Rights Sub Committee.

53. The Trust has registered as being Disability Confident Committed and is working towards Disability Confident Employer.

54. Within the Specialist Learning Disabilities Division a program has been put in place to support the elimination of discrimination that can be experienced by both people using services and people employed by the Division. It has involved support from voluntary agencies and the police to develop an understanding of hate crime and the support available to people.

55. The Trust held a community event in Liverpool to celebrate International Day Against Homophobia, Biphobia and Transphobia (IDAHOBIT) which brought together individuals, community networks public bodies and staff side representatives.

56. The Trust is also engaged in a number of networks to support people seeking asylum and refugees. We host and Chair a health network looking specifically at the physical and mental wellbeing with the asylum process and those who have been granted leave to remain. We have been supporting the setting up of a network for LGBT people seeking asylum with a view to addressing issues of isolation and discrimination that people face called Many Hands One Heart. Plans are in place to coordinate the Liverpool (IDAHOBIT) event with Many Hands One Heart for 2018.

CHAPTER 6 – COMPLAINTS AND COMPLIMENTS

57. The Trust uses learning from complaints and compliments as a further means of measuring performance. From 1 April 2017 to 31 March 2018, a total of 415 complaints were received, compared with 646 for the same period in 2016/17. Overall the Trust has seen a reduction of approximately 36% in the number of complaints received during 2017/18 which continues to reflect the work done with our services on learning from complaints, addressing themes and trends and working closely with the Patient Advice and Liaison team to resolve concerns quickly without the need for formal investigation.

58. As a Trust, we welcome all types of feedback. This enables us to continually improve our services for the communities which we serve. We recorded 359 compliments in 2017/18 through a mix of verbal, written and face to face from service users, carers, families and external organisations. This figure has increased from 2017/18 when we recorded 58 compliments. This increase is largely due to the South Sefton Community Division who record all compliments within their teams. It has now been made accessible for all teams to log compliments on Datix and the complaints team have encouraged wards/teams to ensure all positive feedback is recorded.

CHAPTER 7 – EMERGENCY PLANNING, RESILIENCE AND RESPONSE

59. The Trust has a Board-approved Major Incident Plan together with supporting plans and business continuity plans, which are regularly tested. Each year these systems and plans are subject to an assurance process led by NHS England. Mersey Care's arrangements are regarded as compliant by NHS England as part of their 2017/18 Assurance Process.

CHAPTER 8 – FINANCE DIRECTOR'S REPORT

Summary

60. The Trust is operating in a challenging national financial climate and a period of significant change for the Trust. Against this backdrop, it has delivered a strong financial performance and has achieved all of its statutory financial duties and financial targets.

61. The Trust has a strong track record of delivering financial targets without compromising service quality. In June 2017, the Trust became the provider of community based physical health services in Sefton and will do the same for

Liverpool from 1 April 2018. Detailed plans to integrate and transform these new and existing services will ensure the Trust continues to make progress in delivering perfect care.

62. Over the next 3 years the Trust is planning for an annual surplus of between £4.1m - £5.5m and has assumed efficiencies of 2% per annum will be delivered in line with national guidance. These efficiencies will come from corporate and non-clinical functions rather than front line clinical services.

63. These efficiencies will support delivery of an annual surplus that will provide cash to support improvements to our estate and IT services.

Financial Duties

64. To achieve a balanced position on the income statement - the Trust made a surplus of £6.9m, before impairments of £9.2m for the twelve month period to 31 March 2018.

65. To achieve a 3.5% return on the net assets owned by the Trust - this target was achieved with a 3.5% return on net assets.

66. The Trust reported a Capital Delegated Expenditure Limit (CDEL) of £17.921m for the year.

Financial Overview

67. The Trust had an income budget of £276.6m in 2017-18. A cost improvement programme of £6.2m was delivered across the Trust which supported the delivery of the surplus of £6.9m. The surplus delivered each year provides funds to support capital investment for the benefit of service users and the local population.

68. Capital investment in 2017-18 includes:

a) purchase of the Thomas Leigh building - £3.2m;

b) new Pharmacy build on the Maghull site - £2.1m;

c) ground clearance work at the Maghull Health Campus site - £1.9m;

d) refurbishment of the Kevin White Unit - £1.5m;

e) Southport Inpatient facility - £1.3m;

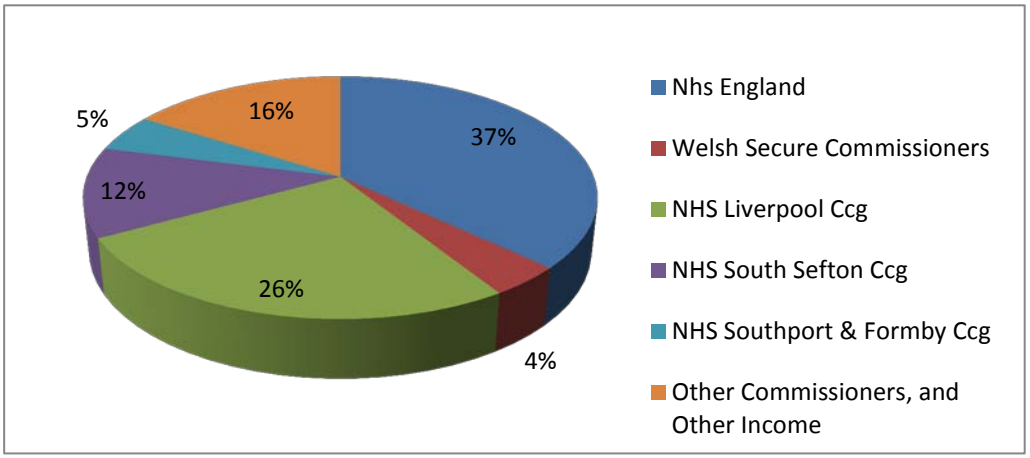
f) Global Digital Exemplar - £0.6m.

Income and Expenditure

Income

69. The Trust received income of £276.6m in 2017-18 which was generated from a number of sources as set out in **Figure 1.**

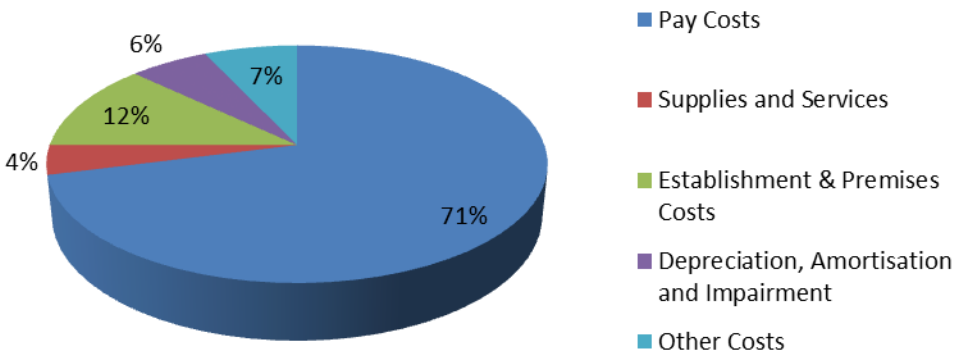
Figure1: Analysis of Trust Income for 2017/18



Operating Expenditure

70. The Trust has used the income it received to fund the cost of services provided. The major areas of cost are summarised in **Figure 2**. The majority of the Trust's costs relate to staff.

Figure 2: Analysis of Trust Expenditure for 2017/18



Better Payments Practice Code

71. The Better Payments Practice Code (BPPC) requires the Trust to pay a minimum of 95% of all NHS and non-NHS invoices within 30 days of receipt of the goods or valid invoice. In 2017-18, the Trust achieved an average of 97.7%.

Prompt Payments Code

72. The Prompt Payment Code is a payment initiative developed by Government with the Institute of Credit Management (ICM) to improve liquidity for small businesses.

73. Mersey Care has signed up to the code and is committed to pay all invoices relating to small and medium businesses and individuals within 10 days.

74. A guide for suppliers and contractors regarding the code is available in finance section of the Trust's website at https://www.merseycare.nhs.uk/about-us/finance/.

Going Concern

75. The Board of Directors have considered the key issues and risks to support the preparation of these accounts on a going concern concept.

76. The Board of Directors have found that there are no material uncertainties that may cast significant doubt on its ability to continue as a going concern. There is a reasonable expectation that the trust's assets and liabilities are recorded on the basis that assets will be realised and liabilities discharged in the normal course of business and there is sufficient cash resources to meet its obligations as they fall due. Therefore, these accounts have been prepared on a going concern basis

Trust Auditors

77. The external auditor for the Trust was Grant Thornton UK LLP, who provides audit services in relation to the statutory audit duties as required by the Department of Health in providing an independent audit opinion. **Table 1a** shows the fee for work carried out during 2017/18 on the financial statements and opinion was £61,020 detailed as follows:

Table 1a: External Audit Fees for 2017/18

Audit Services	£
Financial statements and value for money	54,180
Other services (including the Trust's Quality Report)	6,840
Total	61,020

Note – the above fees include VAT

Longer Term Outlook

78. The financial framework supports the delivery of the Trust's strategy and ensures the Trust retains a strong financial position. The key principles of the financial framework will ensure:

a) a continued drive to transform and integrate clinical services, improve efficiency and effectiveness whilst supporting front line staff;

b) the financing of an annual cost improvement programme (CIPs) from non-clinical services;

c) continued progress to deliver the Five Year Forward View (FYFV) for Mental Health;

d) financial governance is strengthened across all services and divisions;

e) divisional costs pressures are funded by additional CIP's within divisions;

f) delivery of an ambitious capital programme;

g) the delivery of statutory financial duties, including control totals.

79. The Trust is operating within an environment of financial distress. At a national level, many NHS providers are in deficit and local commissioners have limited resources to invest. The Trust is required to deliver annual cost improvement savings of circa 2% per annum to meet additional patient demand and is required to deliver new access targets with minimal support.

80. 2017/18 was the second year of the Five Year Forward View (FYFV) for the NHS, which outlined how the NHS will need to change in the five years to 2020/21. The NHS faces a funding gap of £22bn by 2020/21. The NHS Operating Planning and Contracting guidance was published in September 2016. Delivering the Forward View detailed nine 'must dos' for the NHS, these remain key priorities for 2018/19. The "Refreshing NHS Plans for 2018/19" guidance issued in February 2018 announced an additional £540m nationally for front line mental health and primary care services.

81. A two year operating plan together with signed commissioner contracts were agreed and submitted in December 2016. A refreshed plan for 2018/19, including community physical health services was submitted in April 2018. Annual turnover will increase from £277m to £365m as a result of taking on Liverpool community based physical health services.

82. All NHS providers have been issued with a financial control total that determines the level of surplus/deficit that providers are required to deliver 2018/19. The Trust's control total for 2018/19, including STF funding, is £5.5m. The trust has a strong recurrent financial position, but the current financial climate has led to the trust incurring a number of non-recurrent cost pressures for 2018/19. As such, delivery of the control total will be subject to the trust managing its financial risks and delivering its CIP's.

83. The control totals for the Trust are shown in **Table 1b**.

Table 1b: Financial Control Totals 2018/19 – 2020/21

Surplus / Deficit (-)	2018/19 £m	2019/20 £m	2020/21 £m
Mersey Care	5.5	4.1	4.1

Conclusion

84. The Trust continues to deliver a strong financial position during a challenging economic climate. I would like to thank all staff who have worked hard to deliver the planned surplus and who have contributed to our investment in the estate and IT equipment. We have opened the refurbished Kevin White Unit as the Hope Unit and started work on the Southport inpatient facility, the Medium Secure Unit and the Global Digital Exemplar. These developments will continue in 2018/19 and the Trust plans to spend £49.9m on all capital schemes. This would not be possible without the commitment to delivery of the financial plans each year.

PART C – ACCOUNTABILITY REPORT

CHAPTER 9 – DIRECTOR'S REPORT

85. The Directors' Report has been prepared under direction issued by Monitor, the independent regulator for NHS foundation trusts acting under the auspices of NHS Improvement, as required by Schedule 7 paragraph 26 of the NHS Act 2006 and in accordance with:

a) Sections 415, 416 and 418 of the Companies Act 2006 (section 415(4) and (5) and section 418(5) and (6) do not apply to foundation trusts);

b) Regulation 10 and Schedule 7 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 ('the Regulations');

c) Additional Disclosures as required by the FReM;

d) Additional Disclosures as required by NHS Improvement.

The Council of Governors

86. Upon becoming a Foundation Trust on 1 May 2016, the Trust established its first Council of Governors. The Constitution of the Trust was amended, together with the composition of the Council of Governors, to take account of the acquisition of Calderstones Partnership NHS Foundation Trust on 1 June 2017.

87. The role of the Council of Governors is set out in the NHS Act 2006 and as amended by the Health and Social Care Act 2012. It includes:

a) appointing and, if appropriate, removing the Trust chairman and other non-executive directors

b) deciding the remuneration and allowances and other terms and conditions of office of the chairman and the other non-executive directors

c) approving (or not) any new appointment of a chief executive

d) appointing and, if appropriate, removing the Trust's auditor

e) receiving the Trust's annual accounts, any report of the auditor on them and the annual report, at a general meeting of the council of governors

f) providing views on the Trust's forward plan

g) holding the non-executive directors, individually and collectively, to account for the performance of the board of directors

h) representing the interests of the members of the Trust as a whole and the interests of the public

i) approving significant transactions

j) approving an application by the Trust to enter into a merger, acquisition, separation or dissolution

k) deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions

l) approving amendments to the Trust's Constitution

88. The Council of Governors operates in accordance with it statutory powers which are described in the Trust's Constitution which is regularly reviewed. The Constitution also provides the Standing Orders for the operation of the Council and its meetings, including information as to how any disagreements between the Council of Governors and the Board of Directors can be managed. No such disagreements took place in 2017/18.

89. It is intended that the Council of Governors meets four times a year, however as can be seen from the list of meeting below a number of extraordinary meeting has to be held in March 2018 in respect of the acquisition of Liverpool Community Health NHS Trust:

a) Thursday 27 April 2017;

b) Wednesday 26 July 2017;

c) Wednesday 25 October 2017;

d) Wednesday 17 January 2018;

e) Wednesday 21 March 2018;

f) Wednesday 28 March 2018.

90. The meetings are supported by an annual cycle of business to help inform meeting agendas and are supported by a Nominations and Remuneration Committee and a Membership & Engagement Working Group, although these groups may only made recommendations which need to be approved by the full Council. Key decisions made by the Council of Governors in 2017/18 include:

a) re-electing their Lead Governor (Hilary Tetlow);

b) appointed a new Non Executive Director and extended the terms of existing Non Executive Directors;

c) considered the Operation Plan for 2018/19 and the Quality Report for 2017/18

d) received the Annual Accounts and external audit opinion;

e) approved changes to the Trust's Constitution;

f) approved the process for and considered the outcome of the Chairman's and Non Executive Directors appraisal process

g) approved the acquisition of Liverpool Community Health NHS Trust by Mersey Care.

91. Governor elections were held in 2017 (the results being issued on 12 September 2017) and then a process was undertaken to ensure the eligibility of Governors. Towards the end of 2017 an induction and training programme was undertaken for new and existing Governors, taking into account the experience of existing Governors of the induction programme undertaken in 2016.

92. A list of Governors can be found in **Table 2** below, which shows those Governors who have left or joined the Council of Governors over the 2017/18 reporting period. Details of Governors attendance at Council meetings can be found in the **Appendix A**.

Table 2: Council of Governors in Post during 2017/18

Constituency	Governor	Term of Office	
		From	To
Public Constituencies (Elected Governors)			
Liverpool	Jayne Moore	01/05/16	30/04/19
	Vacant	-	-
	Vacant	-	-
Sefton	John Mousley	01/05/16	30/09/18
	Vacant (1)	-	-
Knowsley	Vacant	-	-
Ribble Valley	Vacant (2)	-	-
Cumbria, Lancashire & Greater Manchester	Mairi Byrne	01/11/17	Resigned 27/02/18
Cheshire, St Helens, Wirral, West Midlands and Wales	Garrick Prayogg	01/11/17	30/09/20
Rest of England	Vacant	-	-
Staff Constituencies (Elected Governors)			
Medical (not from Calderstones)	Hetalkumar Mehta	01/05/16	Resigned 29/09/17
Medical (from Calderstones)	Sayed Ahmed	01/11/17	30/09/20
Nursing Staff (not from Calderstones)	Scott Parker	01/05/16	30/09/18
	Maria Tyson	01/05/16	30/04/19
Nursing Staff (from Calderstones)	Tracey Cummins	01/11/17	30/09/20
Other Clinical, Scientific, Technical and Therapeutic Staff (not from Calderstones)	Sara Finlayson	01/05/16	30/04/19
	David Kitchen	01/05/16	30/09/18
Other Clinical, Scientific, Technical and Therapeutic Staff (from Calderstones)	Paul Allen	01/11/17	30/09/20
Non Clinical Staff	Mandi Gregory	01/05/16	30/04/19
	Mike Jones	01/05/16	30/04/19

Constituency	Governor	Term of Office	
		From	To
Service User and Carer Constituencies (Elected Governors)			
Service User Local (Liverpool, Sefton & Knowsley)	Johanna Birrell	01/05/16	30/04/19
	Debra Doherty	01/05/16	30/04/19
	Mark McCarthy	01/05/16	30/04/19
	Martin Murphy	01/05/16	30/04/19
	Paul Taylor	01/11/17	30/09/20
Service User (Rest of England and Wales)	Vacant (3)	-	-
Carer Local (Liverpool, Sefton & Knowsley)	George Allen	01/05/16	30/09/18
	Brian Murphy	01/05/16	30/09/18
	Hilary Tetlow	01/05/16	30/09/18
Carer (Rest of England and Wales)	Vacant	-	-
Appointed Governors			
Academic (Edge Hull University)	Clare Austin	01/05/16	30/09/19
Clinical Commissioning Group (Liverpool)	Jane Lunt	01/05/16	31/03/18
Local Authority (Sefton Council)	Veronica Webster	01/05/16	30/04/19
Local Authority (Ribble Valley Council)	Vacant	-	-
Voluntary Sector (Sefton Carers)	Vicky Keeley	1/08/2017	30/04/19

Notes		
	1	Elected Governor resigned before taking up post
	2	Elected Governor resigned before taking up post
	3	Elected Governor was found not to meet the eligibility criteria

93. Further details about the Trust's Governors can be found on the Trust's website at https://www.merseycare.nhs.uk/council-of-governors/. Information about Governors' interest can be found on the following website at https://merseycare.mydeclarations.co.uk/home?AspxAutoDetectCookieSupport=1), and for those without access to a computer via application to the Trust Secretary.

94. As a result of the acquisition of Liverpool Community Health NHS Trust the Council of Governors and Board of Directors reviewed the membership constituencies and the composition of the Council of Governors. A new Constitution has been approved which came into force on 1 April 2018 which

a) reduced the number of public constituencies from seven to four, and reduced the number of public elected Governors from ten to eight

b) reduced the number of classes in the service user and carer constituency from four to one, and reduced the number of service user and carer elected Governors from ten to eight;

c) reduced the number of staff constituencies from seven to four, and reduced the number of staff elected Governors from ten to eight;

d) retained the number of Appointed Governors, although changed one of the bodies they would be representing.

95. The overall effect of these changes is to reduce the number of Governors from 35 to 29 from 1 April 2018. Elections will take place for those posts that are vacant or where the elected Governor terms of office is ending by the end of September 2018.

96. Governors can be contacted via one of the following methods:

a) by emailing MerseycareCoG@merseycare.nhs.ukand clearly state the name of the Governor you wish to contact

b) by email one of the constituencies of Governors
   i) Service Users and Carers - serviceuser-carer.Governors@merseycare.nhs.uk

   ii) Mersey Care staff - Staff.Governors@merseycare.nhs.uk

   iii) Members of the public - Public.Governors@merseycare.nhs.uk

97. If you wish to become a member of Mersey Care then please either go the Trust's website at https://www.merseycare.nhs.uk/getting-involved/become-a-member/ or ring the Membership Secretary on 0151 471 2303 for further information.

The Board of Directors

98. The Board of Directors is a unitary board, which means that the both the Non-Executive Directors (NEDs) and the Executive Directors are jointly and severally responsible for the actions they take. In compliance with The NHS Foundation Trust Code of Governance. The Trust's Constitution provides for the composition of the Board of Directors as follows;

a) a Chairman;

b) up to seven Non Executive Directors;

c) up to seven Executive Directors, including the Chief Executive

Other directors attend the Board in a non-voting capacity.

99. The role of the Board of Directors is to:

a) establish the Trust's vision, mission and values;

b) set the Trust's strategy and structure'

c) provide leaders to the Trust;

d) agree those matters that should be delegated to management;

e) exercise accountability to regulators, members and stakeholders

100. How the Board of Directors exercises it powers is described in the Trust's Constitution, including the Standing Orders for the operation of its meetings and how the Board, through its Chairman and Non Executive Directors (who are independent), are accountable to the Council of Governors. The agendas for meetings of the Board and its Board Committee are informed by annual cycle of business which are approved by the Board. Details of these Board Committees can be found in paragraph 348 (Table 16) below and their Board approved terms of reference can be found in the Trust's Scheme of Reservation and Delegation of Powers (available in the policies and procedures section of the Trust's website. Details about Board members can be found below and details of member's attendance at Board and Board Committee meetings can be found in the appendices supporting Chapter 15 – Annual Governance Statement.

101. The Board of Directors regularly reviews and approve a Scheme of Reservation and Delegation of Powers which details those matters which are reserved for decisions by the Board only and those matters delegated to management. In accordance with the Foundation Trust Code of Governance matters are only delegated to executive (i.e., voting) members of the Board, unless statue allows delegation to another officer of the Trust.

102. Details about the membership of the Board may be found in **Table 3** (see paragraph 104) below.

103. During the reporting period of this Annual Report, 2017/18, the following changes have occurred with the Board of Directors:

a) Non Executive Directors:
   i) Brenda Roe – resigned 15 May 2017,
   ii) Gaynor Hales – appointed 23 May 2017,
   iii) Robert Beardall – resigned 6 March 2018;

b) Executive Directors:
   i) Ray Walker – departed as Executive Director of Nursing on 28 February 2018,
   ii) Trish Bennett – appointed as Executive Director of Nursing from 1 March 2018;

c) Other Directors (non-voting)
   i) Jim Hughes – retired as Director of Informatics and Performance Improvement on 31 August 2017;
   ii) Trish Bennett – stepped down as Director of Integration on 28 February 2018 following her appointment as Executive Director of Nursing (see above).

104. A full list of the Board of Directors is provided in **Table 3** overleaf. Further details regarding the directors' skills, expertise and experience is available from in paragraph 106 below.

Table 3: The Board of Directors for the Year Ending 31 March 2017

Name	Title		Term of Office	
			From	To
Chairman and Non-Executive Directors		**Time in Office**		
Beatrice Fraenkel ^	Chairman	3yrs 5 mths	01/04/08	03/11/19
Gerry O'Keeffe ^	Non-Executive Director	3yrs 11 mths	18/04/13	17/04/20
Matt Birch	Non-Executive Director	4yrs 3 mths	05/09/12	31/08/20
Nick Williams	Non-Executive Director	3yrs 10 mths	01/01/14	31/12/19
Pam Williams ^	Non-Executive Director	4yrs 1 mth	15/06/15	14/06/20
Cath Green	Non-Executive Director	3yrs	02/02/17	01/02/20
Gaynor Hales	Non-Executive Director	3yrs	23/05/17	22/05/20
Brenda Roe	Non-Executive Director	n/a	16/05/13	15/05/17 (Resigned)
Robert Beardall ^	Non-Executive Director	n/a	01/04/16	06/03/18 (Resigned)
Note – The Foundation Trust Code of Governance calls for Non Executives to usually serve no more that 6 years in office. When Mersey Care became a Foundation Trust, the terms of office of existing Chairman / Non Executives were reset to start from 1 May 2016 in accordance with the Trust's Constitution (i.e. that date Mersey Care became a Foundation Trust). The 'Time in Office' column shows how long a Non Executive ***will have*** been in post at the end of their ***existing*** term of office				
Executive Team Members				
Executive Directors (Voting)				
Joe Rafferty ^	Chief Executive		01/09/12	N/A
Neil Smith ^	Executive Director of Finance/Deputy Chief Executive		04/05/04	N/A
David Fearnley ^	Medical Director		03/08/05	N/A
Amanda Oates ^	Executive Director of Workforce		01/08/13	N/A
Elaine Darbyshire	Executive Director of Communication and Corporate Governance		01/06/13	N/A
Mark Hindle	Executive Director of Operations		23/09/13	N/A
Trish Bennett ^ *	Executive Director of Nursing		01/03/18	N/A
Ray Walker	Executive Director of Nursing		20/06/11	Seconded (28/2/17)
Other Directors (Non-Voting)				
Trish Bennett ^ *	Director of Integration		01/08/16	28/02/18
Louise Edwards	Director of Strategy		12/11/12	N/A
Jim Hughes	Director of Informatics and Performance Improvement		01/03/13	31/8/17
Andy Meadows	Trust Secretary		21/03/14	N/A
^ Served as a member of Liverpool Community Health NHS Trust's Board from 1 November 2017 ** Trish Bennett took up her appointment as Executive Director of Nursing from 1 March 2018*				

Register of Interests

105. The Trust maintains a Register of Interests and all Board of Directors and Council of Governors members are asked to declare any potential conflicts of interest prior to the commencement of meetings. The Register of Interests for the Board of Directors and the Council of Governors is held via a dedicated Trust website used for the recording of all interest – the Staff Declarations Website - which is available at https://merseycare.mydeclarations.co.uk/home?AspxAutoDetectCookieSupport=1) and for those without access to a computer via application to the Trust Secretary.

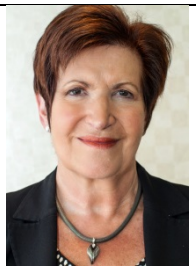
Skills, Expertise and Experience of Board of Directors

106. The individual members of the Board of Directors bring a wealth of varied skills, knowledge, expertise and experience to the Trust which ensures balance and provides completeness and appropriateness to the requirements of the Trust. A summary of their individual skills and experience is provided below:

Non Executive Directors

Note – Non Executive Directors are regarded as independent members of the Board and are not employees of the Trust. Their appointment / terms of office are subject to approval by the Council of Governors

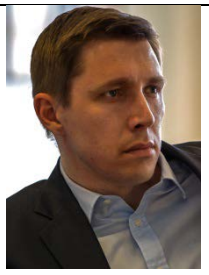
Chairman: Beatrice Fraenkel



Beatrice has been Chairman of the Trust since 2008. She has many years experience in the private sector, having built up a successful family owned commercial property business. As Independent Chairman of the North West Regional Centre of Excellence, she led the development of a regional design review panel, and helped develop and deliver a regional understanding of the economic impact of design, and the impact of design on developing sustainable communities.

Qualifications: Solicitor, Chartered Secretary, Notary Public.

Non Executive Director: Matt Birch



Matt was appointed on 5 September 2012. Since September 2017 he has been the Trading Executive at Central England Cooperative Limited. Prior to this he held various roles at Sainsbury's Supermarkets Ltd including Director of Commercial Operations (2015-2017), Director of Retail and Property Finance (2014-15), Regional Manager (2012-14), Director of Assets and Estates (2010-12) reporting to the Property Director, responsible for sales and corporate portfolio. Previously he was Operations Director for Sainsbury's Property Investments (2007-10) and Property Director for Tchibo GB Limited (2005-07). He is a Member of the Royal Institution of Chartered Surveyors.

Qualifications: MA (Hons) Cantab, MRICS

Non Executive Director: Cath Green

Cath was appointed on 2 February 2017. Cath worked in local government for 27 years and in the registered social housing sector since 2010. She is a Fellow of the Chartered Institute of Housing.
She was appointed as the Chief Executive for First Choice Homes Oldham in November 2010. Prior to that Cath worked for Liverpool City Council from 2002 to 2010 and held two positions; Assistant Executive Director (Housing and Neighbourhoods) and Executive Director for Community Services. Prior to this Cath was Assistant Executive Director of Housing and Neighbourhoods. Before joining Liverpool, Cath worked for 19 years for two other Local Authorities, Salford and Rochdale, where she was Assistant Director of Strategy and Resources and Head of Regeneration respectively.

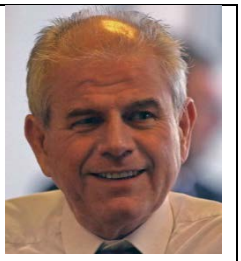
Qualifications: Fellow of Chartered Institute of Housing, Honorary Fellowship Award for Services to Vocational Education in Oldham from University Campus Oldham.

Non Executive Director: Gaynor Hales

Gaynor was appointed on 23 May 2017. Now a management consultant, until 2017 Gaynor was Regional Director of Nursing (North) at NHS Improvement and from October 2014 to March 2016 was Nurse Director (North) at the NHS Trust Development Authority. Prior to this she was Director of Nursing & Quality at NHS England's Merseyside Area Team (including a secondment as Portfolio Director for Specialised Commissioning) (2013 – 2014) and from 2002 to 2013 held the roles of Interim Chief Executive, Deputy Chief Executive / Director of Nursing & Quality and Director of Nursing Quality & Environment at the Countess of Chester NHS Foundation Trust.

Qualifications: RGN, BSc (Hons), Masters in Health Service Management

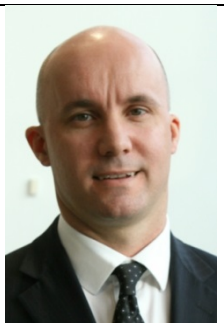
Non Executive Director: Gerry O'Keeffe
(also the Senior Independent Director and Vice Chairman)



Gerry was appointed on 18 April 2013. Currently retired, he worked for CSC from 2000 until 2014 and was their Chief Operating Officer from 2011, reporting to the CEO for UK & Ireland, responsible for ensuring P&L, Client Satisfaction and revenue growth were delivered by all parts of the business. Other roles at CSC included Head of UK Healthcare Business Unit (2007-11), Vice President of the NHS Account (2006-07), New Business Capture Executive (2005-06) and Chief Operating Officer National Grid Account (2003-05).
He has lifetime experience of working in information technology and consulting businesses, strong business profit and loss experience in many complex global companies, leadership experience managing large teams in both UK and international companies and executive leadership experience of large transformational programmes to meet changing business needs.

Qualifications: MBA Heriot-Watt University.

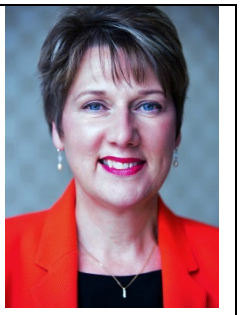
Non Executive Director: Nick Williams



Nick was appointed on 1 January 2014. Currently Consumer Digital Director of Lloyds Banking Group (2014-present), reporting to the Managing Director of Products and a member of the Executive Committee, accountable for changes management. Previously he was Product Change Director, Lloyds Banking Group (2011-2014) responsible for ongoing investment in business and driving strategic growth, Business Integration Director, Lloyds Banking Group (2009-11), responsible for integrating Europe's largest mortgage business, an asset portfolio of £350bn and Head of Infrastructure, Halifax Bank of Scotland (2006-09). He is also a Non Executive Director of Halifax Share Dealing Ltd.

Qualifications: MEng. Chemical Engineering, Loughborough University (1997).

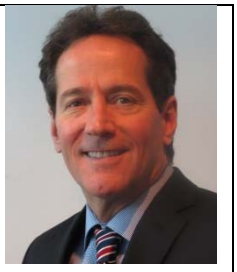
Non Executive Director: Pam Williams



Pamela was appointed on 15 June 2015. Pamela was previously a Non Executive Director and Chair of the Audit Committee and the Finance and Investment Committee at Manchester Mental Health and Social Care Trust (since July 2014). She began her local government career with North Shropshire District Council, where she qualified as an accountant and became a member of the Chartered Institute of Public Finance and Accountancy. She then held various posts with a variety of Councils and during this time she achieved membership of the Chartered Management Institute and SOLACE (Society of Local Authority Chief Executives). She was, until her recent retirement, Executive Director of Finance at Tameside Metropolitan Borough Council (2007-15).

Qualifications: Chartered Management Institute (1994), Chartered Institute of Public Finance and Accountancy (CIPFA), University of Wolverhampton (1989), BSc (Hons) Economics, University of Swansea (1981).

Non Executive Director: Robert Beardall



Note – Robert resigned from the Board on 6 March 2018

Robert was appointed on 1 April 2016. Robert has a broad medical leadership background with over 24 years experience in family and aerospace medicine, clinical quality improvement, population health management, clinical epidemiology and health informatics. Robert is currently the Managing Director of Health Synectics Ltd and has senior management experiences in management consulting, governance, strategic and operational planning and the creation and delivery of integrated care organisations and operational models. Since 2012 Robert has been an Industrial Fellow at the Northwest Institute for BioHealth Informatics at the University of Manchester. Robert was previously was a flight surgeon / chief of clinical services with the US Air Force.

Qualifications: Doctor of Medicine, Masters in Public Health (Epidemiology), Board Certification: American Board of Preventive Medicine, Fellow American College of Preventive Medicine.

Non Executive Director: Brenda Roe

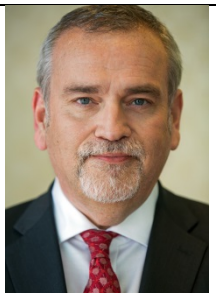
Note – Brenda resigned from the Board on 15 May 2017

Brenda was appointed in May 2013. A registered General Nurse, Public Health Nurse Specialist and Health Visitor with NED experience (her last appointment was as NED of North Cheshire Hospitals NHS Trust 2001-03). Currently Professor of the Health Research, Evidence Base Practice Research Centre, Faculty of Health and Social Care at Edge Hill University (since 2007) and is a Member of Health and Social Care Research Committee. She is also an Honorary Fellow of the Personal Social Services Research Unit at the University of Manchester (since 2010). She was previously Professor of Health Services at the Faculty of Health and Applied Social Sciences at Liverpool John Moore's University (2005-07). She is currently a member of the Royal College of Nursing, The British Society of Gerontology and of The British Geriatrics Society and a Fellow of The Royal Society for Public Health and The Queens Nursing Institute.

Qualifications: BSc (Hons) Human Biology, Oxford Polytechnic (1979), Registered Nurse, The Nightingale School, St Thomas' Hospital, London (1982), MSc (Method II Research), Geriatric Medicine, University of Manchester (1986), PhD Geriatric Medicine, University of Manchester (1989), BSc (Hons) Community Health; Public Health Specialist/Health Visitor, Manchester Metropolitan University (2002.)

Executive Directors

Chief Executive: Joe Rafferty



Before coming to Mersey Care Joe held the post of Director of Commissioning Support at the NHS Commissioning Board, having national responsibility for the design and delivery of a significant component of the commissioning side reforms outlined in the White Paper: Liberating the NHS. Prior to this, he was seconded from the Chief Executive role at NHS Central Lancashire, to become the Director of Commissioning Development for NHS North West, with a remit to lead the development of commissioning reforms across the North West of England

From 2007 to 2010 he was the Chief Executive of NHS Central Lancashire. Joe was the Regional Director of Commissioning and Strategy for NHS North West from 2006-2008. Other Board-level roles have included Director of Performance in Cumbria and Lancashire SHA and Director of System Reform at Bolton Hospital NHS Trust. Prior to these roles he was part of the team that set up Greater Manchester SHA. Joe joined the NHS in 1999 as a National Trainee on the NHS General Management Training Scheme and previously worked at a post-doctoral level as a team leader in molecular genetics at the Paterson Institute for Cancer Research in Manchester and before that at Strangeway's Research Laboratory in Cambridge.

Qualifications: PhD in Genetics, BSc (Hons), Diploma in Health Services Management

Executive Director of Nursing: Trish Bennett

Note - Trish took up this post on 1 March 2018. Prior to this Trish was the Director of Integration with the Trust, a non-voting position on the Board

Trish has worked in the NHS for over 30 years in various nursing leadership positions in Leeds, Liverpool and Manchester in both provider and commissioning roles and joined Mersey Care from NHS England, were she was the Director of Nursing for the Lancashire & Greater Manchester Sub Region responsible for professional nurse leadership, oversight and leadership to safeguarding adults and children, clinical leadership to the transformation service change programmes.

In her previous roles Trish has been responsible for the professional leadership of the Merseyside nursing workforce. She was also responsible for service improvement, incorporating quality and safety, safeguarding, resilience and emergency planning, continuing healthcare, equality and diversity, Choose and Book, children's commissioning, mental health, urgent care, dementia, offender health and substance misuse.

Qualifications: RGN**, BA Health Studies**

Executive Director of Communications and Corporate Governance: Elaine Darbyshire

Elaine was appointed to the Trust in June 2013. From 2014-15 she was seconded 2 days a week to the Department of Health as the Deputy Director of Communications for the Prime Minister's Dementia Challenge.

Before joining Mersey Care she held the post of Director of NHS Communications at NHS England (North, Midlands & East England). From 2011-2012 she was the Director of Communications for NHS North of England, covering the North West, North East and Yorkshire and Humber areas of England. From 2009-2011 she was the Director of Strategic Communications of NHS North West. Prior to joining the NHS in 2009, she worked for Guardian Media Group's Regional Division for 22 years in a number of posts including Marketing Director, Communications and Public Affairs Director. She was a Non Executve Director at East Cheshire NHS Trust (2007-2009).

Qualifications: BSc Biology and Chemistry, Chartered Institute of Marketing post graduate diploma and Fellow of the Chartered Institute of Marketing

Medical Director: Dr David Fearnley

Appointed as the Medical Director in August 2005. Deputy Chief Executive (2007-10). Since 2016, Chair of NHS England's Adult Secure Clinical Reference Group and NHS England's Associate National Director for Secure Mental Health.

David qualified in 1993 (University of Wales College of Medicine), and undertook basic psychiatric training; joined the higher forensic psychiatry training scheme in 1998, working in high and medium secure units. He was appointed as a Consultant Forensic Psychiatrist at Ashworth Hospital in 2001. Clinical Director of Mental Health Services and then Associate Medical Director at Ashworth Hospital. He has been the Royal College of Psychiatrists Special Advisor on Appraisal since 2009 and was awarded Royal College of Psychiatrists 'Psychiatrist of the Year' 2009.

David chaired the North West Mental Health Care Pathways Group (2009/10) and has been a Board Member Advancing Quality Alliance (AQuA) since 2011.

Qualifications: MB BCh, MSc, FRC Psych, MBA

Executive Director of Operations: Mark Hindle

Mark was appointed in July 2016 and was formerly Chief Executive of Calderstones Partnership NHS Foundation Trust. He was previously Chief Operating Officer at Lancashire Care NHS Foundation Trust. Prior to that, Mark was Managing Director of Community Services across Blackburn with Darwen, Central Lancashire and East Lancashire PCTs. Previous roles include Preston PCT's Director of Corporate Development and Director of Operations at Lancashire teaching hospitals. Mark's background is as a biomedical scientist.

Qualifications: Masters in Business Administration, Diploma in Management Studies, Fellowship of Institute of Biomedical Scientists, Manchester Metropolitan University.

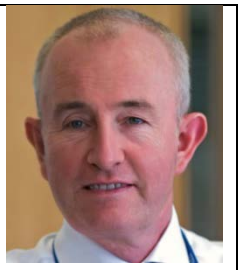
Executive Director of Workforce – Amanda Oates

Amanda was appointed in August 2013, initially as a non voting member of the Board, prior to her appointment in January 2015 as Executive Director of Workforce.

She has previous experience as HR Director at two other NHS trusts and as board director since 2008. She delivered significant improvements in HR and L&D and led the team to win the national HR team of the year at the 2013 HPMA Awards at the Walton Centre NHS FT. Amanda spearheaded a regional Health and Wellbeing initiative through the development of the NHS Games, and gained recognition both regionally, winning the Health and Wellbeing Leader Award at the NHS Leadership Academy Awards in 2012, and nationally, at the HPMA awards in June 2013. She is an elected member of the Cheshire and Merseyside Local Workforce Education Group and a member of the HR Network Chairs group. She joined the NHS in 1998 from the private sector as a Graduate Trainee.

Qualifications: BA (hons), MSc Strategic HRD, F.C.I.P.D

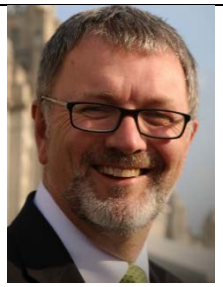
Executive Director of Finance / Deputy Chief Executive: Neil Smith



Appointed September 2004, Neil assumed the Deputy Chief Executive portfolio in 2013. Neil was previously the Executive Director of Finance and Performance, Mersey Care NHS Trust (2004-2013).
He was a Regional Finance Trainee (1985-1989) and his previous roles have been Senior Finance Manager roles in acute and community hospitals (1989-1992), Chief Financial Planner at Liverpool Health Authority (1992-1995), Deputy Director of Finance at Sefton Health Authority (1995-2000), Director of Finance at Sefton Health Authority (2000-2001), National Finance Lead High Secure Services at the Department of Health (2001-2002) and Head of Finance and Performance Management at Ashton, Leigh and Wigan PCT (2002-2004).

Qualifications: BA (Hons), Chartered Institute of Public Finance and Accountancy Qualified Accountant.

Executive Director of Nursing: Ray Walker
Note – Ray was seconded to HEE at end of February 2018



Appointed to the Trust in June 2011, Ray is a Registered Nurse (Adult and Mental Health) and has over 30 years experience of working in the public sector across the UK, 10 years clinical practice, 10 years in academia and more than 10 years in mental health management. He has worked on policy at the Department of Health and as a senior manager in a strategic health authority. He has been an Executive Director since 2006 (which includes experience in achieving foundation trust status) and has served on numerous groups National Mental Health/Nursing Groups. He is a member of the NHS Top Leaders Programme and a member of Prime Minister's Commission on Nursing.

Qualifications: MBA University of Northumbria (1997), BA (Hons) Health Studies University of Lancaster (1994), Certificate in Adult Education – Jordan Hill College Glasgow (1990), Dip Nursing University of Wales (1988), Registered Nurse (Adult and Mental Health) (1981 and 1984).

Non-Voting Member of the Board

Director of Strategy: Louise Edwards

Louise was appointed in November 2012 and was made a non-voting member of the Board from 1 September 2015.
She is an experienced Board level strategist and leader who has a track record of achievement in leading change in both NHS commissioning and provider organisations, policy development, and service improvement across the public sector. She has extensive experience at both strategic and operational levels in the NHS, having had Board level roles in primary care trusts and NHS trusts with responsibility for strategy and planning, organisational development, communications, patient and

public involvement and partnership development. Louise has also worked on strategy and commissioning development for strategic health authorities, and on commissioning assurance for the NHS Commissioning Board (now NHS England). Prior to joining the NHS in 2005, Louise had leadership roles in the not-for-profit sector and was an academic at Manchester University. This varied experience across health, social care and government has enabled her to develop a strong network and deep insight into strategic change in the health service, in national government and local government, and health care improvement in partnership with other sectors.	
Qualifications: BA Hons Combined Studies (Arts), Manchester Univ.; MPhil History; PhD History	

Nominations and Remuneration Process

107. **Council of Governors** – from time to time the Council of Governors will establish a Nominations Group and / or a Nominations and Remuneration Group. The role of the Council's nominations and remuneration groups are to review the terms, conditions and remuneration of the Chairman and Non Executive Directors as well as the appraisal process (see paragraphs 110 and 111 below). The last time a review of remuneration was undertaken was in 2016/17. More frequently a Nominations Group will be established comprising the Chairman and a few Governors to interview potential Non Executive Directors. In these circumstances the person specification will have been approved by the full Council before any post is advertised. Any recommendation from the Nominations Group is then taken to be considered by the full Council, who ultimately make the appointment (subject to the necessary checks). Normally any Group will include the Lead Governor as a member.

108. The composition of the Board of Directors is informed by regular Board Skills Reviews, the last two undertaken by the Trust's external auditor, Grant Thornton. These Board Skills reviews have been shared with the Council of Governors and are used to inform discussions between the Chairman and the Council of Governors in respect of the development of person specification for new Non Executive Director posts / the appointment of new Non Executives (which is the responsibility of the Council of Governors). A further independent Board Skills Review is planned in the next financial year.

109. **Board of Directors** – the Board of Directors has a Remuneration Committee which is required to meet at least annually. Its membership comprises of the Chairman and all the Non Executive Directors. Its role is to consider the remuneration and terms of service of those managers on Senior Manager Pay, as well as any applications for Mutually Assured Resignation Schemes the Trust may operate or redundancies proposed by the Trust. It has no role in reviewing the remuneration, terms and conditions of service of the Chairman or Non Executive Directors.

Appraisal of Directors Performance

110. The Council of Governors agreed a framework for the annual performance review of the Non-Executive Directors by the Chairman and the process for the annual review of the Chairman. The performance of the Chairman is reviewed by the Senior Independent Director in conjunction with the Lead Governors. The Council of Governors has a duty to review the performance of the Chairman and Non-Executive Directors, in particular when considering re-appointment, which is undertaken by the Nominations Committee, prior to being reported to the Council of Governors.

111. The performance of the Executive Directors is reviewed annually by the Chief Executive with the Chairman undertaking the performance review of the Chief Executive through formal Personal Achievement and Contribution Evaluations (PACE).

Board of Directors Remuneration

112. Details of the Board of Director's remuneration are provided in the Remuneration Report (see Chapter 12).

Better Payment Practice Code

113. Details of the Trust's compliance with the Better Payment Practice Code can be found in Chapter 8 - Finance Director's Report.

The Late Payment of Commercial Debts (Interest) Act 1998

114. There were no claims for late payments during the year made against the Trust.

Cost Allocation and Charging

115. Mersey Care complies with the cost allocation and charging requirements set out in HM Treasury and Public Sector information guidance.

Financial Instruments

116. There were no risks arising from the use of financial instruments (see also the Annual Accounts for 2017/18).

Stakeholder Communications

117. The Trust continued to use established methods of communication to engage with service users, patients, staff and carers. These included: the weekly newsletter via email, yourSpace (intranet for staff), and the quarterly magazine that has a hard copy distribution of 8,500, is sent to all Trust members, Trust sites, community centres, libraries, council offices and GP practices.

118. All staff initiatives, successes, events and campaigns are also supported by a comprehensive social media strategy that is steadily increasing our following.

119. yourBrief is circulated to all staff to provide an accessible summary of the main issues discussed at the Board of Directors meetings and a Stakeholder Briefing is

sent out every month to Governors, GPs, MPs, local councillors and local Clinical Commissioning Groups

120. The Trust is a member of the Transforming Care Strategic Partnership Board chaired by NHS England, which is looking at the future of learning disability services in light of NHS England's decision to no longer commission learning disability services at the Whalley site. Following the acquisition of South Sefton's community services the Trust has established the South Sefton Strategic Partnership Board, chaired by Mersey Care's Chief Executive, and involving representatives from local NHS providers, Sefton Council and South Sefton Clinical Commissioning Group and GPs to help oversee the development and integration of community services in South Sefton. As a result of being announced the 'Preferred Acquirer' the Chief Executive now also chairs the Liverpool Provider Alliance, with representatives from local NHS providers, adult and children's social services and local GPs, to examine better ways to integrate services across Liverpool. The Trust is also involved in the work of the Cheshire and Merseyside Sustainability and Transformation Partnership.

121. Working with NHS England and local Cheshire and Merseyside NHS and private sector secure mental health providers, Mersey Care is the Lead Provider for the PROSPECT Partnership, a New Care Model pilot which is collaborating to help inform the commissioning intentions of NHS England in respect of local mental health secure commissioning. In future it is hoped that the PROSPECT Partnership will take on certain commissioning responsibilities from NHS England, with the providers themselves commissioning secure mental health services for people across Cheshire and Merseyside.

Additional Disclosures Required by the Finance Reporting Manual (FReM)

122. Accounting policies for pensions and other retirement benefits are set out in note 1.2 to the Annual Accounts and details of senior employees' remuneration can be found in the Remuneration Report (see Chapter 12).

Income Disclosures Required by Section 43(2A) of the NHS Act 2006

123. The Trust receives the majority of income from the provision of goods and services for the purposes of the health services in England. Other income received has no impact on its provision of goods and services for the purposes of the health services in England.

Compliance with UK Corporate Code of Governance

124. Mersey Care NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012

125. During 2017/18 the Board of Directors can confirm that it has complied with the provisions of the NHS Foundation Trust Code of Governance and that it has in place:

a) a clear vision, underpinned by a 5-year Strategy and a 2-year Operational Plan

b) a regularly reviewed Constitution governing the operation of the Council of Governors (and its working groups) and the Board of Directors (and its committees and their supporting sub committees and work groups, together with a range of regularly reviewed corporate policies including:
   i) Scheme of Reservation and Delegation of Powers
   ii) Standing Financial Instructions
   iii) Standards of Business Conduct (incorporating NHS England's model conflicts of interest guidance and Codes of Conduct for the Governors and Directors)
   iv) Governor's Handbook
   v) Anti-Fraud, Corruption and Bribery Policy
   vi) Risk Management Strategy
   vii) Freedom to Speak Up Policy;

c) at least half the Board of Directors, excluding the Chair, comprises independent Non Executive Directors (with one identified as a Senior Independent Director) (see **Table 3**);

d) regular private meetings between the Chair and Non Executive Directors;

e) a robust annual appraisal process for the Chair and Non Executive Directors that has been developed and approved by the Council of Governors;

f) a robust recruitment process for the appointment of Non Executive Directors;

g) an induction process for Non Executive and Executive Directors, together with a comprehensive induction programme and ongoing training programme for Governors;

h) processes to annually review compliance with the Fit and Proper Persons' criteria for all Directors;

i) publicly accessible Register of Interests for Directors, Governors and senior staff (see paragraph 105);

j) effective infrastructure to support the Council of Governors and it working groups, including a Membership Strategy reported to the Council of Governors.

Directors' responsibility for preparing financial statements

126. The Directors of the Trust consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

Statement as to disclosure to auditors

127. In accordance with the requirements of the Companies (Audit, Investigations and Community Enterprise) Act 2004, the Trust confirms that for each individual who was a director at the time that the director's report was approved, that:

    a) so far as each of the Trust Directors is aware, there is no relevant audit information of which the Trust's Auditors are unaware;

    b) each Director has taken all steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information, and to establish that the Trust's Auditor is aware of that information.

128. For the purposes of this declaration:

    a) relevant audit information means information needed by the Trust's auditor in connection with preparing their report and that;

    b) each director has made such enquiries of his/her fellow directors and taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the Trust to exercise reasonable care, skill and diligence.

Additional information

129. The Trust has not made any political donations during the year

CHAPTER 10 – STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

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

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

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

a) observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

b) make judgements and estimates on a reasonable basis;

c) state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;

d) ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and

e) prepare the financial statements on a going concern basis.

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

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

	24 / 05 / 18
Joe Rafferty **Chief Executive**	**Dated**

CHAPTER 11 – AUDIT COMMITTEE

Role of the Audit Committee

135. The Audit Committee is a committee of the Board of Directors which undertakes detailed scrutiny of the Trust's governance and assurance processes on behalf of the Board of Directors. The Audit Committee is chaired by a suitably qualified Non Executive Director (Pam Williams) with two other Non Executive Directors (Gerry O'Keeffe and Nick Williams) as members. The Audit Committee met on six occasions in 2017/18 and all meetings were quorate (details of members' attendance can be found in **Appendix B**).

136. The Audit Committee has Terms of Reference which are regularly reviewed, taking account of the NHS Audit Committee Handbook and other guidance, and approved by the Board of Directors. The work of the Audit Committee in 2017/18 has been to review the effectiveness of the organisation and its systems of governance, risk management and internal control through a programme of work involving the scrutiny of assurances provided by internal audit, external audit, local anti-fraud officer, Trust managers, finance staff and the clinical audit team along with reports and reviews from other external bodies.

137. The Audit Committee has an annual cycle of business that is informed by the External Audit Plan, the Internal Audit Plan and the Anti-Fraud, Corruption and Bribery Response Plan for the Trust. As the Trust hosts Informatics Merseyside, which provides a range of IT services to local NHS organisations, the annual cycle of business is also informed by the Internal Audit Plan for Informatics Merseyside. The annual cycle of business is approved by the Board of Directors.

138. Members of the Audit Committee also hold regular meetings with the Trust's internal and external auditors, where officers of the Trust are not present.

Main Activities in 2017/18

Internal control and risk management

139. The Committee, having reviewed relevant disclosure statements for 2017/18 and other appropriate independent assurance, together with the Director of Internal Audit Opinion, external audit opinion (at its May 2018 meeting), considers that the 2017/18 Annual Governance Statement is consistent with the Committee's view on the Trust's system of internal control. Accordingly the Committee supported the 2017/18 Annual Governance Statement for approval by the Board of Directors.

140. The Audit Committee receives regular assurance on the Trust's risk management processes through the Executive Lead for risk (Executive Director of Nursing until February 2018 and then the Medical Director), supported by the Risk Management Group. Further work is planned to embed risk management across the Trust, including the proposed move to a single risk management system (Datix).

141. Risk priority areas for 2017/18 included

a) the Committee receiving assurance on robustness of the professional advisers commissioned by the Trust to undertake the due diligence exercises that identified the risks the Trust needed to mitigation in respect of the South Sefton's community physical health services in June 2017 and the acquisition of Liverpool Community Health NHS Trust in April 2018;

b) following the widespread cyber attack on the NHS in May 2017 (see paragraphs 313 and 314), the Audit Committee has sought a range of assurance from both Informatics Merseyside and the Trust's internal auditors on the response to this attack and the adequacy of both the Trust's and Informatics Merseyside's arrangements going forward;

c) a range of other issues including Freedom to speak up issues (whistleblowing), consultant job planning and clinical audit arrangements.

Internal audit

142. Throughout the year, the Committee worked effectively with its internal auditors, Mersey Internal Audit Agency (MIAA),to ensure that the design and operation of the Trust's internal control processes are sufficiently robust.

143. The Committee has given considerable attention to the importance of follow-up in respect of internal audit work in order to gain assurance that appropriate management action has been implemented. This included an exercise to ensure the closure of all follow-up actions from internal audit reviews undertaken over the last several years.

144. The Committee has considered the major findings of internal audit and where appropriate has sought management assurance that remedial action has been taken.

145. The Committee reviewed and approved the internal audit plan and detailed programme of work for 2017/18 at its April 2017 meeting. This include reviews of combined financial systems, clinical information systems, information governance toolkit, workforce planning, corporate governance compliance and the assurance framework.

146. MIAA has supported the Non Executive Directors over the year through the provision of networking events, policy advice, and Insight updates.

Anti-Fraud

147. The Committee reviewed and approved the counter fraud work plan for 2017/18 at its April 2017 meeting noting coverage across all mandated areas of strategic governance, inform and involve, prevent and deter and hold to account. The Committee also during the course of the year regularly reviewed updates on proactive counter fraud work and fraud investigations.

External audit

148. Grant Thornton continued as the Trust's external auditor from 1 April 2018 following a tender exercise overseen by the Council of Governors from September 2016 to January 2017. As a result the Trust let a three year contract for external audit subject to regular effectiveness reviews. The Trust has procedures for considering any non-audit services provided by external audit.

149. The Audit Committee routinely receives a progress report from the external auditor, including an update annual accounts audit timetable and programme of work, updates on key emerging national issues and developments which may be of interest to Committee members alongside a number of challenge questions in respect of these emerging issues which the Committee may wish to consider.

Management assurance

150. The Committee has frequently assessed the adequacy of wider corporate assurance processes as appropriate and has requested and received assurance reports from executives, managers and wider Committee representation throughout the year. In 2017/18 management assurance outside of the audit action plans was received in respect of the prioritisation framework to support the delivery of the Trust's Strategy and security arrangements at Ashworth Hospital.

Financial Assurance

151. The Audit Committee has reviewed the annual financial statements prior to submission to the Board of Directors and considered these to be accurate. It has ensured that all external audit recommendations have been addressed.

Other Assurance

152. The Committee has routinely received reports on Losses and Special Payments and Single Source Tender Waivers.

Review of Audit Committee Effectiveness

153. The Audit Committee undertakes an annual review of its effectiveness using the self-assessment tool provided in the NHS Audit Committee Handbook. This was completed in August 2017. Of the 62 questions in the self-assessment, the Audit Committee concluded that 61 were being met and 1 was deemed as not applicable.

	24 / 05 / 18
Pam Williams **Chair of the Audit Committee**	**Dated**

CHAPTER 12 – REMUNERATION REPORT

What this report covers

154. This report to stakeholders:

a) sets out the Trust's remuneration process, i.e., it explains the process under which the Chairman, Non Executive Directors and Executive Directors / Other Board Directors were remunerated for the financial period 1 April 2017 to 31 March 2018;

b) provides tables of information showing details of the salary and pension interests of all Directors for the financial period 1st April 2017 to 31st March 2018;

c) has been prepared in accordance with Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3); Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008(SI2008/410) ("the Regulations"); Parts 2 and 4 of Schedule 8 of the Regulations as adopted by Monitor and Elements of the NHS Foundation Trust Code of Governance;

d) outlines the approach adopted by the Council of Governors when setting the remuneration of the Chairman and Non Executive Directors;

e) outlines the approach adopted by the Board of Directors' Remuneration and Terms of Service Committee when setting the remuneration of the Executive Directors and Other Board Directors who have authority or responsibility for directing or controlling the major activities of the organisation. The following posts have been designated as fitting this criterion and are collectively referred to as the senior managers within this report:

i) Executive Directors:
- Chief Executive
- Executive Director of Finance (Deputy Chief Executive)
- Medical Director
- Executive Director of Nursing
- Executive Director of Communications and Corporate Governance
- Executive Director of Workforce
- Executive Director of Operations

ii) Other Directors (non-voting):
- Director of Strategy and Planning
- Director of Integration
- Director of Performance and Informatics

Board of Directors' Remuneration and Terms of Service Committee

155. **Role** - the Remuneration and Terms of Service Committee is a committee of the Board of Directors. An effective committee is key to ensuring that executive directors' remuneration is aligned with stakeholders' interests and that executive directors are motivated to enhance the performance of the Trust.

156. **Membership** - all Non-Executive Directors are members of the Remuneration and Terms of Service Committee. The Chief Executive and the Trust Secretary are normally in attendance at meetings of the Committee, except when their positions are being discussed. The Executive Director of Workforce also attends meeting, as appropriate, to provide advice and expertise and the committee has the option to seek further professional advice as required. Details of member's attendance at this Committee's meetings can be found in the appendices support Chapter 15 – Annual Governance Statement.

157. The work of the Remuneration and Terms of Service Committee during 2017/18 has included:

a) approval of a number of redundancy payments in line with the Trust's Organisational Change Policy;

b) a review of the role and principal accountabilities of the Medical Director;

c) considered and approved settlement details of a pending employment tribunal;

d) noted a series of secondments that would be required to support the Interim Management Agreement with Liverpool Community Health NHS Trust (LCH);

e) noted the resignation of the Executive Director of Nursing (Ray Walker)[3] and plans to appoint to the post;

f) ratified the recommendation of the interview panel to appoint Trish Bennett as Executive Director of Nursing from 1 March 2018;

g) approved a series of recommendations put forward by the Chief Executive regarding the Executive Directors' / Other Board Directors remuneration and in line with his delegated authority;

h) approved the required funding to support applications for the Mutually Assured Resignation Scheme (MARS) established by the Trust.

Remuneration for the Chairman and Non Executive Directors

158. The remuneration and terms of service for the Chairman and the Non-Executive Directors are set, in line with statute and the Trust's Constitution, by the Council of Governors and implemented locally by the Trust. The Council of Governors last reviewed the remuneration of the Chairman and Non Executive Directors in

[3] Although Ray Walker resigned as Executive Director of Nursing on 28 February 2018, he remains employed by the Trust and has been seconded to Health Education England

September 2016, assisted by benchmark data and advices provided by an external consultancy. The following remuneration was approved

a) the Chairman - £47,500 per annum;

b) the Non Executive Director also undertaking the role of Senior Independent Director - £15,500 per annum;

c) the Non Executive Director also undertaking the role of Chairman of the Board of Directors' Audit Committee - £16,500 per annum;

d) all other Non Executives - £13,000 per annum.

Remuneration for Executive Directors / Other Board Directors

Employment Contracts

159. All Executive Directors / Other Board Directors have employment contracts. Contracts are usually awarded on a permanent basis, unless the post is for a fixed period of time. Executive Directors (including the Chief Executive) have a six month notice period within their contracts of employment (see **Table 4**).

160. Termination payments are made in accordance with contractual agreements.

Table 4: Executive Director / Other Board Directors Contractual Data

Name	Title	Contract Date	Term (Notice Period)	Early Termination Provisions
Joseph Rafferty	Chief Executive	01/09/2012	Permanent (6 months)	None
David Fearnley	Medical Director	03/08/2005	Permanent (6 months)	None
Neil Smith	Executive Director of Finance (Deputy Chief Executive)	04/05/2004	Permanent (6 months)	None
Ray Walker (1)	Executive Director of Nursing	20/06/2011	Permanent (6 months)	None
Elaine Darbyshire	Executive Director of Communications and Corporate Governance	01/06/2013	Permanent (6 months)	None
Amanda Oates	Executive Director of Workforce	01/08/2013	Permanent (6 months)	None
Mark Hindle	Executive Director of Operations	01/07/2016	Permanent (6 months)	None
Louise Edwards	Director of Strategy and Planning	12/11/2012	Permanent (6 months)	None
Trish Bennett (2)	Director of Integration / Executive Director of Nursing	01/08/2016	Permanent (6 months)	None
Jim Hughes (3)	Director of Informatics & Performance Improvement		Permanent (6 months)	None

Notes		
	1	Resigned as Executive Director of Nursing with effect from 28 February 2018
	2	Appointed as Executive Director of Nursing with effect from 1 March 2018
	3	Retired as Director of Performance & Informatics from 31 August 2017

Remuneration Process for Executive Directors / Other Board Directors

161. Executive Directors' / Other Board Directors' contracts of employment include a fixed annual salary payment, which is disclosed in the Annual Report and Accounts.

162. Starting salaries for Executive Directors / Other Board of Directors are determined by the Board of Directors' Remuneration and Terms of Service Committee by reference to independently obtained NHS salary survey information, internal relativities and equal pay provisions and other labour market factors where relevant, e.g. for cross sector, functional disciplines such as human resources.

163. Progression is determined by the Committee for:

a) annual inflation considerations in line with nationally published indices, Department of Health and Social Care guidance and other nationally determined NHS pay settlements;

b) specific review of individual NHS salary survey information, other labour market factors where relevant, e.g. for cross sector, functional disciplines, internal relativities and equal pay provision. Such review is only likely where an individual director's portfolio of work or market factors change substantially.

164. Executive Directors participate in an annual appraisal process which identifies and agrees objectives to be met. This is supported by a personal development plan where appropriate.

165. The Trust does not operate a performance related pay scheme.

Future Process on Remuneration of Executive Directors / Other Board Directors

166. The following elements of remuneration are determined as follows:

a) salary – as determined by the Board of Directors Remuneration and Terms of Service Committee;

b) car allowance – the Trust operates a 'Trust contribution lease car scheme' which is available to each of the identified senior managers. Alternatively a cash equivalent is offered of £3,600 (Chief Executive) or £3,200 (other senior managers);

c) NHS Pension Scheme[4] – employer and employee contributions as specified by NHS Pension Agency unless the senior manager opts out;

d) Additional benefits[5] - tax-free childcare voucher scheme, salary sacrifice lease car scheme, salary sacrifice home electronics scheme.

[4] The NHS pension arrangements are available to all employees of the Trust

167. There are no senior managers that have tailored arrangements outside of those described above.

168. Whilst the benefits and senior manager remuneration offered by the Trust is in line with other NHS Foundation Trusts, it is important to recognise this supports the long-term strategic direction of the Trust during a period of transformation and ensures that a stable senior team is in place to manage the process.

Remuneration in excess of £150,000 per Annum

169. The Civil Service has set the threshold at £150,000 per annum, above which approval is required by the Chief Secretary to the Treasury, as set out in guidance issued by the Cabinet Office. This currently equates to the Prime Minister's ministerial and parliamentary salary. The Cabinet Office approvals process does not apply to NHS Foundation Trusts. However, the guidance advises that in circumstances where one or more senior managers are paid more than £150,000, the Trust should explain (not necessarily on an individual basis), the steps taken to satisfy itself that this remuneration is reasonable.

170. In respect of those senior managers who are paid more than £150,000, the Trust has considered comparable data from other similar organisation in determining the rate that should be paid to attract and retain staff of the calibre required to deliver the Trust's objectives.

Note: Please note that elements of the Remuneration Report are subject to audit, namely the salary and pension entitlements of senior managers, compensation paid to former directors, details of amounts payable to third parties for the services of a director (if made) and the median remuneration of the Trust's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director.

Salaries and Allowances for the Period Ended 31 March 2018

171. Guidance requires that when producing its Annual Report the Trust provides information about the salaries and allowances for members of the Board compared to the information contained in its last Annual Report, i.e., from 2016/17. Please note that this information is not directly comparable this year as the data for 2017/18 coverers a full financial year (i.e. 12 months), but the data for 2016/17 is only for part of the financial year (i.e., 11 months from may 2016 to March 2017). This was because Mersey Care became a Foundation Trust on 1 May 2016 and so the 2016/17 Annual Report only covers the period from when Mersey Care became a Foundation Trust (i.e. it does not include data from April 2016).

172. **Tables 5 to 8** below provide details of the salaries and / or allowances for the Chairman / Non Executive Directors and the Executive Directors / Other Board Directors for both 2016/17 and 2017/18. **Table 9** provides details of the Pension Benefits.

[5] Additional benefits are available to all employees of the Trust

Table 5: Executive Directors / Other Board Directors Salaries (April 2017 to March 2018)

		2017-2018					
		Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	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 (bands of £5,000)
	Notes	£'000	£'00	£'000	£'000	£'000	£'000
Executive Directors							
Joseph Rafferty - Chief Executive	1	210 - 215	49			0	215-220
David Fearnley – Medical Director	1	255 - 260	64			90.0-92.5	350-355
Neil Smith – Executive Director of Finance / Deputy Chief Executive	1	145 - 150	55			37.5-40.0	185-190
Ray Walker - Executive Director of Nursing		125 - 130	56			20.0-22.5	150-155
Elaine Darbyshire - Executive Director of Governance & Communications		120 - 125	53			32.5-35.0	160-165
Amanda Oates - Executive Director of Workforce	1	115 - 120	97			52.5-55.0	180-185
Mark Hindle - Executive Director of Operations		145 - 150				2.5-5.0	150-155
Louise Edwards - Director of Strategy and Planning		110 - 115	35			47.5-50.0	165-170
Trish Bennett - Director of Integration	1	115 - 120	23			57.5-60.0	175-180
Jim Hughes - Director of Informatics and Performance Management	2	35 - 40	13			0	0
Band of Highest Paid Director's Total Remuneration (£'000)	255 - 260						
Median Total Remuneration of all staff	27,540						
Pay Multiple Ratio	9.3						

Notes

a) Benefits in kind are the taxable value attributed to lease cars and salary sacrifice schemes.

b) Pension related benefits are the total increases in benefits that will be payable by the NHS Pension Scheme from normal retirement age (age 60 for members of the 1995 section, age 65 for member of the 2008 section and age 67 for a member of the 2015 scheme).

Table 6: Chairman / Non Executive Directors Allowances (April 2017 to March 2018)

		2017-2018					
		Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	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 (bands of £5,000)
	Notes	£'000	£'00	£'000	£'000	£'000	£'000
Non Executive Directors							
Beatrice Fraenkel - Chairman	**1**	45 - 50	19				45 - 50
Matt Birch		10 - 15					10 - 15
Gerry O'Keefe	**1**	15 - 20					15 - 20
Christopher Dowrick	**3**	0					0
Catherine Green	**4**	10 - 15	12				10 - 15
Pamela Williams	**1**	15 - 20	9				15 - 20
Nicholas Williams	**5**	0					0
Robert Beardall	**1,6**	10 - 15					10 - 15
Gaynor Hales	**7**	10 - 15	6				10 - 15
Brenda Roe	**8**	0 - 5					0 - 5

Table 7: Executive Directors / Other Board Directors Salaries (May 2016 to March 2017)

		2016-2017 (May 2016 - March 2017)					
		Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	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 (bands of £5,000)
	Notes	£'000	£'00	£'000	£'000	£'00	£'000
Executive Directors							
Joseph Rafferty - Chief Executive	1	165-170	94			0	165-170
David Fearnley – Medical Director	1	195-200	52			32.5-35.0	235-240
Neil Smith – Executive Director of Finance / Deputy Chief Executive	1	125-130	51			65.0-67.5	195-200
Ray Walker - Executive Director of Nursing		110-115	43			30.0-32.5	145-150
Elaine Darbyshire - Executive Director of Governance & Communications		110-115	42			30.0-32.5	145-150
Amanda Oates - Executive Director of Workforce	1	100-105	84			52.5-55.0	165-170
Mark Hindle - Executive Director of Operations		110-115	0			15.0-17.5	125-130
Louise Edwards - Director of Strategy and Planning		95-100	31			37.5-40.0	135-140
Trish Bennett - Director of Integration	1	70-75	0			27.5-30.0	100-105
Jim Hughes - Director of Informatics and Performance Management	2	95-100	29			77.5-80.0	180-185
Band of Highest Paid Director's Total Remuneration (£'000)		195-200					
Median Total Remuneration of all staff		24,727					
Pay Multiple Ratio		7.9					

Table 8: Chairman / Non Executive Directors Allowances (May 2016 to March 2017)

		2016-2017 (May 2016 - March 2017)					
		Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	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 (bands of £5,000)
	Notes	£'000	£'000		£'000	£'00	£'000
Non Executive Directors							
Beatrice Fraenkel - Chairman	**1**	40 - 45	16				45 - 50
Matt Birch		10 - 15					10 - 15
Gerry O'Keefe	**1**	10 - 15					10 - 15
Christopher Dowrick	**3**	5 - 10					5 - 10
Catherine Green	**4**	0 - 5					0 - 5
Pamela Williams	**1**	15 - 20	13				15 - 20
Nicholas Williams	**5**	0					0
Robert Beardall	**1,6**	10 - 15					10 - 15
Gaynor Hales	**7**	0					0
Brenda Roe	**8**	10 - 15					10 - 15

Notes:

1 In accordance with the Interim Management Agreement to provide support to Liverpool Community Health NHS Trust (LCH), the identified senior officers were also members of LCH's Board from 01/11/2017. No financial transactions were involved.

2 Jim Hughes retired from the Trust on 31/08/2017.

3 Christopher Dowrick resigned as a non executive director with effect from 30/11/2016.

4 Catherine Green was appointed as a non executive director with effect from 02/02/2017.

5 In accordance with his contract of employment, Nicholas Williams received no remuneration from the Trust.

6 Robert Beardall resigned as a non executive director with effect from 05/03/2018.

7 Gaynor Hales was appointed as a non executive director with effect from 23/05/2017.

8 Brenda Roe resigned as a non executive director with effect from 31/05/2017.

Pension Benefits

173. The Chairman and the Non Executive Directors do not receive pensionable remuneration, as such there will be no entries in respect of pensions for the Chairman and the Non Executive Directors. **Table 9** below shows the pension benefits received by the Executive Directors / Other Board Directors

Table 9: Executive Directors / Other Board Directors Pension Benefits (April 2017 to March 2018)

Name and title	Real increase / (decrease) in pension at pension age (bands of £2500) £'000	Real increase in lump sum at pension age (bands of £2500) £'000	Total accrued pension at pension age at 31.03.17 (bands of £5000) £'000	Lump sum at pension age related to accrued pension at 31.03.18 (bands of £5000) £'000	Cash Equivalent Transfer Value at 01.04.17 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31.03.18 £'000	Employers Contribution to Stakeholder Pension £'000
Joseph Rafferty - Chief Executive	0	0	55-60	165-170	1160	0	1160	0
David Fearnley – Medical Director	5.0-7.5	12.5-15.0	45-50	140-145	727	104	831	20
Neil Smith – Executive Director of Finance / Deputy Chief Executive	2.5-5.0	7.5-10.0	55-60	175-180	1088	116	1204	21
Ray Walker - Executive Director of Nursing	0.0-2.5	5.0-7.5	20-25	70-75	478	62	540	18
Elaine Darbyshire - Executive Director of Governance and Communications	2.5-5.0	0	15-20	0	216	40	256	18
Amanda Oates - Executive Director of Workforce	2.5-5.0	2.5-5.0	25-30	55-60	327	63	390	17
Louise Edwards - Director of Strategy and Planning	2.5-5.0	2.5-5.0	15-20	35-40	211	50	261	17
Jim Hughes - Director of Informatics and Performance Improvement	0	0	35-40	115-120	892	0	0	7
Patricia Bennett - Director of Integration	2.5-5.0	7.5-10.0	30-35	100-105	583	100	683	7
Mark Hindle - Executive Director of Operations	0.0-2.5	2.5-5.0	70-75	215-220	1519	66	1585	21

Cash Equivalent Transfer Values (CETV)

174. A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and 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

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

Pay Multiples

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

177. The banded remuneration of the highest paid director in Mersey Care NHS Foundation Trust in the period April 2017 to March 2018 was £256,270 (11 months to 31 March 2017, £197,747). This was 9.31 times (11 months to 31 March 2017, 7.9) the median remuneration of the workforce, which was £27,540 (11 months to 31 March 2017, £24,727).

178. For the period April 2017 to March 2018, 0 employee (11 months to 31 March 2017, 0) received remuneration in excess of the highest-paid director. Remuneration ranged from £14,120 to £256,270 (11 months to 31 March 2017, £14,120 to £218,690).

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

180. The average number of full time equivalent staff for the period April 2017 to March 2018 was 4,483 (11 months to 31 March 2017, 4,506)which generated a pay multiple of 9.31 (11 months to 31 March 2017, 7.9). The increase is due to members of our

Board of Directors being remunerated for providing interim management support to Liverpool Community Health NHS Trust. In addition to this our highest paid director has received additional remuneration relating to their involvement with NHS England (Associate National Clinical Director for Secure Mental Health) and NHS Improvement (Deputy National Clinical Director for Mental Health).

Reporting of Other Compensation Schemes – Exit Packages

181. **Table 10** shows the exit payments were calculated in accordance with contractual terms based on length of service.

Table 10: Exit Payments for 2017/18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies (£'000)	Number of other departures agreed	Cost of other departures agreed (£'000)	Total number of exit packages	Total cost of exit packages (£'000)	Number of departures where special payments have been made	Cost of special payment element included in exit packages (£'000)
<£10,000	10	£50	57	£173	67	£223		
£10,001 to £25,000	16	£310	16	£258	32	£568		
£25,001 to £50,000	22	£784	5	£173	27	£957		
£50,001 to £100,000	4	£291	2	£159	6	£450		
£100,001 to £150,000	2	£234			2	£234		
£150,001 to £200,000								
>£200,000								
Totals	***54***	***£1,669***	***80***	***£763***	***134***	***£2,432***		

182. Other departure costs have been paid in accordance with the provisions of the NHS Scheme / Trust's Mutually Agreed Redundancy Scheme (MARS). Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. 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 within this table.

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

	Number of Agreements	Total value of agreements (£000's)
Mutually agreed resignations (MARS) contractual costs	29	£613
Contractual payments in lieu of notice	51	£150
Total	***80***	***£763***

Approved by:

	24 / 05 / 18
Joe Rafferty **Chief Executive**	**Dated**

CHAPTER 13 – STAFF REPORT

Analysis of Average Staff Numbers

184. **Table 11** below shows information on the number of staff employed by the Trust by whole time equivalents (WTE)

Table 11: Average Staff Numbers (WTE)

Staff Group	Permanent (wte)	Other (wte)	Total (wte)
Medical and Dental	162.0	-	162.0
Nursing	1,214.0	-	1,214.0
Scientific, Therapeutic & Technical	447.0	-	447.0
Health Care Support staff	1,662.0	-	1,662.0
Admin and Estates	998.0	-	998.0
Agency and contract staff	-	149.0	149.0
Bank Staff	-	304.0	304.0
All Staff Groups	**4,483.0**	**453.0**	**4936.0**

Staff Breakdown by Gender

185. **Table 12a** below shows information, as a head count, on the number of staff by gender and the role they undertake. This table does not include information on Bank Staff.

Table 12a: Staff By Gender and Role as at 31 March 2018 (WTE)

Title	Female	Male	Total
Non-Executive Directors	4	3	7
Executive Directors	3	4	7
Other Employees	3,185	1,725	4,910
Total	**3,192**	**1,732**	**4,942**

Note – As we only have 1 'Other Board Director', their data has been included in 'Other Employees' so their information is not personably identifiable.

Staff Breakdown by Disability

186. **Table 12b** below shows information, as a head count, on the number of staff by gender and the role they undertake. This table does not include information on Bank Staff.

Table 12b: Staff By Disability and Role as at 31 March 2018 (WTE)

Title	Yes	No	Not Stated	Total
Non-Executive Directors	-	7	-	7
Executive Directors	-	7	-	7
Other Employees	283	4,158	469	4,910
Total	**283**	**4,172**	**469**	**4,942**

Note – As we only have 1 'Other Board Director', their data has been included in 'Other Employees' so their information is not personably identifiable.

Staff Breakdown by Ethnicity

187. **Table 12c** below shows information, as a head count, on the number of staff by ethnicity and the role they undertake. This table does not include information on Bank Staff.

Table 12c: Staff By Ethnicity and Role as at 31 March 2018 (WTE)

Title	Asian or Asian British	Black or Black British	Chines or Any Other Ethnic Group	Mixed	Not Stated / Disclosed	Undefined	White	Total
Non-Executive Directors	-	-	-	-	-	-	7	7
Executive Directors	-	-	-	-	-	-	7	7
Other Employees	96	78	36	60	116	121	4,403	4,910
Total	**96**	**78**	**36**	**60**	**116**	**121**	**4,417**	**4,924**

Note – As we only have 1 'Other Board Director', their data has been included in 'Other Employees' so their information is not personably identifiable.

Staff Breakdown by Sexual Orientation

188. **Table 12d** below shows information, as a head count, on the number of staff by gender and the role they undertake. This table does not include information on Bank Staff.

Table 12d: Staff By Sexual Orientation and Role as at 31 March 2018 (WTE)

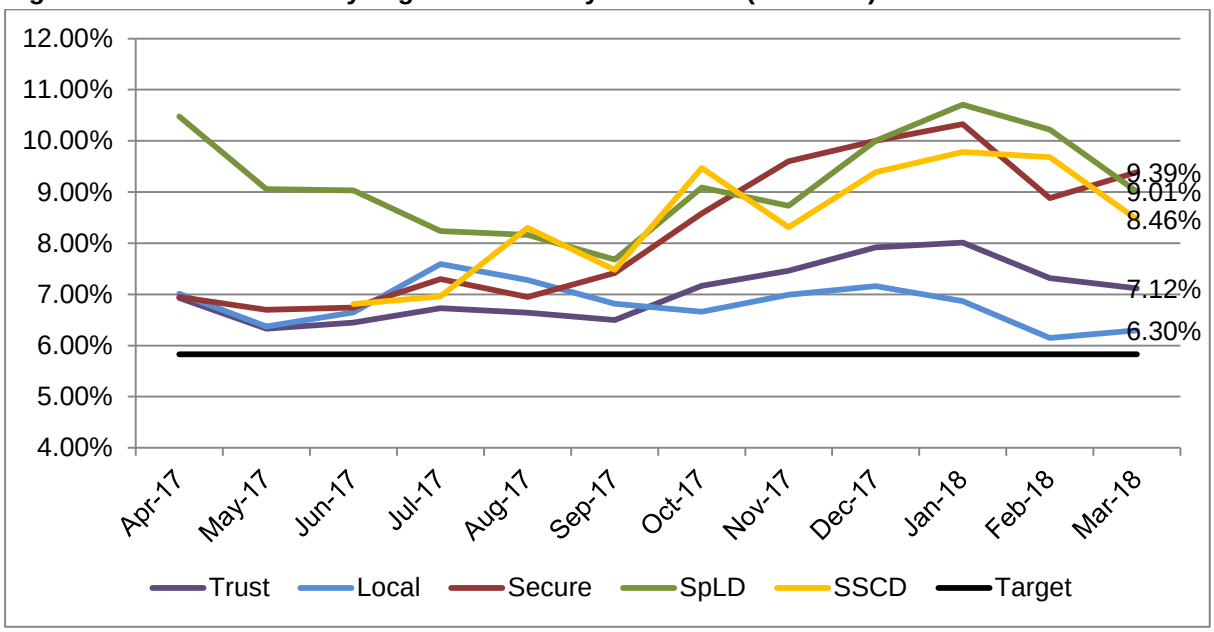
Title	Bisexual	Gay	Hetero-sexual	Lesbian	Not Stated / Disclosed	Undefined	Total
Non-Executive Directors	-	-	7	-	-	-	7
Executive Directors	-	-	6	-	1	-	7
Other Employees	25	60	4,092	40	434	259	4,910
Total	**25**	**60**	**4,105**	**40**	**435**	**259**	**4,924**

Note – As we only have 1 'Other Board Director', their data has been included in 'Other Employees' so their information is not personably identifiable.

Sickness Absence

189. **Figure 3** below shows information on staff sickness as a percentage of the whole time equivalent (WTE) employed by the Trust, showing information for each of the four clinical divisions

Figure 3: % of Sickness Days against WTE Days Available (In-Month)



190. To support the reduction of sickness absence, the Trust has developed a Sickness Absence Reduction Plan which is centred around the Department of Health's 5 High Impact Changes. In addition, the Trust has also undertaken a review of the Supporting Attendance Policy (HR07) and has plans to ensure that a programme of training for managers on the application of this Policy will be rolled out during 2018/19.

Staff Policies and Actions Applied

For giving full and fair consideration to applications for employment by the company made by disabled persons, having regard to their particular aptitudes and abilities.

191. Mersey Care is recognised as a 'Two Ticks' organisation. This means that we actively encourage applications from disabled individuals in accordance with the Equality Act 2010. As an organisation we are committed to employ, keep and develop the abilities of disabled staff and this is reflected in the Trust's Recruitment and Selection Policy (HR21). During the recruitment process, we are committed to making adjustments where necessary. Candidates who have declared a disability need only to meet the essential criteria to be guaranteed an interview.

192. The Trust is also signed up to the charter on being a Mindful Employer which aims to put good practice into place to ensure employees and job applicants who declare a mental health issue receive the right level of support.

193. Managers ensure that all adverts, job descriptions and person specifications provided to Resourcing Team do not include statements which could be deemed discriminatory.

194. The Resourcing Team ensure that any direct or indirect reference to discrimination is removed from all application forms and that equality and diversity information (Part A of the application form) is removed from the shortlisting process.

For continuing the employment of, and for arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company.

195. The Trust is committed to supporting staff to remain in work and have a Supporting Staff with Mental or Physical Disabilities Policy (HR27) which is used for both newly recruited employees with a disability who make their needs known at the recruitment stage and those staff who are currently employed by the Trust who become disabled whilst in employment. This Policy ensures that NHS guidance, advice and necessary training is provided to managers.

196. The Supporting Attendance Policy is used in conjunction with the Supporting Staff with Mental or Physical Disabilities Policy and provides flexibility for employee's where their disability may increase their levels of sickness. Time off for treatment or rehabilitation, which may be categorised as disability leave may be given as a reasonable adjustment. Also where an employee's disability will increase the levels of disability related sickness the Trust may, as a reasonable adjustment, allow a greater level of sickness absence before progressing through the stages of the policy.

Otherwise for the training, career development and promotion of disabled persons employed by the company.

197. The Trust's Learning and Development Policy (HR05) acknowledges that "no one size fits all" with regards to training and supports access to a range of learning and development opportunities that meet individuals' learning styles and are appropriate to the individuals' circumstances. Access to education, training and development is as open and flexible as possible, with no discrimination in terms of the protected characteristics and available to part-time/full time staff irrespective of working pattern and geographical location. Courses are advertised in the Learning and Development prospectus and are available to all.

Informing and Consulting with our Staff

198. Mersey Care has a number of formal vehicles where management and staff side meet to deal with employee relations issues, namely:

a) the Joint Negotiation and Consultative Committee (JNCC), which meets quarterly;

b) the clinical divisions have collaborative meetings which meet monthly and deal with pressing local issues within the divisions that can be dealt with quickly to enable good working relationships;

c) the Local Negotiating Committee (LNC), which meets quarterly with local and regional medical representatives to discuss the strategic overview for the medical workforce, policies, workloads, clinical excellence awards, rotas, recruitment and junior doctors.

We continue to meet in these forums to discuss and consider the impact on the quality of service in relation to the quality and transformation of services.

199. The Trust also actively engages with staff in local meetings and holds additional extra meetings to consult, discuss, debate and inform staff where changes are planned that impact on them directly.

200. During periods of transition, communication with staff is seen as a priority to ensure that all staff are fully informed at each step of the development, as well as being part of the on-going consultation process. Therefore, the Trust has implemented a range of innovative programmes as part of the Board's commitment to 'listen and act', including the Chief Executive's 'divisional road shows' and 'Mega Conversations' meetings with staff.

201. These meetings have proved extremely popular with staff as a means of both raising issues and keeping up to date with relevant information. Feedback has featured prominently on the board agenda and Board members are well briefed on issues affecting staff and staffing.

202. The Trust's appraisal process continues to be enhanced and aims to embed the Trust values, helping staff to understand their role in delivering the Trust's performance and also encouraging and empowering 'leadership' at every level.

203. The Trust will continue to engage, consult and work positively with staff side to foster true partnership working and ensure that the Trust and its employees are able to move forward and meet the challenges ahead.

Staff Survey

204. The 2017/18 National Staff Survey for Mersey Care was conducted on line and was sent to all staff.

205. We continue to reassure our staff regarding the confidentiality of their responses and always provide feedback on the results and how we are addressing issues raised through divisional actions plans.

206. Mersey Care's response rate for the National Staff Survey for 2017 was 60%, remaining static from 2016. For the 2017 staff survey, the Trust was benchmarked against other mental health / learning disability trusts, this will change for the 2018 staff survey to reflect the fact that the Trust now provides physical health services.

207. When compared to other mental health / learning disability trusts, the 2017 for Mersey Care results show:

a) six key findings where our performance is above average (19%);

b) fourteen key findings where our performance is average (44%);

c) twelve fey findings where our performance is below average (37%).

208. **Table 13** below outlines these key findings

Table 13: Analysis of Mersey Care's Key Findings from the 2017 National Staff Survey

Key Findings	Description of the Key Findings
Performance above average	• KF02 – satisfaction with quality of work and care able to deliver • KF16 – percentage of staff working extra hours • KF20 – discrimination at work in last 12 months • KF27 – percentage of staff reporting most recent experience of harassment, bullying or abuse • KF24 – percentage of staff reporting most recent experience of violence • KF31 – staff confidence and security in reporting unsafe clinical practice
Average performance	• KF01 – staff recommendation of the Trust as a place to work or receive treatment • KF03 – percentage of staff agreeing their role makes a difference to patients / service users • KF05 – recognition and value of staff by managers and the organisation • KF06 - reporting good communication between senior management and staff • KF11 – percentage of staff appraised within the last 12 months • KF14 – staff satisfaction with resourcing / support • KF17 – feeling unwell due to work related stress in the last 12 months • KF19 – organisational and management interest in and action on health and wellbeing • KF21 – equal opportunities for career progression • KF25 – percentage of staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months • KF26 – percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months • KF28 – witnessing potentially harmful errors, near misses, incidents • KF29 – reporting errors, near misses or incidents • KF32 – effective use of patient / service user feedback
Performance above average	• KF04 – staff motivation at work • KF07 – staff ability to contribute towards improvements at work • KF08 – satisfaction with level of responsibility and involvement • KF09 – effective team working • KF10 – support from immediate managers • KF12 – quality of appraisal • KF13 – quality of non-mandatory training, learning or development • KF15 – satisfaction with opportunities for flexible working • KF18 – attending work in last 3 months despite feeling unwell • KF22 – percentage of staff experiencing physical violence from staff in the last 12 months • KF23 – percentage of staff experiencing psychical violence from staff in the last 12 months • KF30 – fairness and effectiveness of procedures for reporting errors, near misses and incidents

209. There were statistically significant improvements in the following areas:

a) KF06 – percentage of staff reporting good communication between senior management and staff;

b) KF30 – fairness and effectiveness of procedures for reporting errors, near misses or incidents;

c) KF31 – staff confidence and security in reporting unsafe clinical practice.

210. There were no areas where there was a statistically significant deterioration in the results.

Staff Survey Action Plans

211. Each division has been tasked with the creation of a tailored Staff Survey Action Plan which will be presented to the Trust's Board of Directors meeting in July 2018.

212. Divisional action planning will concentrate on the areas where the Trust scores were worse than average for mental health / learning disability trusts and are in the bottom five worse ranked scores as well as areas of significance linked to their Transformation Plans. In addition to the divisional action plans an overarching Trust action plan to address the main concerns raised and interventions for long term improvements is in place. The implementation of these plans is due to commence in July 2018.

Embedding "A Just and Learning Culture"

213. The launch of the Trust's commitment to a Just and Learning Culture in February 2017 ensures balanced accountability for both individuals and our Trust; a culture that fosters openness and a willingness to report errors without concern so that we can learn. The emphasis is to learn and share, and ask what happened, and not who is responsible. Reporting when things do not go as planned is not something to be feared but rather, something to inspire us to learn. This remains a key priority for the Trust.

214. Professor Sidney Dekker visited the Trust again in January 2018 and set a number of challenges in how we must meet hurt with healing. It was though a positive and valuable visit in which he was clear that we demonstrated our movement towards a restorative justice culture.

215. During 2017/18 the Trust set the following objectives:

a) **Objective 1 - within one week of an incident, a copy of its 72-hour report review will be shared with all members of the relevant teams**

Our Deputy Medical Director is the Operational Lead. The initial aim for delivery on this objective was July 2017. It became apparent quite quickly that different approaches exist in the divisions and these processes do not easily lend themselves to support the requirements of the objective.

Other Trust initiatives also impact upon the practicalities of the objective such as the streamlining of our incident reporting systems and the work being done

to manage and resolve incidents and complaints. Our work has progressed to now mutually influence and shape those other projects.

b) **Objective 2 - Good Practice Stories will be published every month in order that we can extract the maximum possible learning from things that go well and from things that did not go as expected**

A Good Practice Stories (GPS) task and finish group was established in June 2017 in order to progress development of this objective.

The group met on four occasions from June to November 2017. Included were key representatives from the divisions, identified Just and Learning Culture ambassadors, and others who because of their role within the Trust were likely to become aware of potential good practice stories (these included the Trust's 'Speak Up Guardian', and representatives of the complaints department and patient safety team). A follow up workshop was also held in February 2018.

Mechanisms to capture, prioritise and publish the stories have been established. An attractive and interactive microsite is in place. This enables the stories to be available and for them to be "voted upon" by staff as to whether they believe the stories are examples of cultural change or not.

c) **Objective 3 - we will publish quarterly data on our website to transparently demonstrate whether our colleagues have felt supported when things haven't gone as expected**

The Trust's Heads of Health and Wellbeing and Human Resources are providing operational leadership to this objective with executive level support from the executive director of workforce.

The development of the new Supporting Colleagues Policy (HR37) presented the Trust with a critical question – "do colleagues feel adequately supported when things don't go as expected?"

All colleagues, who by virtue of an incident or situation are guided through the supporting process, will be formally canvassed at month 1 and 3 post incident to seek their feedback data as to how effective they found the process and support options that were made available to them. As colleagues need different support dependant upon the individual circumstances and events, we are aware of and acknowledge that what one employee may find supportive another does not and so we aim to provide a tailored support package for staff that meets their individual need.

Just and Learning Ambassadors

216. We have now appointed more than twenty ambassadors across our Trust and recruitment and interest is growing. They are much more than a visible presence; they are the people that give credibility to the goals that we set, help shape the way in which we learn and demonstrate our commitment to, and value of our workforce.

217. Ambassadors are part of a multidisciplinary network. Across our Trust they are a point of communication that will enable collective leadership. Our Just and Learning Culture is guided not by hierarchy but by openness and lived experience. Our ambassadors will inform, encourage and support employees in circumstances where concerns should be reported and lessons learnt. Our ambassadors will help create a better place to work, a safer place to receive care and an organisation that is led by compassion.

Our Leadership Approach to a Just and Learning Culture

218. The leadership model - 'Leading Perfect Care' was co-produced. The model includes a full associated pathway of leadership and management development programmes and master classes for emerging strategic and systems leaders. They are all aligned to delivery on our strategy and the development of our Just and Learning Culture.

219. We believe everyone is a leader at Mersey Care. This means it is everyone's responsibility to improve our services and create an open, healthy, productive environment in which to work.

Friends and Family Test 2017/18

220. The annual NHS Staff Survey is carried out during quarter 3 of every year. During quarters 1, 2 and 4 of each year the staff Friends and Family Test serves as a more dynamic test of staff engagement. The two core questions check the likelihood of staff recommending Mersey Care as a place to receive treatment and the likelihood of staff recommending Mersey Care as a place to work. Despite the survey taking just a couple of minutes to complete, our response rates remain low usually at around 15%. The results for both questions fluctuate slightly from quarter to quarter and remain within expected parameters. The "place to work" question scores slightly less than the "place to receive treatment".

221. 2018 will see the use of an internal tool, "The Culture of Care Barometer" to further explore staff mood, engagement and culture on a team by team basis.

Staff Engagement Plan 2018/19

222. Our Staff Engagement Plan is updated annually to reflect the changing needs of the organisation based in part on the results of the annual NHS Staff Survey. The plan continues to be based upon the "building blocks" proposed by the Kings Fund paper *'Staff Engagement: six building blocks for harnessing the creativity and enthusiasm of NHS staff',* specifically:

a) Block One - develop a compelling, shared strategic direction;

b) Block Two - build a collective and distributed leadership;

c) Block Three - adopt supported and inclusive leadership styles;

d) Block Four - give staff the tools to lead service transformation;

e) Block Five - establish a culture based on integrity and trust;

f) Block Six - place staff engagement firmly on the board agenda.

223. The Plan contains all the workstreams and activities carried out throughout the year relating to staff engagement and this year has an explicit focus on our Just and Learning Culture objectives. Creating opportunities for open and honest conversations throughout the Trust remains a priority as does the development of strong, compassionate leaders and high performing teams. This approach is robust and purposeful and will be introduced to new areas of the organisation whilst at the same time we continue to embed in our original clinical divisions.

Expenditure on Consultancy

224. Reporting bodies are required to disclose the expenditure on consultancy. For the purposes of this report, 'consultancy' is defined as in the Department of Health Group Accounting Manual 2017/18 (strategy; finance; organisational and change management; IT; property and construction; procurement; legal services; marketing and communications; HR; training and education programme and project management; technical). The expenditure incurred in the period 1st April 2017 to 31st March 2018 was £1,346,000.

Off-Payroll Engagements

225. All public sector bodies are required to report arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and National Insurance arrangements, not being classed as employees).

226. For all off-payroll engagements as of 31 March 2018 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	2
Of which, the number of staff that have existed:	
• for less than one year at the time of reporting	0
• for between one and two years at the time of reporting	2
• for between 2 and 3 years at the time of reporting	0
• for between 3 and 4 years at the time of reporting	0
• for 4 or more years at the time of reporting	0

227. For all new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which:	
• number assessed as caught by IR35	0
• number assessed as not caught by IR35	2
• number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
• number of engagements reassessed for consistency / assurance purposes during the year	0
• number of engagements that saw a change to IR35 status following the consistency review	0

228. For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

	Number
Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility, during the year	0
The total number of individuals both on and off-payroll that have been deemed "board members and / or senior officials with significant financial responsibility", during the financial year. This total figure must include both on payroll and off-payroll engagements.	7

Reporting of Other Compensation Schemes – Exit Packages

229. The exit payments were calculated in accordance with contractual terms based on length of service.

Table 14: Exit Payments by Type and Cost Band for 2017/18

Numbers / Costs for 2017/18	Exit Package Cost Band (including any special payment element)							Total
	Less than £10,000	£10,000 to £25,000	£25,001 to £50,000	£50,001 to £100,000	£100,001 to £150,000	£150,001 to £200,000	More than £200,00	
Number of Compulsory Redundancies	10	16	22	4	2	0	0	54
Cost of Compulsory Redundancies	£50,000	£310,000	£784,000	£291,000	£234,000	£0	£0	£1,669,000
Number of Other Departures Agreed	57	16	5	2	0	0	0	80
Costs of Other Departures Agreed	£173,000	£258,000	£173,000	£159,000	£0	£0	£0	£763,000
Total Number of Exit Packages	67	32	27	6	2	0	0	134
Total Cost of Exit Packages	£233,000	£568,000	£957,000	£450,000	£234,000	£0	£0	£2,432,000
Number of Departures where Special Payments have been made	0	0	0	0	0	0	0	0
Cost of Special Payment Element including in Exit Packages	£0	£0	£0	£0	£0	£0	£0	£0

230. Other departure costs have been paid in accordance with the provisions of the NHS Scheme/Trust's Mutually Agreed Redundancy Scheme (MARS). Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. 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 within this table.

CHAPTER 14 – SINGLE OVERSIGHT FRAMEWORK

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

a) quality of care;

b) finance and use of resources;

c) operational performance;

d) strategic change;

e) leadership and improvement capability (well-led).

232. Based on information from these themes, providers are ***segmented*** from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. Foundation Trusts will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence. As at 31 March 2018, Mersey Care has been assessed as being **SEGMENT 2** (i.e., a provider who is offered targeted support by NHS Improvement as there are concerns in relation to one of more of the themes. Providers are not obliged to take up the support that is offered)

233. The Trust's ***Finance and Use of Resources*** score for the period ending 31 March 2018 is a ***1*** overall (on a scale of 1 to 4, where 1 reflects the strongest performance)

NHS Improvement Single Oversight Framework

Theme	Type	Measure	Frequency	Threshold/ National Median	Latest Data	Date of Latest data	Source
Quality of Care	Caring	Written Complaints - Rate	Quarterly	National Median: 16.24	21.7	Q3 2017/18	NHS Digital
Quality of Care	Caring	Staff FFT % Recommended	Quarterly	No Threshold/ National Median Applied	71.13%	Q3 2017/18	NHS England
Quality of Care	Safe	Occurrence of Never Events	Monthly (six month rolling)	Green = 0, Red = 1 or more	0	March-18	Mersey Care Internal Reporting
Quality of Care	Safe	Patient Safety Alerts not completed by deadline	Monthly	Green = 0, Red = 1 or more	0	March-18	Mersey Care Internal Reporting
Quality of Care	Safe	Admissions to adult facilities of patients under 16 years old	Monthly	Green = 0, Red = 1 or more	0	March-18	Mersey Care Internal Reporting
Quality of Care	Safe	Potential under-reporting of patient safety incidents	Monthly	National Median: 43.47	28.13	December-17	NHS Improvement
Quality of Care	Caring	Mental health scores from FFT - % positive	Monthly	No Threshold/ National Median Applied	87.37%	March-18	Unify Return
Quality of Care	Caring	Community scores from Friends and Family Test - % positive	Monthly	No Threshold/ National Median Applied	98.80%	March-18	Unify Return
Quality of Care	Organisational Health	CQC Community Mental Health Survey	Annual	Performance maintained or no material reduction observed = green; material reduction observed = red.		2017	Care Quality Commission

Theme	Type	Measure	Frequency	Threshold/ National Median	Latest Data	Date of Latest data	Source
Quality of Care	Effective	Care Programme approach follow up within 7 days	Monthly	Green =>95% Red <95%	96.24%	March-18	Unify Return
Quality of Care	Effective	% clients in settled accommodation	Monthly	National Median: 67%	60%	January-18	NHS Digital via MHSDS
Quality of Care	Effective	% clients in employment	Monthly	National Median: 7%	4%	January-18	NHS Digital via MHSDS
Operational Performance	Operational Performance	People with a first episode of psychosis begin treatment with a NICE recommended care package within 2 weeks of referral.	Monthly (three month rolling)	Green =>50% Red <50%	67.02%	March-18	Unify Return
Operational Performance	Operational Performance	IAPT – waiting time to begin treatment (from IAPT minimum data set) within six weeks	Monthly (three month rolling)	Benchmark 75%	97%	March-18	NHS Digital
Operational Performance	Operational Performance	IAPT – waiting time to begin treatment (from IAPT minimum data set) within 18 weeks	Monthly (three month rolling)	Benchmark 95%	100%	March-18	NHS Digital
Operational Performance	Operational Performance	Inappropriate out-of-area placements for adult mental health services (OBDS) - External only	Monthly	Trajectory from April 2018	0	March-18	Clinical Audit Platform – NHS Digital
Operational Performance	Operational Performance	IAPT - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	Quarterly	Benchmark 50%	37%	Q3 2017/18	NHS Digital
Operational Performance	Operational Performance	Data Quality Maturity Index (DQMI) - MHSDS Dataset Score	Quarterly	Green =>95% Red <95%	97.10%	Q2 2017/18	NHS Digital

Theme	Type	Measure	Frequency	Threshold/ National Median	Latest Data	Date of Latest data	Source
Operational Performance	Operational Performance	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards	Annual	Green =>90% Red <90%	66%	2016/17 2017/18 data to be available in June 2018	Royal College of Psychiatrists
Operational Performance	Operational Performance	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services	Annual	Green =>90% Red <90%	41.95%	2016/17 2017/18 data to be available in June 2018	Royal College of Psychiatrists
Operational Performance	Operational Performance	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)	Annual	Green =>65%Red <65%	8%	2016/172017/18 data to be available in June 2018	Royal College of Psychiatrists
Leadership & Improvement	Leadership & Improvement	NHS Staff Survey	Annual	National Median: 3.67	3.67	2017/18	NHS England
Leadership & Improvement	Leadership & Improvement	Proportion of Temporary Staff	Monthly	National Median: 4.63%	4.62%	March-18	Provider Return
Leadership & Improvement	Leadership & Improvement	Staff Sickness	Monthly	National Median: 5.19%	7.12%	March-18	Mersey Care Internal Reporting
Leadership & Improvement	Leadership & Improvement	Turnover	Monthly	National Median: 1.03%	1.53%	March-18	Mersey Care Internal Reporting

CHAPTER 15 – ANNUAL GOVERNANCE STATEMENT

SCOPE OF RESPONSIBILITY

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

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

235. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Mersey Care NHS Foundation Trust for the period ending 31 March 2018 and up to the date of approval of the annual report and accounts.

CAPACITY TO HANDLE RISK

Leadership

236. The Board of Directors 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[6] who is supported by the Risk Management Group.

237. I, as Chief Executive, with overall responsibility for risk within the Trust, ensure the work of the Executive Committee and other specialist sub-committees is reviewed by the Board of Directors. 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.

238. The Board of Directors 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

6 From April 2017 to February 2018 the Executive Lead was the Executive Director of Nursing. From March 2018 this responsibility was assumed by the Medical Director.

the Risk Management Group and relevant sub-committees, are made to the Board of Directors where competing priorities are debated and agreed or accepted.

239. The capacity of the Trust to handle risk is achieved through delegated responsibilities in place as defined in the Scheme of Reservation and Delegation of Powers and the Risk Management Strategy, both documents being approved by the Board of Directors. 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.

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

a) the Board of Directors 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;

b) the Executive Committee, the Performance, Investment & Finance Committee and the Quality Assurance Committee undertake the detailed scrutiny of those risks that fall within their terms of reference on behalf of the Board of Directors, recommending new or revised risks to the Board as appropriate;

c) the Audit Committee on behalf of the Board of Directors ensures that the Trust's risk management systems and processes are robust;

d) the Risk Management Group, although accountable to the Executive Committee, reports and advises all Board Committees on potential / existing strategically significant risks, as well as liaising with the Operational Management Boards to ensure the consistency of risk reporting and also overseeing the Trust's Risk Register;

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

f) the Lead Executive Director, the Executive Director of Nursing)from April 2017 to February 2018) then the Medical Director (from March 2018), has responsibility, on behalf of the Chief Executive, for managing the Trust's risk management processes;

g) each member of the Executive Team has responsibility for the identification and management of risks within their executive portfolios;

h) 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;

i) the Deputy Director of Nursing, as Director for the Prevention and Control of Infection (DIPC), is accountable for the management and prevention of health care associated infection;

j) the Deputy Director of Nursing and Quality is the Nominated Individual with the Care Quality Commission (CQC);

k) the Executive Director of Nursing is accountable for CQC registration.

241. 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 Mersey Care website to internal and external stakeholders for comment, scrutiny and reference.

Training

242. Trust policies are available on the Trust's intranet and internet 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 monthly briefing issued to staff.

243. 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 programme which includes adverse incidents, Health and Safety, Fire Safety, Infection Control and Prevention, Safeguarding Children and Vulnerable Adults, Information Governance, Moving and Handling, Conflict Resolution, Complaints Handing, Care, Suicide Prevention, Fraud Awareness, and Equality and Diversity. This training is mandatory for all staff and is identified via a training needs analysis that is reflected in the Trust's Induction and Mandatory Training Policy.

244. All new employees of the Trust are required to attend a corporate induction programme that covers key aspects of risk management. In addition, to ensure a consistent approach to root cause analysis and investigation focussed training sessions are provided to relevant members of staff. 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 Plan.

245. Compliance with mandatory training is reported to the Board of Directors (in addition to the Executive Committee and Performance Investment and Finance Committee) on a bi-monthly basis and monthly reports informing managers of staff who require update training are sent to all Divisional and Departmental Managers.

246. Staff across the organisation that have a key role in respect of risk assessment and management have attended bespoke, externally facilitated training sessions in the reporting period which focused on the identification, assessment, mitigation and reporting of risk.

247. To further encourage a positive safety culture and to ensure learning, the Trust's internal weekly newsletter, 'Your News', features regular articles on the learning arising from the analysis of claims, incidents and complaints. The newsletter also

features regular articles highlighting key risk management areas and promoting the update training that staff are required to complete. In addition, the Trust regularly holds Oxford Model 'Dare to Share' events which focus on the learning from specific incidents across divisions.

248. The Risk Management Group have been subject to bespoke, externally led training on risk management processes and are champions for risk management across the organisation, ensuring consistent risk management approaches are utilised.

249. The Trust also delivers additional risk management training and development to the Board members (both Executive and Non-Executive Directors), both internally and externally facilitated.

THE RISK AND CONTROL FRAMEWORK

The Risk Management Framework

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

a) overarching strategic aims for risk management;

b) the Trust's Risk Management Strategy;

c) the Trust's Risk Management Policy;

d) organisational risk management objectives;

e) the organisational process for risk identification and analysis;

f) a definition of significant risk and acceptable risk within the organisation;

g) organisational risk management structures;

h) the development and application of risk registers within the organisation;

i) incident reporting;

j) the accountability and responsibility arrangements for risk management;

k) the Board Assurance Framework.

251. Throughout the reporting period the Executive Committee, Performance, Investment and Finance Committee, Quality Assurance Committee and the Audit Committee were the Board's overarching committees responsible for scrutinising the arrangements in place for managing risk. These committees are supported by the following sub-committees / groups:

a) Remuneration and Terms of Reference Committee;

b) Mental Health Act Managers Sub-committee;

c) Operational Management Boards;

d) Health & Safety Sub-committee;

e) Infection Control Sub-committee;

f) Mortality Committee;

g) Drugs & Therapeutics Sub-committee;

h) Digital Board;

i) Joint Information Governance, SIRO & Caldicott Sub-committee;

j) Safeguarding Group;

k) Risk Management Group;

l) Weekly Divisional Surveillance Group meetings;

m) Weekly Executive Safety Huddle surveillance meetings.

Risk Management Strategy

252. 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 and changes, including:

a) a clear commitment of the Board of Directors in respect of risk management, including a plan to achieve this over the next 2 years;

b) a system of risk classification and risk stratification that makes clear who and where risks are to be escalated and reviewed;

c) the Trust's appetite for risk , which is reviewed by the Board of Directors on an annual basis;

d) a single Trust-wide Risk Register,

e) a combined risk report and Board Assurance Framework;

f) a process to moderate and standardised the approach to assessing risk (coordinated by the Risk Management Group);

g) the requirement for all risks to have three risks scores – an initial score, a current score and a target risk score;

h) greater alignment between risk identification and quality improvement;

i) greater alignment between risks and the assurance in respect of the controls / mitigation that has been put in place.

253. Mersey Care NHS Foundation Trust recognises the need for significant and robust focus on the identification and management of risks and therefore places risk within an integral part of our overall approach to quality. Therefore, risk management is an explicit process in every activity the Trust and its employees take part in.

254. The Director of Patient Safety who has overall operational responsibility for risk management, is responsible for implementing the effective systems and processes of risk management across the organisation, the identification, management and monitoring of risks; providing reports, information and training as appropriate. As well as the Executive Team and Non-Executive Directors, managers and individual staff members are responsible for ensuring that they engage with risk management objectives in order to ensure that their clinical and managerial responsibilities for risk management are met.

255. All members of the Executive Team and managers are responsible for ensuring that within their designated area(s) and scope of responsibility:

a) there are appropriate and effective risk management processes in place and that all staff are made aware of the risks within their work environment and of their personal responsibilities;

b) there are effective systems in place for the identification, control, monitoring and review of risks and that risks are evaluated using the Trust framework for the grading of risks and that the appropriate level of management action is initiated and completed appropriately;

c) they, and all their staff, receive the necessary information, instruction and training to enable them to work safely and comply with appropriate Trust procedures, including incident reporting, risk assessments, fire arrangements and all health and safety procedures;

d) staff are identified and released to attend mandatory training and other appropriate training, adequate attendance records are kept and non-attendance is monitored and followed up;

e) staff know and understand their responsibilities and duties under the Trust health and safety policy and have appropriate arrangements to ensure that these are met.

256. Each Division has governance arrangements in place and a local governance lead is responsible for implementing the corporate risk management processes locally and in addition facilitating the sharing of best practice co-ordinated by the relevant Operational Management Board.

257. Embedding risk management as a core activity within the organisation is achieved through many systems and processes. 2017/18 has seen:

a) a full review of the Board Assurance Framework, along with continued development of the systems and processes that support its production;

b) review of the Board's risk appetite;

c) review of the Risk Management Strategy to take account of the creation of the South Sefton Community Services Division from 1 June 2017;

d) continued development of the Risk Management Group, as a sub-committee of the Executive Committee, to undertake additional analysis of strategic risk, to develop mitigation plans and ensure in-depth reviews of key risks;

e) provision of bespoke risk training to key staff across the organisations;

f) continued development and scrutiny of risks within the Clinical Divisions;

g) maintenance of compliance with the Care Quality Commission's Fundamental Standards, supported by Quality Review Visits and Board Assurance Visits, to further support compliance;

h) the annual review and updating of the Trust's Anti Fraud, Corruption and Bribery Policy and Response Plan;

i) continued development of organisational policies, including implementation of the new policy template;

j) continued registration, without improvement conditions, from the Care Quality Commission.

258. 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. An opinion on the assurance framework has been provided by Mersey Internal Audit Agency. The opinion (review) states that:

> *"The organisation's Assurance Framework meets the NHS requirements, is visibly used by the Board and reflects the risks discussed by the Board"*.

Risk Appetite

259. Risk Appetite is the level at which the Board of Directors determines whether an individual risk, or a specific category of risks, is deemed acceptable or unacceptable based upon the circumstances / situation facing the Trust. This determination may well impact on the prioritisation of resources necessary to mitigate or reduce the impact of a particular risk and / or the time the timeframe required to mitigate a risk.

260. The Board of Directors reconsidered its appetite for risk at its board meeting in January 2017 and approved the following statement.

Mersey Care NHS Foundation Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff the public and strategic partners. As such, Mersey Care will not accept risks that materially provide a negative impact on patient safety. However Mersey Care has a greater appetite to take considered risks in terms of their impact on organisational issues. Mersey Care has greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment. Further detail on the statement is provided below. The risk appetite is shown in **BOLD** text	
Compliance and Regulatory	• There is a **LOW** risk appetite for risk, which may compromise the Trust's compliance with its statutory duties and regulatory requirements.
Financial	• Mersey Care has a **LOW** risk appetite to financial risk in respect of meeting its statutory duties. • Mersey Care has a **MODERATE** appetite for risk to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. • Mersey Care has a **MODERATE** appetite for investments which may grow the size of the organisation
Quality, Innovation and Outcomes	• Mersey Care has **NO** appetite for risk that compromises patient safety. • Mersey Care has a **LOW** risk appetite for risk that may compromise the delivery of outcomes, that does not comprise the quality of care • Mersey Care has a **SIGNIFICANT** risk appetite to innovation that does not compromise the quality of care.
Reputation	• Mersey Care has a **LOW** risk appetite for actions and decisions that whilst taken in the interest of ensuring quality and sustainability of the patient in our care may affect the reputation of the organisation.

Risk Assessment

261. As has been outlined above, although it is recognised that the Trust had robust arrangements for the management of risks, the trust's risk management processes have been further reviewed and refined with the adoption of a revised Risk Management Strategy, taking account of good practice guidance and external reviews. In the reporting period, the Trust has:

a) refined the format of its Board Assurance Framework which is reviewed and approved every two months by the Board of Directors taking account of the views of the Executive Committee, the Performance, Investment and Finance Committee and the Quality Assurance Committee;

b) further embedded a single Trust-wide Risk Register and reporting system;

c) fundamentally reviewed and integrated the risks identified within the new South Sefton Community Services Division following the transfer of South Sefton's physical community health services from Liverpool Community Health NHS Trust on 1 June 2017;

d) embedded the refined role of Board Committees in overseeing and considering different categories of risk, making recommendation to the Board of Directors as appropriate as to whether strategically significant risks should be added, revised or removed. All strategically significant risks are categorised as shown below, with particular Board Committee's taking the lead in reviewing these risks:

   i) compliance / regulatory risks (Executive Committee),

   ii) financial risks (Performance, Investment and Finance Committee),

   iii) innovation / quality / outcomes risks (Quality Assurance Committee),

   iv) reputation risks (Executive Committee);

e) clarified the escalation process for risks from wards / teams to the Board, including via the Trust's surveillance processes;

f) embedded the arrangements for the Risk Management Group, chaired by the Director of Patient Safety, with senior representatives from every division whose role is to:

   i) oversee the Trust's Risk Register (advising on the completeness and standardisation of risks, their controls, mitigation, action plans and assurance through the Trust's governance systems) and ensures the risks recorded take account of the Risk Appetite,

   ii) take account of the Risk Register, to advise the Board of Directors (via the Board Committees) on the strategically significant risks for inclusion, update or removal on the Trust's Board Assurance Framework (taking account of the Risk Appetite);

   iii) liaise with the Operational Management Boards on the standardisation of risk descriptions and risk scores an the robustness of the controls to mitigate those risks included in the Trust's Risk Register (and Board Assurance Framework)

   iv) assist the Executive Director of Nursing (from March 2018 the Medical Director) on providing assurance to Audit Committee on the robustness of the Trust's risk management processes;

g) ensuring that all risks include:
   i) an initial, current and target risk rating score
   ii) the date the risk was added and a date when it will be reviewed
   iii) an Action Lead, Accountable Manager and Executive Owner so as to ensure clear ownership;

262. The on-going enhancement to the Trust's risk management processes means that the Trust now has a more dynamic approach to risk management, which is reflected in the risks escalated to the Board of Directors and Board Committees to be considered as strategically significant risks by the Risk Management Group.

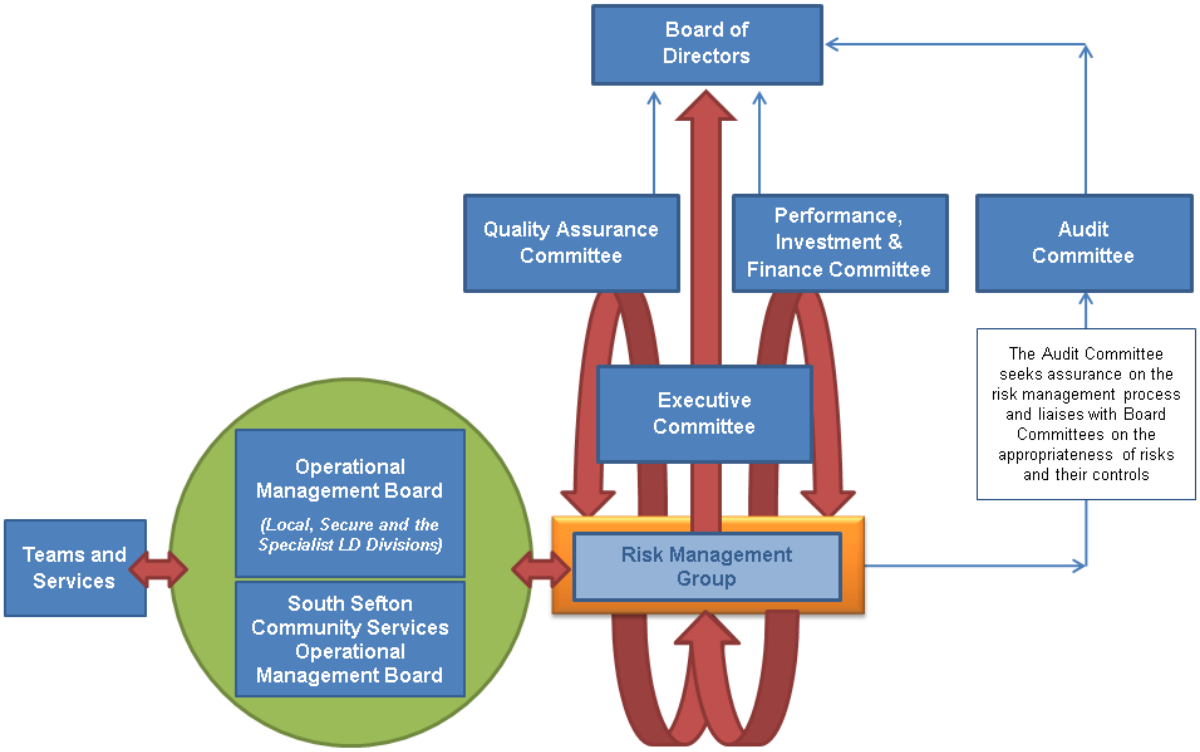


Figure 4: Risk Escalation Process (from June 2017)

Strategically Significant Risks in 2017/18

263. 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 was approved by the Board of Directors in May 2017 and a revised version was considered in July 2017 following the creation of the South Sefton Community Services Division in June 2017.

264. 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 normal Board / Board Committee reporting cycles.

265. **Table 15** below highlights the strategically significant risks the Board considered in March 2018, listed against the Trust's four main strategic objectives.

Table 15: Board Assurance Framework (March 2018)

If the new corporate services strategy and operational model are not produced based on the Carter Review recommendations, then corporate services may not be fit for purpose and corporate CIPs may not be delivered. (Strategy Objective – Our Services)	**Executive Lead:** Executive Director of Workforce

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Finance	4	3	12	4	2	8

If the Trust fails to develop a workforce model that is aligned to the clinical delivery model, which takes into account the available workforce supply and existing gaps, then the safety, responsiveness and quality of the care provided may be compromised. (Strategy Objective – Our People)	**Executive Lead:** Executive Director of Workforce

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality	4	3	12	4	2	8

If the measures used to provide assurance for performance are not valid and reliable then the delivery of high quality care may not be evidenced, resulting in poor decision making, inefficient management and planning and complications with commissioning and partnership working. (Strategy Objective – Our People)	**Executive Lead:** Executive Director of Nursing

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality	3	3	9	2	2	4

If the organisation's strategic options are not progressed in partnership with appropriate other organisations, and then opportunities for improvement and future growth may be lost. (Strategy Objective – Our Future)	**Executive Lead:** Director of Strategy

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Reput-ational	3	3	9	3	1	3

If the Global Digital Exemplar programme is not implemented effectively, then the Trust may face financial and reputational consequences and opportunities to improve care and treatment may be lost. (Strategy Objective – Our Resources)	**Executive Lead:** Medical Director

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Reputation al	3	3	9	3	2	6

If the Trust does not implement the transformation programmes for clinical services timely and effectively, then the quality of services may be negatively affected including a potential increased use of Out of Area Treatments. (Strategy Objective – Our Services)	**Executive Lead:** Executive Director of Operations

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality; Finance	4	2	8	4	1	4

If the organisation's estates strategy is not implemented appropriately, then the delivery of perfect care and transformation programmes may not be effectively supported, resulting in quality of care not improving and financial implications for the Trust. (Strategy Objective – Our Services)	**Executive Lead:** Executive Director of Communications & Corporate Governance

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality; Finance	4	2	8	4	1	4

If the organisation does not successfully operationalise South Sefton Community Services, then mental health and primary care may fail to integrate, resulting in the Trust not meeting its deliverables for the improvement of quality of care and performance. (Strategy Objective – Our Services)	**Executive Lead:** Executive Director of Nursing

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality	4	2	8	4	1	4

If the organisation's financial activity and workforce plans are not consistent with Sustainability and Transformation Plans, then partnerships may be compromised, resulting in negative financial implications for the Trust and uncertain future growth. (Strategy Objective – Our Future)	**Executive Lead:** Director of Strategy

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Finance	4	2	8	4	1	4

If the Life Rooms model is not implemented fully, then increased pressures may be put on services in the form of bed occupancy, increased community attendance with lower recovery, employment and patient satisfaction rates. (Strategy Objective – Our Services)	**Executive Lead:** Executive Director of Communications and Corporate Governance

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality; Reput-ational	3	2	6	3	1	3

Risk that the TCPs and Mersey Care are unable to agree an appropriate model for CCG-commissioned inpatient beds (Strategy Objective – Our Future)	**Executive Lead:** Executive Director of Operations

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality	4	5	20	4	2	8

If there is insufficient clinic appointments to meet demand than service users may fail to receive an appointment within the specified timeframe which could result in a deterioration in their mental health (Strategy Objective – Our People)	**Executive Lead:** Executive Director of Operations

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality	4	4	16		1	4

If there are long term Consultant Psychiatrist vacancies within the Local Division then there is a risk that the quality and safety of care is being compromised (Strategy Objective – Our People)	**Executive Lead:** Medical Director

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality/ Reput-ational	4	4	16	3	3	9

If service users are not adhering to the Trust's Smoke Free Policy then there is an increased risk of fires occurring (Strategy Objective – Our Resources)	**Executive Lead:** Executive Director of Operations

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality/ Regulatory	5	4	20	4	1	4

If improvements are not made to Park Lodge environment then there is a risk of breaches in Safety Regulations, increases in health related, security and safety incidents, reduction in staff morale, service users experience and damage to reputation (Strategy Objective – Our Resources)	**Executive Lead:** Executive Director of Operations

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality/ Reput-ational	4	4	16	4	1	4

There is a Risk that the target number of transfers of Service Users on the Whalley site into community care programmes is not possible to achieve, in time required, leading to an inability to close the site resulting in additional costs for the Trust. (Strategy Objective – Our Resources)	**Executive Lead:** Executive Director of Operations

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Regulatory	4	4	16	4	1	4

There is an increasing trend in the reporting of Community Acquired, Avoidable pressure ulcers across the Division due to identified hot spots within community services where further training, awareness and timely intervention is required. (Strategy Objective – Our Services)	**Executive Lead:** Executive Director of Nursing

Risk Type	Current Risk Scores			Target Risk Scores		
	Impact	Likelihood	Score	Impact	Likelihood	Score
Quality	4	4	16	4	2	8

266. All risks are monitored and managed throughout the year through a series of well-embedded arrangements including:

a) monthly scrutiny of risks through the Risk Management Group, which report to the Executive Committee;

b) regular scrutiny and challenge of relevant risks by the appropriate Board Committee;

c) Board of Directors' scrutiny, on a bi-monthly basis, of the Board Assurance Framework;

d) regular review of each risk by the appropriate Risk Lead to ensure appropriateness of scoring, robustness of controls and mitigations and addressing of actions and gaps in assurance identified;

e) full reviews of all strategic risks by the Board of Directors following approval of the Annual Operational Plan;

f) testing of risk controls via the Trust's Internal Auditors.

Provider License

267. This Annual Governance Statement provides an outline of the various structures and mechanisms that the Trust has in place to maintain a sound system of governance and internal control, amongst other things, to meet the requirement of the Foundation Trust License Condition 4 (FT Governance). It takes assurance from these structures and its various committees as well as feedback from internal and external audit and other internal and external stakeholders regarding the robustness of these governance structures. The Trust monitors compliance with the Provider License through a range of mechanisms, including:

a) monthly monitoring through the Trust's Board-level performance report (until January 2018 this was the Care at a Glance report, which has now been replaced by the Executive Performance Report)

b) requirements that all Board of Directors, Board Committee and sub-committee reports include details of any impact on the Trust's Provider Licence;

c) seeking of legal advice in respect of business development opportunities, including mergers and acquisitions, to ensure compliance with licence conditions.

268. Following the Monitor assessment process, Mersey Care was authorised as a Foundation Trust on 1 May 2016 with no condition places upon its license. The Trust was also subject to the NHS Improvement assessment during its acquisition of the former Calderstones Partnership NHS Foundation Trust (from 1 June 2016). The Trust has also been subject to an NHS Improvement assessment in respect of the transfer of South Sefton physical community services to the Trust (from 1 June 2017) and in respect of being identified as the 'Preferred Acquirer' to acquire Liverpool Community Health NHS Trust (Note – Mersey Care acquired Liverpool Community Health with effect from 1 April 2018).

Corporate Governance Statement

269. The Board of Directors, as required under NHS Foundation Trust Condition 4 (8)(b) assures itself of the validity of its Corporate Governance Statement. The Board considered and approved its Corporate Governance Statement for 2016/17 at its Board meeting in May 2017. As part of NHS Improvement's assessment of the Trust's bid to acquire Liverpool Community Health NHS Trust a Revised Corporate Governance Statement, based on the 2016/17 Statement, was approved by the Board at its meeting in March 2018. The Board of Directors will consider its Corporate Governance Statement for 2017/18 at its meeting in May 2018. In doing so, the Board ensured that the declarations being made could be supported with evidence.

270. In the course of approving the Corporate Governance Statement, the Board has had regard for a series of supporting evidence, in addition to details of the risks and mitigations to each statement made.

QUALITY GOVERNANCE

271. In March 2015 the Board of Directors approved the Trust's Framework for the Governance of Quality. The Framework was developed to ensure:

a) standards are clearly articulated;

b) accountability for the delivery of those standards is clear;

c) structures, processes and measures are in place that ensure quality concerns can be identified and addressed promptly.

272. The Surveillance process has been identified by a number of organisations as exemplar of good practice and was further developed in May 2016. A revised 'Clinical Governance and Quality Review Process' was reported to the Quality Assurance Committee in September 2017 to further improve the robustness of the Trust's arrangements for governing quality. The surveillance process is outlined in **Figure 5** below.

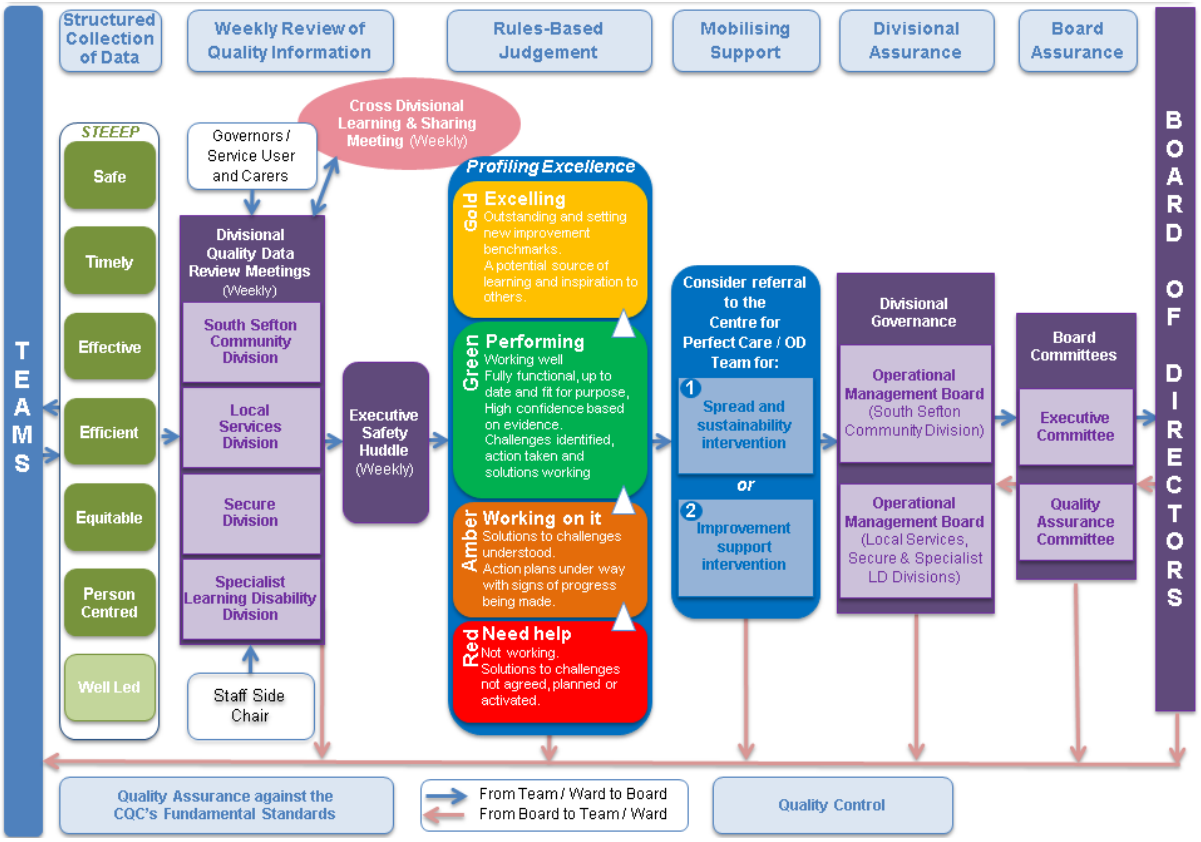


Figure 5: Clinical Governance & Quality Review Process

273. This provides mechanism to regularly and routinely monitor compliance with Care Quality Committee requirements including:

a) a process where a key set of data and intelligence relating to the Trust's quality strategy and the CQC Fundamental Standards is reviewed at a weekly surveillance meeting;

b) the Well Led domain is included in the Framework to reflect the importance of leadership in quality and the need to provide assurance of compliance with the CQC Fundamental Standards;

c) the Quality Surveillance process is supported by a Quality Dashboard which provides 'live' data pertaining to the 'our services' aspects of the Trust's Strategy. This is strongly aligned to the CQC Well Led domain and provides evidence of CQC compliance;

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

275. A Programme of Clinical Audit and Improvement was in place for 2017/18 outlining the key quality areas of focus and implementation of this Programme was overseen by the Quality Assurance Committee and Audit Committee in line with their terms of reference. Key areas of focus for audit and improvement during this period were:

a) Nationally-led audits;

b) Fundamental/ Regulatory Standards;

c) Perfect Care and Quality Account Priorities;

d) Divisional quality priorities (including NICE guidance);

e) National Clinical Audit Patients Outcomes Programme (NCAPOP);

f) Participation in National Accreditation Schemes;

g) Clinical and student led audits.

276. Assurance on the performance against the programme has been provided to the Quality Assurance Committee through the year.

277. The Board of Directors receives information pertaining to all serious untoward incidents through the Quality Report, with more detailed scrutiny undertaken by the Quality Assurance Committee on behalf of the Board of Directors. In addition the Board receives, in full, all internal and external independent investigations reports into serious incidents, together with actions plans which outline how lessons are learnt and appropriate controls are either refreshed or put in place to prevent / reduce the possibility of reoccurrence. Assurance on the delivery of these action plans is overseen by the Quality Assurance Committee on behalf of the Board of Directors.

278. Following the publication in December 2015 of the independent review commissioned by NHS England from Mazars into the quality of processes for investigating and reporting patient deaths in mental health and learning disability services at Southern Health NHS Foundation Trust, the Trust commissioned a report from Mersey Internal Audit Agency into Mersey Care's structure and systems for investigating the deaths of service users in order to provide the Board with independent assurance. Members of the Executive Team have also met with representatives from Mazars to facilitate greater learning of the issues raised in their report. In light of the National Guidance on Learning from Deaths (published by the National Quality Board in March 2017) a Mortality Review Team was established in the early part of 2017/18 and a Mortality Review Panel meets on a weekly basis. In September 2017 the Trust has approved a Learning from Deaths Policy (SA45) and identified a Non-Executive Director lead for Learning from Deaths (Gaynor Hales). Mortality data is provided to the Quality Assurance Committee and Board of Directors every six months and mortality data has been included in this year's Annual report

279. It is recognised that good quality information is vital to enable individual staff and the organisation to evidence they are delivering high quality/perfect care that supports people on their recovery journey, and to reach their goals and aspirations whilst keeping themselves and others safe. It also enables the efficient management of services, service planning, performance management, business planning, commissioning and partnership working. The Trust assures the quality of data though a series of mechanisms:

280. The Policy and Procedure for Information Governance Policy (IT12) provides the framework through which the Trust ensures that information (both clinical and management) is efficiently managed to meet current legislation. This includes reference to data quality in terms of accurate and reliable recording;

281. The Corporate Data Quality Policy (IT11) defines a series of data quality standards for inputs to the Trust's clinical information systems. Compliance with these standards is routinely monitored by the data quality steering group (reporting to the Information Governance Committee) through data analysis and audits;

282. The Performance Indicator Kite-Marking Policy (SA41) defines the policy and procedure for implementation of the performance indicator kite-mark which is published alongside all indicators featuring Trust's performance reports;

283. Data completeness indicators within the Trust's performance assurance framework e.g. NHS number, GP, Date of Birth. These are reported upon via the Trust and divisional performance reports, usually by exception.

284. The Trust agrees a Data Quality Improvement Plan with commissioners on an annual basis. Implementation of this is monitored via contract management arrangements and includes arrangements for agreeing amendments to contract key performance indicator methodology in year (if required);

285. Ad-hoc audits / analysis are carried out to provide assurance of good data quality and / or identify opportunities for improvement The findings of such pieces of work are shared with the Audit Committee as required;

286. Internal and external audit are commissioned to undertake audits that assess the quality of data used for internal and external performance reporting e.g. kite-mark indicator testing by Mersey Internal Audit, quality account indicator testing by external auditors. The findings from internal and external audit are received by the Audit Committee along with any actions agreed and the Committee oversees the implementation of such actions.

287. The Trust's Board performance report (Care at a Glance / Executive Performance Report) includes a kite mark against all key performance indicators so as to allow the Board of Directors to be assured of data quality. This report is scrutinised in detail at the Performance, Investment and Finance Committee.

288. Mersey Care is subject to monitoring against waiting time and other access targets. These relate to Referral to Treatment (RTT) indicators in relation to its Improving Access to Psychological Therapies (IAPT) service (known locally as Talk Liverpool) and the Early Intervention in Psychosis indicators.

EMBEDDING RISK MANAGEMENT

289. Risk management is embedded within the organisation as is reflected in evidence of appropriate escalation of risk at all levels.

290. In December 2016 the Trust launched the development of a Learning and Just Culture in response to feedback received by staff members which aims to aid the confident use of the incident reporting and courage both accountability and learning. Learning and Just Culture Ambassadors have been identified across the organisation and meet regularly to oversee this initiative.

291. Every day in the NHS we expect our staff to deliver high quality, effective care within ever trying conditions. It is acknowledged that staff should expect a compassionate response when things go wrong. The development of a Learning and Just Culture is a quality priority for the Trust for 2018/19 and therefore is reflected in our 2017/18 Quality Report.

292. The Trust has a performance management system that measures performance monthly against the Trust's key strategic objectives, which ensures that the risk management processes are embedded. Alongside these reports and the regular quality reports, the Trust also produces regular comprehensive risk reports.

293. Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. In line with equality legislation, all public organisations must declare their compliance with the General and Specific Duties of the Public Sector Equality Duty (PSED) on an annual basis. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives.

294. All NHS organisations must undertake a self assessment of current performance against the criteria stated in the National Equality Delivery System (EDS) on an annual basis and prepare and publish at least one equality objective from each of the four EDS Goals. Throughout 2017/18 the Trust continued to work with Healthwatch organisations and community organisations to monitor the Trust's activity within the EDS framework. The Trust reviewed its EDS assessment in 2016/17 and established priorities for 2017/18. Progress against the Trust's EDS Action Plan and Equality Objectives is monitored by the Equality and Human Rights Committee (chaired by a Non-Executive Director) and overseen by the Executive Committee through receipt of chairs report and minutes.

295. Equality Impact Assessments are integrated into core business. All Trust-wide policies and procedures must be subject to the equality and human rights analysis prior to approval, publication and implementation and for any service implementation and re-design. In addition, where available, quality data is reported by protected characteristic to allow identification and scrutiny of any equality issues.

PUBLIC STAKEHOLDERS INVOLVEMENT IN MANAGING RISKS

296. The Trust continually seeks to improve its risk management arrangements and Board Assurance Framework and further develop mitigations in order to assess the potential risks that threaten the achievement of the Trust's strategic objectives.

297. The organisation is involved with a multitude of partners including Clinical Commissioning Groups, Social Services, Education, Police, Prisons and the voluntary sector. The Executive Team and senior managers work closely with the above partners, to provide a local integrated service to our public and stakeholders.

298. In 2017/18 these arrangements have been enhanced by the development of the Cheshire and Merseyside Sustainability and Transformation Plan and more specifically the work the Trust is doing with other mental health providers across

Cheshire and Merseyside (i.e., Cheshire & Wirral Partnership NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation Trust).

299. The key ways in which public stakeholders are involved in managing risks which impact on them include:

a) the Council of Governors at quarterly meetings take the opportunity to hold the Board of Directors to account on its performance, including quality and risk;

b) the Trust's commitment to the commissioners, Chief Officer and Chief Executive meetings and consultation as required with the Overview and Scrutiny Committees and Healthwatch;

c) consultation for the Quality Report involves key stakeholders, and this is evidenced in our inclusion of their feedback

d) consultation with key stakeholders regarding key change programmes, service development and capital schemes

e) Executive Team, senior management and clinician involvement in the Sustainability and Transformation Plan and associated meetings.

300. The Trust recognises that risk management is a two way process between healthcare providers across the health economy. Issues raised through the Trust's risk management processes that impact on partner organisations would be discussed in the appropriate forum, so that action can be agreed.

301. There is service user and carer representation on a wide range of key committees in the Trust, including representation on the Quality Assurance Committee, Performance, Investment and Finance Committee, Audit Committee, Operational Management Board in addition to representation in Quality Review Visits and Patient Environment Action Team (PEAT) visits.

302. More recently in 2018 the Chief Executive now chairs the Liverpool Provider Alliance, a meeting that brings together representatives from NHS providers in Liverpool together with local GPs, social care colleagues from Liverpool City Council and representatives of the voluntary sector to address the integration of health and social care across the Liverpool. The Chief Executive also chairs the South Sefton Strategic Partnership Board which bring together NHS providers, local GPs, Sefton Council and NHS South Sefton Clinical Commissioning Group to look at areas of mutual interest since the Trust established the South Sefton Community Services Divisions in June 2017. The Trust also a member of the Strategic Partnership Board, chaired by NHS England and with representatives from Clinical Commissioning Groups across Lancashire and Greater Manchester, which is look at the future of Learning Disability Services at the Trust's Whalley site.

303. The Trust is subject to quarterly Quality Review Visits with NHS Improvement throughout the year, the process includes a formal letter outlining the conclusion and required actions from NHS Improvement in respect of the issues raised at these meetings. As part of the bidding and implementation processes to acquire both the

South Sefton and Liverpool community services from Liverpool Community Health NHS Trust, the Trust has met weekly with representatives from NHS Improvement, and through the NHS Improvement chaired Transaction Board, with other key stakeholders (including the local authority and the Clinical Commissioning Group) to ensure the seamless transfer of services to Mersey Care so as to ensure no impact to services users.

304. Although the Trust hosts Informatics Merseyside, the Trust holds regular contract performance meeting in respect of the services Informatics Merseyside provides to the Trust. The Trust also holds regular contract performance meetings with its payroll supplier (until February 2018 this was NHS Business Services Authority, now St Helens & Knowsley Teaching Hospitals NHS Trust).

305. In addition, the Trust has a Major Incident Plan in place which ensures involvement in system-wide emergency planning and business continuity arrangements.

INFORMATION GOVERNANCE AND DATA SECURITY

306. The Trust utilises the Information Governance Toolkit to identify and manage information risks and reports incidents regularly to the Board of Directors 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.

307. The Executive Director of Finance is the Senior Information Risk Officer and the Medical Director is both the Caldicott Guardian and the Chief Clinical Information Officer. They are supported in this role by the Interim Chief Information Officer and teams.

308. Specific issues and risks are also raised through the Joint SIRO, Information Governance and Caldicott Committee which reports to the Executive Committee, which in turn reports to the Board of Directors. 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.

309. The Trust experienced the following issues in respect of nine information governance incidents which occurred in 2017/18 and met the Information Commissioners Office (ICO) reporting criteria:

a) an email containing the Virtual Ward Multi-Disciplinary Team review of service users and their personal identifiable information was sent to and incorrect service provider who reported the incident to the Trust and confirmed its deletion. An investigation was undertaken and the operational process reviewed within the Division. Training was provided to the clerks involved in the Virtual ward process. The case was closed by the ICO;

b) the Trust processed a Subject Access Request and provided copy records to a service user. The service user identified that within their records it

contained 8 nursing observation sheets relating to another service user. The Trust provided an apology to the recipient, notified the other service user verbally and in writing of the incident and unauthorised disclosure. This case has been forwarded to NHS Resolution due to solicitors acting on behalf of the service user whose information was incorrectly disclosed seeking financial compensation. This case was closed by the ICO;

c) a list of employees involved in TUPE process was sent to three CCGs containing personal identifiable information which should have been redacted. The sender identified the error immediately, contacted each CCG and requested deletion – email confirmation was received from the CCGs confirming deletion of the original email and list. A new list was provided with personal identifiable information removed, 1:1 training was provided to the employee who sent the email and list. The case was closed by the ICO;

d) copies of a deceased service users clinical record were provided to the Coroner. It was identified by the partner of the deceased that the copy records contained 2 sides of an A4 document incorrectly scanned which related to another service user. The Director of Patient Safety contacted the Coroner and met with the partner & family of the deceased. The service user whose data had been scanned into the incorrect record was notified of the incident. Mersey Internal Audit Agency have been commissioned to undertake a “Deep Dive” into scanned documentation within the Trust to identify weaknesses in the scanning operational process. The Trust reported the incident to the ICO who closed this incident;

e) a list of service users due for ward review was sent to an incorrect recipient at NHS England in error. The recipient contacted the Trust to notify them of the incident and confirmed the deletion of the list. The Trust conducted 1:1 training with the member of staff and the matter was reported this incident to the ICO. The Trust is awaiting further contact from the ICO;

f) a letter was sent from the Local Division to a service user however, it contained within the envelope confidential correspondence relating to 5 other named service users. The correspondence had been enveloped up with the intention of being sent to a GP but had been incorrectly sent to one of the service users. The Trust was notified of the incident by service users family and the correspondence was retrieved by a member of staff. The Trust contacted other service users involved to notify them of the incident, 1:1 training was completed with the member of staff. The Trust reported this incident to the ICO and is awaiting further contact from the ICO;

g) a list was sent to Specialist Commissioners which contained personal identifiable information. The Trust was notified of this incident by the Commissioner who confirmed its deletion. The list was resent securely with personal identifiable information removed. The Trust conducted 1:1 training with the member of staff and the incident was reported to the ICO. The Trust awaits further contact from the ICO;

h) the Trust was notified by solicitors acting on behalf of a deceased service user that the set of copy records contained incorrectly scanned documentation. The incorrectly scanned documentation was returned to the Trust. The Trust has commissioned Mersey Internal Audit Agency to undertake a ”Deep Dive” in respect of the scanning operational process. The Trust has reported this incident to the ICO and is awaiting further contact from the ICO;

i) a secure encrypted email which contained a referral letter was sent to Cheshire Independent Domestic Violence Advisor (IDVA) instead of Halton Independent Domestic Violence Advisor containing sensitive confidential information. The Trust was contacted by Cheshire IDVA and advised of the incident and that they had forwarded the referral securely onto Halton IDVA. The team who sent the encrypted email were notified of the incorrect email referral address. The case has been closed by the ICO.

310. In respect of these incidents, the Trust undertook appropriate internal investigations, including root cause analysis, for each of these incidents. All data loss / data breach incidents were reviewed at meetings of the Information Governance & Caldicott Sub-Committee (which reports to the Executive Committee), with further reviews undertaken by the relevant service to provide a full report back to the Senior Information Risk Owner. The ICO was satisfied by the action taken by the Trust for each of those incidents which have been reviewed, whilst the Trust is awaiting contact from the ICO in respect of allocating a case worker for four of these incidents.

311. The Trust did receive ‘significant assurance’ in respect of the Information Governance Toolkit and attained 89% compliance as at 31 March 2018.

312. In May 2017 the NHS was subject to a widespread cyber attack (ransomware). Mersey Care itself was affected by this attack but the Trust also played a key role as the host organisation for Informatics Merseyside. As a result a major incident was declared by the Trust on 12 May 2017 and both the Trust and Informatics Merseyside initiated their major incident and business continuity plans. Subsequently NHS England declared a major incident across the NHS and both the Trust and Informatics Merseyside worked closely with NHS England, NHS Digital and other local NHS organisation on its response. The major incident remained in place over the weekend and business continuity arrangements were put into place to ensure minimal impact and the maintenance of clinical service. A report was subsequently submitted to the Audit Committee and circulated to the Board of Directors in respect of the Trust’s response and the lessons learnt.

313. One of the consequences is that the Audit Committee is now in receipt of regular reports so as to provide assurance to the Board of Directors on the adequacy of arrangements in place to protect the Trust’s information systems. This is especially important as the Trust hosts Informatics Merseyside which provides IT services too many local NHS organisations and represents the Trust on the STP cyber security work stream.

NHS PENSION SCHEME

314. 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.

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

316. 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 ECONONY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

317. The Trust has robust arrangements in place for setting financial objectives and targets over the short, medium and long term. These arrangements include:

    a) approval of the Annual Operational Plan by the Board of Directors in line with the Trust's Five Year Strategy;

    b) development and approval by the Board of Directors of an Annual Financial Framework;

    c) ensuring the financial plan is affordable;

    d) ensuring the development and delivery of safe cost improvement plan requirements;

    e) compliance with the terms of authorisation;

    f) co-ordination of financial objectives with corporate objectives as approved by the Board of Directors;

    g) regular reporting to the Board of Directors and Executive Committee on the trust's financial position;

    h) regular reporting to the Performance, Investment and Finance Committee in detail on the financial position of the Trust and its divisions.

318. Annual budgets are approved by the Board of Directors following sign-off by delegated budget holders. There is comprehensive reporting (Care at a Glance / Executive Performance Report) to every meeting of the Board of Directors on key performance indicators, covering quality and safety, finance, activity and human resources targets. In addition, this report is scrutinised at every meeting of the Performance, Investment and Finance Committee and the Executive Committee. The

Performance, Investment and Finance Committee also receive a regular detailed report on financial performance which allows detailed scrutiny of financial information at a Divisional level as well as delivery of the Trust's statutory financial duties.

319. Cost Improvement Plans, whilst developed by divisions in conjunction with the Finance Team, are scrutinised by both the Medical Director and Executive Director of Nursing to ensure such plans will not impact upon quality or safety, prior to approval and implementation. Where concerns regarding the impact of Cost Improvement Plans on quality or safety are identified, alternative plans are requested. These plans are also reviewed by the Quality Assurance Committee.

320. Cost pressures are reviewed prior to the commencement of each financial year and a prioritisation process applied to determine which pressures can be funded. In addition, details of the mitigation plans in place for those pressures which can not be funded is reported to the Performance, Investment and Finance Committee. In year cost pressures are rigorously reviewed and challenged, and alternatives for avoiding cost pressures are always considered.

321. Value for money is an important component of the internal and external audit plans that provides assurance to the Trust regarding processes that are in place to ensure effective use of resources.

ANNUAL QUALITY REPORT

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

323. The annual Quality Report is published as part of the Trust's Annual Report. The Quality Account for 2017/18 has been developed in accordance with national guidance with its development being led by the Executive Director of Nursing.

324. The Council of Governors and other stakeholders are consulted upon the Trust's draft priorities and receive a draft version of the report for comment, with feedback reflected within the final version submitted to, and approved by the Board of Directors.

325. The Quality Report represents a balanced view and there are appropriate controls in place to ensure the accuracy of the data. The following provides evidence of the steps in place to provide this assurance:

Governance and leadership

326. The quality priorities within the report have been presented to and monitored by the Quality Assurance Committee throughout the year, the minutes and chairs reports of which are submitted to the Board of Directors. Delivery of the quality priorities is supported through the Perfect Care and Wellbeing Sub-Committee with a nominated

lead identified for each area. The Council of Governors and the Audit Committee has also received assurance on the Trust's Quality Report via its External Auditors. The Trust has consulted and sought the feedback of the Council of Governors regarding the quality priorities for 2018/19.

Policies and plans

327. The Trust had put controls in place to ensure the quality of care provided and accuracy of data used in the Quality Report. Key policies include, but are not limited to:

a)	SA02	Risk Management Strategy
b)	SA02a	Risk Management Policy
c)	SA03	Reporting, Management and Review of Incidents
d)	SA06	Management of Complaints/ Concerns
e)	SA41	Performance Indicator Kite-Marking
f)	IT04	Policy for Records Management
g)	IT10	Confidentiality & Information Sharing
h)	IT11	Data Quality

328. All data owners and staff have access to all Trust-wide policies, procedures and guidance documents.

Systems and processes

329. The Trust has robust processes in place to ensure data quality. Data is processed by the Business Intelligence Team and reviewed prior to inclusion in the Reports to the Board, Quality Assurance Committee and Council of Governors. Data is reviewed when presented to Quality Assurance Committee and any queries or concerns are fed back to the Performance Team or data owner for a resolution or explanation. Data completeness indicators within the Trust's performance assurance framework are reported upon via the Trust and divisional performance reports, by exception.

330. The Trust agrees a Data Quality Improvement Plan with commissioners on an annual basis, implementation of which is monitored via contract management arrangements. This will include arrangements for agreeing amendments to contract key performance indicator methodology in year (if required). Ad-hoc audits / analysis are carried out to provide assurance of good data quality and / or identify opportunities for improvement. The findings of such audits are also be shared with the Audit Committee as required. Internal and external audit are commissioned to undertake audits that assess the quality of data used for internal and external performance reporting e.g. kite-mark indicator testing by Mersey Internal Audit, quality account indicator testing by external audit (Grant Thornton). The findings from internal and external audit are received by the Audit Committee along with any actions agreed.

People and skills

331. The Quality Report has been shared with members of the Perfect Care and Wellbeing Sub-committee, the Standing Committee of the Service User & Carer Assembly, Executive Team and the Board of Directors to ensure all of the information contained within is accurate. To determine the quality improvement priority areas for 2017/18 the Trust engaged in extensive consultation, this included the Council of Governors, internal groups and committees, service users and carers, local Healthwatch and commissioners.

Data use and reporting

332. The Trust has implemented a performance indicator kite-mark to provide visual assurance of the quality of the data reported for the performance indicators included in performance reports to the Board of Directors, its Committees and the Clinical Divisions. A prioritisation process and schedule for internal audit has been agreed for completion of indicator testing.

REVIEW OF EFFECTIVENESS

333. As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to the Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the results of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, the Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

334. The systems of internal control are overseen by the Board of Directors and therefore the Board utilises a number of systems to assure itself that the systems are working effectively. The formal structure of the Committees reporting through to the Board of Directors, are remitted to maintain effective systems and identify and, where appropriate, escalate all risks emerging from the business transacted.

335. The Board of Directors, supported by the Audit Committee, the Executive Committee, the Quality Assurance Committee and the Performance, Investment and Finance Committee have routinely reviewed the Trust's system of internal control and governance framework. The Executive Committee and the Quality Assurance Committee have also regularly reviewed the Trust's approach to maintaining compliance with CQC fundamental standards. As part of its annual cycles of business the Audit Committee receives assurance on the delivery of the Trust's internal and external audit plans. As with all other Board Committees, it reviews its terms of reference annually and self-assesses its performance (a session that is facilitated by the Trust's internal auditors)

336. The Audit Committee plays a key role in receiving assurance on the Trust's systems of internal control. The Audit Committee has three Non Executive Director members and receives assurance from officers of the trust, the Trust's internal auditors (Mersey Internal Audit Agency) and the Trust's external auditors appointed by the Council of Governors (Grant Thornton). The Audit Committee meets regularly with both the internal and external auditors without officers present.

337. The Assurance Framework provides the Board of Directors with evidence that the effectiveness of controls that manage the risks to delivery of the Trust's strategic objectives and key strategic priorities have been reviewed.

338. At the Audit Committee in May 2018, the Director of Audit Opinion and Annual Report 2017/18 from Mersey Internal Audit Agency (the Trust's internal auditor) provided significant assurance for the period 2017/18 that there was a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. This Opinion was based upon the Assurance Framework which "*meets the NHS requirements [and] is visibly used by the Board and reflects the risks discussed by the Board*".

339. An annual Quality Improvement and Audit Programme is agreed by the Quality Assurance Committee and reflects national and local audit priories. A quarterly review of progress against the Programme is reported to the Quality Assurance Committee and any significant issues that emerge are escalated to the Audit Committee.

340. Internal Audit has reviewed and reported upon control, governance and risk management processes, based on the Annual Audit Plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS internal audit standards. Where score for improvement was found, recommendations were made and appropriate actions plans agreed for management.

341. The Head of Internal Audit Opinion is that *"**substantial assurance** can be given that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently*".

Board Committee Structure & Corporate Governance Arrangements

342. 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 Framework.

343. The Board of Directors is responsible for providing strategic leadership to the organisation and ensuring that the Trust exercises its functions effectively and efficiently. The Board of Directors monitors the arrangements that are in place to maintain the quality and safety of the Trust's services, including ensuring processes are in place for the management of risk.

344. A significant change for Trust's governance arrangements was the creation of the South Sefton Community Services Division following the transfer of South Sefton's

community physical health services from Liverpool Community Health NHS Trust on 1 June 2017, together with the creation of the South Sefton Community Services Operational Management Board (which reports to via the Executive Committee to the Board of Directors) to oversee these services. The membership of the majority of the Trust's Board Committees have been amended to ensure representation this new clinical division.

345. The terms of reference for all Board Committees were reviewed, updated and then approved by the Board of Directors in May 2017, as a result of the creation of the South Sefton Community Services Division, and then again in March 2018, as part of the annual review of terms of reference.

346. Both the Board of Directors and its Board Committees have agreed annual cycles of business in place which outlined the area of business to be considered throughout the financial year.

347. The committee structure, to support achievement of the organisations strategic objectives, is outlined in **Table 16** below. Any Board Committee can request that a risk be considered for inclusion on the Trust's risk register in line with the Trust's risk management and risk escalation arrangements set out in the Risk Management Strategy.

Table 16: NHS Foundation Trust Board of Directors' Committee Structure

Committee	Role
Audit Committee	• acts as the central means by which the Board of Directors is assured that effective internal control arrangements are in place as part of its annual cycle of business • provides a form of independent check upon the executive arm of the Board of Directors. • provides independent verification to the Board of Directors on internal financial controls based on reports from internal and external auditors • ensures effective organisational controls and risk management
Performance, Investment & Finance Committee	• provides assurance that the key performance and outcome measures for assessing delivery of the Trust's strategic framework and annual operating plan are appropriate and that performance is consistent with those measures • oversees and scrutinises financial strategically significant risks on behalf of the Board of Directors, proposing new or revised risks where necessary • ensures that financial plans, investment policy and major investment proposals are robust and that there are measures in place to identify and mitigate the risks and keep under review the management and status of those risks • scrutinises in year financial performance (against the trust's budgets and plans), strategic financial plans and the delivery of cost improvement plans in both the short and long term

Committee	Role
Quality Assurance Committee	• provides assurance to the Board of Directors that the quality of service provision across the organisation is of the highest standard. • oversees the delivery of action plans resulting from independent inquiries into serious untoward incidents • oversees and scrutinises quality strategically significant risks on behalf of the Board of Directors, proposing new or revised risks where necessary
Executive Committee	• supports the Board of Directors 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. • oversees and scrutinises regulatory and reputational strategically significant risks on behalf of the Board of Directors, proposing new or revised risks where necessary
Remuneration and Terms of Service Committee	• determines the policy on executive and very senior manager remuneration and contracts • ensures that appropriate performance management arrangements are in place for Executive Directors and work with the Chief Executive to relate performance judgements to pay • advises on the Trust's overarching reward and benefit strategy for all staff, the arrangements in the wider NHS and any relevant guidance from the Treasury and regulators

348. The chairs of the Board Committees routinely present written and verbal reports to the Board of Directors, to highlight any key issues, risks, concerns and decisions. Approved minutes of each Board Committee are also presented at public Board meetings (with the exception of the Remuneration & Terms of Service Committee which instead provides a highlight report to the Board).

Individual Reviews

349. In addition, the performance of individual Board members has been assessed through annual appraisal processes as follows:

a) the Trust's Chairman and Non-Executive Directors are subject to an annual assessment process agreed by the Council of Governors and undertaken internally. The Lead Governor and the Senior Independent Director undertake the review of the Chairman and the Chairman undertakes the reviews of the Non-Executive Directors against their agreed objectives;

b) Executive Directors are subject to the organisational-wide Personal Achievement and Contribution Evaluation (PACE) process which links individual's objectives to the Trust's Strategic Framework objectives.

350. The Trust commissions regular reviews of its delegation arrangements through the internal audit function and the Audit Committee receives assurances of the effectiveness of the Board Committees through provision an Annual Board Committee Reports. In addition, the Board of Directors undertakes regular reviews of its delegated arrangements through on-going reviews of its Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

BOARD AND ORGANISATIONAL REVIEWS

351. The Trust's governance arrangements have been subject to a series of external reviews since 2015, the findings of which have been utilised to inform the ongoing development of the Trust's governance framework. Such reviews included:

a) assessment of the Trust's application for Foundation Trust status by regulators.

b) two independent reviews of Board Skills undertaken by External Auditors (both of which have been shared with the Council of Governors in order to inform Non-Executive Director appointments and re-appointments);

c) the Chief Inspector of Hospitals Inspections of the Mersey Care in June 2015 and March 2017 (reported June 2017), the report on the 2017 inspections was received at June 2017's Board of Directors meeting with an action plan being report to the Quality Assurance Committee at its meeting in July 2017;

d) the NHS Improvement assessment of the Trust's proposal to acquire Calderstones Partnership NHS Foundation Trust (acquired 1 June 2016), the transfer of South Sefton community physical health services from Liverpool Community Health NHS Trust (from 1 June 2016) and the proposed acquisition of Liverpool Community Heath NHS Trust (acquired 1 April 2018).

352. Board Skills Reviews – the Trust commissioned these reviews from its external auditor, Grant Thornton, and the reviews involved interviews with all members of the Board of Directors together with observations of Board Committee meetings. The report of the most recent review was received in October 2016 and one of its conclusions was "we concur with the main findings of the two previous governance reviews (by the TDA and the Good Governance Institute), that [Mersey Care] has an experienced and capable board". This year the Council of Governors has appointed Gaynor Hales as a Non-Executive Director, who has a nursing and senior NHS management background.

353. Chief Inspector of Hospitals Inspection (Care Quality Commission) – the first inspection took place at the beginning of June 2015, with the Quality Summit and report being published in October 2015. The Trust received an overall rating of 'good' as a result of the inspection with the report noting that

> *"The trust was well led …. the Board was highly aspirational and committed to delivering services which were of high quality and where every person matters. It was clear most staff across the organisation understood, and were committed to, the vision and values of the*

organisation. These were well communicated and the work to win both the hearts and mind was apparent"

"We concluded that the Board worked well together and were professional and respectful in their interactions. They were able to offer high challenge, without rancour or defensiveness. They were passionate about people and committed to understanding, first and foremost, the lived 'experience' of people who use services".

354. The report of the March 2017 Care Quality Commission inspection was received in June 2017. The Trust received an overall rating of 'good' as a result of the inspection with learning disability and autism secure services being rated as 'outstanding'. The report noted that

"Leadership at all levels of the trust was visible and effective. Leaders encouraged collaborative and supportive relationships among staff"

355. The results of these reviews have informed the continuing review and development of the Trust's governance and risk management arrangements.

Report of the Liverpool Community Health Independent Review (Kirkup Review)

356. As a result of a Care Quality Commission (CQC) inspection in 2013 and issues raised following whistleblowing concerns raised by Liverpool Community Health NHS Trust (LCH) staff with Rosie Cooper MP, together with concerns about the treatment of her own father, questions were raised in Parliament in February 2014. In response to these issues, together with increase local media interest, LCH's Board commissioned Capsticks to undertake a detailed review of the issues raised in the CQC's Inspection Report. The resultant report – *Quality, safety and management assurance review at Liverpool Community Health NHS Trust* (commonly referred to as the *Capsticks Report*)[7] - found a number of failures. The Capsticks Report generated a level of concern about the management culture of LCH and the quality of services provided, which resulted in NHS Improvement commissioning Dr Bill Kirkup to undertake an independent review of LCH with terms of reference to look not only at Liverpool Community Health but the wider health economy and the role of regulators between November 2010 and December 2014.

357. This Independent Review published its report on 8 February 2018.

358. Although the report focussed on Liverpool Community Health many of the recommendations of the Kirkup Review impact on those NHS providers who now provide / will provide former Liverpool Community Health Services. Mersey Care has developed a Draft Action Plan[8] to respond to the Kirkup Review because:

a) the Trust has provided the former Liverpool Community Health's services for South Sefton since 1 June 2017;

7 Published in March 2016 and available on LCH's website by clicking here.

8 Presented to the Board of Directors at its meetings in February and March 2018 and to the Council of Governors at its meeting in March 2018.

b) the Trust will be providing the former Liverpool Community Health's services for Liverpool from 1 April 2018;

c) the Trust will be providing mental health services at HM Prison Liverpool from 1 April 2018[9].

359. It is expected that the recommendations of the Kirkup Review will result in the Trust being subject to additional external scrutiny in the coming year, especially as one of the recommendations calls for NHS Improvement and NHS England to review former Liverpool Community Health services "*after a year to ensure services and now safe and effective*". As part of the Draft Action Plan the Trust has commissioned a range of independent reviews, including an external Well-led and Board Skills Review, to be completed over the next financial year. The Draft Action Plan will be finalised early in 2018/19.

Acquisition of South Sefton Community Health Services

360. On 1 June 2016 the Trust acquired the physical community health services for South Sefton, previously provided by Liverpool Community Health NHS Trust. This followed a bidding process where the Trust, in partnership with North West Boroughs Healthcare NHS Foundation Trust (NWB), was awarded the contract to provide community physical healthcare services by NHS South Sefton Clinical Commissioning Group. The Trust is the main contractor and NWB is the sub-contractor. It was unsuccessful at this time in being awarded the contract for Liverpool's community physical health services (which would have meant it would have acquired Liverpool Community Health NHS Trust).

361. Although the transaction was subject to NHS Improvement's assessment process it was judged to be a 'minor' transaction, not requiring the full assessment. The transaction was subject to the Trust undertaking a due diligence exercise in accordance with national guidance. To oversee this work the Trust established a Transaction Steering Group (chaired by the Transaction Programme Director) which reported to a Joint Oversight Group (co-chaired by the Chief Executives of Mersey Care and NWB). The Chief Executives reported to their Board of Directors.

362. As this was a 'minor' transaction approval was only required by the Board of Directors. When the services transferred on 1 June 2017, the Trust created the South Services Community Services Division to manage these services, with assurance being provided through the newly established South Sefton Community Services Operational Management Group via the Executive Committee to the Board of Directors.

9 Liverpool Community Health NHS Trust provided prison healthcare services at HMP Liverpool until 2015, when NHS England terminated their contract and awarded it to Lancashire Care NHS Foundation Trust. Lancashire Care gave notice to quit this contract with effect from the end of March 2018. From April 2018 the contract to provide prison healthcare services has been awarded to Spectrum Healthcare Community Interest Company, who have sub-contracted the provision of mental health services to Mersey Care

Acquisition of Liverpool Community Health NHS Trust

363. At the end of March 2018, the Board of Directors and Council of Governors conditionally approved the submission of a joint application to acquire Liverpool Community Health NHS Trust and its remaining services. This acquisition was regarded a 'significant' transaction and was subject to the full assessment process by NHS Improvement.

364. The opportunity to acquire Liverpool Community Health arose after the initial NHS trust identified failed the assessment process. A second bidding process was initiated by NHS Improvement and, in October 2017, Mersey Care was identified as the 'Preferred Acquirer'. As part of this process of assessing the acquisition, NHS Improvement appointed an assessment team to review the application, which also included a full due diligence process in line with national guidance. This assessment process involved a further review of the trust's proposed governance and assurance arrangements for the acquisition.

365. To oversee the development of the Trust's plans the Trust formed a Transaction Steering Group (chaired by the Transaction Programme Director) which reported via the Executive Team through the Trust's Board Committees to the Board of Directors. In February 2018 this became the Transaction and Mobilisation Steering Group.

366. In February and March 2018 the Board of Directors agreed a range of changes to the Trust's leadership and governance arrangements to take account of the proposed acquisition of Liverpool Community Health. These changes, which will come into effect from 1 April 2018, include:

a) the creation of an Executive Director of Nursing and Operations role to oversee the activities of all 4 clinical divisions[10];

b) the creation of a new clinical division, the Liverpool and South Sefton Community Division, comprising the services acquired from Liverpool Community Health during both the South Sefton and Liverpool acquisitions;

c) re-organisation of the Trust's two Operational Management Board, so that:

   i) the Liverpool & South Sefton Community Division is with the Local Services Division, and

   ii) the Secure Division is with the Specialist Learning Disabilities Division;

d) the creation of the Liverpool Community Services Transition Sub-Committee, chaired by a Non-Executive Director and reporting via the Quality Assurance Committee to the Board of Directors.

[10] Trish Bennett will undertake this role. Mark Hindle, the current Executive Director of Operations, will be leaving the Trust at the end of June 2018. Mark will remain an Executive Director until he leaves the Trust but will support Trish in her new role.

CONCLUSION

367. The overall opinion is that no significant internal control issues have been identified during the reporting period and therefore significant assurance can be given that there is generally a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Accountable Officer:	Dr Joe Rafferty, Chief Executive
Organisation:	Mersey Care NHS Foundation Trust (RW4)
Signature:	
Date:	24 / 05 / 18

APPENDICES

APPENDIX A – ATTENDANCE AT COUNCIL OF GOVERNORS MEETINGS

Governors

Constituency	Name	27 Apr '17	26 Jul '17	25 Oct '17	17 Jan '18	21 Mar '18	28 Mar '18
Governor - Public Liverpool	Jayne Moore	N	N	N	Y	N	Y
Governor - Public Sefton	John Mousley	Y	Y	Y	N	Y	Y
Governor - Public Cumbria, Lancashire & Greater Manchester	Mairi Byrne *	N/A	N/A	Y	N	N/A	N/A
Governor - Public Cheshire, St Helens, Wirral, West Midlands and Wales	Garrick Prayogg *	N/A	N/A	Y	Y	Y	Y
Governor - Staff Medical	Hetalkumar Mehta	Y	N	N/A	N/A	N/A	N/A
Governor - Staff Medical	Sayed Ahmed *	N/A	N/A	Y	Y	Y	Y
Governor - Staff Nursing	Scott Parker	Y	N	N	N	Y	Y
Governor - Staff Nursing	Maria Tyson	Y	Y	N	Y	Y	Y
Governor - Staff Nursing	Tracey Cummins *	N/A	N/A	Y	Y	Y	N
Governor - Staff Other Clinical, Scientific, Technical and Therapeutic	Sara Finlayson	Y	Y	Y	Y	Y	Y
Governor - Staff Other Clinical, Scientific, Technical and Therapeutic	David Kitchen	Y	Y	Y	Y	N	Y
Governor - Staff Other Clinical, Scientific, Technical and Therapeutic	Paul Allen *	N/A	N/A	Y	N	Y	N
Governor - Staff Non Clinical	Amanda Gregory	N	Y	Y	Y	Y	Y
Governor - Staff Non Clinical	Mike Jones	Y	N	Y	Y	Y	Y
Governor - Service User Local	Johanna Birrell	Y	Y	Y	Y	Y	Y
Governor - Service User Local	Debra Doherty	Y	Y	N	Y	Y	Y
Governor - Service User Local	Mark McCarthy	Y	N	Y	Y	Y	Y
Governor - Service User Local	Martin Murphy	Y	N	Y	N	N	N
Governor - Service User Local	Paul Taylor *	N	N	N	N	Y	Y
Governor - Carer Local	George Allen	N	Y	Y	Y	N	Y

Constituency	Name	27 Apr '17	26 Jul '17	25 Oct '17	17 Jan '18	21 Mar '18	28 Mar '18
Governor - Carer Local	Brian Murphy	Y	N	Y	N	Y Y	N
Governor - Carer Local	Hilary Tetlow	Y	Y	Y	Y	Y	Y
Appointed Governors - Academic	Clare Austin	Y	Y	N	Y	Y	N
Appointed Governors - CCG	Jane Lunt	N	N	N	N	N	Y
Appointed Governors - Local Authority	Veronica Webster	Y	Y	Y	Y	Y	Y
Appointed Governors – Voluntar	Vicky Keeley ^	N/A	Y	N	N	N	N

Notes: * = took up post in November 2017 ^ = took up post in August 2017

Board of Directors

Constituency	Name	27 Apr '17	26 Jul '17	25 Oct '17	17 Jan '18	21 Mar '18	28 Mar '18
Chairman	Beatrice Fraenkel	Y	Y	Y	Y	Y	Y
Non Executive Director	Matt Birch	N	Y	N	N	N	N
Non Executive Director	Gerry O'Keeffe	Y	N	Y	N	N	N
Non Executive Director	Cath Green	N	N	Y	Y	N	N
Non Executive Director	Gaynor Hales	N	N	Y	N	N	N
Non Executive Director	Nick Williams	N	N	N	N	N	N
Non Executive Director	Dr Robert Beardall	N	N	Y	Y	N/A	N/A
Non Executive Director	Pamela Williams	N	Y	Y	N	Y	N
Chief Executive	Joe Rafferty	Y	N	N	Y	Y	Y
Executive Director of Communications and Corporate Governance	Elaine Darbyshire	N	Y	Y	N	Y	N
Medical Director	Dr David Fearnley	N	N	Y	Y	Y	N
Executive Director of Operations	Mark Hindle	N	Y	Y	Y	N	N
Executive Director of Workforce	Amanda Oates	Y	Y	Y	Y	Y	Y
Executive Director of Finance / Deputy Chief Executive	Neil Smith	N	N	Y	Y	Y	Y
Executive Director of Nursing	Ray Walker	Y	Y	N	N	N/A	N/A
Director of Strategy and Planning	Louise Edwards	N	N	Y	Y	N	Y
Director of Integration / Executive Director of Nursing	Trish Bennett	N	N	Y	Y	N	Y

APPENDIX B – ATTENDANCE AT THE BOARD OF DIRECTORS AND BOARD COMMITTEE MEETINGS

Board of Directors / Board of Directors Development Sessions

Name	2017 Meetings										2018 Meetings				
	26 Apr		24 May	18 Jun	26 Jul	30 Aug	27 Sep	25 Oct	29 Nov	20 Dec	31 Jan	12 Feb	28 Feb	21 Mar	27 Mar
	Board	Dev	Board	Dev	Board	Dev	Board	Dev	Board	Board	Board	Board	Dev	Board	Board
Chairman / Non Executive Directors															
Fraenkel, Beatrice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Beardall, Robert	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Not in post	
Birch, Matt	Y	N	Y	Y	Y	Y	N	N	N	Y	Y	Y	N	N	N
Green, Cath	Y	Y	Y	N	Y	Y	Y	Y	N	N	Y	Y	Y	N	N
Hales, Gaynor	Not in Post		Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
O'Keeffe, Gerry	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y
Roe, Brenda	N	Y	N	Not in post											
Williams, Nick	Y	Y	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Williams, Pam	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Executive Directors / Other Board Directors															
Rafferty, Joe	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	N	Y	Y
Darbyshire, Elaine	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Fearnley, David	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hindle, Mark	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Oates, Amanda	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Smith, Neil	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Walker, Ray	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	N	N	N
Edwards, Louise	Y	Y	Y	N	N	Y	N	Y	Y	N	Y	Y	N	N	N
Bennett, Trish	Y	Y	Y	N	Y	Y	N	Y	N	Y	Y	Y	N	N	N

Audit Committee

Members	April 2017	May 2017	August 2017	October 2017	December 2017	February 2018
O'Keeffe, Gerry	N	Y	Y	Y	Y	N
Williams, Nick	Y	Y	N	N	Y	Y
Williams, Pam (Chair)	Y	N	Y	Y	Y	Y

Executive Committee

Members	2017 Meetings									2018 Meetings		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Rafferty, Joe (Chair)	N	Y	Y	Y	N	N	N	N	Y	Y	Y	Y
Smith, Neil (Deputy Chair)	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y
Darbyshire, Elaine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Fearnley, David	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y
Oates, Amanda	Y	Y	Y	Y	N	N	Y	Y	Y	N	Y	Y
Walker, Ray	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Not in Post	
Edwards, Louise	Y	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y
Hindle, Mark	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bennett, Trish	Y	Y	Y	Y	N	N	Y	Y	N	N	Y	N

Performance, Investment and Finance Committee

Member	April 2017	June 2017	August 2017	October 2017	December 2017	February 2018
Non Executive Directors						
Birch, Matt (Chair)	Y	Y	Y	N	N	Y
O'Keeffe, Gerry	Y	N	Y	Y	Y	Y
Williams, Nick	Y	Y	Y	Y	Y	Y
Green, Cath	N	N	Y	Y	Y	Y
Executive Directors						
Oates, Amanda	Y	Y	Y	Y	Y	N
Darbyshire, Elaine	Y	Y	Y	Y	Y	Y
Smith, Neil	Y	N	N	Y	Y	Y
Hindle, Mark	Y	Y	Y	Y	Y	Y

Quality Committee

Member	May 2017	July 2017	September 2017	November 2017	January 2018	March 2018
Non Executive Directors						
Beardall, Robert (Chair – July '17 to Jan '18)	N	Y	Y	N	Y	Not in post
Roe, Brenda (Chair until May 2017)	Y	Not in post				
Green, Cath	N	Y	Y	Y	Y	N
Hales, Gaynor (Chair from March 2018)	Not in post	Y	Y	Y	N	Y
Executive Directors						
Fearnley, David	Y	y	Y	Y	Y	Y
Oates, Amanda	N	Y	Y	N	Y	Y
Walker, Ray	Y	N	Y	Y	Y	Not in post
Trish Bennett	Not in post					N

Remuneration and Terms of Service Committee

Member	May 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	March 2018
Beatrice Fraenkel	Y	Y	Y	Y	Y	N	Y	Y
Robert Beardall	Y	Y	Y	Y	Y	Y	Y	Not in post
Roe, Brenda	N	Not in post						
Matt Birch	Y	N	N	N	N	Y	Y	N
Gerry O'Keeffe	Y	N	Y	Y	Y	N	Y	N
Gaynor Hales	Y	Y	N	Y	Y	Y	Y	Y
Nick Williams	N	Y	Y	N	Y	Y	N	N
Pam Williams	Y	Y	Y	Y	Y	Y	Y	Y
Cath Green	Y	Y	Y	Y	Y	N	Y	N

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Mersey Care NHS Foundation Trust

Quality Report 2017/18

Contents

Independent Practitioner's Limited Assurance Report to the Council of Governors of Mersey Care NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Mersey Care NHS Foundation Trust to perform an independent limited assurance engagement in respect of Mersey Care NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Early Intervention in Psychosis – people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.
- Inappropriate out of area placements for adult mental health services.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner
The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2017 to 24 May 2018;

- papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
- feedback from commissioners dated 18, 21 and 23 May 2018;
- feedback from governors dated 12 April 2018;
- feedback from local Healthwatch organisations dated 19 March 2018;
- feedback from the Overview and Scrutiny Committee dated 24 May 2018;
- the Trust's 2017 complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009;
- the national patient survey dated 15 November 2017;
- the 2017 national staff survey dated November 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated March 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Mersey Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting Mersey Care NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Mersey Care NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management

- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Mersey Care NHS Foundation Trust.

Our audit work on the financial statements of Mersey Care NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Mersey Care NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Mersey Care NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Mersey Care NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Mersey Care NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Mersey Care NHS Foundation Trust and Mersey Care NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Royal Liver Building
Liverpool
L3 1PS

24 May 2018

PART ONE - INTRODUCTION AND STATEMENT ON QUALITY BY THE CHIEF EXECUTIVE

1.1 Introduction and Statement on Quality by the Chief Executive

We are delighted to present on behalf of the Board of Directors, the Mersey Care NHS Foundation Trust Quality Report for 2017/18 This provides details of how we have improved the quality of care we provide, particularly in the priority areas we set out in our previous Quality Account (2017/18). The purpose of our Quality Report is to:

- enhance our accountability to our service users, carers, the public and other stakeholders of our quality improvement agenda
- enable us to demonstrate what improvement we have made and what we plan to make
- provide information about the quality of our services
- show how we involve and respond to feedback from our stakeholders
- ensure we review our services, decide and demonstrate where we are doing well but also where improvement is required.

We continue to make quality the defining principle of the Trust and demonstrate quality improvements in the care and services we provide. To assist us in determining our priorities for quality improvement for 2018/19 a range of engagement events were held with key stakeholders.

2017/18 saw significant change and new opportunity for Mersey Care, as we became a provider of community physical health services in Sefton and Liverpool. Taking on the provision of community physical health services for the populations of Liverpool and Sefton changes the nature of Mersey Care as a provider organisation and presents significant opportunity to provide integrated physical and mental health services, designed to meet the needs of the communities that we serve.

Mersey Care is striving to provide perfect care for the people we serve. At its core, this means we are an organisation that does not accept compromises in the quality of care or minimum targets set by others, but supports learning and improvement in our services so that we strive to get the basics of care right every time, for every service user. This is a bold ambition in difficult times, but with engaged and motivated staff and supportive commissioner and partner organisations, we firmly believe it is possible.

We hope that you find our Quality Report helpful and informative. The information supporting the content of the Quality Reports is to our knowledge accurate and will be published by the Board on 30 June 2018.

	24 / 05 / 18
Joe Rafferty **Chief Executive**	**Dated**

1.2 Our Strategic Direction: Transforming our Trust

1. In 2017/18, Mersey Care's priority is to deliver safe care whilst developing integrated services, designed to meet the needs of the communities that we serve. This means bringing together physical and mental health services for local people as well as aligning our own clinical divisions as our organisation grows and develops.

2. We see increasingly complex need amongst the communities we serve reflected within continued rising demand for mental health and physical health services. This is illustrated by GP referrals to our mental health services, which have risen by over 30% since 2011/12. In this context, we have an ambitious approach to providing community services to meet people's long term health needs more effectively and to support people's long term physical and mental health more holistically. We have the opportunity to integrate services in Liverpool and Sefton and make community services the core component of the local health system, operating with a 'One Team' ethos, uniting primary care, social care, community physical and mental health services and creating ways for hospital specialists to provide care in community settings.

3. In addition to seizing these new opportunities, Mersey Care must also accelerate delivery of our existing transformation plans within our clinical services. In the face of increasing demand and acuity for our services, and a cash-constrained environment for the services we provide, it has never been more important to genuinely transform our service and workforce models and our Board will be relentlessly focused on assuring delivery of our plans and delivering quality services.

Our services – we will improve the quality of our services, and strive to provide safe, timely, effective, equitable and person-centred care every time, for every service user. As we strive for continuous improvements in quality, we will also strive for find ways to save time and money.

Our people – we will have a productive and high performing workforce that work in great teams, and we will work side by side with service users and carers.

Our resources – we will make full use of our resources, ensuring our buildings work for us, and using technology to help improve our care.

Our future – we will create opportunities for improvement and grow in the future, by working more closely with primary care and other organisations, delivering the benefits of research, development and innovation, and by growing our services.

1.3 Improving Quality

4. Mersey Care was formed in 2001 and in that time we have seen a great deal of change, both in terms of the fields in which we work and the pressures under which we deliver our services. What hasn't changed is the motivation and commitment of our staff to provide the highest possible standard of care to those they serve. In order to support our staff and ensure that they can continue to do the best job possible for those they serve, we have recognised that we need to adjust the way in which we support improvement in our services from getting the basics of care right, through to pioneering work that influences changes to practice in our sector nationally.

5. Mersey Care has an overall 'Good' rating from the CQC. In 2017, services were rated as 'Good' for being effective, caring, responsive, and well led, and as 'Requires Improvement' for being safe.

1.4 Pursuing Perfect Care

6. Perfect Care means getting the basics of care right every time, whilst setting our own stretching goals for improvement and relentlessly pursuing safer care through a learning culture. In practice this means that we try to make every episode of care **S**afe, **T**imely, **E**ffective, **E**quitable, **E**fficient and **P**ositively experienced (STEEEP).

7. We have set ambitious goals in pursuit of perfect care:

   a) adopt a 'No Force First' approach (avoid physical restraint, including medication-led restraint);

   b) zero suicide for those in our care;

   c) physical health for service users;

   d) a just and learning culture – promoting accountability within a blame-free environment;

   e) zero community acquired pressure ulcers.

8. The Centre for Perfect Care and Well-being (the Centre) was established in January 2014 and has been successful in challenging stigmatised attitudes towards suicide, reducing self harm and assaults on our inpatient wards, and implementing the No Force First approach to reducing the use of restraint in mental health. Building on this success, Mersey Care is striving for a step change in improvement, whereby everyone feels that quality improvement is their business and continuous improvement is supported at every level, and in all roles in Mersey Care. To support continuous improvement in this way, it is important to see quality improvement activity as a continuum, ranging from our ability to improve care that falls below basic standards, right through to world-leading innovation, research and development.

PART TWO – PRIORITIES FOR IMPROVEMENT 2018/19 AND STATEMENT OF ASSURANCE FROM THE BOARD

2.1 Priorities for Improvement 2018/19

9. In preparation for our Quality Report the Trust has undertaken a process of involvement and engagement with key stakeholders to establish their views on what our key priorities for 2018/19 should be.

10. Representatives from the following groups have been engaged and invited to provide feedback:

a) Healthwatch for Liverpool, Sefton and Knowsley;

b) Local Overview and Scrutiny Committees;

c) NHS England (Cheshire and Merseyside) ;

d) NHS Liverpool Clinical Commissioning Group;

e) NHS South Sefton Clinical Commissioning Group;

f) NHS Southport and Formby Clinical Commissioning Group;

g) NHS East Lancashire Clinical Commissioning Group;

h) Knowsley Clinical Commissioning Group;

i) the Council of Governors;

j) local service user groups.

11. In addition to the above, the perfect care steering group has considered suggestions for **2018/19** quality improvement priorities. These are consistent with the six key elements in the Trust's Model of Quality: **STEEEP**:

a) **S**afety of Patients

b) **T**imely care

c) **E**ffectiveness

d) **E**fficient care

e) **E**quitable care

f) **P**ositive patient experience.

12. After consultation and discussion with key stakeholders and with the Trust Board the areas of quality improvement for **2018/19** will be:

a) **Priority 1: Reducing Restrictive Practice**

i) develop and implement a strategy on rapid tranquilisation and depot administration to reduce prone restraint by 50% from baseline by March 2019;

ii) reduce physical restraint associated with self-harm by 20% by March 2019 and develop a clinical model which incorporates assessment management strategies and training that manages both risk to self and others;

iii) review of ligature incidents by June 2018 and develop an implementation plan to address risks using the strategies from the P4P2 project;

iv) implement Zero Segregation action plan to reduce long term segregation by 20% from the baseline cohort by the end of financial year 2018 – 2019;

v) by March 2019 a further Research Evaluation of the implementation of the Guide to Reducing Restrictive Practice Guide will be completed;

vi) compile and publish good practice stories on reducing restrictive practice from across the Trust by December 2018.

b) **Priority 2: Towards Zero Suicide**

i) 100% of patients in Local Services Division in-patient settings who have the capacity to engage in the process will be offered the opportunity of completing a safety plan on-going. By March 2019 50% of patients discharged from Local Services Division in-patient settings will be discharged with a safety plan;

ii) targeted suicide prevention interventions to be provided to teams that have experienced a suicide or near fatal event as an on-going intervention;

iii) 100% of former Liverpool Community Health staff will complete Level 1 Suicide Awareness Training by March 2019;

iv) 7-day follow up for those service users on care programme approach. By June 2018 we will understand the areas that need additional support. By March 2019 we will meet the national target of 95% compliance;

v) Centre for Perfect Care to provide an analysis of post incident reviews of suicides to identify key targeted areas for improvement by March 2019.

c) **Priority 3: Improvements in Physical Health Pathways**

i) For clinical staff to recognise the deteriorating patient through NEWS2 to ensure prompt intervention to treatment required;

ii) Measures:
- 100% of inpatient wards have implemented NEWS 2
- 100% of inpatient wards have implemented the sepsis pathway
- Physical health community division implemented NEWS2;

iii) by March 2019, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented.

d) **Priority 4: A Just and Learning Culture**

i) by the end of March 2019, 100% of leaders Band 7 and above and equivalent will have been assessed and have a development plan to support their teams in a Just and Learning environment;

ii) to support colleagues' psychological safety through the development of bullying awareness for staff based on a preventative approach to recognise bullying behaviour and develop a process to resolve issues;

iii) to develop a standardised framework to support learning from incidents including supporting staff, how to debrief, and to provide governance and validation mechanisms to improve the safety and experience of the people we serve and our colleagues so that risks are addressed and learning is maximised;

iv) produce a guide for colleagues and service users on Just and Learning expectations to describe the shared responsibility between individuals, teams and the organisation to create a safe and compassionate environment.

e) **Priority 5: Reduction in Community Acquired Pressure Ulcers**

i) aim for zero deterioration of Grade 2 and 3 pressure ulcers whilst when under our the care;

ii) raise awareness training for managing pressure ulcers in the mental health in patient wards;

iii) reduction plan in place with a target trajectory for reduction of Grade 2 and 3 pressures ulcers;

iv) zero grade 4 pressure ulcers.

f) **Priority 6: Learning from Deaths**

i) scope for reviewing individual community deaths will have been agreed and implemented by March 2019;

ii) scope for reviewing individuals in mental health care will have been reviewed and new standards adopted by March 2019.

iii) single action plan for monitoring completion of learning points will be developed and completion of actions monitored by March 2019;

iv) four thematic reviews will be conducted per year based on an analysis of mortality figures by March 2019;

v) process for undertaking pathway reviews will have been developed and implemented in association with partner organisations March 2019;

vi) data from GPs, specifically the cause of death will be used as part of the mortality review process.

Ensuring Equality and Tackling Health Inequalities

13. All work steams within this project are looking at the specific issues for people who are more likely to experience discrimination within mental health and learning disability services. This has included specific analysis for BME people in relation to each work stream priority.

14. Each priority lead will ensure this is reflected in the work stream reporting framework.

Monitoring and Reporting Arrangements

15. A nominated lead will be identified for each priority and will chair a work stream forum which will coordinate progress and monitor activity.

16. The delivery of the Quality Report will be monitored by the Centre for Perfect Care Sub Committee and reported to the Quality Assurance Committee and the Executive Committee, both of which are committees of the Board.

17. The above priorities are all aligned to the Trust's Strategic Framework and ensure quality remains at the forefront of our agenda.

2.2 Review of Quality Performance 2017/18

18. In June 2017**,** the Trust published its Quality Report reporting on the quality of services against five areas of priority. Following engagement with key stakeholders the following priorities would be the key areas of quality improvement:

a) Priority 1: No Force First;

b) Priority 2: Towards Zero Suicide;

c) Priority 3: Improvements in Physical Health Pathways;

d) Priority 4: A Just and Learning Culture;

e) Priority 5: Reduction in Community Acquired Pressure Ulcers;

19. The following table summarises the elements of achievements in relation to these priority areas.

Table 1: Quality Report Progress 2017/18

Priority	Description	Delivery
1	**No Force First**	
	• By September 2017 all wards will implement a debriefing protocol after incidents for both service-users and staff to ensure individual and organisational learning takes place following incidents	Achieved
	• By March 2018 the core strategies from the Reducing Restrictive Practice Guide will be implemented on all wards. The wards will produce evidence of these strategies and the impact on the ward. This will be reported into the Reducing Restrictive Practice Monitoring Group.	Achieved
	• By March 2018 planned prone restraint (face down floor based restraint) will be reduced by 20% as part of our longer term strategy to eliminate completely.	Achieved
	• By March 2018 a Research Evaluation of the programme will be completed by Liverpool University.	Achieved
2	**Towards Zero Suicide**	
	• By September 2017 a Suicide prevention dashboard will be in place to track and monitor progress on the 10 key parameters for safer mental health services. By March 2018 a report will be produced on the effectiveness of the dashboard as a performance improvement tool, to support clinical decisions.	Partially Achieved
	• By March 2018, the safety planning intervention will be integrated to the Level 2 Suicide Prevention training and will be made available at high risk transition points.	Partially Achieved
	• By March 2018 in-patient wards will be implementing a design based solution to reduce self-harm, with an evaluation completed.	Achieved
	• By March 2018 a proof of concept study on the zero suicide app in conjunction with Stanford University will have been completed.	Partially Achieved
	• The Safe from Suicide team will continue to monitor and measure suicide and near-fatal self-harm data and respond with enhanced support and interventions, including training, supervision, psychologically informed risk formulations and safety planning. Specific team based interventions will result from the suicide data, where problems are identified.	Achieved

Priority	Description	Delivery
3	**Improvements in Physical Health Pathways**	
	• By September 2017, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented.	Partially Achieved
	• By September 2017, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented.	Not Achieved
	• By March 2018, there will be a 90% uptake of the Annual Health Check (AHC) for all long stay inpatients across all clinical divisions.	Achieved
	• By March 2018, 100% of inpatients screened as smokers will have prescribed nicotine replacement therapy on admission.	Achieved
4	**Just And Learning Culture**	
	• Within one week of an incident, a copy of its 72 hour review will be shared with all members of the relevant teams (July 2017).	Achieved
	• Good practice stories will be published every month in order that we can extract the maximum possible learning from things that go well and from things that did not go as expected (September 2017).	Achieved
	• We will publish quarterly data on our web site to transparently demonstrate whether our staff have felt supported when things in our care haven't gone as expected (September 2017).	Achieved
5	**Reduction of Community Acquired Pressure Ulcers**	
	• 20% reduction compared to 2016/17 for Grade 2 Community Acquired Avoidable Pressure Ulcers	Achieved
	• 10% reduction compared to 2016/17 for Grade 3 Community Acquired Avoidable Pressure Ulcers	Not Achieved
	• Zero Grade 4 Community Acquired Avoidable Pressure Ulcers	Achieved

Detailed Progress on Quality Report Objectives 2017/18

Priority 1 Progress: No Force First

- Dr Jennifer Kilcoyne is the Consultant Psychologist is the nominated lead for No Force First.
- No Force First (NFF) is Mersey Care's Restrictive Practice Reduction Programme and is a central priority for the organisation. The impact of No Force First on wards, when implemented well, reduces conflict and restraint and associated work related sickness with significant benefits for service users and staff.
- The programme has progressed well this year and built upon the successful roll out to all areas across the Trust achieved in March last year. The focus of this years work has been to achieve more comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice.

Priority 1 Objectives for 2017/18
By September 2017 all wards will implement a debriefing protocol after incidents for both service-users and staff to ensure individual and organisational learning takes place following incidents
• The debriefing documentation has been rolled out across the organisation for both service users and staff to identify any learning and ensure appropriate support is provided following any form of physical restraint. The debriefing documentation has been modified in Specialist Learning Disability Division (SLDD) to an easy read version in collaboration with experts by experience. In addition, we have developed auditing systems to monitor debriefing across the divisions to ensure sustainability of this important intervention.
By March 2018 the core strategies from the Reducing Restrictive Practice Guide will be implemented on all wards. The wards will produce evidence of these strategies and the impact on the ward. This will be reported into the Reducing Restrictive Practice Monitoring Group
• The Reducing Restrictive Practice (RRP) team continue to meet with all ward managers across the Trust following establishing baselines in relation to the RRP core strategies. An auditing tool has been developed to ensure all strategies implemented are evidenced and appropriate support is provided were required. We have obtained evidence from all inpatient wards across the trust in relation to its implementation and developed a short video consisting of ward managers and clinical leads from across the divisions, outlining how they have implemented the RRP Guide and its associated benefits. • *Reducing Restrictive Practice Guide Implementation Video – https://youtu.be/KM_Q_US4s-s*
By March 2018 planned prone restraint (face down floor based restraint) will be reduced by 20% as part of our longer term strategy to eliminate completely.
• Following the development of a number of work streams to reduce the use of planned prone restraint; o the delivery of PSS Training, ensuring it is only used if there are cogent reasons for doing so o by exploring alternative sites to administer depot & rapid tranquillisation medication o engagement sessions to explore the reasons why nursing staff are not considering administering prescribed medication in alternative sites and o reviewing all prone restraints across the Trust, we have seen a 30.9% reduction in the use of prone restraint.
By March 2018 a Research Evaluation of the programme will be completed by Liverpool University.
• A pilot of evidence-based tools, Care Zoning, the DASA (Dynamic Appraisal of Situational Aggression) checklist and One-Page Plans, in addition to the NFF approach, has commenced on six wards in the Secure Division to further improve the efficacy of NFF in reducing restraint and conflict on wards. • This work has been independently evaluated by Liverpool University which consisted of

conducting semi-structured interviews/discussions with service users and members of staff. In total 23 participants (12 members of staff and 11 service users) were recruited from the 6 wards in the Secure Division. The service evaluation report outlined a number of themes in relation to the implementation of the pilot; Staff reported a) an improvement to safety on the ward in regards to a reduction of restraints/conflict, b) improved relationships between staff and service users, c) more collaborative work with service users as their views/opinions were being embedded into care planning and clinical practice d) required more training on the approaches. Service users reported; a) feeling safe on the ward, b) staff were already doing enough to reduce conflict and improve safety c) requested more grounds access and increased staffing levels.

Sustainability:

- We continue to progress on the 5 year implementation plan to ensure NFF is sustained in culture and clinical practice change.
- Our Clinical Guide for Reducing Restrictive Practice has been rolled out across all inpatient wards. Some wards continue to encounter challenges in meeting reduction targets, therefore we have developed plans through examining strategies to increase sustainability and provide further support to wards in achieving objectives. We are also in the process of evaluating the implementation of the guide to determine its impact. Individualised performance outcomes will be developed in future.
- The Trust Reducing Restrictive Practice Implementation Group continues to incorporate all developments and initiatives in relation to reducing harm with a view to greater integration.
- We have developed a new Personal Safety Training curriculum incorporating reducing restrictive practice, enhanced de-escalation and staff health & wellbeing training as an integral part of the mandatory components. The training will be governed by a curriculum group which will ensure that the training is consistent with National guidance and NFF principles.

National Profile:

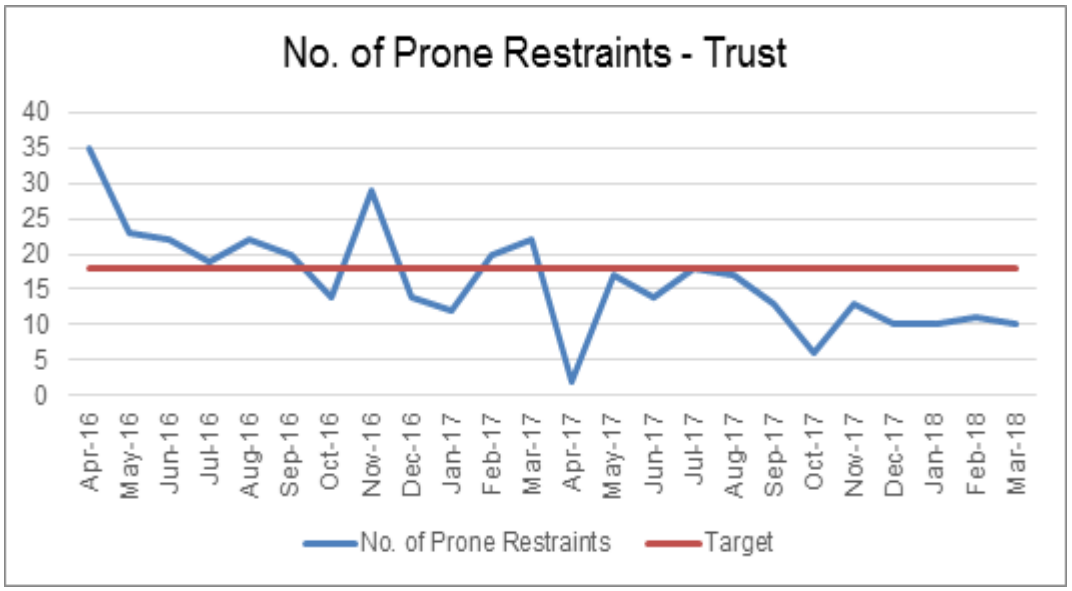
- Mersey Care NHS Foundation Trust has been recognised by the Care Quality Commission as an exemplar case study for Reducing Restrictive Practice. https://www.cqc.org.uk/sites/default/files/201701207b_restrictivepractice_resource.pdf
- Mersey Care Foundation Trust has been recognised a case study on reducing assaults on staff in a National Publication: Violence against NHS staff: a special report by HSJ and Unison - With strong evidence that violence against NHS staff is rising, HSJ and Unison research explores the factors influencing these attacks and the initiatives underway to reduce them - https://guides.hsj.co.uk/5713.guide
- We are currently providing support in conjunction with NHS Improvement to other organisations and developing a National Model to reduce restrictive practice.

National / International conference presentations:

- The International Association of Forensic Mental Health Services Annual Conference 2017
- National Association of Psychiatric Intensive Care Units (NAPICU) National Conference 2017
- Restraint Reduction Network (BILD) Annual Conference 2018
- Ensuring Adherence to the 2017 National Quality Standard for Violence and Aggression Conference 2018

National Awards:

- 2017 Nursing Times Award Winners – Patient Safety
- 2017 Positive Practice in Mental Health Award Winners – Quality Improvement
- 2018 Restraint Reduction Network Award Winners
- 2018 Health Service Journal Value Awards Finalists (Winner TBA)



Priority 2 Progress: Zero Suicide

- Dr Rebeca Martinez, Consultant Psychiatrist/Associate Medical Director for Suicide Prevention, is the identified lead for this priority area and chairs the Safe from Suicide team established to oversee the implementation of the Zero Suicide Strategy and Policy.

Priority 2 Objectives for 2017/18

By September 2017 a Suicide prevention dashboard will be in place to track and monitor progress on the 10 key parameters for safer mental health services. By March 2018 a report will be produced on the effectiveness of the dashboard as a performance improvement tool, to support clinical decisions

- The suicide prevention dashboard is now available and is being further enhanced to reflect the '10 ways to improve safety' which has been developed by the National Confidential Inquiry (NCI) team at Manchester University.
- The dashboard currently contains 19 separate metrics which are intended to provide an overview of current performance against key risk factors. These metrics include:
    - Leave of absence
    - Self harm
    - DNA outpatients
    - Average time (in days) assessed to contact
    - Vacancy and turnover rates
- Items to be added to the dashboard, to bring in line with NCI requirements, include:
    - Safer wards
    - Out of area admissions

- As part of a joint research project into suicidality, data has been given to researchers at the NCI team at the University of Manchester. Work is on-going with the NCI team to ensure they have adequate data to enable a report to be produced in April. As part of this research project interviews with key Mersey Care staff, including Board members, will take place in March.

By March 2018, the safety planning intervention will be integrated to the Level 2 Suicide Prevention training and will be made available at high risk transition points

- The safety planning intervention has now been implemented on the inpatient wards in Broadoak, Clock View, the Park Unit, Windsor House, Rathbone Rehab and the Personality Disorder hub. Further training and implementation within South Sefton Neighbourhood Centre is now complete and safety plans are in use. A dashboard is being created with the BI team to enable the capturing of key measurement data.
- Data collected in the initial implementation phase indicated a 0% readmission to inpatient wards after fully implementing the intervention with a reduction in presentations to A and E for all those discharged with a safety plan. Complaints against staff were reduced with service users indicating increase in positive relationships with frontline staff. Individual measures noted an increase in emotional coping and improvement in alliance. Dashboards have been created for each ward/team to enable further monitoring of the impact of this intervention.
- In addition one high secure ward are implementing the plan for further feasibility with a view to building this into the PACIS system in the near future.
- The Safe from Suicide Group will continue to refine and adapt the safety plan as we learn from its implementation across both inpatient and community settings.

By March 2018 in-patient wards will be implementing a design-based solution to reduce self-harm, with an evaluation completed

- There are currently 4 inpatient wards that are implementing design-based solutions to reduce self-harm. Harrington (Broadoak female), Dee (Clock View female), Poplar (Scott Clinic female) and Arnold (Ashworth male) wards have all introduced solutions following detailed work over the past year following the design thinking model. Current data shows that collectively there has been a 55% reduction in incidents of self-harm since the programme began with further reductions expected as solutions become embedded. Sickness absence is also lower than the Trust average, on the pilot wards, with a reduction of 2% since commencement along with 5% less bank and agency usage than other inpatient wards.
- Discussions are currently being held with divisional leadership teams to identify how the successful interventions from this pilot will be spread at scale across the divisions and the levels of support required from the Centre for Perfect Care. Work is, however, starting to roll out specific interventions within the four mixed wards in the Local Division

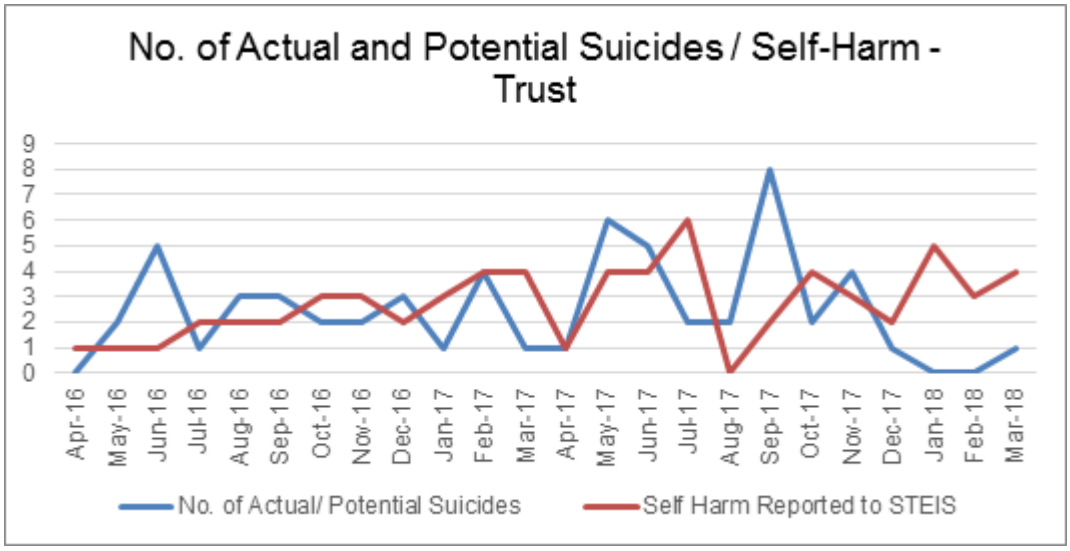
By March 2018 a proof of concept study on the zero suicide app in conjunction with Stanford University will have been completed

- The study has been approved by ethics and is ready to commence, based in the in-patient units at Broadoak, Clock View and the Park Unit with the support of research assistants from Liverpool University.

- The Trust has developed a robust protocol for the study which has now commenced with the first participants being recruited towards the middle of January with 11 service users having tested the app at the end of January.

The Safe from Suicide team will continue to monitor and measure suicide and near-fatal self-harm data and respond with enhanced support and interventions, including training, supervision, psychologically informed risk formulations and safety planning. Specific team based interventions will result from the suicide data, where problems are identified.

- The Safe from Suicide Team meet monthly to monitor progress against the strategic goals against the Zero Suicide Strategy. Monitoring and Measuring Suicide and near fatal self-harm data.
- The table below shows the progress made against the key indicators in the Suicide Prevention Strategy. These indicators were chosen due to the identified trend in previous years of suicides post discharge and reflect the overall aim to reduce death by suicide by 20% year on year.



Target reduction areas for suicide prevention strategy

- As at the end of December the indicators reflect a very positive impact on the number of deaths by suicide following discharge at; 3 days, 7 days and 3 months with significant improvements on the previous two years.
- As part of the groups monitoring areas of concern are examined and highlighted, looking for areas of higher than expected suicide rates, and changes in patterns. The team have actively supported areas that have experienced difficulties or increased risks.
- The team is currently completing an overview of all deaths, related to suicide, since January 2016. This is looking at action plans and specific responses from Oxford model events, with an aim to provide a wider learning outcome for suicides. This review will collate the action plans into specific areas of improvement as identified by the NCI's '10 ways to improve safety'.
- The team is working on an improvement in the feedback that teams receive following the conclusion of investigations.

Training

- Currently the Trust is 88% compliant with Level 1 suicide prevention training. This,

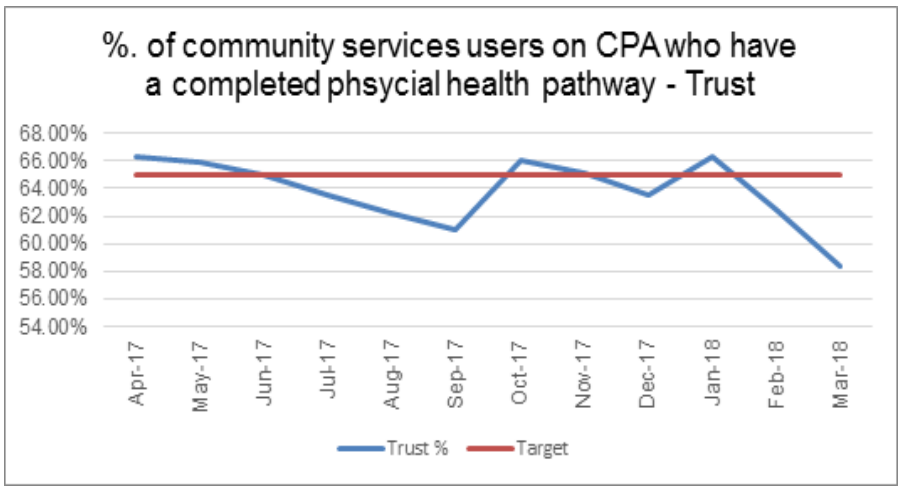
along with all suicide prevention training, is being reviewed and developed further to include shorter 'refresher' type training alongside more detailed suicide prevention packages for clinicians.

- The Trust has just completed a Suicide Awareness and Intervention resource which has been made available to the general public via the Zero Suicide Alliance website following a national launch event in mid-November. It is hoped that the Zero Suicide Alliance approach will see the Mersey Care suicide awareness training reach a national audience.
- The Level 2 Prevent training has been delivered across three pilot sites – Park Lodge, Clock View and Southport Locality and is due to commence in the Norris Green Hub. This training has been completed by 268 staff, and was being further developed following the engagement with Relias. This may lead to further 'levels' of training being delivered in different formats to suit both internal and external markets.
- Supportive interventions have been delivered to teams across the Trust following potential suicides which includes support with risk formulations, Safety Planning and MDT attendance. This support also includes help with learning from these events and sharing of this learning across the organisation. Further interventions are planned with Park Lodge and Southport.

Priority 3: Progress Improvements in Physical Health
• Dr Simon Tavernor, Consultant Psychiatrist is the nominated lead for this priority area. A Trust wide physical strategy group supports and oversees this priority area.
Priority 3 Objectives for 2017/18
By September 2017, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented
• There have been several adjustments to the community physical health pathway for the development in line with recommendations from NHS England in relation to cardio metabolic risk. This now includes brief interventions and recording outcome pathways for the relevant parameters of Hypertension, Diabetes and Dyslipidaemia. Completion of the APHC is being encouraged regularly by the Physical Health team. Several meetings around the completion of the form and information transfer between secondary care and primary care are being arranged. A shared care protocol between primary and secondary care on completion of the APHC is being looked at within the CQUIN. Regular communication continues with the community teams to ensure the completion of the form. A small team of community physical health nurses have been recruited to support the completion of the required documentation and provide a comprehensive physical assessment in-line with the assessment tool. There is an expectation that Q4 2018 there will be an improvement demonstrated for this physical health pathway.

By September 2017, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented

- There are numerous work streams under development to address the need to improve the compliance for completion of physical health checks for community service users.
  Graph 2: Percentage of community service users on CPA who have an annual health check – Trust



- There have been changes to working practice within the Primary Care Liaison team which led to the team no longer inputting APHC check information from the GP practices. Therefore this has impacted on compliances demonstrated by the figures inputted as there have only been 2 members of staff across Local division working on the APHC within the CMHTS. Despite the increasing awareness of the APHC and training sessions taking place across all CMHT's, there remains a lack of improvement demonstrated in the physical health care outcomes for the services users.
- Over the next 6 months there will be a focus on communication from the physical health care team for the need for completion of the physical health assessment forms and meeting with the CMHTS to look at the physical health pathway within each area. Consultants are also being asked to include a physical health assessment within CPA reviews and template of information to be included within this will be developed. CQUIN Physical health dashboard has yet to be developed fully and when operational this will capture the effectiveness of the assessment with referral rates and actions taken around screening and intervening cardio metabolic risks.
- There will also be data gathered from PHYSLOC10 on the overall percentage of completion rates. Further work will be carried out to ensure teams focus on the physical health form leading to end of Q4. The Business Intelligence finalised the system for monitoring compliance in December 2017. This date has been delayed in development due to capacity and demands on the Business Intelligence Team whilst implementing Rio. There is a trajectory for local division to achieve 95% by June 2018

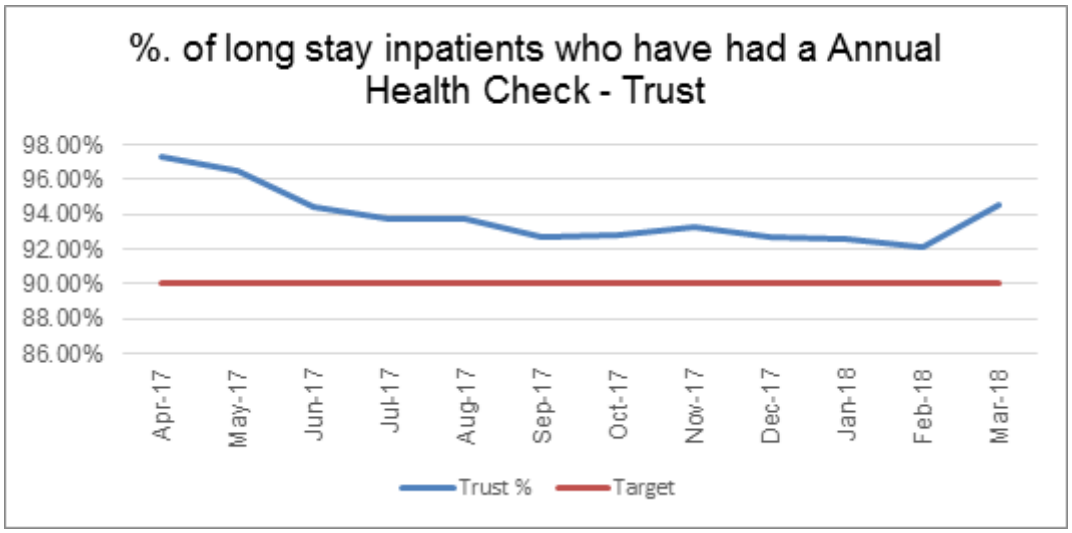
By March 2018, there will be a 90% uptake of the Annual Health Check (AHC) for all long stay inpatients across all clinical divisions

- This target has been difficult to achieve. There is work required amongst the teams to raise awareness and understanding the importance of ensuring annual physical health checks are completed and documented for long term patients. Other regions have concentrated on investment in primary care to ensure this takes place. Liverpool and

Sefton CCG currently have no primary care physical health investment that works across primary and secondary care. This may need to be considered in the 2018/19

Graph 3: Percentage of long stay inpatients who have had an annual health check - Trust

- Despite the provision of the a very small community Phyical Health Team , some barriers still exist for the effective transfer of information from primary care to secondary care. EMIS has limted access availability under the current confidentiality contract and the view of the mental health review is not able to be viewed even with patient consent. There is still a lack of motivation from care co-ordinators and some CMHT leads to increase the frequency of the physical health through the referrals to the CPHT or the Assistant Pracititioners who operate physical health clinics. Further work and emphasis needs to be carried out from the Physical Health Team to convey the importance of the documentation of the asssessment for the long term health outcomes of our clients.

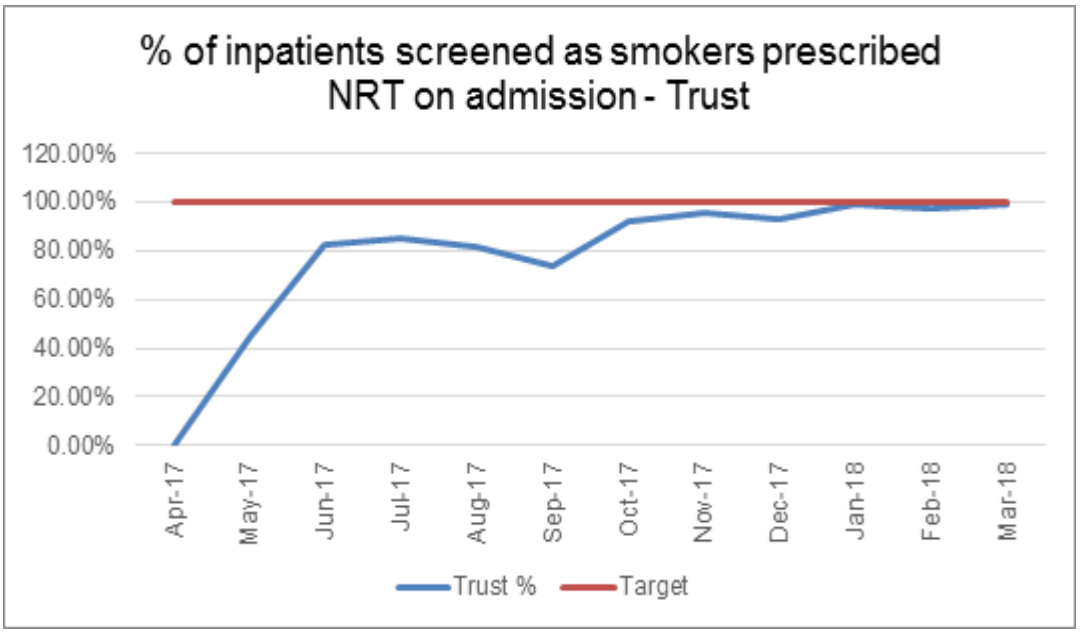


- The modern Matrons for Local and Corporate has delivered training on completion of the electronic assessment tool to the new medical staff at induction in December. Whereby we should start to see an improved percentage for the completion of electronic assessment that can be reported monthly through the Business Intelligence Team.
- The local division is engaging with the medical staff to address the issues of assessment form completion through junior doctor induction and with the in-patient consultant led medical teams. The BIT reporting system has reviewed data collection issues from Epex as the current system did not pull through to record the blood results and this means that the performance is reported as zero percentage if all elements of the assessment tool are not recorded. The new reporting template for the Business Intelligence Team reporting template was completed the end of December. We expect to see an improvement demonstrated in the electronic reporting for this target for Q4

By March 2018, 100% of inpatients screened as smokers will have prescribed nicotine replacement therapy on admission

- Graph 4 shows an increase in patient using nicotine replacement. The steering group and Division will continue to monitor performance.
- The planned launch for smoke free happened in October 2017. The Trust lead continues to work with the services to ensure a smooth transition into smoke free Trust the Trust lead remains visible within services and has provided market stalls which provide information to staff and service users to enable them to make an informed choice. The Trust Wide Nicotine Management Group will be reviewing all Datix information at next week at there meeting to ensure lessons learnt and any themes relating to smoke free agenda are actioned to improve the process. Local division are being supported by perfect care to address issues raised following the implementation of smoke free Trust.
- Following guidance from Public Health England and CQC, the trust wide group continue to support the use of e-cigarettes as one of the options available for patients as an aid to smoking cessation

Graph 4: Percentage of inpatients screened as smokers prescribed NRT on admission – Trust



Priority 4: A Just and Learning Culture

Priority 4 Objectives for 2017/18

Within one week of an incident, a copy of its 72 hour review will be shared with all members of the relevant teams (July 2017).

- Dr Arun Chidambaram, Deputy Medical Director, is the nominated lead for this objective.
- A sub-group led by Dr Arun undertook a review of current practices in relation to the use and application of 72 Hour Reviews. The group is made up of members of the JLC committee, consultants, managers, clinicians and members of the patient safety Team.
- There is an inconsistent approach across the Trust to how incident reports are reviewed and actions to be taken. The review processes do not support the aim to provide a 72 Hour Review report to the relevant team within the timescale that has been set.
- The Task and Finish Group are working to standardise the process and produce guidance to assist the decision making on incidents that may require a 72 Hour Review.
- The Trust's DATIX and Ulysses systems are being developed to aid and support the application of 72 Hour Reviews with new "drop down tick boxes" and a "virtual validation" process is being considered that will enable swifter feedback to the relevant teams.
- The work of this group links with other work streams such as the publication of "Good Practice Stories" and the management and resolution of incidents and complaints.

Good practice stories will be published every month in order that we can extract the maximum possible learning from things that go well and from things that did not go as expected (September 2017)

- Tim Riding, Associate Director, Centre for Perfect Care, is the nominated lead for this objective.
- Robust mechanisms to identify, prioritise and then publish good practice stories have now been established. This includes a small 'editorial group' which meets on a monthly basis and undertakes the following tasks:
    - Considers and shortlists the range of submissions received;
    - Seeks further information where necessary;
    - Drafts potential stories;
    - Puts forward suggested stories for 'sign off' by the Executive Director of Workforce.
- The Just and Learning Culture 'microsite' has also been finalised and launched. This will be used as an opportunity to publish the first of our good practice stories simultaneously, with a view to publishing 1 – 3 stories in each subsequent month.

We will publish quarterly data on our web site to transparently demonstrate whether our staff have felt supported when things in our care haven't gone as expected (September 2017).

- Amanda Smith, Head of Health and Wellbeing, is the nominated lead for this objective.
- All employees who by virtue of an incident / situation are guided through the supporting process and will be formally canvassed at month 1 and 3 post incident to seek their feedback (data) as to how effective they found the process and support options that were made available to them by the Trust. As employees needs different support dependent upon the individual circumstances / event we are aware of and acknowledge that what one employee may find supportive another does not and so we aim to provide a tailored support package for staff that meets their individual needs.
- The feedback from staff will be reported on a quarterly basis via the Trust's website and to divisional leads which will support us to continuously learn and improve staff experience when something didn't go as expected.
- The staff stories where reported as part of the week with Sydney Decker for developing the Just and learning Culture.

Priority 5: Reduction of Community Acquired Pressure Ulcers

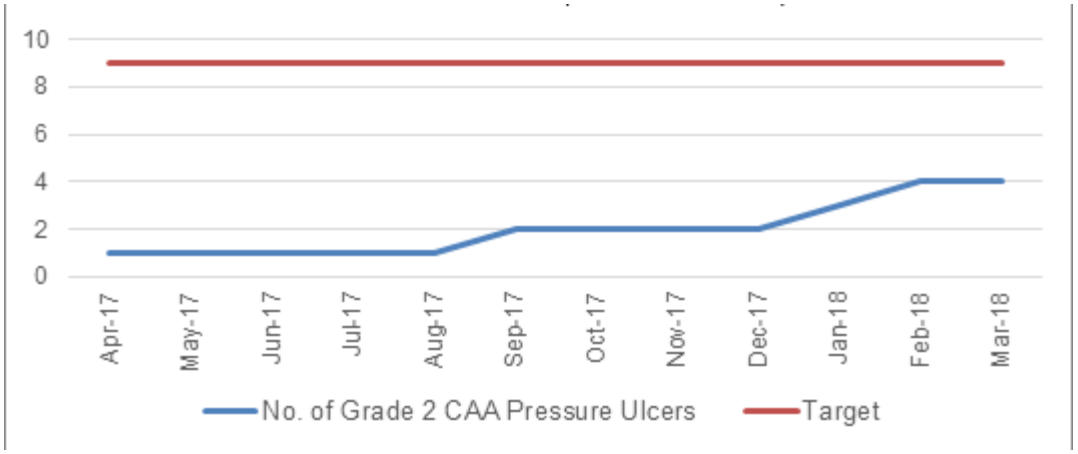
- Nicky Ore, Clinical Lead Sefton Locality, is the nominated lead for this priority.
- The prevention and management of pressure ulcers remains our highest clinical risk with South Sefton Community Services Division and is an issue across the whole health economy due to increasing complexity of patients who remain at home or in residential homes or nursing homes. Nationally pressure damage is one of the highest clinical risks, the reduction of pressure ulcers forms part of many national and local initiatives including NICE and CQUIN.
- The division has embedded the divisional pressure ulcer reduction programme (PURP) in continues to work in collaboration with Liverpool Community Health and Sefton CCG. Bi-monthly collaboration meetings with Sefton CCG have been established as part of the Divisions Harm Free Care workstreams. The PURP action plan concentrates on 6 key themes to support the reduction of pressure ulcers.
- The Trust will aspire for zero Community Acquired Avoidable pressure ulcers (all grades). The Division continues to work with the Perfect Care Team to support the reduction program. However the following has been set a target of reduction for community acquired ulcers as part of the Quality Account Targets 2017/18.

Priority 5 Objectives for 2017/18

Target 1 - 20% reduction compared to 2016/17 for Grade 2 Community Acquired Avoidable Pressure Ulcers (Target 9).

- The current level of performance against target – Grade 2: 3 (YTD)

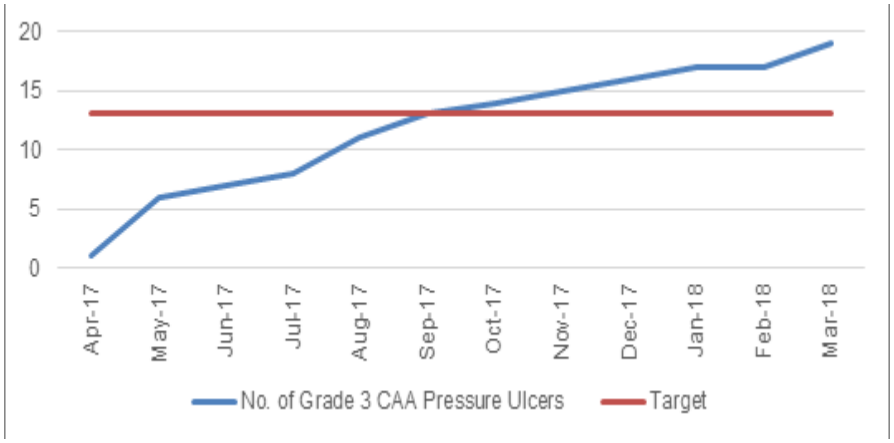
Graph 5: Grade 2 Community acquired pressure ulcers



Target 2 - 10% reduction compared to 2016/17 for Grade 3 Community Acquired Avoidable Pressure Ulcers (Target 13) (STEIS).

- Current level of performance against target – 17 community acquired grade 3 pressure ulcers YTD. This objective is rated red as a result of current performance against target.

Graph 6: No of grade 3 community acquired avoidable pressure ulcers (cumulative)

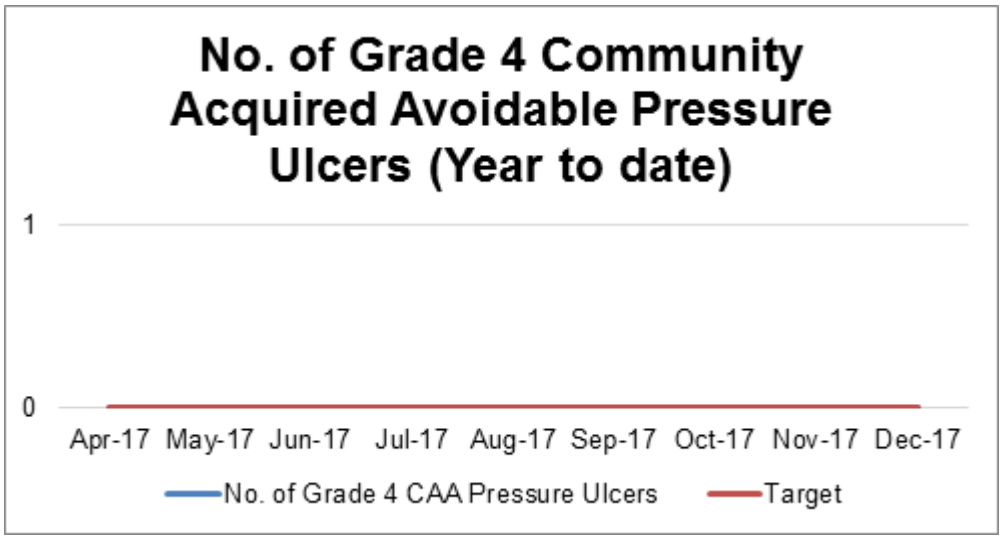


- Reason for underperformance:
  - Hotspot areas identified in relation to CAA Grade 3 pressure ulcers – local improvement plans in place which link to overall Divisional Pressure Ulcer Improvement Plan;
  - Recovery plan in relation to CAA Grade 3 pressure ulcers implemented with a target completion date of end of March 2018. Main focus of the recovery plan is around the main key themes from RCA's - first holistic assessment and shared decision making.
  - The divisional pressure ulcer programme continues to be supported by the Skin

Service, Safeguarding and Divisional Governance and Quality Team in developing initiatives and working with teams to embed at service level to ensure that pressure ulcer reporting is escalated promptly and lessons learnt are shared throughout the organisation.

Target 3- Zero Grade 4 Community Acquired Avoidable Pressure Ulcers (STEIS).

- Current level of performance as at 30.09.17 – 0 community acquired pressure ulcers YTD



- Grade 4: 1 (YTD)* this has since been requested to be removed from StEIS as deemed non community acquired following investigation. Awaiting confirmation from CCG.
- The Pressure Ulcer Reduction Programme continues with a focus to reduce community acquired pressure ulcers particular focus on Grade 3 pressure ulcers, work continues in collaboration with NHSE to support a whole system approach to pressure ulcer reduction. The divisional programme continues to be supported by the Skin Service, Safeguarding, divisional Governance and Quality team in developing initiatives and working with teams to embed at service level to ensure that pressure ulcer reporting is escalated promptly and lessons learnt are shared throughout the organisation. The division has commenced work with perfect Care to support the reduction program of pressure ulcers.

2.3 Statements of Assurance from the Board: Review of Services

20. During 2017/18 Mersey Care NHS Foundation Trust provided 42 NHS services to NHS Commissioners, including public health (local authorities).

21. During 2017/18, the Trust contracted with:

a) NHS Liverpool CCG (with Liverpool City Council) and NHS Sefton CCG (and associates), for local mental health and learning disability services across the Liverpool, Sefton, Knowsley, Halton, St Helens and West Lancashire areas;

b) NHS Liverpool CCG for addiction services;

c) NHS Liverpool CCG for Improved Access to Psychological Therapies (IAPT);

d) NHS South Sefton CCG, NHS Southport and Formby CCG, NHS Liverpool CCG and Aintree Hospital NHS FT for Sefton community physical health services.

e) Sefton Council:

i) Residential Substance Misuse Medically Managed Detoxification Service,

ii) Ambition Sefton – Adult Substance Misuse Treatment and Recovery Service (within the Ambition Sefton contract there are a number of Pharmacy Services that provide Needle Exchange and Supervised Consumption);

f) NHS England (through its regional and various sub-regional teams) for:

i) low, medium and high secure services and colleagues from NHS Wales in respect of high secure services,

ii) low and medium secure services for specialist learning disabilities services,

iii) personality disorder services at HM Prison Garth;

g) Aintree University Hospitals NHS Foundation Trust for the Liverpool Community Alcohol Service;

h) NHS Lancashire CCG (and associates) for low and medium secure services and enhanced community support services for specialist learning disabilities services;

i) Alder Hey Children's NHS Foundation Trust – CQUIN transition from CAMHS to Adult Mental Health and Learning Disability Service;

j) Liverpool Womens NHS Foundation Trust for Perinatal Service;

k) Manchester Mental Health and Social Care Trust for psychiatry services to HMP Manchester;

l) National Probation Service for community personality disorder services, Resettle and Psychologically Informed Planned Environment (PIPE) services;

m) NHS East Lancashire CCG for Learning Disabilities Enhanced Support Services;

n) Lancashire Care NHS Foundation Trust for Dental services for low and medium secure services. **This is a commissioned service i.e. expenditure**;

o) Lancashire Care NHS Foundation Trust for Speech and Language Services. **This is a commissioned service i.e. expenditure.**

p) Liaison & Diversion service (CJLT) - within secure main contract;

q) Sex Offender Treatment Programme at HM Prison Wymott – within OPD element of main secure contract;

r) Psychiatry service to HM Prison Altcourse (Primecare);

s) National Probation Service / NOMs OPD work in Cheshire.

22. The Trust also provides ***staff support services*** to a number of local NHS and non-NHS organisations,

a) NHS Shared Business Service;

b) Liverpool Heart and Chest Hospital NHS Foundation Trust;

c) Southport College;

d) Aintree University Hospitals NHS Foundation Trust;

e) St Helens Council;

f) Liverpool Mutual Homes;

g) Liverpool Womens Hospital NHS Foundation Trust;

h) The Walton Centre NHS Foundation Trust;

i) Liverpool Community Health NHS Trust;

j) Royal Liverpool & Broadgreen University Hospitals NHS Trust;

k) St Helens & Knowsley Hospitals NHS Trust;

l) VIVUP;

m) Royal Surrey;

n) Bristol Commissioning Support Unit

23. Mersey Care has reviewed all of the data available on the quality of care in all of these services

24. The Trust also hosts Informatics Merseyside which provides services to a range of local NHS organisations.

25. *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 Mersey Care NHS Foundation Trust for 2017/18.*

2.4 Participation in National and Local Clinical Audits and National Confidential Enquiries

National Clinical Audit Reports 2017/18

26. During 2017/18 **four** national clinical audits and **two** national confidential enquiry covered relevant health services that Mersey Care NHS Foundation Trust provides.

27. During that period Mersey Care NHS Foundation Trust participated in 100% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

28. The national clinical audits and national confidential enquiries that Mersey Care NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

    a) National Confidential Enquiry into Suicide and Homicide by people with Mental Illness;

    b) Learning Disability Mortality Review Programme (LeDeR);

    c) National Clinical Audit on Psychosis;

    d) POMH: The use of depot/long acting injections (LAI) antipsychotic medications for relapse prevention;

    e) POMH: Rapid Tranquillisation;

    f) POMH: Prescribing High Dose and Combined Antipsychotics.

29. The national clinical audits and national confidential enquiries that Mersey Care NHS Foundation Trust participated in during 2017/18 are as follows:

    a) National Confidential Enquiry into Suicide and Homicide by people with Mental Illness;

    b) Learning Disability Mortality Review Programme (LeDeR);

    c) National Clinical Audit on Psychosis;

    d) Prescribing Observatory for Mental Health (POMH): The use of depot/long acting injections (LAI) antipsychotic medications for relapse prevention;

    e) POMH: Rapid Tranquillisation;

    f) POMH: Prescribing High Dose and Combined Antipsychotics.

30. The national clinical audits and national confidential enquiries that Mersey Care NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

a) National Confidential Enquiry into Suicide and Homicide by people with Mental Illness (100% - 58 submitted, 15 returned);

b) Learning Disability Mortality Review Programme (LeDeR) (100% - 25 submitted);

c) National Clinical Audit on Psychosis (100% - 300 submitted);

d) POMH: The use of depot/long acting injections (LAI) antipsychotic medications for relapse prevention (100%);

e) POMH: Rapid Tranquillisation (100%);

f) POMH: Prescribing High Dose and Combined Antipsychotics (100%).

31. The reports of 4 national clinical audits were reviewed by the provider in 2017/18 and Mersey Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

a) From the POMH: Rapid Tranquillisation the actions to improve quality are:-
   i) The recording of service user's preferences about Rapid Tranquillisation needs to improve within the Local Division,
   ii) Increase the recording of assessment of the mental and behavioural state of the service user needs in the clinical notes;

b) From the POMH: The use of depot/long acting injections (LAI) antipsychotic medications for relapse prevention the actions to improve quality are:
   i) To increase the number of cases notes that have full documentation of an annual assessment of side effects,
   ii) To increase the documentation of a clinical plan of how staff should respond when a service user fails to attend for an appointment to administer the medication;

c) From the POMH: Prescribing high dose and combination antipsychotics the actions to improve quality is:
   i) To review the prescribing of PRN antipsychotics.

d) From the National Physical Health CQUIN of Cardio Metabolic Assessment for patients with Schizophrenia the actions to improve quality is:
   i) Development a new community physical health pathway with improved specialist staff to support access and record keeping systems and an intranet portal developed to support the physical health pathway.

Participation in Trust Wide Clinical Audits

32. The reports of 30 completed clinical audits were reviewed by the Trust in 2017/2018 and it intends to take action to improve the quality of healthcare provided (see appendix 1 for list of clinical audit topics and brief synopsis).

33. All of the Trust's clinical audits are presented to and reviewed by the Quality Assurance Committee and Audit Committee and provide the assurance that quality issues are being addressed at Board level. The Trust encourages all services to be quality focused and as such encourages all clinical areas and disciplines to participate in the review of services through clinical audit. Audit findings have been shared at divisional governance forums.

34. Please see Annex 3 for Local Clinical Audit Report 2017/18.

2.5 NHS Staff Survey Results 2017

35. Findings from staff survey regarding Indicators KF26 and KF21 are shown in table overleaf.

Key Finding	2017	National Average (MH/LD)	2016	Comment
KF26 - %age of staff experiencing harassment, bullying or abuse from staff in last 12 months **(lower the better)**	21%	21%	20%	No statistically significant change since last year and in line with national average
KF 21 percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (**higher the better)**	White 84% BME 77%	87%	White 82% BME 83%	No statistically significant change for overall staff score since last year and statistically in line with national average. Drop in scores from BME staff members from 83% in 2016 to 77% in 2017

2.6 Research and Development

36. The Trust has continued to give priority to supporting NIHR (National Institute for Health Research) adopted studies along with a large variety of student, staff and internally generated research studies. We have supported 121 open studies (including those in set-up, actively recruiting and in write up), of which 54 were adopted NIHR studies and the remaining 67 were student, Trust specific and own account studies.

37. The number of service users recruited during this period to participate in research, approved by a research ethics committee was 866. In addition, 213 staff and 154 carers participated in research studies – a grand total of 1,233 (compared to 1,039 last year – a 19% increase). Of these, 490 service users, 128 carers and 89 staff (a

total of 707) recruits were from NIHR adopted portfolio studies and 526 from non-adopted studies.

38. The range of studies being supported continues to be varied including learning disability, mental health, forensic, genetics, dementia, IAPT, social work, perinatal mental health, shared reading, seclusion, alcohol abuse and offender personality disorder pathway. We were particularly pleased to be able to deliver our first NIHR adopted studies in the Eating Disorder Service. The first one for service users investigating the efficacy of a web-based guided self-help intervention for people with bulimia, binge eating disorder and other eating disorders with binge eating. The second one for carers of individuals with anorexia nervosa. For both these studies we are the highest recruiting site outside of the sponsor site. Studies have also expanded to include several technology focused studies supporting service users and carers living in the community and on in-patient wards. Interestingly one preliminary study is exploring any potential links between memory and concentration problems in people with MH, neurodevelopmental and neurodegenerative disorders and blood supply to the heart and brain. The variety of studies will continue to expand with the recent acquisition of Liverpool Community Health Trust (LCH) and the return of services in Liverpool Prison. We have also had more staff only studies this year compared to previous years which have been welcomed and supported by staff colleagues.

39. Performance metrics for NIHR adopted studies are based on approval times and delivery of participants to time and target. We have maintained our excellent record in achieving time to set up, first participant and time to target throughout 2017/18 and have again surpassed the recruitment target for the number of people participating in NIHR research studies We welcomed the recent confirmation of recurrent, funding from the NW Coast Comprehensive Research Network (CRN) for an additional member of delivery staff which has had a significant impact in terms of recruitment and study promotion. Our own trust funded staff in the Specialist LD (SpLD) service have also supported recruitment to NIHR adopted studies this year alongside their service specific studies. Additional funding from the CRN for a 0.4wte clinical trials pharmacist has allowed the post holder to develop her knowledge of delivery of clinical trials from a pharmacy perspective through shadowing opportunities. She has also developed pharmacy standard operating procedures and staff training packages for Mersey Care in readiness for supporting clinical trials in the future.

40. Engaging service users and carers is crucial to ensure research leads to improvements and changes in healthcare delivery which is core to providing patient-centred care. The ability to demonstrate meaningful participation within research from PPI groups also promotes opportunities for external funding. In readiness for the roll-out of our new patient information system (RIO) we have been busy promoting Consent to Contact with our service users, carers and families to increase opportunities for service user and carer involvement in research and innovation. This initiative supports interested people to register their interest in being contacted about potential research and innovation opportunities – as participants, members of research teams or just to receive information. We have also developed an easy read pictorial version of Consent to Contact for people with learning difficulties and cognitive impairment which was co-developed with service users in the Specialist LD

(SpLD) service. Through working closely with the RiO team, we are delighted to have specific research pages on RiO and the facility to record Consent to Contact. RiO will help identify and raise the profile of involvement of service users in research and support better data collection. We have also worked to promote a national initiative entitled Join Dementia Research (JDR) with the use of a recruitment booth from the JDR team. The R&D team has developed a research newsletter whose main focus is promotion of research to service users and carers but also to raise the profile of research to staff.

41. Staff have been supported in obtaining internships from the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) to undertake service evaluations – one in Life Rooms and one in the PD Hub.

42. The Trust has continued to invest in technology to aid research and innovation. We are one of only 15 trusts to invest in the CRIS programme and the only MH trust in the North West. This innovative research solution will retrieve data from the RiO record system, pseudonymise it to protect patient identities and then load it in to a database which can be queried to provide an opportunity to compare and search an extensive amount of clinical data. It will also support screening for research participants. The use of CRIS will enable research opportunities that would otherwise be intrusive and/or prohibitive due to cost, time and privacy. It will be rolled out when RiO becomes fully implemented later in 2018.

43. Through tenacity and determination the research team facilitated the first ever recruit to an NIHR study in LCH. This allowed the NW Coast Comprehensive Research Network to achieve, for the first time, their key objective of 100% of NHS Trusts recruiting to NIHR studies.

44. A newly developed collaboration with North West Boroughs Healthcare NHS Foundation Trust (NWBHFT) has allowed us to offer participation in a dementia clinical trial to Trust Service Users. NWBHFT are the recruiting site with Mersey Care acting as an identification site. Through shadowing and supporting Trust Service Users through this trial, the research team are building knowledge and capacity whilst also giving access to a clinical trial for Mersey Care service users.

45. We have continued to support several genomics studies related to mental health and learning disability which enables Mersey Care to be formally involved in the emerging medical field of genomics. For over a year now, the Trust has been a delivery partner in a national genomics project (100,000 Genomes Project) which aims to sequence 100,000 whole genomes from NHS patients to accelerate the development of new diagnostics and treatments. The project focuses on patients with rare disease and their families. We are supporting the recruitment of participants with severe learning disabilities with associated congenital malformation and autistic tendencies. It is an exciting time for the project as results are just now starting to filter back and clinicians are eagerly waiting to hear the results for our service users who have taken part which could have a significant impact on their future treatment.

46. Through a longstanding collaboration between clinicians, researchers, users, and technology developers at Stanford Risk Authority (incl. Stanford University and

Hospitals) , LeanTaas (AI/Technology experts, Silicon Valley), Mersey Care and the University of Liverpool, we have developed and are recruiting to a pilot research study investigating the feasibility and acceptability of a phone app called SWiM (Strength Within Me). The aim of this study is to develop an algorithmic risk score that is valid in predicting suicide risk and recruitment within in-patient wards is progressing well. This is part of a bigger project developing and testing *m*Health applications and linked to the trust's Zero Suicide Strategy.

47. We successfully delivered a half day workshop for staff entitled "Preparing to Deliver Clinical Trials" as part of a programme of work to raise awareness and interest in research. We were supported in this event by colleagues from the Royal Liverpool and Broadgreen University Hosptial and Aintree Hosptial who have agreed to offer support to the R&D team in preparing for clinical trial delivery. A number of events have been held with professional groups – medical colleagues, psychologists – to raise awareness of research.

48. The Secure Division has been successful in developing a programme of PhD studentships focussing on their specialist areas of need along with relevant publications.

49. The Trust continues to support several studies within the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) programme.

50. Recruitment has been completed to a Trust hosted research study (funded by NIHR Research for Patient Benefit programme) in collaboration with UCLAN, University of Manchester, Lancashire Care NHS Trust and MAHS-CTU to a project entitled: A feasibility trial of glycopyrrolate in comparison to hyoscine hydrobromide and placebo in the treatment of clozapine-induced hypersalivation. The final report will be submitted in May 2018.

51. Recruitment is continuing to a randomised controlled trial (RCT) to investigate whether MBT (Mentalisation Based Therapy) is an effective treatment for high-risk men in the community with antisocial personality disorder as part of the Offender Personality Disorder Pathway. The Trust is one of only 11 sites in the UK and the study is being jointly delivered by the National Probation Service and partner Health Service Providers as an integrated part of the Offender Personality Disorder Pathways Strategy.

52. The Research team is part of the Centre for Perfect Care and the website (www.centreforperfectcare.com/) now holds all the information and advice relating to the process for submitting research and a comprehensive list of all studies currently open to recruitment.

53. Through an established collaboration with the University of Liverpool entitled the *Perfect Care Research Collaboration* and the employment of a Research Associate and Research Assistants, several research and evaluation projects have been delivered to support the Perfect Care priorities and develop programmes of research to support Perfect Care. These have included :- No Force First; DASA; CORE24; SWiM app; Management of Aggression; HOPE (Hospital Outpatient Psychotherapy Engagement Service) evaluation (a service providing rapid access to psychological

therapy, specifically tailored for those presenting at Accident & Emergency Departments in Liverpool City Centre following an episode of self-harm). The HOPE evaluation lead to a successful bid to Liverpool CCG for funding to investigate the potential for making a shift to delivering this self-harm intervention in the community. Following this a bid has now been submitted for funding to test out the delivery of this service in the community – Community Outpatient Psychotherapy Engagement (COPE). A joint collaboration event held in the summer of 2017 celebrated this collaboration with the University of Liverpool and provided updates on a selection of on-going and planned studies to an audience of 70+ staff, service users and carers.

54. We have established and continue to build strong links and networks with other research active organisations including the Innovation Agency, Liverpool Health Partners (LHP), Northwest Coast Genomics Health Care Alliance and the Collaboration for Leadership in Applied Health Research and Care (CLAHRC). We remain involved in the analysis of data from the CLAHRC Household Survey which supports the discovery of local level and socio-economic factors that affect inequalities in physical and mental health with other partners.

55. We are members of the UK Pharmacogenetics and Stratified Medicine Network with positive and collaborations with pharmacogenetics at the Wolfson Centre for Personalised Medicine at the University of Liverpool continuing to be developed in the area of mental health.

56. We continue to maintain links with the NW Coast Clinical Research Network, Liverpool University, Liverpool John Moores University, Edge Hill University, University of Central Lancashire, Chester University, Lancaster University and Manchester University. High Secure Services have maintained and built upon their longstanding collaboration with UCLAN. As a result we have been involved in a number of international, national and local research projects and external funding bids. International research links have also included joint bids, honorary contracts, memorandums of understanding and joint working with colleagues in Norway, Netherlands, Switzerland, Sweden, Australia, Maastricht and the USA.

57. We have continued to submit funding bids to the NIHR with our academic colleagues from several universities. For example, the MRC Mental Health Data Pathfinder scheme with Liverpool and Sheffield Universities and Innovate UK with two small businesses.

58. It is anticipated that 2018/19 will be both exciting and challenging. Our biggest challenge and priority for the year ahead is the impact of the acquisition of Liverpool Community Health. This will bring huge potential for a wider range and number of studies in a new area - physical health - and for combined studies looking at mental health, dementia and physical health. It will also present challenge as it comes with no additional staff resource. This will impact on the capacity of the current delivery and research staff in terms of understanding the new teams and services, promoting and delivering research to this vastly different and bigger group whilst not losing focus and maintaining successful delivery of mental health, learning disability and dementia studies. The Clinical Trials pharmacist (funded by the CRN) will also be looking for opportunities in terms of sites/clinics/capacity/suitable recruits for taking a

physical health clinical trial into the newly acquired sites. Another challenge will be the additional patient information system and how we access, screen and record participation for Community Health patients.

2.7 Sign Up to Safety Campaign

59. Sign Up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

60. Mersey Care is committed to Sign Up to Safety and support the philosophy of locally led, self-directed safety improvement.

61. The original sign up to safety pledges were developed with the clinical divisions and signed off by the executive team. They were developed to ensure they mirror the objectives contained within the Quality Report and align with our perfect care goals.

62. The Trust has continued, as part of its Duty of Candour policy to appoint family liaison officers who will support family members and carers when incidents occur and ensure they are guided and supported through the entire post incident review process. All national targets are now being achieved. The Trust has identified an individual manager in the Trust who coordinates the Trust's response to Duty of Candour Incidents this has increased the quality of the work undertaken. They have also:

    a) updated policy and procedure;

    b) provided training to staff particularly in High Secure Services;

    c) undertaken the role of Family Liaison Manager for the majority of incidents within the Local Division;

    d) monitored incidents to ensure that those incidents that meet the criteria for Duty of Candour are moved through the agreed process.

63. The Sign Up to Safety agenda in the Trust has been reviewed .Following a stock take of progress made so far the Just Culture campaign and appointment of the Freedom to Speak up (FTSU) Guardians have been focusing on reducing the concerns that many staff have had when an incident has occurred. Previously staff have felt that they would be blamed for the incident and potentially suspended. The FTSU guardian role has provided staff with a vehicle to raise their concerns about risks and safety in a way that is controlled, supportive and remains internal to the trust. This means that the organisation can deal with issues more contemporaneously and implement remedial actions to enhance the safety and quality of service provision.

64. The Trust has been working with Stanford University to undertake improvement work to reduce the number of self harm incidents in the Trust. It has used Design Thinking Methodology to do this. The first group of wards have completed their initial programme of work, a significant reduction in the number of incidents has occurred across all wards in the project. Changes to practice have included:

a) using safety huddles to share information with staff on current plans to manage ward/ incident risk;

b) providing specific training on the prevention and management of self harm to staff;

c) increasing social and recreational activities;

d) providing patients with alternatives to self harm;

e) increasing the availability of therapeutic problem solving groups;

f) providing staff with time to reflect on the care they give and learn from their experiences with the aim of enhancing their resilience and skill.

65. Another group of wards have now started on the programme and are in the process of identifying the key actions that they will be taking to reduce self harm in their wards.

66. The Trust continues to review the number and type of assaults that are inflicted on staff with the aim of identifying ways that the number and level of harm caused by of assaultive behaviors can be reduced. The Trust's Personal Safety Team have focused their work on providing clinical guidance to staff regarding specific and complex individuals as it was recognised that the majority of violent incidents were caused by a small number of vulnerable and complex patients. The number of violent incidents across the Trust is gradually reducing in the Trust. The PSS teams have also been actively involved in supporting wards in implementing the smoke free policy with the aim of increasing safety and reducing assaultive behavior.

Mortality - Learning from Deaths

67. The Trust agreed to fund the development of a Mortality and Incident Review Team with the aim of meeting national guidelines and enhance the quality and timeliness of the learning reviews that are undertaken to learn from deaths. This is a Trust priority 6 for 2018/19The Trust has used Mazars and Lockton's, two external agencies to provide guidance regarding best practice in this area.

68. The Trust has started to undertake a series of thematic mortality reviews to identify learning following the deaths of patients in certain diagnostic groups. The reviews undertaken have included deaths that have occurred within the Trusts inpatient services and deaths that have occurred where the patient was being prescribed Clozaril. Both these reviews have been praised by Mazars as good examples of a thematic review process. Actions that have emanated out of these have included a further audit of adherence to MEWs across the Trust , which has been completed and review of the Clozaril management policy which is now underway.

69. Mersey Internal Audit Agency (MIAA) have undertaken an audit of the processes used to manage mortality within the organisation. They found that there was significant assurance, they have recommended some improvement actions to be taken including enhanced oversight by Executive Directors and increased focus on

gaining evidence of the learning that has taken place following the reviews that take place.

70. All deaths that are in scope are reviewed by the Trust using its three stage process:

    a) triage using an agreed review tool;

    b) Structured Judgement Review/seventy hour review;

    c) Root Cause Analysis Review

71. The Trust reports the findings of this process on a bi monthly process to the Quality Assurance Committee and the Board of Directors as per national guidance.

72. A small number of cases have been taken through the three stages of the mortality review process; this has included a death related to the death of a patient with a Learning Disability. The Duty of Candour process was commenced and the families were engaged in the investigation. An oversight group that reported through to Executive Surveillance monitored the implementation of the action plan which included Consultant Psychiatrist's liaising with GPs who referred patients into the respite service to clarify how best the needs of those individuals with complex physical health care needs could most appropriately be managed. The full action plan has now been completed though on going work in the unit is being undertaken to enhance the skills of staff in relation to physical health care.

73. One of the national targets for undertaking incident reviews is to increase the skill and experience of those undertaking reviews therefore the new Mortality and Incident Review Team have received specialists training from an external agency which specialises in this area of work and some staff are also undertaking an academic course facilitated by the University of Central Lancashire. The Trust is also participating in a project facilitated by the Royal College of Psychiatrists to develop national best practice standards in the delivery and learning from Serious and Incident reviews. This work commenced in April 2018 and will involve the Trust in working with other mental health organisations nationally. This project will allow the work of the newly developed Mortality and Incident Review Team to be evaluated with aim of assessing whether the quality of the incidents process has improved thus allowing more appropriate and effective learning to take place.

74. The Trust is now focusing on increasing the number of wards that undertake Safety Huddles within the organisation; the aim is to provide more clarity re the role and function of huddles, though at the same time ensuring they are used to enhance the specific risks of the ward.

75. The Trust will be developing a project to focus on reducing the variance of clinical practice across inpatient wards, recent incidents have shown that there are significant differences in the way that staff in inpatient area provide care , this also occurs across shifts on the same ward. The Trust will use Design Thinking Methodology to identify a small number of standards to implement.

76. **The Five Sign Up to Safety Pledges:**

a) ***Putting Safety First*** - the Trust is committed to reducing avoidable harm in the organisation. We will do this by focusing on our zero suicide, no force first and self harm projects. Safety is at the centre of our perfect care work and one of our six quality domains;

b) ***Continually Learn*** - the Trust will make the organisation more resilient to risks by acting on feedback from patients and by constantly measuring and monitoring how safe our services are. Post incident reviews, particularly related to serious self harm and suicides will be a significant part of this process;

c) ***Honesty*** - the Trust will be transparent with people about the progress it has made to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. We will continue to develop our internal systems for raising concerns and appoint a "Freedom to Speak Up" guardian. We will continue to implement the national Duty of Candour guidance in full and measure the use of this process across the organisation. Encouraging and guiding our staff to raise concerns using a variety of methodologies will remain a key priority;

d) ***Collaborate*** - we will take a leading role in supporting collaborative learning to ensure improvements are made across all of the services that patients use. We are part of a UK collaborative with six other hospitals and The Risk Authority at Stanford in the United States working on a 'partnership for patient protection' project which aims to raise patient safety to a new level using technology never used in healthcare, to make our services as safe as possible.

Working closely with our commissioners and external agencies we will review our root cause analysis to ensure it meets national guidance and develop internal outcome measures;

e) ***Support*** - we will help people understand why things go wrong and how to put them right. We will give staff the time and support needed to improve and celebrate progress. Staff involved in incidents and complaints will be supported when things go wrong and also enable them to learn from these events. We will continue to develop our internal mechanisms for supporting staff including the use of counselling and post incident debriefs

2.8 Commissioning for Quality and Innovation (CQUIN)

77. Details of the CQUIN Schemes for 2017/19**.** The Trust will report quarter four CQUIN targets to commissioners on the 30th April 2018 and commissioners are expected to confirm performance in May 2018.

78. The Trust will report 'green' for all CQUIN targets in quarter four, with the following exceptions.

79. The Local Division may fail to achieve the National Physical Health CQUIN. The 2017-18 audit results may not reflect the improvements in physical health monitoring which will be realised in the 2018-19 audits.

80. The Trust has implemented several changes in the recording of physical health screening for patients across the Trust, including a comprehensive training plan and improvements in the recording of interventions. It was expected that the Royal College of Psychiatrists audit would take place in Quarter 3, (Jan 2018) therefore the impact of these changes would have been realised in the audit results.

81. NHS England have advised that instead of a separate audit, the physical Health indicators from the NCAP audit which was conducted in August 2017 will be used to inform CQUIN performance. The timing of the audit has therefore had a negative impact on the audit results. A maximum of £0.10m may be identified to reinvest in the service to improve performance.

82. Results of the Staff survey have confirmed that the trust has not achieved the Corporate CQUIN, Improvement of Health and Wellbeing of NHS staff, Staff Survey indicator. Under this year's contractual arrangements for the Local Division £0.079m has been identified to reinvest back into the CQUIN to improve performance. For the Secure, Specialist Learning Disabilities and South Sefton Community Services Divisions, £0.159m will be returned to commissioners for underperformance

83. There is a risk that the South Sefton Community Service Division may fail to achieve targets for the Preventing Ill health by risky behaviours CQUIN. The maximum financial risk is £0.014m, to be returned to commissioners for underperformance.

Local Services Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
National Staff Health & Wellbeing	**1a**. Improving staff health and Wellbeing (staff survey).	1a. Amanda Smith	**1a**. A 5% improvement in the answer to 2 out of 3 questions on the staff survey, relating to health and wellbeing, MSK and stress, in order to demonstrate the trusts commitment to staff health and wellbeing.
	1b. Healthy food for NHS staff, visitors and patients.	1b. Joanne Ashley	**1b.** Changes in catering provision to reduce the fat, sugar and calorie content of food and drink items on trust sites.
	1c. Improving the uptake of flu vaccinations for front line staff within Providers.	1c Joanne Scoltock	**1c** 70 % of frontline staff to have received their flu vaccination by the 28th February 2018.

Local Services Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
National Physical Health	**2a.** Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses **2b**. Collaboration with primary Care Clinicians	Nicola Lamont	**2a** To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: • Inpatient wards – 90% • All community based mental health services for people with mental illness (patients on CPA), excluding EIP services – 65% • EIP Services – 90% Audit of patient records to take Place in Q4. 90% of patients to have either an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. Audit to take place in Q2.
Primary Care Liaison Service	Improving collaborative working between Primary and Secondary Mental Health Care.	Alex Henderson	Development of a Primary Care liaison service to establish closer links between Secondary and Primary Care. The four core elements are : • Direct patient Care – brief interventions. • Support and Advice for Primary Care Practitioners • Education and Service Development. • Bringing Secondary Care closer through shared learning.
Improving attendances at A&E	Improving services for people with mental Health needs who present to A&E.	Mark Sergeant	In collaboration with Acute trusts, reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.

Local Services Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
Preventing ill Health by risky behaviours – Alcohol and Tobacco	**Part a**. Tobacco screening **Part b.** Tobacco Brief Advice **Part c**. Tobacco referral and Medication Offer **Part d.** Alcohol screening **Part e**. Alcohol brief advice & referral	Linda Roberts	Trust to demonstrate for all inpatient admissions • Percentage of adult patients screened for tobacco and alcohol use. • Patient records to include status and referral as necessary Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions.
Child and Young Person MH Transition	Transition out of children's and young people's Mental health Services (CYPMHS).	Nicky Fearon	Trust to collaborate with acute colleagues to evidence improvements to the experience and outcomes for young people as they transition out of Children's and Young Peoples mental Health Service.
IAPT- Training and education for community based nurses	Training for community nurses to recognise and respond to people with poor psychological wellbeing and comorbid chronic physical health conditions.	Jo Webster	The aim is to educate community practitioners to understand long term conditions and their link to poor mental health. This will inform referral to IAPT and voluntary sector provision and enable practitioners to offer initial low level interventions.

Secure Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
National Staff Health & Wellbeing	**1a.** Improving staff health and Wellbeing (staff survey). **1b**. Healthy food for NHS staff, visitors and patients. **1c.** Improving the uptake of flu vaccinations for front line staff within Providers.	1a. Dale Williams 1b. Dale Williams 1c Bridget Clancy	**1a**. A 5% improvement in the answer to 2 out of 3 questions on the staff survey, relating to health and wellbeing, MSK and stress, in order to demonstrate the trusts commitment to staff health and wellbeing. **1b.** Changes in catering provision to reduce the fat, sugar and calorie content of food and drink items on trust sites. **1c** 70 % of frontline staff to have received their flu vaccination by the 28th February 2018.

Secure Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
National Physical Health	**2a**. Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses. **2b**. Collaboration with primary Care Clinicians.	Dale Williams	**2a** To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: • Inpatient wards – 90% • All community based mental health services for people with mental illness (patients on CPA), excluding EIP services – 65% • EIP Services – 90% Audit of patient records to take Place in Q4. 90% of patients to have either an up to date CPA, care plan or a comprehensive discharge summary shared with their GP. Audit to take place in Q2.
Implementing Sense of Community in High Secure Wards	Developing a Sense of Community across high secure wards to improve inpatient wellbeing.	Alison Baker	The aim of the CQUIN is to implement an intervention across selected wards focusing on developing a psychological sense of community. This will bring a sense of belonging that patients belong to a community and to each other and that individual needs can be met through a shared sense of community.
Recovery College for Medium and low secure patients	Education and training programmes to support recovery.	Fran Cairns	The establishment of a co developed and co delivered programmes of education and training to complement other treatment approaches in adult secure services.
Reducing Restrictive Practices within Adult Secure Services	The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, in order to improve service user experience whilst maintaining safe services.	Jennifer Kilcoyne	The overall aim is to develop an ethos in which people with mental health problems are able fully to participate in formulating plans for their well-being, risk management and care in a collaborative manner. As a consequence more positive and collaborative service cultures develop reducing the need for restrictive interventions.

Secure Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
Discharge and Resettlement	Reduction of length of stay in specialised MH Inpatient Services	Fran Cairns	This CQUIN is designed to achieve at least a 10% reduction in the current average length of stay
Preventing ill health by risky behaviours – Alcohol and Tobacco	**Part a**. Tobacco screening **Part b**. Tobacco Brief Advice **Part c**. Tobacco referral and Medication Offer **Part d**. Alcohol screening **Part e**. Alcohol brief advice & referral	Dale Williams	Trust to demonstrate for all inpatient admissions: • Percentage of adult patients screened for tobacco and alcohol use. • Patient records to include status and referral as necessary. Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions.

Specialist Learning Disabilities Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
National Staff Health & Wellbeing	**1a**. Improving staff health and Wellbeing (staff survey). **1c**. Improving the uptake of flu vaccinations for front line staff within Providers.	1a. Dale Williams 1b.Dale Williams 1c Bridget Clancy	**1a**. A 5% improvement in the answer to 2 out of 3 questions on the staff survey, relating to health and wellbeing, MSK and stress, in order to demonstrate the trusts commitment to staff health and wellbeing. **1b.** Changes in catering provision to reduce the fat, sugar and calorie content of food and drink items on trust sites. **1c** 70 % of frontline staff to have received their flu vaccination by the 28th February 2018.
National Physical Health	**2a**. Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses.	Dale Williams	**2a** To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: • Inpatient wards – 90% • All community based mental health services for people with mental illness (patients on CPA), excluding EIP services – 65% • EIP Services – 90% Audit of patient records to take

Specialist Learning Disabilities Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
	2b. Collaboration with primary Care Clinicians.		Place in Q4. 90% of patients to have either an up to date CPA, care plan or a comprehensive discharge summary shared with their GP. Audit to take place in Q2.
Recovery College for Medium and low secure patients	Education and training programmes to support recovery.	Fran Cairns	The establishment of a co developed and co delivered programmes of education and training to complement other treatment approaches in adult secure services.
Reducing Restrictive Practices within Adult Secure Services	The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, in order to improve service user experience whilst maintaining safe services.	Jennifer Kilcoyne	The overall aim is to develop an ethos in which people with mental health problems are able fully to participate in formulating plans for their well-being, risk management and care in a collaborative manner. As a consequence more positive and collaborative service cultures develop reducing the need for restrictive interventions.
Discharge and Resettlement	Reduction of length of stay in specialised MH Inpatient Services	Fran Cairns	This scheme is designed to achieve at least a 10% reduction in the current average length of stay.
Preventing ill health by risky behaviours – Alcohol and Tobacco	**Part a**. Tobacco screening **Part b.** Tobacco Brief Advice **Part c**. Tobacco referral and Medication Offer **Part d**. Alcohol screening **Part e**. Alcohol brief advice & referral	Dale Williams	Trust to demonstrate for all inpatient admissions: • Percentage of adult patients screened for tobacco and alcohol use. • Patient records to include status and referral as necessary. Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions.
Exit / Transition Strategy service users Moving to Community Settings	Developing a strategy to assist the transfer of inpatients to community services.	Lynne Kirwan	To support the transfer of patients on the Whalley to supported living in the community.

South Sefton Community Services Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
National Staff Health & Wellbeing	**1a**. Improving staff health and Wellbeing (staff survey). **1b**. Healthy food for NHS staff, visitors and patients. **1c**. Improving the uptake of flu vaccinations for front line staff within Providers.	1a. Dale Williams 1b. Dale Williams 1c Bridget Clancy	**1a**. A 5% improvement in the answer to 2 out of 3 questions on the staff survey, relating to health and wellbeing, MSK and stress, in order to demonstrate the trusts commitment to staff health and wellbeing. **1b.** Changes in catering provision to reduce the fat, sugar and calorie content of food and drink items on trust sites. **1c** 70 % of frontline staff to have received their flu vaccination by the 28th February 2018.
Supporting proactive and safe discharge	Improving the discharge process for patients.	Michelle Bilsbarrow	Collaboration with acute trusts to increase the proportion of patients discharged from acute trusts to their usual place of residence within 7 days of admission by 2.5% from the set baseline. This CQUIN is supported by the ICRAS work steam.
Improving the assessment of wounds	Improving the assessment of wound care for patients.	Kim Bennet	Target to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.
Preventing ill Health by risky behaviours – Alcohol and Tobacco	**Part a**. Tobacco screening **Part b**. Tobacco Brief Advice **Part c**. Tobacco referral and Medication Offer **Part d**. Alcohol screening **Part e**. Alcohol brief advice & referral	Catherine McGiveron	Trust to demonstrate for all inpatient admissions: • Percentage of adult patients screened for tobacco and alcohol use. • Patient records to include status and referral as necessary. Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions.

South Sefton Community Services Division			
CQUIN Indicator	**Summary:**	**Lead:**	**Deliverables**
Personalised care and Support Planning	Embedding personalised care and support planning for patients with long term conditions.	Michelle Bilsbarrow	CQUIN delivery over two years to embed personalised care and support planning for patients with long term conditions. This will enable those patients to have the skills, knowledge and confidence to self care, in order to manage their own health and live independently.

Financial Statement

84. The trust has six main commissioner contracts, each of which has its own national and local Commissioning for Quality and Innovation (CQUIN) schemes. The national CQUINs are mandated as part of the NHS standard contract. Local CQUINs are negotiated with commissioners in line with trust and Clinical Commissioning Group (CCG) local priorities. The commissioners allocate 2.5% of the contract value for the delivery of these schemes, which equated to £5.7m for the trust in 2017/18. The trust reported quarter four CQUIN performance to commissioners on the 30th April 2018 and commissioners are expected to confirm performance by the end of May 2018.

2.9 Care Quality Commission

Registration and CQC Ratings

85. Mersey Care is required to register with the Care Quality Commission and during 2017/18 there was 23 active locations registered with CQC with no conditions attached to registration.

86. The Care Quality Commission last inspected the Trust in March 2017, and the report following this inspection visit was published on 27 June 2017. The current CQC rating is GOOD following that process of inspection.

87. The CQC has not taken enforcement action against the Trust during 2017/18 and the Trust has not been subject to any in-depth enquiries or investigations by the Care Quality Commission during the reporting period.

88. CQC undertook an announced focused inspection of Mersey Care NHS Foundation Trust during March 2017 because:

    a) there had been a significant change in the Trust's circumstances. The Trust had acquired Calderstones NHS Foundation Trust on 1 July 2016;

    b) the inspection was to include high secure services as a new core service;

    c) CQC had to assess if the Trust had addressed some of the areas where they identified breaches of regulation at their previous inspection in June 2015.

89. During this focused inspection the CQC inspected the following core services provided by the Trust:

a) other specialist services: high secure services (Ashworth Hospital);

b) forensic inpatient/secure wards (medium/low secure);

c) wards for older people with mental health problems;

d) wards for people with learning disabilities and autism.

90. The CQC also looked at two additional non-core services:

a) learning disability and autism secure services;

b) substance misuse services.

91. The ratings of these specific services were published following inspected March 2017:

a) High Secure Services :Ashworth Hospital – Good;

b) wards for older people with mental health problems -Requires Improvement;

c) wards for people with Learning Disability or Autism -Requires Improvement;

d) Forensic Inpatient Secure (MSU/LSU)- Good;

e) Substance Misuse Services – Good;

f) Learning Disability and Autism Secure Services –Outstanding.

Requirement Notices

92. The Trust was issued with 6 requirement notices in respect of Regulatory Breaches, these are summarised as follows:

a) **Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect** At Wavertree Bungalow and the STAR unit;

b) **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** on wards for older people Wavertree Bungalow and the STAR unit;

c) **Regulation 15 HSCA (RA) Regulations 2014 Premises and Equipment** Scott Clinic;

d) **Regulation 17 HSCA (RA) Regulations 2014 Good governance** Trust wide Policies and the STAR unit.;

e) **Regulation 18 HSCA (RA) Regulations 2014 Staffing** Staff on wards for older people, STAR unit and the Bungalow;

f) **Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents** Oak ward, Boothroyd, Irwell ward and Heys Court.

93. These are described in detail in the published inspection report which can be found at http://www.cqc.org.uk/sites/default/files/new_reports/AAAG3923.pdf.

94. The Trust has responded as required with a provider action plan response that was accepted and confirmed by CQC in August 2017.

Other CQC Activity

95. The Trust has participated in two thematic reviews across partner agencies where CQC look at the 'whole systems approach' to care being delivered.

96. These reviews have consisted of a focussed review of S136 practices where Mersey Care was the lead, and a system wide review of older people's services across Liverpool with the Local Authority as lead.

97. From the CQC report received following the focussed review of S136 practices, it was noted that the Prenton Suite within Clock View contains a dedicated Section 136 suite. It comprised of two rooms for the use of people detained and brought to the hospital by the police under Section 136. The suite met the requirements of the Code of Practice and there were no specific actions for Mersey Care except to ensure that there was a clock available to view for patients using the suite.

98. The report regarding the system wide review across Liverpool has not yet been published; this report is expected on 5 May 2018.

99. During 2017/18 CQC also undertook a review of S134 – withholding patients' mail and telephone call monitoring. The report from CQC found that there was Good Practice and noted that Mersey Care NHS Foundation Trust's policies and procedures for the stoppage of mail and telephone call monitoring were in line with section 134 of the Mental Health Act, the Mental Health Act Code of Practice and the High Security Psychiatric Directions. CQC found that in all cases of withheld mail, staff had followed the trust policies.

100. Across Mersey Care inpatient services that are registered to provide care to patients under the Mental Health Act 9 1983) the Trust was subject to 23 unannounced Care Quality Commission/Mental Health Act inspections in 2017/18 of wards within local, secure and specialist learning disability services as part of their programme of inspections. These inspections consider the domains:

a) purpose, respect, participation and least restriction;

b) admission to the ward;

c) tribunals and hearings;

d) leave of absence;

e) general healthcare;

f) other areas such as environment, standard of food etc.

101. The CQC's Mental Health Act reports have all been responded to within agreed timescales and have shown in the vast majority of cases that previous issues raised have been acted upon appropriately. It is notable that in two areas there were no

actions identified as provider requirements by CQC – this is significant, given the wide remit of these visits.

102. However, the inspections have highlighted the following areas during recent reviews:

a) not all ward areas are able to clearly evidence that Care plans are being shared with service users;

b) not all ward areas are able to clearly evidence that patients' rights are being explained in accordance with the Code of Practice or Trust policy.

103. Completed provider action response plans have been sent to CQC for all ward areas describing the actions to be taken to address these shortfalls in practice.

104. In relation to wider Trust wide focus, there continues to be a particular focus on mortality reviews within the Trust, developing thematic reviews and undertaking detailed post death reviews following the guidance from the Mazars review report published in December 2015. There is a Trust Wide group that focuses on this area and learning from deaths to improve practice where this is possible.

105. During 2017/18 South Sefton Community Services was acquired by Mersey Care NHS Trust, this was previously part of Liverpool Community Hospital Trust and this organisation has a current registration status of: 'Requires Improvement'. There has been ongoing support and a focus on improvement within this service as a new division of the Trust, since acquisition in June 2017.

106. Further information about the Care Quality Commission registration status of Mersey Care can be found at: http://www.cqc.org.uk/directory/rw4.

Summary of CQC Inspection Findings 2017

Overall rating for services at this Provider	Good
Are Mental Health Services safe?	Requires improvement
Are Mental Health Services effective?	Good
Are Mental Health Services caring?	Good
Are Mental Health Services responsive?	Good
Are Mental Health Services well-led?	Good

2.10 Duty of Candour

107. Duty of Candour is ensuring all communication is open, honest and transparent, especially when related to a notifiable safety incident, as identified in Regulation 20 (Health and Social Care Act (2008) (Amendment) Regulations 2015).

108. Regulation 20 is a direct response to recommendation 181 and the aim of this regulation is to ensure that healthcare providers are open and transparent with service users and other "relevant persons" in relation to care and treatment and sets out requirements that must be adhered to when things go wrong.

109. This includes informing people of the incident and providing an apology, truthful information and reasonable support.

110. There must be a culture that encourages candour at all levels and should be central to organisational and personal learning.

111. The definitions of openness, transparency and candour used by Robert Francis in interpreting the regulation are:

a) ***Openness*** - enabling concerns and complaints to be raised freely without fear and questions asked to be answered;

b) ***Transparency*** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators;

c) ***Candour*** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

112. The Patient Experience/ PALS/Duty of candour Lead undertakes this work liaising closely with all clinical divisions to ensure that all appropriate incidents are identified as requiring the Duty of Candour process. This is undertaken though each clinical division's surveillance meeting.

113. The central management of this process ensures that investigators who are primarily clinical staff are supported to share the findings of reviews in a timely and professional manner. This change of process has ensured that all national targets are now being met. The capacity to do this work will be increased as the appointment of Mortality and Incident Practitioners.

114. The Quality Assurance Committee receives updates at every meeting regarding adherence to each of the steps within the Duty of Candour national guidance, this includes information on:

a) informing service users/ carers verbally that an incident has occurred;

b) providing a follow up letter which includes details of any review process that will occur;

c) sharing the outcomes of the review process with service users/ carers.

115. All actions are recorded on the Trust's Risk Management data base (Datix) as are copies of letters and incident reports.

a) since April 2017 over 280 patient safety incidents have been considered for, and assessed against the criteria for Duty of Candour. Duty of Candour has been applied to 52 incidents;

b) there were 35 deaths, 28 as a result of an incident and 7 identified as natural causes where there was a full RCA (root cause analysis) review undertaken;

c) there were 7 incidents with severe harm, including 4 self harm, 2 falls and a homicide;

d) of the 10 moderate harm incidents, 9 related to G3 pressure ulcers and one to a delay in treatment;

e) of the 52 incidents a family liaison manger was appointed in 47 cases, 1 person declined any contact or involvement, 4 contacted by clinicians;

f) an apology and letter was given all cases apart from 5 were there was no family or contact details, one declined all contact and one deemed not clinically appropriate due to palliative care and bereavement;

g) of the completed reviews 22 investigations have been shared, 5 declined and 5 there was no family or contact details, 20 reviews are on-going.

Duty of candour	Family liaison manager appointed	Apology / Letter	Report shared	On-going
52	**47**	**45**	**22**	**20**

116. Duty of Candour targets have been fully met within the organisation, this has been achieved through the development of a Duty of Candour lead role within the organisation we who has:

a) updated the policy and procedure;

b) provided training to staff, particularly in High Secure Services;

c) undertaken the role of Family Liaison Manager for the majority of incidents within the Local Division;

d) monitors incidents to ensure that those incidents that meet the criteria for Duty of Candour are moved through the agreed process.

117. The staff that are now in the newly developed role of Mortality and Incident Practitioner have now been trained to undertake the role of Family Liaison Manager under the supervision of the Duty of Candour Lead. This has ensured that the completion of processes are not disrupted due to holidays and sickness etc. The Trust has received positive feedback from patients and families regarding the way they are kept informed of investigations and the support they receive at inquests.

118. There are continued concerns regarding the time it takes to complete reviews and therefore feedback the findings to patients and their families, the improvement of this situation has been achieved through the appointment of the Mortality and Incident review team. Monitoring of all parts of the Duty of Candour process takes place via by regular reports to the Quality Assurance Committee.

	2017/18
Duty of Candour Incidents	**52**
Breakdown of Duty of Candour Incidents	**Total**
Deaths as a result of an Incident	28
Natural Causes	7
Total Deaths	35
Self-harm Incidents	4
Fall Incidents	2
Homicide Incident	1
Total Severe Harm Incidents	7
CAA Grade 3 Pressure Ulcers	9
Delay in Treatment	1
Total Moderate Harm Incidents	10

2.11 Data Quality Improvement Plans

119. Good quality information (that is information which is accurate, valid, reliable, timely, relevant and complete) is vital to enable individual staff and the organisation to evidence that they are delivering high quality/perfect care that supports people on their recovery journey, and to reach their goals and aspirations whilst keeping themselves and others safe.

120. Good quality information also enables the efficient management of services, service planning, performance management, business planning, commissioning and partnership working.

121. The Trust has a Corporate Data Quality Policy in place and a trust Data Quality Strategy which includes an agreed set of Data Quality Standards. The trust Data Quality Steering Group meets bi-monthly and oversees an annual Action Plan which also feeds into the Information Governance Toolkit requirements for Data Quality including the Annual Audit of Nationally Submitted Data Sets e.g. CDS, MHSDS.

122. The Trust's corporate Data Quality Team run regular validation routines on the trusts electronic health record systems and on the National Data Set submissions. Local and National Data Quality reports are used to validate and update data with key themes highlighted to Clinical Divisions for action.

123. The importance of Data Quality is also highlighted in Clinical Information Systems training along with the importance of Good Record Keeping.

Quality Report 2016/17

124. Mersey Care NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

a) which included the patient's valid NHS number was:

i) 99.9% for admitted patient care,

ii) 99.9% for outpatient care;

b) which included the patient's valid General Medical Practice Code was:

i) 99.7% for admitted patient care,

ii) 99.6% for outpatient care.

Latest data (SUS DQ dashboard) available from NHS Digital on 30 May 2017 relates to M12 2016/17 (April 2016 to March 2017

2.12 Information Governance

125. The Trust Information Governance compliance score 2017/18 was 89% (Green – satisfactory) with the Trust attaining a minimum level two in all standards. The Trust was also awarded "significant assurance" status following audit of the Information Governance Toolkit.

PART THREE – QUALITY INDICATORS

3.1 Quality Indicators

Quality Report 2017/18 Nationally Mandated Indicators (Section 2.3)

NHS foundation trusts are required to publish the data reported by the NHS Digital for each indicator for the reporting period, i.e. the 2017/18 financial year. For some indicators, no data or only partial year data is available for 2017/18 the latest data set should be published for last two reporting periods or data covering the minimum of a year.

The data reported below relates to the latest information available via the defined data sources as at 25 April 2018.

Comparisons are with other mental health / learning disability providers.

Mandated Indicator	Data period	Data Source	Mersey Care NHS Foundation Trust	National average	Highest national position	Lowest national position	Statement
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	Q1 2017/18	http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/	93.9%	96.7%	100.0%	71.4%	The Mersey Care NHS Foundation Trust considers that this data is as described for the following reasons: it has been submitted in accordance with detailed reporting local guidance informed by national reporting rules and advice taken from regulators over the years. The Mersey Care NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by establishing performance reports within its business intelligence system available to operational staff that enables ready identification of those due to be followed up and also enables scrutiny of any "breaches" to enable lessons to be learnt and practice changed if required to avoid similar situations occurring in future.
	Q2 2017/18		94.9%	96.7%	100.0%	87.5%	
	Q3 2017/18		90.6%	95.4%	100.0%	69.2%	
	Q4 2017/18		98.4%	95.5%	100.0%	68.8%	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	Q1 2017/18	http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/	88.9%	98.7%	100.0%	88.9%	The Mersey Care NHS Foundation Trust considers that this data is as described for the following reasons: it has been submitted in accordance with detailed reporting local guidance informed by national reporting rules and advice taken from regulators over the years. The Mersey Care NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by establishing performance reports within its business intelligence system available to operational staff that enables scrutiny of any "breaches" to enable lessons to be learnt and practice changed if required to avoid similar situations occurring in future.
	Q2 2017/18		94.0%	98.6%	100.0%	94.0%	
	Q3 2017/18		91.4%	98.5%	100.0%	84.3%	
	Q4 2017/18		100.0%	98.7%	100.0%	88.7%	

Mandated Indicator	Data period	Data Source	Mersey Care NHS Foundation Trust	National average	Highest national position	Lowest national position	Statement
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	2015	Dataset: 21. Staff who would recommend the trust to their family or friends (Q21d)	61%	58%	82%	37%	The Mersey Care NHS Foundation Trust considers that this data is as described for the following reasons: it has been obtained via the annual national NHS staff survey which is subject to ROCR approval. The Mersey Care NHS Foundation Trust has taken the following actions to improve this score, and so the experience of staff, by having established internal governance processes in all divisions to ensure appropriate review and response to results. This is supported by a programme of activities led by our workforce and organisational effectiveness teams and is monitored through the annual staff survey and quarterly Friends and Family Test results.
	2016		60%	61%	82%	45%	
	2017		63%	61%	84%	42%	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	2012	Indicator: 4.7 Patient experience of community mental health services	88.1	86.5	91.8	82.6	The Mersey Care NHS Foundation Trust considers that this data is as described for the following reasons; it has been obtained via the annual national community mental health service user survey which is subject to ROCR approval. The Mersey Care NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by the development of an internal patient experience survey across both inpatient and community services. The two clinical divisions have established internal governance process to ensure appropriate review and response to results. This is supported by review by a trust wide quality surveillance meeting on a monthly basis and review on a quarterly basis by the trust's quality assurance committee where specific areas of focus are identified.
	2013		89.3	85.8	91.8	80.9	

Mandated Indicator	Data period	Data Source	Mersey Care NHS Foundation Trust	National average	Highest national position	Lowest national position	Statement
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	April 2016 to September 2016	Dataset: 5.6 Patient safety incidents reported	4,664 incidents; 35.4 per 1000 bed days	2,963 incidents per organisation; 46 incidents per 1000 bed days	89 incidents per 1000 bed days	10.3 per 1000 bed days	The Mersey Care NHS Foundation Trust considers that this data is as described for the following reasons: It has been reported in accordance with the guidance laid down by the NRLS for recording patient safety incidents. The Mersey Care NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by developing local action plans to increase reporting levels as well as deploying technology driven reporting platforms to encourage reporting in community settings. Following the implementation of the trust's mortality committee, the trust is to commence incident reporting on all deaths for service users who have had contact with the trust. This will enable a review of all deaths to identify if they should be reported as patient safety incidents and be subject to further investigation. Historically, the requirement has been to report "unexpected deaths" only. Quality surveillance dashboards have been developed to provide live whole trust incident monitoring and alerts.
	October 2016 to March 2017		2,851 incidents; 22 per 1000 bed days	2,910 incidents per organisation; 41 incidents per 1000 bed days	88.2 incidents per 1000 bed days	11.2 per 1000 bed days	
	April 2016 to September 2016	Dataset: 5.6 Safety incidents involving severe harm or death	39 incidents resulting in severe harm or death (0.30 incidents per 1000 bed days)	33 incidents resulting in severe harm or death per organisation; 0.58 incidents per 1000 bed days	4.07 incidents resulting in severe harm or death per 1000 bed days	0.04 incidents resulting in severe harm or death per 1000 bed days	The Mersey Care NHS Foundation Trust considers that this data is as described for the following reasons: It has been reported in accordance with the guidance laid down by the NRLS for recording patient safety incidents. Following the implementation of the trust's mortality committee, the trust is to commence incident reporting on all deaths for service users who have had contact with the trust. This will enable a review of all deaths to identify if they should be reported as patient safety incidents and be subject to further investigation. Historically, the requirement has been to report "unexpected deaths" only. The Mersey Care NHS Foundation Trust is taking the following actions to improve this rate by using all data available to develop preventative strategies i.e. falls reduction strategy, "No Force First" and suicide reduction strategy. The trust has implemented a series of perfect care projects in relation to suicide prevention, physical health care and restraint.
	October 2016 to March 2017		74 incidents resulting in severe harm or death (0.57 incidents per 1000 bed days)	33 incidents resulting in severe harm or death per organisation; (0.46 incidents per 1000 bed days)	2.30 incidents resulting in severe harm or death per 1000 bed days	0.04 incidents resulting in severe harm or death per 1000 bed days	

3.2 Re-admissions

Quality Report 2017/18

126. The Quality Report reporting arrangements for 2017/18 includes an indicator on readmissions for all trusts. Review of the NHS Digital indicator portal for the quality account highlighted the following methodology for reporting (this was initially confirmed for the completion of the 2014/15 account, no change in methodology has subsequently been notified to the Trust).

127. To find the percentage of patients aged 0-15 years readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days of discharge: indirectly standardised percentage, <16 years, annual trend, P" (Indicator P00913) from the HSCIC Portal and select from the "Indirectly age, sex, method of admission, diagnosis, procedure standardised percentage" column.

128. To find the percentage of patients aged 16 years or over readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days of discharge : indirectly standardised percentage, 16+ years, annual trend, P" (Indicator P00904) and select from the "Indirectly age, sex, method of admission, diagnosis, procedure standardised percentage" column.

129. The latest version of both readmission reports were uploaded in December 2013 and the "Next version due" field states "TBC"

130. As Mersey Care N does not provide inpatients services for under 16 year olds, data for this indicator for the 0 to 15 year old patient group is not included

131. No data relating to Mersey Care is included in the "Emergency readmissions to hospital within 28 days of discharge: indirectly standardised percentage, 16+ years, annual trend, P" (Indicator P00904) report downloaded from HSCIC indicator portal. Data for mental health trusts is incomplete with only a small number of trusts allocated to the mental health cluster reporting any data. Therefore it is deemed inappropriate to include any data for this indicator in the Trust's 2016/17 Quality Account.

132. Dataset 3.16 (P01863) Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over provides readmissions information at CCG level but not provider level. Data comes from MHLDS (previously MHMDS). The latest version was published March 2016 and this is the only available data currently in the HSCIC Portal.

3.3 Performance against NHS Improvement's Single Oversight Framework Indicators

133. "In preparing the Quality Report for 2017/18, NHS Foundation Trusts are required to report on indicators that appeared in both NHS Improvement's Risk Assessment Framework and the Single Oversight Framework.

Performance has been reported for the ""Admissions to inpatient services had access to crisis resolution/home treatment teams"" indicator in Section 2.3 (the core mandated indicators) so is not repeated here in line with the guidance.

Please note that the indicators for mental health trusts are reported on a quarterly basis so this is how the data is presented here and the full year position (based on the arithmetic mean) is calculated on that basis."

CPA 7 day Follow-Up: This is reported nationally on a quarterly basis which is why the data published in the quality accounts is only quarterly so it aligns should anyone wish to compare. Commissioners wish to have oversight on this metric on a monthly basis which is why we report internally on this.

EIP: The data published in the quality accounts was quarterly i.e. Q4 2017-18 (Jan-March). I have therefore accessed the monthly EIP datasets from published data and this will be included in the quality accounts.

Indicator	Performance threshold	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Full year position
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	>=50%	72.97%	70.77%	63.63%	67.02%	68.60%
Improving access to psychological therapies (IAPT): Proportion of People completing treatment who move to recovery.	>=50%	35.00%	37.00%	37.00%	Not Available	36.33%
Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	>=75%	95.00%	94.00%	97.00%	Not Available	95.33%
Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	>=95%	99.00%	99.00%	100.00%	Not Available	99.33%
Inappropriate out-of-area placements for adult mental health services (OBDS) - External only	STP Trajectory from April 2018				0	0

Note - 2017/18 data not available until June 2018

Indicator	Threshold	Q4 2016/17
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards	>=90% green; <90% red	66.00%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services	>=90% green; <90% red	41.95%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)	>=65% green; <65% red	8.00%

3.4 Stakeholder Metrics

134. The following indicators have been selected in consultation with stakeholders and agreed by the Quality Assurance Committee, which is a committee of the Board, the indicators selected are presented for each of the following quality domains;

a) patient safety;

b) clinical effectiveness;

c) patient experience

Stakeholder Metrics

Theme	Indicator	Performance Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Patient Safety*	Incidents of Harm - Proportion of incidents that result in harm (classified as low, moderae, severe or death)	Green <=26.95% Amber<=31.62% Red >31.62%	10.31%	9.31%	13.15%	12.95%	12.93%	12.22%	11.14%	12.95%	13.26%	17.82%	10.39%	11.64%
	Safe Staffing - % of shifts filled by nurses against planned establishment (NHS England Fill Rate Measure/ CHPPD	% of shifts filled by nurses against planned establishment	105.19%	109.92%	108.69%	109.58%	105.24%	100.30%	112.62%	111.91%	106.71%	109.35%	108.59%	106.97%
Clinical Effectiveness	Number of Out of Area Placements - External "Inappropriate" Only	0	11	8	3	4	9	3	4	6	0	0	0	0
	Number of Out of Area Placements Occupied Bed Days - External "Inappropriate" Only	0	100	109	19	26	76	4	23	78	0	0	0	0
	Bed Occupancy - Number of Occupied Bed Days (including Leave) - Culmulative	Green 85% to 90% Amber <85% or >90% Red <80% or >95%	17,506	35,019	53,744	71,905	90,244	135,100	155,370	178,620	199,551	223,078	243,556	266,054
Patient Experience	Overall Patient Experience Score	Green >=95% Red < 95%	95.13%	95.35%	95.53%	95.18%	95.27%	94.46%	95.09%	95.35%	97.33%	96.09%	95.18%	93.25%
	Access to Services - Can you access services when you need them?	Green >=95% Red < 95%	91.89%	90.93%	92.86%	89.08%	92.69%	96.52%	92.95%	94.30%	95.30%	93.13%	92.98%	93.03%
	Involved in care - Have you been involved in the development of your care plan?	Green >=95% Red < 95%	96.38%	95.35%	98.16%	96.08%	96.80%	96.02%	95.00%	96.35%	98.88%	98.10%	93.57%	93.20%

* The third indicator Duty of Candour can be found within 2.10 of the report.

ANNEX 1
STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANISATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

COMMISSIONERS

NHS South Sefton Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group
Quality Account Statement 2017/18
Mersey Care Mental Health and Community NHS Foundation Trust

Liverpool, South Sefton, Southport and Formby and Knowsley CCGs welcome the opportunity to jointly comment on the Mersey Care NHS Trust Draft Quality Account for 2017/18. It is acknowledged that the submission to commissioners was draft and that some parts of the document require updating. Commissioners look forward to receiving the Trust's final version of the Quality Account.

We have worked closely with the Trust throughout 2017/18 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care. The Account reflects good progress on most indicators.

This Account indicates the Trust's commitment to improving the quality of the services it provides with commissioners supporting the key priorities for the improvement of quality during 2017/18 which were:

Priority 1: No Force First
Priority 2: Towards Zero Suicide
Priority 3: Improvements in Physical Health Pathways
Priority 4: A Just and Learning Culture
Priority 5: Reduction in Community Acquired Pressure Ulcers

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and what actions are needed to achieve these goals, in line with their Quality Strategy.

Through this Quality Account and on-going quality assurance process, the Trust clearly demonstrates their commitment to improving the quality of care and services delivered.

The Trust places significant emphasis on its safety agenda, promoting an open and transparent culture, and this is reflected with the work the Trust has undertaken under the "Sign up to Safety" agenda. Of particular note is the work the Trust has undertaken to improve outcomes on the following work streams:

- Mersey Care NHS Foundation Trust has been recognised by the Care Quality Commission as an exemplar case study for Reducing Restrictive Practice
- As at the end of December 2017, in relation to the zero suicide aim, the indicators reflect a very positive impact on the number of deaths by suicide following discharge at 3 days, 7 days and 3 months, with significant improvements on the previous two years.

- The Trust has worked closely with Mazars and Locktons to develop and establish a mortality review process. The Trust has also worked with acute hospital providers to further develop systems to share information - Mazars has recognised the Trust was one of the first organisations in their experience to do this.
- Level 1 suicide training has been undertaken by 88% of staff.
- There has been a significant increase in the number of patients using nicotine replacement therapy, which is now in line with the Trust target.
- Within the South Sefton Community Division, the Trust acknowledged that pressure ulcer prevention and management remains the highest clinical risk. The division continues to work with the Perfect Care team to embed the pressure ulcer reduction programme, and has reported no grade 4 pressure ulcers during 2017-2018.

Commissioners acknowledge the significant engagement work undertaken by the Trust in preparation for the transaction of Liverpool Community Health into Mersey Care on 1st April 2018. The CCGs look forward to working with the Trust in relation to the acquired community services and monitoring any quality related issues. The focus on pressure ulcer reduction and learning from deaths is an important focus for the organisation in 2018/19.

Commissioners are aspiring through strategic objectives to develop an NHS that delivers great outcomes, now and for future generations. This means reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

Liverpool CCG	**South Sefton CCG** **Southport and Formby CCG**	**Knowsley CCG**
Jan Ledward Chief Officer	Fiona Taylor Chief Officer	Dianne Johnson Chief Executive
Date 23.05.18	Date 21.05.18	Date 18.05.18

COMMISSIONERS

Note – awaiting formal feedback from West Lancashire commissioners.

HEALTHWATCH

Healthwatch Liverpool welcomes this opportunity to comment on the 2017-18 Quality Account for Mersey Care NHS Foundation Trust. This commentary relates to the contents of a draft Quality Account document provided by the Trust.
This commentary has also been informed by our ongoing engagement with Mersey Care during 2017-18. We received feedback about the Trust through our information and signposting service, partner organisations like the Liverpool Mental Health Consortium and members of our Student Health and Wellbeing Group, as well as via independent web-based resources such as www.careopinion.org.uk.

Additionally, Healthwatch Liverpool held Listening Events at Mersey Care in September 2017, visiting Baird House, the Life Rooms in Walton, and Talk Liverpool in the city centre to learn from people using the services what they thought was good and what improvements they would like to see. We spoke to 56 people who gave mostly positive feedback, especially about the staff. However, some less positive comments mentioned waiting times for appointments at Talk Liverpool, and the location of Baird House.

Healthwatch Liverpool is assured that the document provides a good summary of the quality of services provided during 2017 -18, and although not all priorities were met, overall we are of the view that the document shows that the Trust is continuing to improve the quality of its services.
We are pleased that good progress was made for most priorities with a mental health focus this year, including again on the 'No Force First' initiative, and that these will remain a priority for 2018-19. Priorities for the coming year have been set out with clear actions and targets identified.

We note that there was an audit to look at the impact of waiting times for Talk Liverpool's IAPT services on patient-related incidents of self-harm and suicide. Whilst, as the audit concludes, the waiting time by itself would not necessarily cause someone to harm themselves, individual feedback Healthwatch receives does indicate that long waiting times can have a negative impact on people's health and wellbeing, as well as their experience of care. There have been significant changes to the service offered in the past year and we are keen to work with Talk Liverpool to see how these changes have been experienced by people who use the service.

The Trust serves and is staffed by people from diverse communities, and Healthwatch was pleased to see that reflected in the document. We would always welcome more information in the Quality Account about any work that the Trust carries out to ensure its services are equitable for all patients.

With Liverpool community health services having joined Mersey Care from April 2018, it is welcome to see that all staff will be trained in suicide awareness. Hopefully a similar crossover of knowledge will help the Trust to reach its targets to improving physical health pathways. The organisation now has a unique opportunity to provide more holistic care to people and to improve both physical and mental health and wellbeing. Healthwatch Liverpool is looking forward to ongoing regular engagement with the Trust in 2018-19 in order to be able to monitor the progress of both quality and equality considerations for the services provided in Liverpool.

OVERVIEW AND SCRUTINY COMMITTEE

Sefton Council

Sefton Council,
Town Hall,
Trinity Road,
Bootle
L20 7AE
24 May 2018
Ref: DAC/CP
Tel: 0151 934 2254
Email: debbie.campbell@sefton.gov.uk

Joe Rafferty
Chief Executive
Mersey Care NHS Foundation Trust
V7 Building
Prescott
LIVERPOOL
L34 1PJ

Dear Mr Rafferty

Mersey Care NHS Foundation Trust – Quality Account 2017/18

As Chair of Sefton Council's Overview and Scrutiny Committee (Adult Social Care and Health), I am writing to submit a commentary on your Quality Account for 2017/18.

Members of the Committee met informally on 17 May 2018 to consider your draft Quality Account, together with representatives from Healthwatch Sefton and from the local Sefton CCGs. We welcomed the opportunity to comment on your Quality Account and I have outlined the main comments raised in the paragraphs below.

Jenny Hurst, Deputy Director of Nursing, attended from your Trust to provide a presentation on the Quality Account and to respond to our questions on it.

We had chosen to comment on the Trust's draft Quality Account, insofar as it relates to community health services in the south of the Borough, as we were aware that the Trust took over as the Provider comparatively recently.

We received a presentation from the Trust representative outlining the following:-

- Refreshing the Operational Plan;
- CQUIN Update;
- Priority Areas 2017/18;
    - No Force First;
    - Zero Suicide;
    - Improvements in Physical Health;
    - Just and Learning Culture;
    - Reduction in Community Acquired Pressure Ulcers;
- Priority Areas 2018/19;
    - Reducing Restrictive Practice;
    - Towards Zero Suicide;
    - Improvements in Physical Health Pathways;
    - Just and Learning Culture;
    - Reduction in Community Acquired Pressure Ulcers;
    - Learning from Deaths; and
- Next Steps.

We asked questions and commented on learning from deaths; zero suicide; the need to include a glossary of terms for the draft Quality Account; staff turnover and the need to provide for succession planning. There are a few references to “NHS Sefton CCG” within the draft Quality Account and these will need to be amended to reflect that it is “NHS South Sefton CCG”.

We considered the Priority Area of Zero Suicide and agreed that one suicide is not acceptable. We asked whether more needs to be done in schools and heard that work is being undertaken to generally reduce the stigma of raising this issue.

We heard that a multi-agency event is to be held during June 2018 to discuss the transition for children into adult services, not just for mental health but for physical health too, and I have asked whether I could attend this event.

We discussed the fragmented nature of the NHS and the delivery of services by different organisations and heard that greater integration is beginning to occur, with incidents being investigated jointly.

The difficulties for some older people in reporting their symptoms on admission to hospital was raised and we were advised that the Community Teams work with nursing homes in relation to the dementia pathway and care of older people, and that dehydration in particular is a sign to look out for in older patients.

Our Healthwatch colleagues referred to historical instances of abuse of adults within care homes and we discussed the need to change the culture to prevent and report on any risks or incidents. We heard that whilst education plays a part in this regard, strong leadership is required and that investment is needed to trial certain approaches and adjust/improve them, as necessary. Our CCG representative also commented that everyone has different perceptions of different practices in different areas and also emphasised the need for strong leadership too.

Reference was made to the need for honest and open investigations to be undertaken when things go wrong, together with the need to support relevant staff in such instances, as it is recognised that the vast majority of staff do not intend to cause harm. I commented that it will be interesting to see the development next year of learning from mistakes in a non-blame context.

We were pleased to hear about the Priority Area of Reduction in Community Acquired Pressure Ulcers and the good results achieved in south Sefton in this regard. In relation to community services in south Sefton, we hope that good progress will be maintained and continued into next year.

We asked about progress in the re-location of the Scott Clinic and we were advised that whilst a lot of work is underway to move medium secure services and learning difficulties too, a number of staff are not particularly enthusiastic about the move.

Under the heading of “Research and Development” within the Quality Account, our Healthwatch colleagues referred to the genomics studies supported by Mersey Care and asked what the purpose of this research is; where will the information go; and how is it controlled. We were advised that information would be sought and provided to us on this.

Similarly, Healthwatch referred to the Care Quality Commission inspection during 2017 and we were advised that detail regarding the improvements required would be sought and provided to us on this.

In relation to the CQUIN indicator of Health and Wellbeing, we asked about the implementation of healthy eating and heard about the need to address obesity and type 2-diabetes in both staff and patients. We heard that staff and patients are offered healthy eating options and staff are encouraged to be role models by not eating takeaway meals on the wards. Jenny offered to share the food strategy with us. We also discussed the difficulties associated with enforcing smoke-free policies outside NHS buildings.

We very much appreciated the opportunity to scrutinise your draft Quality Account for 2017/18 and were grateful for attendance at our meeting by the Trust representative. I hope you find these comments, together with the suggestions raised at the meeting, useful.

Please accept this letter as my OSC`s formal response to your Quality Account.

Yours sincerely,

Councillor Catie Page
Chair of Sefton Council's Overview and Scrutiny Committee (Adult Social Care and Health)

ANNEX 2
STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

1. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

   a) the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance;

   b) the content of the Quality Report is not inconsistent with internal and external sources of information including:

      i) Board minutes for the period April 2017 to the 24 May 2018,

      ii) papers relating to quality to the Board over the period 1 April 2017 to the 24 May 2018,

      iii) feedback from commissioners dated 18, 21 and 23 May 2018,

      iv) feedback from governors dated 12 April 2018,

      v) feedback from local Healthwatch organisations dated 19 March 2018,

      vi) feedback from the local Overview and Scrutiny Committee dated 24 May 2018,

      vii) the Trust's 2017complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,

      viii) the national patient survey dated 15 November 2017,

      ix) the 2017 national staff survey dated November 2017,

      x) the Head of Internal Audit's Annual Opinion over the Trust's control environment dated March 2018,

   c) the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

   d) the performance information reported in the Quality Report is reliable and accurate;

   e) there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

   f) the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

g) the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Report regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

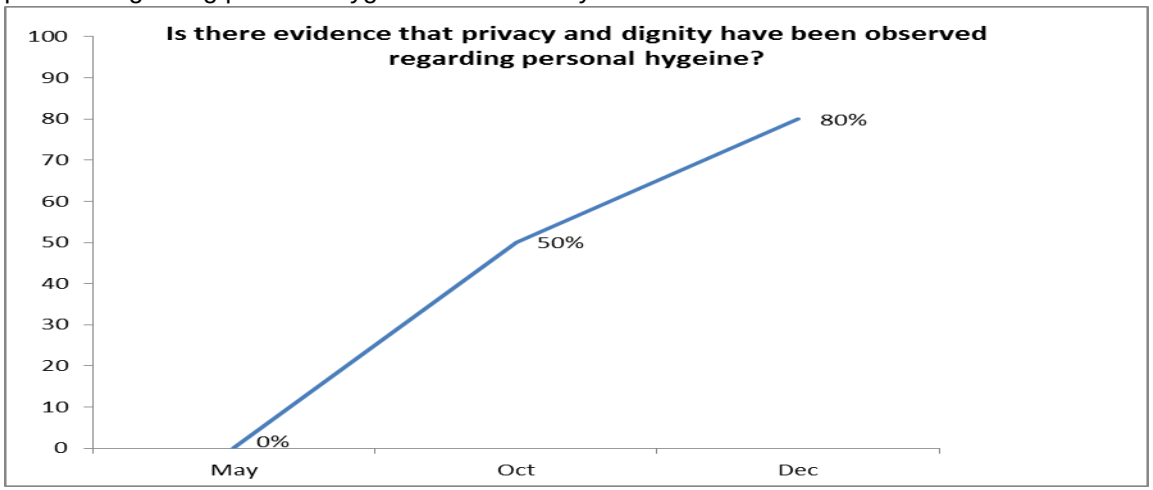
By order of the Board of Directors:

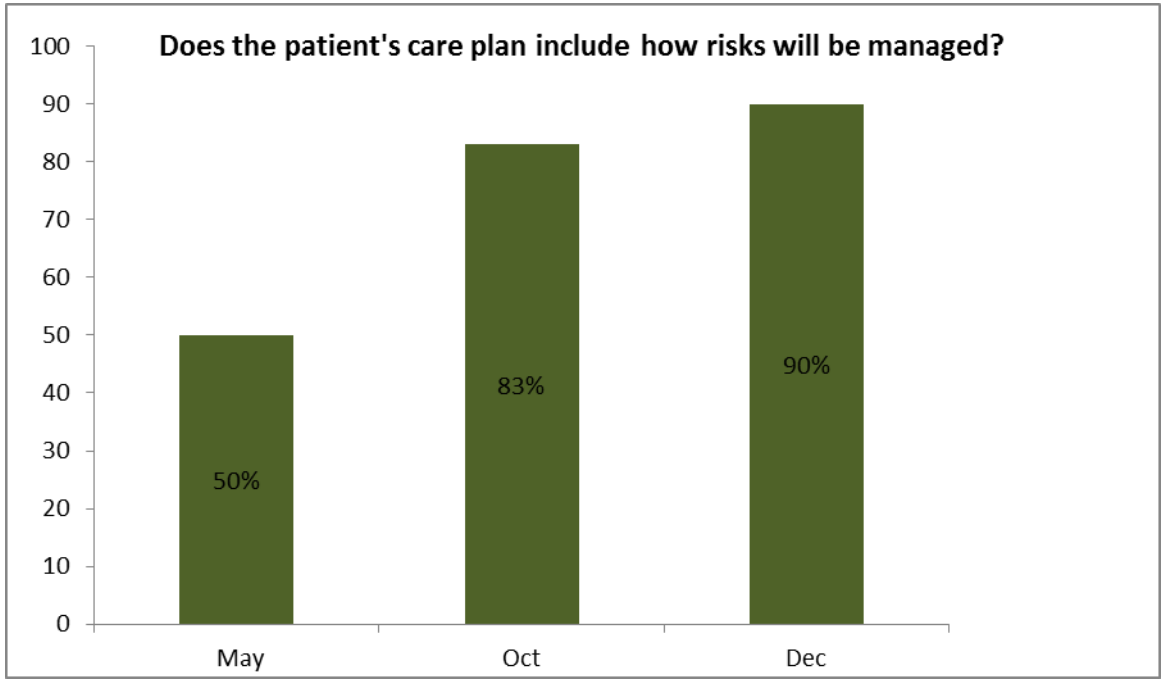
	24/05/18
Beatrice Fraenkel **Chairman**	**Dated**
	24/05/18
Joe Rafferty **Chief Executive**	**Dated**

CLINICAL AUDIT REPORT 2017/18

	TRUST WIDE		
	Topic	**Outcomes**	**Actions/Improvements**
1.	**Record Keeping** Trust wide audit aiming to provide assurance that the organisation has a good standard of compliance with the Health Records Policy & Procedure (IT06) and can comply with Information Governance Toolkit Version 14.1.0 in respect of Clinical Information Assurance.	Findings: Standard 1: • 80% were entered during the shift where the contact / visit took place; a 1% decrease in compliance compared to last year (81%) Standard 2a: • 99% reflected the purpose of the contact / visit; a 2% increase in compliance compared to last year (97%) Standard 2b: • 99% have visible next steps / plans of care; a 51% (significant) increase in compliance compared to last year (49%) Standard 3: • 87% were written in plain English including the correct use of grammar and spelling; a 4% decrease in compliance compared to last year (91%) Standard 4: • 65% contained evidence of counter-signature (65%); a 40% increase in compliance compared to last year (1%) Standard 5: • 99% contained abbreviations, which were understood (99%); a 2% increase in compliance compared to last year (97%)	Each Division has a breakdown of data relating to their own area. The emphasis for action and improvement is countersignature of entries by staff that cannot authorise a clinical note. There is a review of the electronic patient records systems in use to review how automation can improve compliance.

	TRUST WIDE		
	Topic	**Outcomes**	**Actions/Improvements**
2.	**Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)** This is audited using the NHS, North Of England, North West, Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) Adult Policy.	There was 100% compliance with all elements of the policy except: Standard 6: Has the person been informed of the decision? According to the Resuscitation Council (UK) decisions relating to cardiopulmonary resuscitation (2016) state that “Discussion about dying and CPR must not be avoided to try and spare the patient distress unless there is good reason to believe that such distress will cause them harm.” The audit found that in 2 cases the decision was discussed with the patient. In both cases the patients had already completed an advance directive to refuse life saving treatment. However, in the remaining cases 5 the patient lacked capacity to make the decision and this was documented on the electronic DNACPR form.	There was a full compliance with the requirements of this procedure, so no explicit actions were required. For future audits this will be incorporated into the work of the Mortality review team

	SECURE DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
3.	**Supportive Observations** The aim of the audit is to determine whether Mersey Care's Supportive Observations policy (SD04) all wards. This audit forms part of a wider study into therapeutic observations and forms part of the baseline assessment. There is a pilot study underway reviewing supportive observations. This audit was repeated in October and December 2017 to monitor the effectiveness of the pilot.	There have been 3 audits completed relating to the Supported Observation Policy in: • May 2017 • October 2017 • December 2017 Overall compliance with the standards for care planning was generally acceptable scoring on average around 75%. The area with limited compliance was around privacy and dignity considerations as part of risk management arrangements and significant events included into the care plan. The focus has been on orientating staff to the requirements of the policy and ensuring an MDT focus on addressing the issues. The following graphs demonstrate how the teams have improved their performance. This chart demonstrates the ward's improvement in the area of privacy and dignity being observed for patients regarding personal hygiene – from a very low base.  	

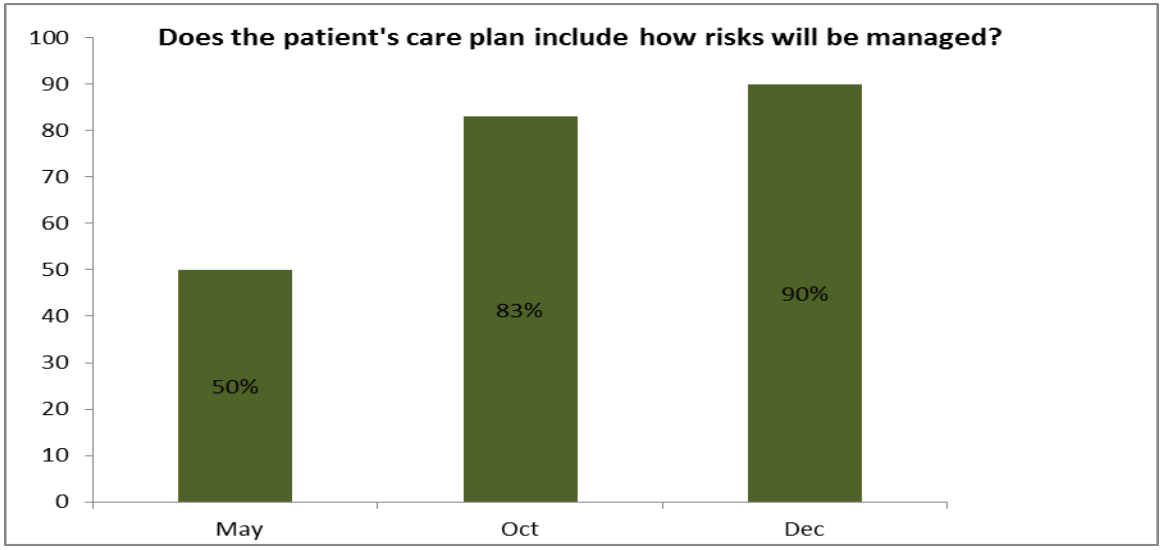
	SECURE DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
		This graph demonstrates the improvement of both wards in the area of the patient's care plan detailing any significant events or dates (e.g. anniversaries).  	
4.	**Red Bag Audit** The aim of this audit was to monitor performance of regular checks of emergency bag (ILS/AED) equipment which are kept on wards in Secure Division against the agreed standards.	There was high levels of compliance with standards relating to content of bags and visual checks on the equipment.	The areas for improvement were signposting to emergency ILS bags and contents lists being present in the bags. This has been factored into routine monitoring at ward level to improve compliance, and is part of regular reviews.

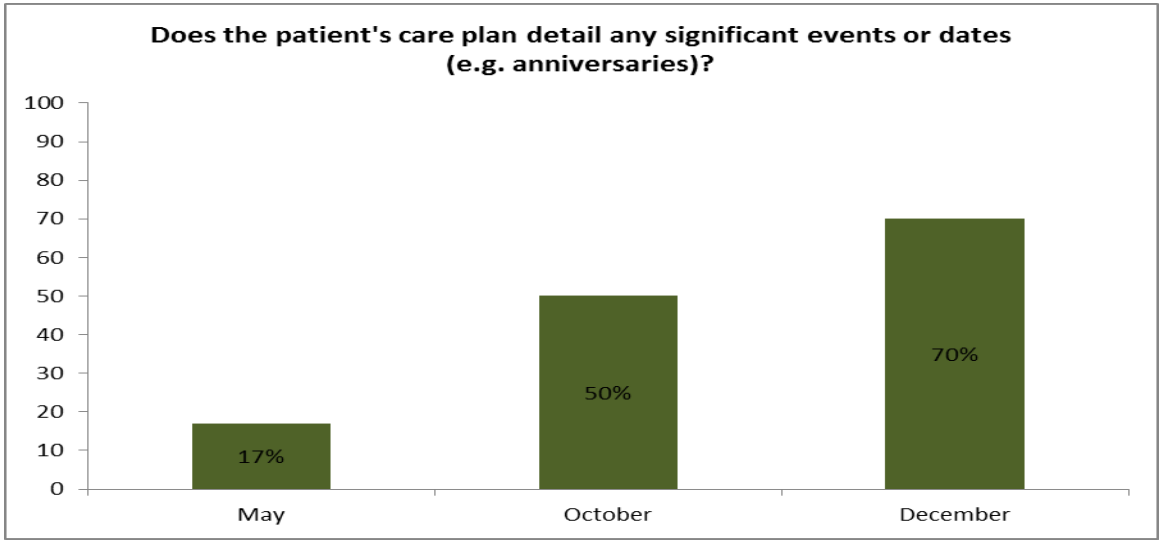
	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
5.	**Clinical Audit on clinical handover at nurse shift change** The aim was to ensure compliance with the standards as outlined in Mersey Care Policy Number SD49 Clinical Handover at Nurse Shift Changes.	The table below outlines the compliance with the standards for the five wards audited. There was significant assurance around compliance with the standards. Ward A and Ward B were fully compliant, however Ward D had limited assurance. The focus of the action plan has been to continue to communicate the importance of the handover standards. There is a requirement for teams to locally audit the quality of handovers five times per month and compliance is monitored via the self-assessment process. This audit is to be repeated in 2018	

Standard – Appendix B taken from Mersey Care Policy Number SD49 Clinical Handover at Nurse Shift Changes	Ward A	Ward B	Ward C	Ward D	Ward E	**Overall**
1. The nurse in charge must handover to the whole of the next team on duty at the beginning of that shift.						
2. The person in charge of handover facilitation should ensure that the team are aware of any new locum or agency members of the team.						
3. The hospital Matron/designated staff member should ensure that there is safe and secure storage and archive of the electronic version of each handover sheet.						
4. Handover should be no longer than 30 minutes in the Community Mental Health and no more than one hour in Inpatient Mental Health Services.						
5. All handovers should have a pre determined format and structure to ensure adequate information exchange.						
6. Shift Leader is responsible for keeping a record of the names and designation of attendance at each handover.						
7. Handover includes information about current service users/clients.						
8. Staff responsible for handover facilitation should highlight those service users with particular problems and information should include dependency and risk scoring						
9. Handover should highlight the high risk areas for physical and recovery focussed approach to care.						
10. Handover should include on-going management plans, and whether or not these have been arranged.						
11. Any Do Not Attempt Resuscitation decisions should be communicated and recorded.						
12. Any outstanding tasks and expected completion times should be handed over and delegated.						
Overall Compliance by Ward						

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
6.	**Dual Diagnosis** The audit reviewed the treatment and management of people with co-morbid substance misuse and mental health	• 65% had an agreed care plan in place for the treatment and management of substance misuse - **An increase on the 33% for quarter 1**. • 85% of patients with an agreed care plan for the treatment and management of substance misuse, had been reviewed - **An increase on the 58% for quarter 1**. • 2% included harm reduction intervention regarding the risk of overdose in relation to lowered tolerance levels and the mixing of substances– **An increase on the 0% for quarter 1**. • 69% included information regarding the care and provision provided by specialist drug or alcohol services– **An increase on the 50% for quarter 1**. • 81% included actions to refer the service user to drug and/or alcohol support specialist services as part of the discharge plan– **An increase on the 17% for quarter 1**	Action taken last year was to identify a Dual Diagnosis lead. The actions taken to date are: • Cascading the audit and its findings to ward managers. • The provision of support to ward teams from psychology and psychology assistants • Identifying the clinical training requirements to support ward staff with dual diagnosis
7.	**Diabetes: Compliance with NICE Quality Standard 6**	Findings: • 0/3 of Ward A patients on oral hypoglycaemic agents had a capillary blood glucose measurement • 0/1 of Ward B patients on oral hypoglycaemic agents had a capillary blood glucose measurement • 0/1 of Ward B patients on insulin had a capillary blood glucose measurement	The actions taken to date are: • Review of diabetic status to be done at every ward review; all episodes of hypoglycaemia or hyperglycaemia taken into account, and acted upon if they haven't been already • All wards to have a named person and designation regarding who to contact for advice regarding diabetes management – there should be a written agreement regarding this and all members of staff should be

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
		• 1/1 of Ward C patients on insulin and oral hypoglycaemic agents had a capillary blood glucose measurement but was after their meal • 0/1 of Ward D patients on oral hypoglycaemic agents had a capillary blood glucose measurement due to the monitoring sheet being misplaced • 1/1 of Ward E patients on insulin and oral hypoglycaemic agents had a capillary blood glucose measurement but was after their meal • 3/3 of Ward F patients on oral hypoglycaemic agents had a capillary blood glucose measurement before their meal so were fully compliant • 3/3 of Ward G patients on oral hypoglycaemic agents had a capillary blood glucose measurement before their meal so were fully compliant	made aware • Blood pressure monitored at least DAILY in all diabetic patients. If not on appropriate antihypertensive therapy, this should be started as an inpatient • ALL diabetic inpatients to have frequency of capillary blood glucose (CBG) monitoring determined at their FIRST ward review, and is at the discretion of the consultant • All CBG monitoring to be consistent – i.e. before meals • Ensuring serum cholesterol / triglyceride profile has been done on admission bloods, if not done within the last 6 months • If serum cholesterol high, statin therapy should be started as an inpatient unless contraindicated. • Levels should be checked every 6 months – if no longer an inpatient, can be at discretion of GP upon discharge • Ensure any hyperglycaemia, AND hypoglycaemia is acted upon and documented. • For persistent hyperglycaemia, advice should be sought from Diabetes Specialist Nurses at local acute trusts. • For hypoglycaemia, the Trust's hypoglycaemia protocol should be used and followed as much as reasonably practical

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
8.	**Supportive Observations** The aim of the audit is to determine whether Mersey Care's Supportive Observations policy (SD04) all wards. This audit forms part of a wider study into therapeutic observations and forms part of the baseline assessment. There is a pilot study underway reviewing supportive observations. This audit was repeated in October and December 2017 to monitor the effectiveness of the pilot	There have been 3 audits completed relating to the Supported Observation Policy in: • May 2017 • October 2017 • December 2017 Overall compliance with the standards for care planning was generally acceptable scoring on average around 75%. The area with limited compliance was around risk management arrangements and significant events included into the care plan. The focus has been on orientating staff to the requirements of the policy and ensuring an MDT focus on addressing the issues. The following graphs demonstrate how the teams have improved their performance. The graph below demonstrates the ward's improvement in respect of the patients' care plans including information on how the risks will be managed.  	

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
		The graph below demonstrates the improvement of both wards in the area of the patient's care plan detailing any significant events or dates (e.g. anniversaries).  *It should be noted that the sample sizes are quite small, which can allow for some significant changes in the percentages recorded*	

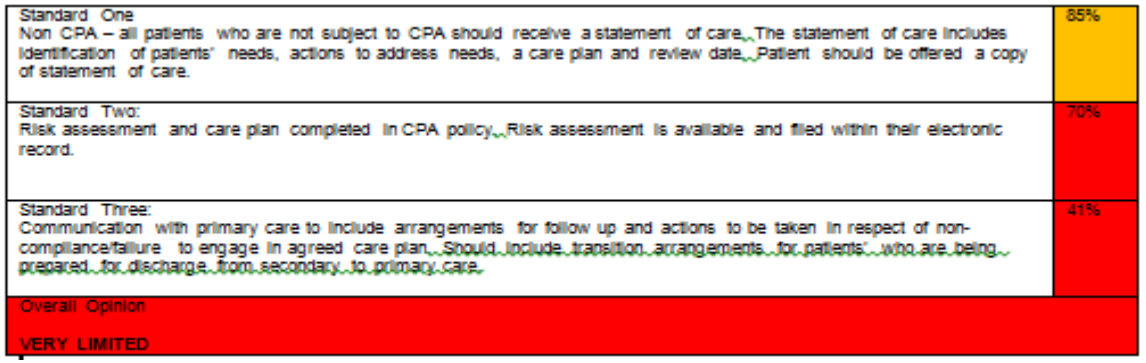
	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
9.	**Schizophrenia – Local Division Community CPA Physical Healthcare** This audit was planned and scheduled to assess compliance with the standards on the National Audit of Schizophrenia.	The overall compliance score was around 5% no real change on last year's results. Calculated on the premise that all patients received screening in line with requirements of the Lester Tool, and subsequently received the appropriate intervention. Development a new community physical health pathway with improved specialist staff to support access and record keeping systems and an intranet portal developed to support the physical health pathway. 

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
10.	**IAPT Impact of Waiting Times** The purpose of this repeat audit is to assess the impact of wait times on self-harm and Trust zero suicide initiatives in Talk Liverpool Improving Access to Psychological Therapies (IAPT) services for people with common mental health conditions	• To date and consistent with the finding of the 2015/16 audit, the patient related incidents of suicide and self harm reported from Talk Liverpool suggest that these occur at all stages of the care pathway with no relationship to the length of time waiting. • By far the largest proportion of reported deliberate self harm occurred before referral. • This would suggest that, as stated in the audit report for 2015/16, rather than assuming a straightforward relationship between length of wait and deliberate self harm, a more nuanced conclusion might be that any relationship that exists for individuals between waiting for treatment and self-harm reflects a complex interplay of factors, as implied by more than one person's attempt at suicide immediately before starting therapy	• Work has been done to address waiting time times to second treatment sessions • Work has been done to enhance assessment of suicide • Talk Liverpool have committed to providing all staff a range of clinical discussions training sessions following team meetings. • Talk Liverpool have provided all staff with Risk Assessment Guidance including screening, assessment, and management of suicide. • Guidance on clinical note taking on IAPTus is in the process of being written. This will include how to record risk, and completion of risk alerts. • Clinical Risk procedures flow chart and urgent call rota provided for staff. • Encouragement for GPs to make a referral on a patients behalf for those with current risk • Talk Liverpool have worked to improve their website (where patients will make their online referrals). The website includes information on self-help resources and how to access urgent help.
11.	**GP Correspondence**	For Community patients: • 55% had discharge correspondence sent within 10 days, although 16% contained the relevant documents within Clinical Pathways but they had not been copied into patient documents. Therefore, the Clinical Audit team cannot be sure that the copy which has gone/may have gone to the GP is the original copy if not seen in Patient Documents and therefore could not	There is a full programme of work reviewing the provision of administrative support to both inpatient and community teams. In parallel the backlog of letters has been outsourced to bring all correspondence in line with the NHS contract requirements

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
		mark them as passing the audit. • 83% contained all the relevant information with the area with the lowest compliance being information around services provided and information around cardio metabolic monitoring. Inpatients: • 83% had discharge correspondence sent within 24 hours; the issue being letters were not headed 'faxed to GP'. • 75% contained all the relevant information with the area with the lowest compliance being information around services provided, information around cardio metabolic monitoring, discharge plan and infection information	
12.	**Consent to Medical Treatment** This audit is based upon consent for examination or treatment based upon 2009 DH guidance, and focussed on the Electro Convulsive Therapy (ECT) suite within Local Division.	All standards were fully compliant with the exception of: • No field on the current consent form to capture the religion of the patient. • signed consent form missing from record • patients not having a record of receiving information about ECT	The following actions have been taken: • Update referring consultants on the importance of ensuring all parts of the ECT paperwork are complete • Review ECT paperwork to ensure that unnecessary data in not being requested • Ensure that RiO system properly records the consent process for ECT
13.	**Red Bag Audit** The aim of this audit was to monitor performance of regular checks of emergency bag (ILS/AED) equipment which are kept on wards in Local Division against the agreed standards.	This was completed Trust wide on all wards across secure and local division. There was high levels of compliance with standards relating to content of bags and visual checks on the equipment. The areas for improvement was signposting to emergency ILS bags and contents lists being present in the bags.	The areas for improvement were signposting to emergency ILS bags and contents lists being present in the bags. This has been factored into routine monitoring at ward level to improve compliance, and is part of regular reviews.

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
14.	**Care Programme Approach (CPA) and Clinical Risk** The audit aim was to review the most recent CPA 07 Care Plan or Statement of Care to monitor the standard of documentation and to measure whether Care Planning is provided in accordance with agreed standards	Findings for CPA Patients:	

Standard One All patients to have a care plan which is reviewed at least annually and is filed within their electronic record. Details of care plan should be consistent with PbR cluster pathway guidelines.	87%
Standard Two: There should be evidence that a copy of the care plan has been offered to the Service User.	80%
Standard Three: Carers and relatives must be involved in care planning, with the Service User's consent.	58%
Standard Four: Care plan should include interventions to ensure achievements of outcomes consistent with 'No health without mental health' are agreed with the Service User.	82%
Standard Five: Outcomes are recovery focused and build on individual strengths, improving quality of life and include reference to employment, accommodation and social relationships as appropriate.	93%
Standard Six: There should be evidence that clear information, which is culturally appropriate, has been given to the Service User to support individual choice.	83%
Standard Seven: There should be evidence that the Service User has been supported to use a personal health budget where appropriate.	70%
Standard Eight: The care plan/statement of care should have a contingency plan which includes contact telephone numbers and action to be taken in the event of a crisis.	100%
Standard Nine: Evidence that advanced statements are captured as part of CPA.	6%
Standard Eleven: Risk assessment and care plan completed in CPA policy. Risk assessment is available and filed within their electronic record.	80%
Standard Twelve: Communication with primary care to include arrangements for follow up and actions to be taken in respect of non-compliance/failure to engage in agreed care plan. Should include transition arrangements for patients' who are being prepared for discharge from secondary to primary care.	34%
Standard Thirteen: Arrange peer review by external team.	0%
Overall Opinion VERY LIMITED	

<table>
<tr><th></th><th colspan="3">LOCAL DIVISION</th></tr>
<tr><th></th><th>Topic</th><th>Outcomes</th><th>Actions/Improvements</th></tr>
<tr><td></td><td></td><td colspan="2">For Non CPA Patients
 

The actions taken to date are:
• Share the findings of the audit shared with all respective Community Managers and Clinical Leads.
• A supervision case management audit template developed for Team Managers to use with Care-Co-ordinators.
• Community caseloads reviewed to include monitoring of CPA caseload.
• Re-Audit the CPA Standards quarterly to monitor progress</td></tr>
<tr><td>15.</td><td>Dementia First Diagnosis Carers Support/Post Diagnostic Support
The audit will aim to demonstrate compliance of Key Performance Indicator target achievement for the following KPI's:
• 97% of carers of service users with Newly Diagnosed Dementia will have a preliminary assessment of their needs and referred for a detailed assessment by relevant agencies where appropriate.
• 97% of service users newly diagnosed with dementia and their</td><td>Findings:
• 25% carers of service users with Newly Diagnosed Dementia had a preliminary assessment of their needs and were referred for a detailed assessment by relevant agencies where appropriate.
• 100% of service users newly diagnosed with dementia and their carers (if applicable) were offered a post diagnostic support group or equivalent.
• 25% of all identified carers were offered a Carers Assessment and/or directed to social care for assessment of Carers Support/Breaks.</td><td>These results have been discussed within the teams and remedial action plans in development</td></tr>
</table>

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
	carers (if applicable) will be offered to attend a post diagnostic support group or equivalent. • 97% of all identified carers will be offered a Carers Assessment and/or directed to social care for assessment of Carers Support/Breaks		
16.	**Communication/Outpatient Letters Including Dementia Statement about carers needs** The audit will aims to demonstrate compliance with KPI: 97% of Outpatient/Clinic letters for service users diagnosed with Dementia will include a statement of carers needs	Findings: Standard 1: Communication - Outpatient Letters (target 95%) • 78% of All Outpatient correspondence/letters to contain the recommended minimum dataset. Standard 2: Communication - Outpatient Letters (target 95%) • 81% of All Outpatient correspondence/letters to contain the recommended minimum dataset. • Standard 3: Communication Dementia - A statement about carers' needs, will be part of all service users with a diagnosis of Dementia assessment and follow up letters (target 97% • 62.5% of Outpatient/Clinic letters for service users diagnosed with Dementia will include a statement of carers needs	These results have been discussed within the teams and remedial action plans in development

<table>
<tr><th></th><th colspan="3">LOCAL DIVISION</th></tr>
<tr><th></th><th>Topic</th><th>Outcomes</th><th>Actions/Improvements</th></tr>
<tr><td>17.</td><td>Risk Assessments on Admission
The audit aim was to monitor whether clear risk assessments and risk management plans are being completed at the point of decision to admit.</td><td>Findings:
82% had a CPA 05 Risk Assessment updated/completed prior to admission. Of the 18% of patients who did not have a Risk Assessment updated/completed prior to admission
10% were completed by the ward staff on the day of admission
5% were completed by ward staff day after admission
3% did not have their risk assessment updated</td><td>The audit findings have been shared widely with Liaison Services and Single Point of Access to ensure that the requirement to update risk assessment prior to admission is fully understood.

This audit is to be repeated in 18/19 and the scope increased to include ‘stepped up care’</td></tr>
<tr><td>18.</td><td>Nutritional Screening and Care Planning (Adapted MUST tool)
The audit aim was to ensure that all new admissions are screened within 72 hours of admission to comply with Local and National guidelines, to ensure all patients have a care plan and all high risk patients are referred to the Dietetic team.

The audit will also aim to provide a brief snap-shot audit of all in-patient wards in order to monitor that the following have been correctly documented:
All patients have a Physical Health – Observations 3 form completed upon admission</td><td colspan="2">Findings:
Key Performance Indicator 1 - Keeping Nourished: MUST Tool Assessment within 3 Days (target 95%).<table><tr><th>Quarters 1 and 2 combined</th><th>Number of patients who had a MUST tool assessment within 3 days</th><th>%</th><th>Above or below the 95% KPI target</th></tr><tr><td>April 2017 to September 2017 inclusive</td><td>1088/1124</td><td>96.80%</td><td>+1.80%</td></tr></table>
Key Performance Indicator 2 – Keeping Nourished: MUST High Score Care Plan offered (target 99%)<table><tr><th>Quarters 1 and 2 combined</th><th>Number of High Risk 2+ patients who had a MUST high score care plan in place</th><th>%</th><th>Above or below the 99% KPI target</th></tr><tr><td>April 2017 to September 2017 inclusive</td><td>117/132</td><td>88.64%</td><td>-10.36%</td></tr></table></td></tr>
</table>

<table>
<tr><th></th><th colspan="3">LOCAL DIVISION</th></tr>
<tr><th></th><th>Topic</th><th>Outcomes</th><th>Actions/Improvements</th></tr>
<tr><td></td><td>

- All patients have a BMI recorded (and for it to be recorded correctly).
- All patients have a MUST score (and for it to be recorded correctly).
- All patients have a CPA 06 Care Plan completed upon admission.

All High Risk patients are referred to the dietician

</td><td colspan="2">

Key Performance Indicator 3 – Spell Admissions for Service Users with High MUST Score (2+) Referred to Dietician (target 99%).

<table>
<tr><th>Quarters 1 and 2 combined</th><th>Service Users with High MUST Score (2+) who were referred to Dietitian</th><th>%</th><th>Above or below the 99% KPI target</th></tr>
<tr><td>April 2017 to September 2017 inclusive</td><td>123/214</td><td>57.48%</td><td>-41.52%</td></tr>
</table>

Physical Health – Observations 3 form

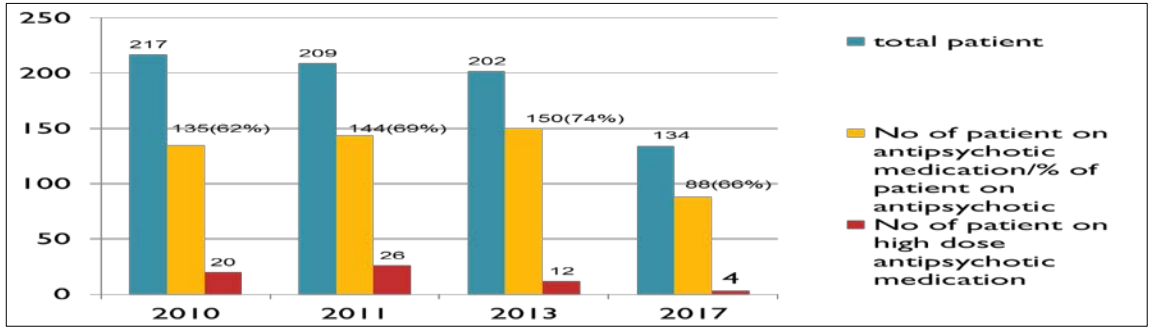
- All 51 patients had a Physical Health – Observations 3 form completed upon admission (100%).
- On the Physical Health – Observations 3 form the patient's height was recorded on all 51 occasions (100%).
- On the Physical Health – Observations 3 form the patient's BMI was recorded on all 51 occasions (100%).
  - 39 had their BMI correctly recorded (76%).
  - 12 did not have their BMI correctly recorded (24%).
- On the Physical Health – Observations 3 form the patient's MUST score was recorded on 50/51 occasions (98%)
  - 44 had their MUST score recorded within 3 days of admission (94%)
  - 3 did not have their MUST score recorded within 3 days of admission and this resulted in breaches (6%).
  - 3 patients were excluded due to timing of audit (6%)
  - 35 patients had their MUST score correctly recorded (70%).
- All 51 patients had a CPA 06 Care Plan completed upon admission (100%)
  - 36 had their Care Plan updated correctly (70%).
  - 5 did not have their Care Plan updated correctly (10%).
  - 10 did not have their MUST score recorded on their care plan (20%).

These results have been discussed within the teams and remedial action plans in development.

</td></tr>
</table>

	LOCAL DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
19.	**Early Intervention in Psychosis (EIPN) (CCQI)** The self assessment provides services with the opportunity to review their practice against a core set of standards which includes an assessment of their ability to offer NICE-recommended interventions, deliver timely assessment and collect appropriate outcome measures. Services will be able to benchmark themselves against other services	The Early Intervention in Psychosis Network works with services to assure and improve the quality of mental health care for people experiencing a first episode of psychosis. Participating services are able to benchmark their practice against similar services and demonstrate the quality of care they provide. The Trust submitted a review of the full caseloads at the time of audit of all Consultant Psychiatrist.	Analysis is still awaited from Royal College of Psychiatrists
20.	**National Audit of Psychosis (NCAP)** This audit was the first audit in a three-year improvement cycle. This is part of the National Audit Programme hosted by Royal College of Psychiatrists. The audit focuses on the following key areas: • Physical health • Health promotion • Prescribing practice • Psychological treatments • Access to crisis care	The Trust submitted 100% of the required sample	Analysis is still awaited from Royal College of Psychiatrists

	SPECIALIST LEARNING DISABILITY DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
21.	**Epilepsy Management in Learning disabilities (Assessment and Treatment Unit for Learning Disabilities)** Compliance with NICE Guidance 137	• Identified 20 patients who had a diagnosis of epilepsy mentioned in the notes • Requested GP summaries and letters from neurology specialists from GP for each patient • Completed the assigned audit tool for each patient. Diagnosis of epilepsy confirmed by Specialist 12/20 (60%) • Of all patients, only 2 had official ICD-10 coding (10%) • 8/20 (40%) are under review under Neurologist • Only 5/20 patients had an Epilepsy section in their 'Acute care plan' • Of those, 3/5 had vague details regarding the seizures but none including all the information required. • Only 5/20 patients had an Epilepsy section in their 'Acute care plan' • Of those, 3/5 had vague details regarding the seizures but none including all the information required. • Evidence of prolonged seizures: 5/20 • Number of Emergency care plan for prolonged seizures: 2/20, of those with evidence of prolonged seizures 2/5. • Only 1 care plan had all the essential details needed.	Recommendations: • Epilepsy care plan and risk assessment to be created by the MDT when a patient with epilepsy is admitted to the ward; to include contact details of the patient's epilepsy specialist nurse. • If evidence of prolonged or repeated seizures ensure there is an emergency care plan in place • Ensure that all staff involved are aware of the care plan and where to find it on Epex. • A local template or checklist has been developed to ensure consistency in the content of each epilepsy care plan based on NICE clinical guideline 137 recommendation 1.3.1. The plan to be reviewed on at least annually

		• No patients had evidence of prescribed rescue medications whilst on ward (now changed) and there was no documentation on EPEX relevant to rescue medications	
	SPECIALIST LEARNING DISABILITY DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
22.	**High Dose Antipsychotic Prescribing & Monitoring** To review/evaluate the current practice of prescribing and monitoring of the High Dose Antipsychotic(HDA) in the Mersey Care Whalley (LD Division).	Findings: In this current audit(2017): • of the 4 patients on HDA were on PRN in combination with other antipsychotic medication and the PRN has been used within last 2-3 weeks. • 2 of 4 patients on HDA was on regular dose of Oral Antipsychotic above BNF limit. • 1 of 4 patients on HDA was on combination of Depot Injection and oral antipsychotic as regular medication. • A significant number of patients on HDA medication have been on these regimes for • months with only approx. • 100% had the treatment and care plan that mentioned about HDA.  • 100% compliance in most of the standard noted in 2017. • 80% compliance used as threshold for good compliance-(set in the previous audit). • Routine bloods done in the last 3 - 6 months • Regular physical observations done in the last 3 months • However, recording in Care note still remains inconsistent and found in different places(medication tab, ICP). Not all monitoring sheet been uploaded. • Capacity assessment/T2/SOAD documentation noted to improve significantly	

	SOUTH SEFTON COMMUNITY DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
23.	**Improving the assessment of wounds** The audit will facilitate the implementation of CQUIN indicator 10 which is focused on increasing the number of wounds which have failed to heal after 4 weeks to receive a full wound assessment	Findings: • The overall compliance with all the requirements of patient assessment was 59%. There were compliance issues with using a holistic assessment tool, recording the duration of the wound, and making specialist referrals. • The overall compliance with specific wound assessment was 72%. There were compliance issues with wound mapping and recording the odour of the wound	Actions taken in respect of: • LCH Skin care team (under SLA) to assess current wound assessment guidelines for compliance with National minimum data set for wound assessment (2017) and amend tools for clinical use • Skin Care Service to develop and implement booklet/diary inserts detailing all wound pathways for ease of reference for staff in Mersey Care • Skin Care service to launch a prevention of infected wound pathway for Mersey Care • DN and Treatment Room team leads to review the baseline of wound care training • Clinical Locality Lead to co-ordinate and establish a locality training plan with Skin Team and share any developed and implemented new wound assessment e-learning package • Skin Care Service to introduce developed competencies for Health Care assistants for use in Mersey Care SSCSD • DN and Treatment Room team leads should undertake random spot check audits on Wound assessments for new patients carried out by their teams • Factors that can delay wound healing and to be considered as part of the wound assessment • The division in conjunction with the Skin Team will produce a glossary of terms to assist nursing staff in completion of these two sections of the wound assessment tool. • Criteria for referral to specialist Skin and other relevant

			services to be re-shared with DN and Treatment Room Nursing teams • South Sefton Community Division to explore and move towards implementation of digital photography to promote accuracy of wound assessment
24.	**Cellulitis Audit (South Sefton Community Services)** The aim of the audit is to determine where the referrals are received from, i.e. GP or Secondary care, adherence to new guidelines and following the change to medication how many patients required their IV antibiotics or oral antibiotics extending	Findings: • All were referred by a GP (100%). None came from a hospital. • 40% patients needed their IV antibiotics extended and all had the number of days it needed extending by recorded. • There were 3 inappropriate referrals were made for management of skin conditions: o 1 – Patient has been admitted to hospital with infected leg ulcer o 1 – Patient was unable to consent to treatment o 1 – No reason documented.	These results have been discussed within the team and the importance of following the standards emphasised by the Team Leader
25.	**Community Matron Clinical Records Audit (South Sefton Community Services)** The aim of the audit is to show that the following risk assessments have been completed by a Community Matron and recorded on Emis Clinical system within the last 3 months prior to the audit being undertaken. • FRAT • MUST • WATERLOW	• 50% had a FRAT assessment completed and recorded in Emis in the three months prior to the audit date • 62% had a MUST assessment completed and recorded in Emis in the three months prior to the audit date • 60% had a WATERLOW assessment completed and recorded in Emis in the three months prior to the audit date	These results have been discussed within the team and remedial action plan in development

	SOUTH SEFTON COMMUNITY DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
26.	**District Nursing and Treatment Room** **Nurse Bag Audit (South Sefton Community Services)** The core aims and objectives of the Audit are: • To understand how nursing bags support the delivery of planned and un-planned treatments in a changeable home location, to ensure that nurses are carrying the essential equipment and tools in nursing bag to the benefit of patients they treat. • To recognise opportunities for new product development and to collectively identify the clinical and design performance necessities needed for a 21st century nursing bag.	There was 38 required items in the bag ranging from equipment, dressings and emergency drugs. Only 1/59 bags had all the 38 required items and 27/59 had all the required documentation e.g. assessment tools.	The South Sefton Community Services are reviewing the audit results and have introduced regular checks. The audit is to be repeated in 2018/19.
27.	**Clinical Audit on Patient Group Directions (PGDs) used for the supply / administration of medicines to patients** The aim of this audit is to assess the skills and competencies and maintaining practices standards in relation to PGDs.	In relation to: • Management of PGDs 2/11 in operation had been suspended and 6/11 were due for review. • Training 5/11 practitioners had not been trained or had on-going review of competency There was full compliance in relation to the standards associated with: • Medication administration • Risk management	Actions taken in respect of: • Team Leaders to ensure all relevant staff are appropriately trained in relation to PGD's applicable to the service • Team Leaders to ensure all relevant staff are continually re-assessed within the agreed timeframes in relation to PGD's applicable to the service • Re-audit to be undertaken as part of 2018/19 audit plan.

		• Storage • Documentation • Inspection Overall good compliance	
	SOUTH SEFTON COMMUNITY DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
28.	**Clinical Content** **Sefton Community Respiratory Team** The audit will aim establish current practice and create a baseline regarding the quality of the clinical content of case notes of patients within the Community Respiratory Team (CRT). The objective is to identify what education/training needs are required to improve the clinical content of case notes of patients within the CRT, and improve patient care.	Findings: • Statement 1 - All case notes should contain a minimum dataset of information relating to the presenting complaint – 97% compliance • Statement 2 – All case notes should contain a minimum dataset of information relating to the recording of Past Medical History – 94% compliance • Statement 3 – All case notes should contain a minimum dataset of information relating to Medications prescribed for the patient – 100% compliance • Statement 4 – All case notes should contain a record of any Allergies the patient may have – 100% compliance • Statement 5 – All case notes should contain a record of any Review of Systems appropriate to episode of Care – 97% compliance • Statement 6 – All case notes should contain an up to date record of any observations relevant to the episode of care – 100% compliance • Statement 7 – All case notes should contain information that a Full Respiratory Examination has been made – 100%	These results have been discussed within the team and remedial action plan in development.

		compliance • Statement 8 – All case notes should contain a Management Plan – 100% compliance • Statement 9 – All case notes should contain information on New Respiratory Medication which has been prescribed for Exacerbation – 88% compliance • Statement 10 – All case notes should contain an up to date record of any Risk Assessments relevant to the episode of care – 86% compliance • Statement 11 – All case notes should contain information on relevant Patient Group Directives (where applicable) which may be in place - 74% compliance • Statement 12 – All case notes should contain information on any referral discussions relevant to the episode of care – 83% compliance • Statement 13 – All case notes records should contain information that is clear, legible, relevant, concise and appropriately dated and should include the following elements – 96% compliance	
29.	**Pressure Ulcer** The purpose of this audit is to enhance adult patient safety across Community Physical Health services. Trend information is important in judging the success of treatment and in identifying deterioration in pressure ulcer care and a patient's clinical condition.	Findings: • Standard 1: completeness of incident details – 100% compliance • Standard 2: completeness of clinical information in relation to pressure ulcer – 96% compliance • Standard 3: completeness of assessment and in relation to pressure ulcer – 90%	These results have been discussed within the teams and remedial action plans in development.

		compliance. Issues of concern are completion of Waterlow and repositioning schedule. • Standard 4: Compliance with of wound and pain management and in relation to pressure ulcer – 82% compliance. Issues of concern are completion pressure ulcer grade category, recording of pain and completion of pain chart. • Standard 5: Compliance with shared decision making tool if patient refuses optimal treatment – 90% compliance. Issues of concern are not documenting shared decision making • Standard 6: Compliance with recording the outcome of the investigation into the incidence of the pressure ulcer – 67% compliance. Issues of concern are not documenting if the pressure ulcer was avoidable or not. • Standard 7: Compliance with recording the learning from the investigation into the incidence of category 3/4 pressure ulcer – 20% compliance. Issues of concern are not documenting and/or sharing any learning from the review	

	SOUTH SEFTON COMMUNITY DIVISION		
	Topic	**Outcomes**	**Actions/Improvements**
30.	**Sefton Community Services: Adult I/V Therapy Team - Infection Control** The aim of the audit, as stated on the audit proposal form, is to determine the adherence to the new guidelines, and following the change to the medication - how many patients required their I/V antibiotics or oral antibiotics extending. The audit tool has been devised in line with Nice Guidelines (CG 139), and the I/V antibiotic policy and CINS guidelines.	Findings: • Q1: Was the dressing to PICC/Midline/Hickman/ Portacath/Cannula satisfactory on discharge from hospital? – 91% compliant • Q2: Was the site inspected daily and documented in VIP/VIAD during the course of treatment? – 95% compliant • Q3: Was there any sign of clinical infection during the course of treatment? – 95% compliant • Q4: Was there any sign of allergic reaction to the dressing at any time during the course of treatment? – 86% compliant • Q5: Was Aspeptic technique used for the duration of the treatment? – 95% compliant • Q6: Was the exit site cleaned weekly? – 82% compliant • Q7: Is Chlorhexidine 2% used to clean exit site? – 95% compliant • Q8: Was a needle free device used during the episode of treatment? - 100% compliant • Q9: Was there any redness or swelling evident on the limb with PICC/ Hickman/Portacath/Cannula during the course of treatment? – 95% compliant	These results have been discussed within the teams and remedial action plans in development.

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Mersey Care NHS Foundation Trust

Annual Accounts 2017/18

Annual Report and Accounts 2017/18

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

Contents

Independent auditor's report to the Council of Governors of Mersey Care NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Mersey Care NHS Foundation 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 Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

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 NHS foundation trust annual reporting manual 2017/2018; 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 Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

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:

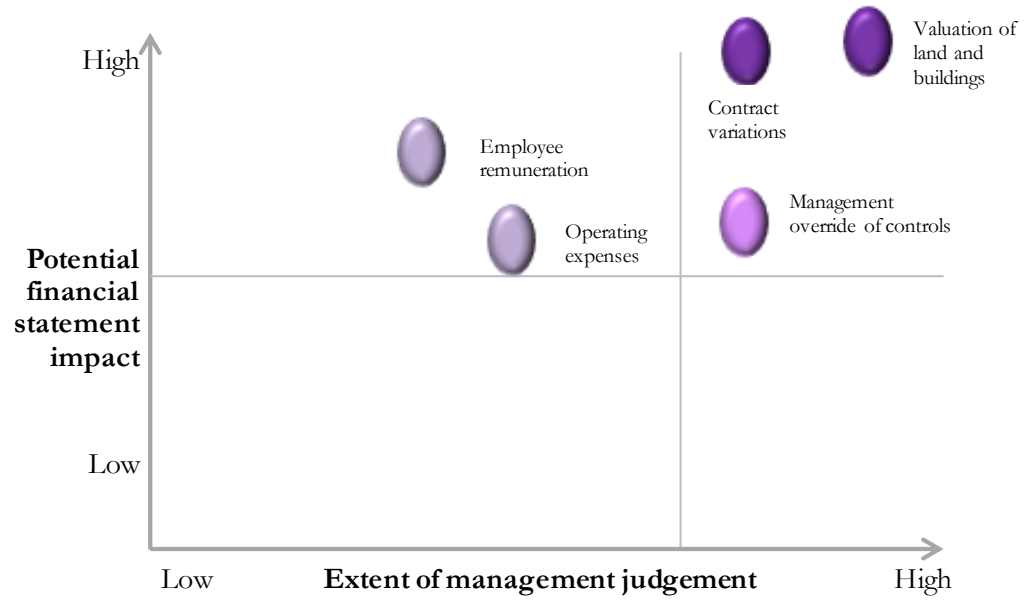
- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's 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.

Overview of our audit approach

- Overall materiality: £4,723,000, which represents 1.75% of the Trust's gross income;
- Key audit matters were identified as:
    - Contract variations
    - Valuation of land and buildings
- We have tested the Trust's material income and expenditure streams and assets and liabilities covering 90% of the Trust's income, 85% of the Trust's expenditure and 80% of the Trust's net assets.

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter	How the matter was addressed in the audit
Contract variations Approximately 82% of the Trust's income is from contracts with NHS Commissioners for patient care activities. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities that are provided in addition to the contract (contract	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognising income from block contract arrangements for appropriateness; • gaining an understanding of the Trust's system for accounting for income from contract variations and evaluating the design of associated controls; • testing, on a sample basis, income from contract variations to signed contract variations, invoices or other supporting

Key Audit Matter	How the matter was addressed in the audit
variations) are subject to verification and agreement by the commissioners. There is a risk that income recognised in the accounts for these additional services has not been agreed by Commissioners. We therefore identified the occurrence and accuracy of income from contract variations as a significant risk, which was one of the most significant assessed risks of material misstatement.	evidence such as correspondence from the Trust's commissioners. • testing, on a sample basis, income from additional non-contract activity to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners. The Trust's accounting policy on income is shown in note 1.3 the financial statements and related disclosures are included in note 3 **Key observations** We obtained sufficient audit evidence to conclude that: • the Trust's accounting policy for income from patient activities is in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18 and has been properly applied; and • income from contract variations is not materially misstated.
Valuation of land and buildings The Trust revalues its land and buildings on an annual basis to ensure that the carrying value is not materially different from the fair value. This represents a significant estimate by management in the financial statements. Management have engaged the services of a valuer to estimate the fair value as at 31 March 2018, including consideration of the assets acquired in relation to the provision of community services in Sefton. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. We therefore identified valuation of land and buildings as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • evaluating management's processes and assumptions for the calculation of the estimate, including the instructions issued to the valuation experts and the scope of their work; • consideration of the competence, expertise and objectivity of the valuation expert; • assessing the overall reasonableness of the valuation movement; • discuss with the valuer the basis on which the valuation has been carried out, in particular any changes from the prior period; • challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding; testing revaluations made during the year to ensure they are input correctly into the Trust's asset register and that the resulting accounting entries have been posted correctly in the financial statements; • evaluating the assumptions made by management for any assets not revalued in year, to understand how management satisfied themselves there was no material change in carrying value. The Trust's accounting policy on valuation of land and buildings is shown in note 1.6 to the financial statements and related disclosures are included in note 14.1. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation of land and buildings was appropriate and the assumptions and processes used by

Key Audit Matter	How the matter was addressed in the audit
	management in determining the estimate were reasonable; • the valuation of land and buildings disclosed in the financial statements is reasonable.

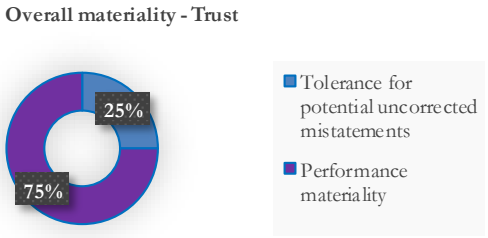
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£4,723,000 which is 1.75% of the Trust's gross income. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in the Trust's income streams. The benchmark for the materiality calculation has changed for the current year to income as the Trust's income base has increased following the acquisition of the community services in Sefton. This has led to a higher level of materiality than the level determined for 31 March 2017 which reflects the increase in activity for the Trust and the fact that this year is a 12 month accounting period compared with 11 months for the prior period.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	Our approach is to carry out procedures to ensure that all significant related party transactions and amounts of director's remuneration have been disclosed in the accounts and to test the accuracy of any unusual transaction disclosures above 1.75% of the total values reported.
Communication of misstatements to the Audit Committee	£235,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and in particular included:

- Gaining an understanding of and evaluating the Trust's internal control environment including its IT systems and controls over key financial systems;
- Assessing whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- Assessing the reasonableness of significant accounting estimates made by the Chief Executive as Accounting Officer;
- Testing, on a sample basis, all of the Trust's material income streams covering 90% of the Trust's income;
- Testing,, on a sample basis, for 85% of the Trust's expenditure;
- Testing, on a sample basis, property plant and equipment and 80% of the Trusts other assets and liabilities.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages **1 to 117 (draft)**, 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 of the Trust 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 resources 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.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable set out on page 43 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit committee reporting set out on page 47 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance.

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 does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. 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.

Our opinion on other matters required by the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting 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 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 Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities set out on pages 45 and 46, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the 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 the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

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

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

Responsibilities of the Accounting Officer

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

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

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources 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 Mersey Care NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Michael Thomas

Michael Thomas
Director
for and on behalf of Grant Thornton UK LLP

Royal Liver Building
Liverpool
L3 1PS

24 May 2018

Foreword to the accounts

Mersey Care NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Mersey Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Joseph Rafferty**
Job title **Chief Executive**
Date **24 May 2018**

Statement of Comprehensive Income

	Note	2017/18 £000	11 months ending 31 March 2017 £000
Operating income from patient care activities	3	253,293	205,272
Other operating income	4	23,288	25,376
Operating expenses	5, 7	(272,407)	(252,505)
Operating surplus/(deficit) from continuing operations		**4,174**	**(21,857)**
Finance income	10	84	71
Finance expenses	11	(2,495)	(2,541)
PDC dividends payable		(4,303)	(4,576)
Net finance costs		**(6,714)**	**(7,046)**
Other (losses)	12	(161)	(484)
Gains arising from transfers by absorption	33	3,554	54,337
Surplus / (deficit) for the year from continuing operations		**853**	**24,950**
Surplus / (deficit) for the year		**853**	**24,950**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(6,084)	(30,504)
Revaluations	15	7,449	19,085
Total comprehensive income for the period		**2,218**	**13,531**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	1,014	470
Property, plant and equipment	14	196,383	189,906
Investment property	16	1,375	1,375
Trade and other receivables	20	109	110
Total non-current assets		**198,881**	**191,861**
Current assets			
Inventories	19	377	370
Trade and other receivables	20	17,312	14,874
Other investments / financial assets	17	-	400
Cash and cash equivalents	21	19,497	21,553
Total current assets		**37,186**	**37,197**
Current liabilities			
Trade and other payables	22	(20,407)	(15,515)
Borrowings	23	(670)	(652)
Provisions	25	(3,296)	(3,259)
Other liabilities	22	(143)	(117)
Total current liabilities		**(24,516)**	**(19,543)**
Total assets less current liabilities		**211,551**	**209,515**
Non-current liabilities			
Borrowings	23	(28,912)	(29,581)
Provisions	25	(22,561)	(23,324)
Total non-current liabilities		**(51,473)**	**(52,905)**
Total assets employed		**160,078**	**156,610**
Financed by			
Public dividend capital		80,217	78,967
Revaluation reserve		58,493	55,441
Other reserves		59,907	59,907
Income and expenditure reserve		(38,539)	(37,705)
Total taxpayers' equity		**160,078**	**156,610**

The notes on pages 237 to 284 form part of these accounts.

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

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**78,967**	**55,441**	**59,907**	**(37,705)**	**156,610**
Deficit for the year	-	-	-	853	**853**
Transfers by absorption: transfers between reserves	-	2,023	-	(2,023)	**-**
Other transfers between reserves	-	(336)	-	336	**-**
Impairments	-	(6,084)	-	-	**(6,084)**
Revaluations	-	7,449	-	-	**7,449**
Public dividend capital received	1,250	-	-	-	**1,250**
Taxpayers' equity at 31 March 2018	**80,217**	**58,493**	**59,907**	**(38,539)**	**160,078**

Statement of Changes in Equity for the 11 month period ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
At start of period for new FTs	**54,149**	**49,257**	**59,907**	**(26,234)**	**137,079**
Surplus for the year	-	-	-	24,950	**24,950**
Transfers by absorption: transfers between reserves	18,818	19,054	-	(37,872)	**-**
Other transfers between reserves	-	(1,451)	-	1,451	**-**
Impairments	-	(30,504)	-	-	**(30,504)**
Revaluations	-	19,085	-	-	**19,085**
Public dividend capital received	6,000	-	-	-	**6,000**
Taxpayers' equity at 31 March 2017	**78,967**	**55,441**	**59,907**	**(37,705)**	**156,610**

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 trust. 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.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Other reserves
The 'Other reserves' relate to the equity received when Ashworth Hospital Authority was transferred to the trust in April 2002.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of Mersey Care NHS Foundation Trust, the predecessor trust (Mersey Care NHS Trust), Calderstones Partnership NHS Foundation Trust (acquired 1 July 2016) and South Sefton Community Services (acquired 1 July 2017).

Statement of Cash Flows

	Note	2017/18 £000	11 months ending 31 March 2017 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,174	(21,857)
Non-cash Income and expense:			
Depreciation and amortisation	5.1	5,741	7,067
Net impairments	6	9,659	34,655
(Increase) / decrease in receivables and other assets		(1,808)	1,164
Increase in inventories		(7)	(12)
Increase / (decrease) in payables and other liabilities		4,551	(728)
Increase / (decrease) in provisions		(968)	1,333
Net cash generated from operating activities		**21,342**	**21,622**
Cash flows from investing activities			
Interest received		84	71
Purchase of intangible assets	13.1	(850)	(336)
Purchase of property, plant, equipment and investment property		(16,593)	(12,089)
Net cash used in investing activities		**(17,359)**	**(12,354)**
Cash flows from financing activities			
Public dividend capital received		1,250	6,000
Capital element of finance lease rental payments		(257)	(235)
Capital element of PFI, LIFT and other service concession payments		(394)	(274)
Interest paid on finance lease liabilities	11.1	(524)	(528)
Interest paid on PFI, LIFT and other service concession obligations		(1,918)	(1,444)
PDC dividend paid		(4,456)	(5,515)
Net cash used in financing activities		**(6,299)**	**(1,996)**
Increase / (decrease) in cash and cash equivalents	21	**(2,316)**	**7,272**
Cash and cash equivalents at 1 April - brought forward		**21,553**	**-**
Cash and cash equivalents at 1 April - restated		**21,553**	**-**
Cash and cash equivalents at start of period for new FTs		**-**	**10,677**
Cash and cash equivalents transferred under absorption accounting	21	**260**	**3,604**
Cash and cash equivalents at 31 March		**19,497**	**21,553**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, 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

The Board of Directors have considered the key issues and risks to support the preparation of these accounts on a going concern concept.

The Board of Directors have found that there are no material uncertainties that may cast significant doubt on its ability to continue as a going concern. There is a reasonable expectation that the trust's assets and liabilities are recorded on the basis that assets will be realised and liabilities discharged in the normal course of business and there is sufficient cash resources to meet its obligations as they fall due. Therefore, these accounts have been prepared on a going concern basis.

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:

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

The Board of Directors continue to evaluate the options available for the retraction of services from the Whalley site. Until a final decision has been reached, current services will continue to operate from Whalley. On this basis, the valuation of the assets at the Whalley site as at 31 March 2018 reflect their value in existing use.

Note 1.2.1 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:

Accounting for Impairments

The trust accounts for impairments using an adaption of IFRS as per the FREM and Department of Health Group Manual for Accounts. Details of impairments are included in note 6.

Financial value of provisions for liabilities and charges

The trust makes financial provision for obligations of uncertain timing or amount at the Statement of Financial Position date. These are based on estimates using as much relevant information as is available at the time the account is prepared. They are reviewed to confirm that the values included in the financial statements best reflect the current relevant information. Where this is not the case, the value of the provision is amended. Details of provisions are included in note 25.

Actuarial assumptions for costs relating to the NHS Pension Scheme

The trust reports as operating expenditure, employer contributions to staff pensions. This employer contribution is based on an annual actuarial estimate of the required contribution to meet the scheme's liabilities. It is an expense that is subject to change.

Note 1.3 Interests in other entities

Joint ventures
Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method with any investment originally recognised at cost.

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.

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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 not material so is not recognised in the financial statements.

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. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

The trust has one employee who is a member of the Teachers Pension Scheme.

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 those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

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.
- items form part of the initial equipping and setting up costs of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, 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.

All assets are measured subsequently at valuation. Land and buildings, used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values are determined as follows:

- land and non-specialised buildings - market value for existing use
- specialised buildings - modern equivalent asset basis taking into account functional and economic obsolescence.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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

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

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

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

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

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

Note 1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.7.5 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
Buildings, excluding dwellings	1	90
Dwellings	41	48
Plant & machinery	10	15
Transport equipment	7	7
Information technology	5	5
Furniture & fittings	5	5

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

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

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.

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
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
Software licences	3	5

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. Details of inventories held by the trust can be found in note 19

Note 1.10 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties. Investment properties are disclosed at note 16.1.

Note 1.11 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 trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 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. Further information on the trust's financial instruments can be found at note 30.

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

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

Classification and measurement
Financial assets are categorised asloans and receivables.
Financial liabilities are classified as other financial liabilities.

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

The trust's loans and receivables comprise: current investments, 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.

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

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Note 1.14 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 1.14.1 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 as 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. Details of finance leases held by the trust can be seen at note 24.

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. The trust's operating leases can be seen at note 9.

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 1.14.2 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 1.15 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. The total value of provisions recognised in the trust's accounts is disclosed at note 25.1.

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 trusts 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 1.16 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 1.17 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. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Service (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 1.18 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 Foreign Exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

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

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

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

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

Note 1.20 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 21.1 to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.21 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 actuals 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 disclosed in note 31 are compiled directly from the losses and compensations register.

Note 1.22 Transfers of functions from other NHS bodies

For functions that have been transferred to the trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within income, but not within operating activities.

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.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.2.3 Standards, amendments and interpretations in issue but not yet effective or adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

The trust has only one material operating segment, that of healthcare. From 1 June 2017 this also includes community services following the acquisition of Sefton Community Services from Liverpool Community Health NHS Trust.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	11 months ending 31 March 2017 £000
Mental health services		
Block contract income	232,690	204,930
Clinical partnerships providing mandatory services (including S75 agreements)	357	342
Community services*		
Community services income from CCGs and NHS England	20,246	-
Total income from activities	**253,293**	**205,272**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	11 months ending 31 March 2017 £000
NHS England	99,910	-
Clinical commissioning groups	130,342	188,685
Department of Health and Social Care	-	-
Other NHS providers	2,726	1,184
NHS other*	1,600	-
Local authorities	6,020	4,539
Non NHS: other**	12,695	10,864
Total income from activities	**253,293**	**205,272**
Of which:		
Related to continuing operations	253,293	205,272

*NHS other includes £1.600m income associated with costs incurred for the Liverpool Community Health NHS Trust transaction

**Non NHS: other includes High Secure contract with NHS Wales for £10.656m

Note 4 Other operating income

	2017/18 £000	11 months ending 31 March 2017 £000
Research and development	281	490
Education and training	7,151	4,578
Non-patient care services to other bodies	8,526	8,562
Sustainability and transformation fund income	2,971	3,268
Rental revenue from operating leases	883	2,776
Other income*	3,476	5,702
Total other operating income	**23,288**	**25,376**
Of which:		
Related to continuing operations	23,288	25,376

*Other income includes £1.045m funding related to the retraction from the Whalley site, £0.911m staff recharges

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18 £000	11 months ending 31 March 2017 £000
Income from services designated as commissioner requested services	253,293	205,272
Income from services not designated as commissioner requested services	21,611	25,376
Total	**274,904**	**230,648**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The trust had no disposals of property, plant and equipment during 2017/18.

Note 5.1 Operating expenses

	2017/18 £000	11 months ending 31 March 2017 £000
Purchase of healthcare from NHS and DHSC bodies	-	302
Purchase of healthcare from non-NHS and non-DHSC bodies	2,504	1,892
Staff and executive directors costs*	197,916	163,254
Remuneration of non-executive directors	141	130
Supplies and services - clinical (excluding drugs costs)	3,597	1,275
Supplies and services - general	4,370	3,286
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,716	3,164
Consultancy costs	1,346	1,313
Establishment	9,194	8,813
Premises	21,596	15,617
Transport (including patient travel)	434	375
Depreciation on property, plant and equipment	5,596	6,959
Amortisation on intangible assets	145	108
Net impairments	9,659	34,655
Increase/(decrease) in provision for impairment of receivables	(68)	454
Change in provisions discount rate(s)	343	2,740
Audit fees payable to the external auditor**		
audit services- statutory audit	54	46
other auditor remuneration (external auditor only)	7	15
Internal audit costs	144	158
Clinical negligence	335	212
Legal fees	646	809
Insurance	467	463
Research and development	673	871
Education and training	2,754	1,134
Rentals under operating leases	1,034	664
Early retirements	156	138
Redundancy	1,582	1,160
Charges to operating expenditure for on-Statement of Financial Position IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	482	428
Car parking & security	318	333
Hospitality	30	47
Losses, ex gratia & special payments	811	25
Other services, eg external payroll	291	153
Other***	2,134	1,512
Total	**272,407**	**252,505**
Of which:		
Related to continuing operations	272,407	252,505

*Staff & executive directors costs have increased due to the acquisition of South Sefton Community Services from Liverpool Community Health NHS Trust

**External audit fees are inclusive of VAT

***Other includes: Professional Fees £1.468m, Costs incurred for the Liverpool Community Health NHS Trust transaction £0.500m and Mental Health Appeals £0.197m

Note 5.2 Other auditor remuneration

	2017/18 £000	11 months ending 31 March 2017 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	7	6
All assurance services not falling within items 1 to 5	-	9
Total	**7**	**15**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (11 months ending 31 March 2017 £2m).

Note 6 Impairment of assets

	2017/18 £000	11 months ending 31 March 2017 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	9,578	35,034
Other	81	(379)
Total net impairments charged to operating surplus / deficit	**9,659**	**34,655**
Impairments charged to the revaluation reserve	6,084	30,504
Total net impairments	**15,743**	**65,159**

The trust had total impairments of £11.467m in 2017/18. £0.831m arose when Cushman & Wakefield valued the Hope Centre following refurbishment. £10.636m arose when the trust's land and buildings were valued by Cushman & Wakefield on 31 March 2018. The valuation of all specialised property assets is on a Modern Equivalent Asset basis taking into account functional and economic obsolescence. Non-specialist asset are valued based on market value for existing use or at fair value if not in use.

Following the valuation of the trust estate by Cushman & Wakefield on 31 March 2018 the values of previously impaired buildings increased and the trust reversed economic impairments (£0.750m) and market price impairments (£1.510m).

Note 7 Employee benefits

	2017/18 Total £000	11 months ending 31 March 2017 Total £000
Salaries and wages	158,944	128,949
Social security costs	14,632	12,094
Apprenticeship levy	754	-
Employer's contributions to NHS pensions	18,593	15,415
Pension cost - other	7	4
Temporary staff (including agency)	9,325	9,438
Total gross staff costs	**202,255**	**165,900**
Total staff costs*	**202,255**	**165,900**
Of which		
Costs capitalised as part of assets	1,670	1,248

Note 7.1 Retirements due to ill-health

During 2017/18 there were 7 early retirements from the trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements is £0.313m.

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.

Note 9 Operating leases

Note 9.1 Mersey Care NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Mersey Care NHS Foundation Trust is the lessor.
During 2017/18, the trust leased 8.5 hectares of land. No buildings formed part of the lease. The lease expired in July 2017.

	2017/18 £000	11 months ending 31 March 2017 £000
Operating lease revenue		
Other	883	2,776
Total	**883**	**2,776**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	-	883
Total	**-**	**883**

Note 9.2 Mersey Care NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Mersey Care NHS Foundation Trust is the lessee.

The trust has operating leases in respect of: rental buildings, photocopiers, vehicles and franking machines.

The trust entered into a 10 year operating lease for the new trust offices in 2012.
During 2017/18 the trust terminated its lease for Switch House and entered into a 10 year operating lease for offices at Saturn House.

	2017/18 £000	11 months ending 31 March 2017 £000
Operating lease expense		
Minimum lease payments	1,034	664
Total	**1,034**	**664**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	756	721
- later than one year and not later than five years;	3,173	2,587
- later than five years.	710	899
Total	**4,639**	**4,207**

Note 10 Finance income

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

	2017/18 £000	11 months ending 31 March 2017 £000
Interest on bank accounts	78	52
Interest on other investments / financial assets	6	19
Total	**84**	**71**

Note 11.1 Finance expenditure

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

	2017/18 £000	11 months ending 31 March 2017 £000
Interest expense:		
Finance leases	524	491
Main finance costs on PFI and LIFT schemes obligations	1,790	1,667
Contingent finance costs on PFI and LIFT scheme obligations	128	97
Total interest expense	**2,442**	**2,255**
Unwinding of discount on provisions	53	286
Total finance costs	**2,495**	**2,541**

Note 12 Other losses

	2017/18 £000	11 months ending 31 March 2017 £000
Losses on disposal of assets	(161)	(176)
Total losses on disposal of assets	(161)	(176)
Fair value losses on investment properties	-	(308)
Total other losses	**(161)**	**(484)**

Note 13.1 Intangible assets - 2017/18

All the trust's intangible assets relate to computer software and have a useful life of between 3-5 years.

Revaluation reserve balance for intangible assets

The trust has no revaluation reserve for intangible assets.

	Software licences £000	Licences & trademarks £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**1,982**	**-**	**1,982**
Additions	689	161	**850**
Disposals / derecognition	(215)	(161)	**(376)**
Gross cost at 31 March 2018	**2,456**	**-**	**2,456**
Amortisation at 1 April 2017 - brought forward	**1,512**	**-**	**1,512**
Provided during the year	145	-	**145**
Disposals / derecognition	**(215)**	**-**	**(215)**
Amortisation at 31 March 2018	**1,442**	**-**	**1,442**
Net book value at 31 March 2018	**1,014**	**-**	**1,014**
Net book value at 1 April 2017	**470**	**-**	**470**

Note 13.2 Intangible assets - 11 months ending 31 March 2017

	Software licences	Licences & trademarks	Total
	£000	£000	£000
Valuation / gross cost at start of period for new FTs	**1,446**	**-**	**1,446**
Transfers by absorption	378	-	**378**
Additions	170	166	**336**
Disposals / derecognition	(12)	(166)	**(178)**
Valuation / gross cost at 31 March 2017	**1,982**	**-**	**1,982**
Amortisation at start of period for new FTs	**1,117**	**-**	**1,117**
Transfers by absorption	**299**	**-**	**299**
Provided during the year	**108**	**-**	**108**
Disposals / derecognition	(12)	-	**(12)**
Amortisation at 31 March 2017	**1,512**	**-**	**1,512**
Net book value at 31 March 2017	**470**	**-**	**470**

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**22,768**	**149,925**	**1,580**	**6,577**	**9,543**	**1,344**	**5,650**	**2,712**	**200,099**
Transfers by absorption	840	2,565	-	-	242	-	-	33	**3,680**
Additions	-	11,858	-	3,462	695	26	604	168	**16,813**
Impairments	(270)	(19,074)	-	-	-	-	-	-	**(19,344)**
Reversals of impairments	1,344	(223)	1	-	-	-	-	-	**1,122**
Revaluations	1,915	4,561	-	-	-	-	-	-	**6,476**
Reclassifications	-	1,415	-	(1,415)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(17)	(11)	(1,090)	-	**(1,118)**
Valuation/gross cost at 31 March 2018	**26,597**	**151,027**	**1,581**	**8,624**	**10,463**	**1,359**	**5,164**	**2,913**	**207,728**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**277**	**-**	**-**	**3,787**	**1,039**	**3,604**	**1,486**	**10,193**
Transfers by absorption	-	**72**	-	-	**52**	-	-	**2**	**126**
Provided during the year	-	**3,729**	**33**	-	**894**	**75**	**447**	**418**	**5,596**
Impairments	-	(1,366)	-	-	-	-	-	-	**(1,366)**
Reversals of impairments	-	(1,080)	(33)	-	-	-	-	-	**(1,113)**
Revaluations	-	(973)	-	-	-	-	-	-	**(973)**
Disposals / derecognition	-	-	-	-	(17)	(11)	(1,090)	-	**(1,118)**
Accumulated depreciation at 31 March 2018	**-**	**659**	**-**	**-**	**4,716**	**1,103**	**2,961**	**1,906**	**11,345**
Net book value at 31 March 2018	**26,597**	**150,368**	**1,581**	**8,624**	**5,747**	**256**	**2,203**	**1,007**	**196,383**
Net book value at 1 April 2017	**22,768**	**149,648**	**1,580**	**6,577**	**5,756**	**305**	**2,046**	**1,226**	**189,906**

Note 14.2 Property, plant and equipment - 11 months ending 31 March 2017

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at start of period as FT	**16,319**	**153,424**	**-**	**2,709**	**9,067**	**1,117**	**4,726**	**3,472**	**190,834**
Transfers by absorption	**6,925**	**41,604**	**2,420**	**4**	**463**	**321**	**1,921**	**805**	**54,463**
Additions	-	4,409	12	5,233	344	61	1,426	57	**11,542**
Impairments	(7,774)	(61,400)	(852)	-	-	-	-	-	**(70,026)**
Reversals of impairments	263	303	-	-	-	-	-	-	**566**
Revaluations	7,035	10,216	-	-	-	-	-	-	**17,251**
Reclassifications	-	1,369	-	(1,369)	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(331)	(155)	(2,423)	(1,622)	**(4,531)**
Valuation/gross cost at 31 March 2017	**22,768**	**149,925**	**1,580**	**6,577**	**9,543**	**1,344**	**5,650**	**2,712**	**200,099**
Depreciation at start of period as FT	**-**	**564**	**-**	**-**	**3,183**	**919**	**4,501**	**2,237**	**11,404**
Transfers by absorption	**5**	**271**	**8**	**-**	**177**	**195**	**1,316**	**514**	**2,486**
Provided during the year	**-**	**5,543**	**21**	**-**	**758**	**70**	**210**	**357**	**6,959**
Impairments	(5)	(4,220)	(29)	-	-	-	-	-	**(4,254)**
Reversals of impairments	-	(47)	-	-	-	-	-	-	**(47)**
Revaluations	-	(1,834)	-	-	-	-	-	-	**(1,834)**
Disposals/ derecognition	-	-	-	-	(331)	(145)	(2,423)	(1,622)	**(4,521)**
Accumulated depreciation at 31 March 2017	**-**	**277**	**-**	**-**	**3,787**	**1,039**	**3,604**	**1,486**	**10,193**
Net book value at 31 March 2017	**22,768**	**149,648**	**1,580**	**6,577**	**5,756**	**305**	**2,046**	**1,226**	**189,906**

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

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	26,597	125,128	1,581	8,624	5,747	256	2,203	1,007	**171,143**
Finance leased	-	5,579	-	-	-	-	-	-	**5,579**
On-Statement of Financial Position PFI contracts and other service concession arrangements	-	19,661	-	-	-	-	-	-	**19,661**
NBV total at 31 March 2018	**26,597**	**150,368**	**1,581**	**8,624**	**5,747**	**256**	**2,203**	**1,007**	**196,383**

Note 14.4 Property, plant and equipment financing - 11 months ending 31 March 2017

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	22,768	124,292	1,580	6,577	5,756	305	2,046	1,226	**164,550**
Finance leased	-	5,644	-	-	-	-	-	-	**5,644**
On-Statement of Financial Position PFI contracts and other service concession arrangements	-	19,712	-	-	-	-	-	-	**19,712**
NBV total at 31 March 2017	**22,768**	**149,648**	**1,580**	**6,577**	**5,756**	**305**	**2,046**	**1,226**	**189,906**

Note 15 Revaluations of property, plant and equipment

The trust's land and buildings were revalued during 2017/18 by Gian Wong (MRICS), a professionally qualified valuer of Cushman & Wakefield. These values were updated on 31 March 2018 in line with work undertaken 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 value of the trust estate decreased by £8.295m from £186.839m on 31 March 2017 to £178.544m on 31 March 2018. This resulted in an impairment of £15.743m which can be seen at note 6 and an upward revaluation of £7.448m.

The estimated useful lives of the trust's assets are as follows:

Buildings (excluding dwellings) between 1 and 90 years
Dwellings between 41 to 48 years
Plant and Machinery between 10 and 15 years

Note 16.1 Investment Property

The trust holds both residential and non-residential investment properties.

	2017/18 £000	11 months ending 31 March 2017 £000
Carrying value at 1 April - brought forward	**1,375**	**-**
Carrying value at 1 April - restated	**1,375**	**-**
Transfers by absorption	-	1,678
Acquisitions in year	-	5
Movement in fair value	-	(308)
Carrying value at 31 March	**1,375**	**1,375**

Note 16.2 Investment property income and expenses

	2017/18 £000	11 months ending 31 March 2017 £000
Direct operating expense arising from investment property which generated rental income in the period	(13)	(13)
Total investment property expenses	**(13)**	**(13)**
Investment property income	88	80

Note 17 Other investments / financial assets (current)

	31 March 2018 £000	31 March 2017 £000
Other current financial assets*	-	400
Total current investments / financial assets	**-**	**400**

*On acquisition of Calderstones, the Trust had an outstanding loan with its previous subsidiary Future Directions CIC Limited. The final repayment was made in September 2017.

Note 18 Disclosure of interests in other entities

In May 2012 Mersey Care NHS Trust established a subsidiary company, Mersey Care Ltd. This company transferred to Mersey Care NHS Foundation Trust on its inception on 1 May 2016. The foundation trust is the sole shareholder of 100 ordinary £1 shares in Mersey Care Limited which is currently registered as a dormant company.

In August 2017 the trust agreed to enter into a formal partnership with Stanford University Medical Network Risk Authority, LLC in the form of a Limited Liability Company called Innovence Augmented Intelligence Medical Systems - Psychiatry (AIMS - Psychiatry).

The partnership is to create and research two apps - SWim and SMile, which are designed to reduce self-harm and suicide. During 2017/18, the trust has contributed to the expenses incurred.

Note 19 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	231	226
Consumables	75	72
Energy	44	44
Other	27	28
Total inventories	**377**	**370**

Inventories recognised in expenses for the year were £5.559m. Write-down of inventories recognised as expenses for the year were £0k.

Note 20.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	8,980	5,867
Accrued income	4,006	5,303
Provision for impaired receivables	(584)	(652)
Prepayments (non-PFI)	2,565	858
PDC dividend receivable	628	475
VAT receivable	185	1,246
Other receivables*	1,532	1,777
Total current trade and other receivables	**17,312**	**14,874**

*Other current receivables include amounts owed by employees for salary sacrifice schemes £1.377m (2016/17 £1.541m)

Non-current		
Other receivables**	109	110
Total non-current trade and other receivables	**109**	**110**

**Other non current receivables are amounts owed by employees for salary sacrifice lease car schemes

Of which receivables from NHS and DHSC group bodies:		
Current	11,720	8,153

Note 20.2 Provision for impairment of receivables

	2017/18	11 months ending 31 March 2017
	£000	£000
At 1 April as previously stated	**652**	**-**
At 1 April - restated	**652**	**-**
At start of period for new FTs	**-**	**189**
Transfers by absorption		9
Increase in provision	263	744
Unused amounts reversed	(331)	(290)
At 31 March	**584**	**652**

The trust makes a provision against trade receivables for:
- specific non NHS receivables older than 60 days
- 5% of non NHS receivables less than 60 days
The trust does not provide for NHS receivables

Note 20.3 Credit quality of financial assets

	31 March 2018 Trade and other receivables	31 March 2017 Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	1,000	382
30-60 Days	72	781
60-90 days	14	11
90- 180 days	20	47
Over 180 days	786	885
Total	**1,892**	**2,106**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	4,737	5,155
30-60 Days	1,267	272
60-90 days	53	254
90- 180 days	510	802
Over 180 days	478	136
Total	**7,045**	**6,619**

Note 21 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	11 months ending 31 March 2017
	£000	£000
At 1 April	**21,553**	**-**
At 1 April (restated)	**21,553**	**-**
At start of period for new FTs	**-**	**10,677**
Transfers by absorption	260	3,604
Net change in year	(2,316)	7,272
At 31 March	**19,497**	**21,553**
Broken down into:		
Cash at commercial banks and in hand	112	57
Cash with the Government Banking Service	19,385	21,496
Total cash and cash equivalents as in Statement of Financial Position	**19,497**	**21,553**
Total cash and cash equivalents as in Statement of Cash Flows	**19,497**	**21,553**

Note 21.1 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	1,605	1,748
Total third party assets	**1,605**	**1,748**

Note 22.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	3,266	3,025
Capital payables	474	254
Accruals	13,208	8,693
Receipts in advance (including payments on account)	390	300
Social security costs	185	2,087
Other taxes payable	245	875
Other payables*	2,639	281
Total current trade and other payables	**20,407**	**15,515**

*Other payables include superannuation £2.485m (2016/17 £0.030m)

Of which payables from NHS and DHSC group bodies:		
Current	3,685	1,181

Note 22.2 Early retirements in NHS payables above

There were no outstanding payables in relation to early retirements at 31 March 2018.

Note 22.3 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	143	117
Total other current liabilities	**143**	**117**

Note 23 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Obligations under finance leases	278	257
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	392	395
Total current borrowings	**670**	**652**
Non-current		
Obligations under finance leases	6,864	7,142
Obligations under PFI, LIFT or other service concession contracts	22,048	22,439
Total non-current borrowings	**28,912**	**29,581**

Note 24 Mersey Care NHS Foundation Trust as a lessee

Obligations under finance leases where Mersey Care NHS Foundation Trust is the lessee.

The trust has two finance leases.

- a 25 year lease with Onward Homes Ltd for the Rathbone Rehabilitation Centre, running to 2032. At the end of the lease in 2032 the property will revert to the trust's ownership. The rental amount is based upon paying the loan Contour Housing took out to build the property, plus a management charge.

- a 25 year lease with The Walton Centre NHS Foundation Trust for the Brain Injuries Rehabilitation Centre, running to 2039. At the end of this lease in 2039 the property will revert to the ownership of The Walton Centre NHS Foundation Trust.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**14,267**	**14,947**
of which liabilities are due:		
- not later than one year;	797	775
- later than one year and not later than five years;	3,341	3,255
- later than five years.	10,129	10,917
Finance charges allocated to future periods	(7,125)	(7,548)
Net lease liabilities	**7,142**	**7,399**
of which payable:		
- not later than one year;	278	257
- later than one year and not later than five years;	1,328	1,241
- later than five years.	5,536	5,901
Contingent rent recognised as an expense in the period	(128)	(97)

Note 25.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**4,816**	**567**	**1,177**	**20,023**	**26,583**
Transfers by absorption	-	-	-	189	**189**
Change in the discount rate	34	-	-	309	**343**
Arising during the year	215	334	1,327	578	**2,454**
Utilised during the year	(421)	(209)	(1,177)	(1,075)	**(2,882)**
Reversed unused	(59)	(204)	-	(620)	**(883)**
Unwinding of discount	10	-	-	43	**53**
At 31 March 2018	**4,595**	**488**	**1,327**	**19,447**	**25,857**
Expected timing of cash flows:					
- not later than one year;	433	488	1,327	1,048	**3,296**
- later than one year and not later than five years;	1,829	-	-	3,744	**5,573**
- later than five years.	2,333	-	-	14,655	**16,988**
Total	**4,595**	**488**	**1,327**	**19,447**	**25,857**

Early Departure Costs - the amounts are pension costs based on the current payments to former staff and estimated life expectancy of the former staff. The trust uses the tables from the National Office for Statistics to estimate the life expectancy.

Other Legal Claims - these figures are provided by NHS Resolution and the trust's solicitors.

Redundancy - the amount relates to liabilities to staff in post that are no longer required as a result of implementation of the trust's Transformation Programme.

Other - £19.286m relates to Injury Benefits payable by the trust under the NHS Pensions Injury Benefit Scheme. The amounts are based on the current payments and estimated life expectancy of those receiving payments. The trust uses life tables from the National Office for Statistics to estimate the life expectancy. £0.161m relates to the Carbon Reduction Commitment Energy Efficiency Scheme.

Note 25.2 Clinical negligence liabilities

At 31 March 2018, £0.985m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Mersey Care NHS Foundation Trust (31 March 2017: £0.796m).

Note 26 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(185)	(173)
Gross value of contingent liabilities	**(185)**	**(173)**
Net value of contingent liabilities	**(185)**	**(173)**
Net value of contingent assets	-	-

The future contingent liabilities of £0.185m relate to potential legal claims. These figures have been provided by the NHS Resolution.

Note 27 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	78,596	7,048
Total*	**78,596**	**7,048**

*Total contractual capital commitments in 2017/18 includes £57.999m for the Medium Secure Unit at Maghull Health Park and £19.072m for the Southport Mental Health Unit.

Note 28 Defined benefit pension schemes

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

Note 29 On-Statement of Financial Position PFI, LIFT or other service concession arrangements

The LIFT Scheme relates to Clock View, situated in Walton, Liverpool that treats local people for a range of mental health issues including depression, anxiety and dementia, providing 80 individual bedrooms all with ensuite bathrooms. It also provides the city's psychiatric intensive care unit for those most in distress and in need of urgent inpatient care.

The LIFT contract ends in December 2044. A monthly unitary payment will be made up to that point. The unitary payment is subject to annual increases in line with RPI. The arrangement requires the operator to deliver services to the trust in accordance with the service delivery specification. Non delivery of quality or performance can lead to a reduction in the service charge being paid by the trust. The trust retains step in rights should the contractor fail to meet minimum standards as set out within the contract. Under IFRIC 12 the asset is treated as an asset of the trust. The substance of the contract is that the trust has a finance lease and payments comprise two elements; imputed finance lease charges and service charges.

Note 29.1 Imputed finance lease obligations

Mersey Care NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**53,766**	**55,950**
Of which liabilities are due		
- not later than one year;	2,151	2,184
- later than one year and not later than five years;	8,435	8,491
- later than five years.	43,180	45,275
Finance charges allocated to future periods	(31,326)	(33,116)
Net PFI, LIFT or other service concession arrangement obligation	**22,440**	**22,834**
- not later than one year;	392	395
- later than one year and not later than five years;	1,713	1,640
- later than five years.	20,335	20,799

Note 29.2 Total on-Statement of Financial Position PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-Statement of Financial Position schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	88,991	91,297
Of which liabilities are due:		
- not later than one year;	2,842	2,799
- later than one year and not later than five years;	11,680	11,498
- later than five years.	74,469	77,000

Note 29.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	11 months ending 31 March 2017 £000
Unitary payment payable to service concession operator	2,799	2,531
Consisting of:		
- Interest charge	1,790	1,667
- Repayment of finance lease liability	395	335
- Service element and other charges to operating expenditure	470	416
- Capital lifecycle maintenance	4	4
- Revenue lifecycle maintenance	12	12
- Contingent rent	128	97
Total amount paid to service concession operator	**2,799**	**2,531**

Note 30 Financial instruments

Note 30.1 Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the trust has with commissioners and the way those commissioners are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's Standing Financial Instructions and policies agreed by the Board of Directors. 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 majority of transactions, assets and liabilities being in the UK and sterling based. The trust's only overseas interest is a partnership with Stanford University Medical Network Risk Authority, LLC as disclosed in note 18. The trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The trust borrows from the government for capital expenditure, subject to affordability as confirmed by the Department of Health. 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 therefore has low exposure to interest rate fluctuations.

Credit risk

As the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with Clinical Commissioning Groups (CCG) and NHS England, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

Fair Value

IFRS 7 requires the trust to disclose the fair value of financial liabilities. The LIFT scheme is a non current financial liability where the fair value is likely to differ from the carrying value. The trust has reviewed the current interest rates available on the market and if these were used as the implicit interest rate for the scheme the fair value of the liability would range from £22.442m to £42.983m.

Note 30.2 Carrying values of financial assets

	Loans and receivables £000	Total book value £000
Assets as per Statement of Financial Position as at 31 March 2018		
Trade and other receivables excluding non financial assets	13,286	**13,286**
Cash and cash equivalents at bank and in hand	19,497	**19,497**
Total at 31 March 2018	**32,783**	**32,783**

	Loans and receivables £000	Total book value £000
Assets as per Statement of Financial Position as at 31 March 2017		
Trade and other receivables excluding non financial assets	12,715	**12,715**
Other investments / financial assets	400	**400**
Cash and cash equivalents at bank and in hand	21,553	**21,553**
Total at 31 March 2017	**34,668**	**34,668**

Note 30.3 Carrying value of financial liabilities

	Other financial liabilities £000	£000
Liabilities as per Statement of Financial Position as at 31 March 2018		
Obligations under finance leases	7,142	**7,142**
Obligations under PFI, LIFT and other service concession contracts	22,440	**22,440**
Trade and other payables excluding non financial liabilities	16,948	**16,948**
Total at 31 March 2018	**46,530**	**46,530**

	Other financial liabilities £000	Total book value £000
Liabilities as per Statement of Financial Position as at 31 March 2017		
Obligations under finance leases	7,399	**7,399**
Obligations under PFI, LIFT and other service concession contracts	22,834	**22,834**
Trade and other payables excluding non financial liabilities	9,659	**9,659**
Total at 31 March 2017	**39,892**	**39,892**

Note 30.4 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	17,618	10,310
In more than one year but not more than two years	685	670
In more than two years but not more than five years	2,356	2,211
In more than five years	25,871	26,701
Total	**46,530**	**39,892**

Note 31 Losses and special payments

	2017/18		11 months ending 31 March 2017	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	23	15	25	14
Bad debts and claims abandoned	5	4	9	7
Stores losses and damage to property	-	-	-	-
Total losses	**28**	**19**	**34**	**21**
Special payments				
Ex-gratia payments	35	12	38	4
Total special payments	**35**	**12**	**38**	**4**
Total losses and special payments	**63**	**31**	**72**	**25**
Compensation payments received		-		-

Note 32 Related parties

During the accounting period none of the Department of Health and Social Care Ministers, Board of Directors or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Mersey Care NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the accounting period Mersey Care NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example:

- Other NHS providers
- CCGs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- NHS Business Services Authority

In addition, the trust has had a number of material transactions with other government departments and other central and local government bodies.

Note 33 Transfers by absorption

On 1 June 2017, the trust acquired South Sefton Community Services from Liverpool Community Health NHS Trust (LCH).

On acquisition, LCH transferred the functions of South Sefton Community Services to the trust. The following assets and liabilities have been recognised in the accounts at the date of acquisition.

	£000
Non Current Assets	3,554
Current Assets	336
Current Liabilities	(336)
Non Current Liabilities	
	3,554

Note 34 Events after the reporting date

On Wednesday 28 March 2018 the Board of Directors and Council of Governors formally agreed to transaction in which the trust formally acquired Liverpool Community Health NHS Trust with effect from 1 April 2018.

On Wednesday 28 March 2018 the Secretary of State signed off the Independent Trust Financing Facility Loan (valued at £60.725m) in respect of the new Medium Secure Unit to be built on the Maghull Health Park. The Stage 4 Contract for construction of the Medium Secure Unit with Kier was signed off by the trust on Thursday 29 March 2018. As at 31 March 2018, no monies had been drawn down in relation to the loan.