NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Mersey Care NHS Foundation Trust

Annual Report 2018/19
Quality Report 2018/19
Annual Accounts 2018/19

Striving for perfect care and a just culture

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

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FOREWORD

Welcome to our annual report covering the financial year 2018/19. As ever, this report gives us a great opportunity to celebrate the many achievements that we have made this year. It also offers a great opportunity for us to showcase our activity and performance across the Trust as Mersey Care ***strives for perfect care delivered through a just and learning culture***.

2018/19 has seen Mersey Care continue to embed community physical health services acquired from the former Liverpool Community Health NHS Trust (LCH) over the last 20 months. We have also taken over responsibility for the mental health services at HM Prison Liverpool. Given the CQC's historical concerns about these prison services prior to Mersey Care becoming their responsible provider, the CQC inspected these services in October 2018. In its report following this inspection, the CQC noted the excellent progress and improvements that had been made to the prison services, whilst still recognising that further work would be necessary to bring these services up to the very best standard in the future[1].

As we noted in last year's annual report, the former LCH services have been subject to a critical external review by Dr Bill Kirkup[2] due to concerns about the historical delivery of services before being acquired by Mersey Care. This has meant that we have given a high degree of focus to help support theses services to be as safe and effective as possible moving forward. Taking responsibility for these former LCH services has meant that Mersey Care has been at the forefront of providing responses to a range of questions raised by NHS Improvement in respect of recommendations 6.6 (serious incidents) and 6.7 (whistleblowing and other HR issues) of the external review, a task that, given the complexity of services, has taken the Trust a year to complete.

At the end of 2018 the CQC inspected a range of the Trust's other services, culminating in a well-led inspection at the end of December 2018. At the beginning of April 2019 the CQC published its inspection report[3]. Although the Trust retained its overall *good* rating, what is most pleasing, from this the Trust's third CQC inspection since 2015, is the shift from a *requires improvement* to a *good* rating for the safe domain together with an improvement from a *good* to an *outstanding* rating for the well-led domain. On behalf of the Board of Directors we would like to thank staff across the whole of the organisation for their dedication and hard work in achieving these ratings - but given our objective of ***striving for perfect care delivered through a just and learning culture*** this is only the start and not the end of this journey.

Increasingly Mersey Care is helping to shape the future of health services across Liverpool and Sefton. Mersey Care has a strong focus on how we can support the system to integrate local health and social care services. We now lead the Provider Alliances - comprising local NHS providers, GPs, local authorities and the voluntary sector - across Liverpool and Sefton. Given the direction of the *NHS Long Term Plan*[4] the integration of services will be an

1 This report, published December 2018, is available on the CQC's website by clicking here.
2 The independent *Report of the Liverpool Community Health Independent Review*, examining the failures at LCH between 2010 and 2014, was published in February 2018. The review is available on NHS Improvement's website by clicking here. Following its publication NHS Improvement asked a number of questions of all those providers who had taken responsibility for the former LCH's services.
3 This latest report is available on the CQC's website by clicking here.
4 Further information on the Plan is available by clicking here.

increasingly important objective for the local health and social care systems in the coming years.

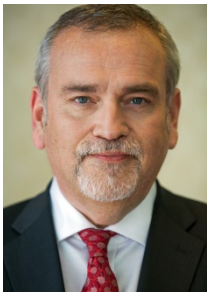
Our ambition to re-shape the Trust's estate has also continued apace and this is clearly evident with the successful build of our new 40-bed inpatient hospital / community hub in Southport. We have named this new facility ***The Hartley Hospital*** it is scheduled to open by the end of 2019. We also continue to be on track with building our new 123-bed mental health and learning disability medium secure unit in Maghull, now named ***Rowan View*** and this impressive facility is scheduled to open in September 2020.

Our three Life Rooms - at Walton, Southport and Bootle - continue to be at the heart of our services for learning, recovery, health and wellbeing as well as a base for our Recovery College and Social Prescribing Services. Over the next 12 months we are planning to develop a Life Rooms in Ashworth Hospital as well as make our Life Rooms offer more accessible to the people of central and south Liverpool.

Despite these and many other achievements we continue to face a range of challenges in the coming year:

- although overall Mersey Care has been rated as *good* by the CQC, for the services we have acquired LCH (that now make up our Community Division), the CQC has provided a rating of *requires improvement*, with three of the five domains being rated as *requires improvement* (safe, effective and well-led) and the other two domains rated as *good* (caring and responsive). As we have only recently assumed responsibility for these services, the CQC has used its permitted discretion not to use these service ratings to affect the overall Mersey Care rating, but nonetheless we will continue our hard work to consistently and sustainably improve these services through 2019/20 and beyond;
- in light of NHS England's decision in 2016/17 to no longer commission learning disability services at our Whalley site, we have worked hard with partners at NHS England and NHS Improvement to obtain clarity from commissioners on the future of the low secure unit and non-secure inpatient services at this site. This has been a passionate focus for the Board of Directors who have maintained a strong focus on the development of these services in order to assure the safe transfer of services into the community and to new secure facilities as they come on stream. The safety and dignity of these vulnerable service users will therefore continue to be a key priority for the Trust.

Finally, as part of our ***zero suicide*** ambition, and in conjunction with the Zero Suicide Alliance, we continue to work together to prevent the 6000 deaths that we see annually from suicide. 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.



Beatrice Fraenkel, Chairman
22 May 2019

Joe Rafferty, Chief Executive
22 May 2019

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 the acquisition of the former Liverpool Community Health NHS Trust, since 1 April 2018 we have provided community services for South Sefton and Liverpool. 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. In 2018/19 we have set six 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;

   f) Priority 6 – Learning from Deaths.

   Details about the Trust's progress against these priorities can be found in the Quality Report for 2018/19.

7. 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 248 - 253 below

8. Over the last 2 years Mersey Care has taken on a range of new services which have changed the size and nature of the Trust, from being solely a mental health and learning disabilities provider to an organisation that provides a range community physical, mental health and learning disability services:

   a) from June 2017 the Trust acquired a wide range of community physical health services for South Sefton and a rehabilitation ward at Aintree University Hospitals;

   b) from April 2018 the Trust acquired a wide range of community physical health services for Liverpool and a range of other services from the former Liverpool Community Health NHS Trust;

   c) from April 2018 the Trust has been sub-contracted by Spectrum Healthcare CIC to provide mental health prison healthcare services;

   d) throughout 2018/19 we have rolled out community forensic learning disabilities teams across Lancashire and Greater Manchester, as part of NHS England's plans to decommission learning disability services at our Whalley site in Lancashire.

9. The Trust is continuing it work to integrate mental health and physical health community services by bring together its Community Services Division with its Local Services Division, as well as bring together the Secure Division with the Specialist Learning Disabilities Division.

10. Some of the other achievements for the Trust for 2018/19 are outlined below[5]:

a) we were subject to our third Care Quality Commission (CQC) inspection, which took place from October to December 2018. The CQC issued its inspection report at the beginning of April 2019, with the Trust being rated as 'good' overall. For the first time the Trust was rated a 'good' for the safety domain and also improved its score for the well led domain to 'outstanding'[6];

b) within the ***Community Services Division***, which was formed following the transfer of South Sefton's community physical health services (June 2017) and the acquisition of Liverpool's community physical health services (April 2018), this has included:

i) reviewing and implementing a single leadership and governance structure across these previously separate services,

ii) in respect of children and young peoples services, seconding two experienced specialist community public health nurses from the division to work with Liverpool City Council's public health team,

iii) recognising that inpatient falls for our Ward 35 service (a ward run by the Trust at Aintree University Hospital) were higher than the national average, establishing a range of workstreams to review the care provided. This has resulted in a reduction of inpatient falls, with zero falls recorded between November 2018 and February 2019,

iv) strengthening not just divisional plans but the Trust's planning for and response to the Winter with Liverpool and Sefton acute providers, local GPs, local authority and voluntary sector colleagues. Operating from October 2018 to the end of Match 2019 these plans are estimated to have saved approximately 4000 additional acute bed days compared to winter 2017/18 and included:

- a 7-day service provision and enhanced input and support to care homes
- same day rapid response from Community Equipment Service
- the provision of COPD medication rescue packs
- an enhanced Treatment Room capacity
- additional Skin Service clinics to support the Homeless community
- the introduction of the Flying squad in the Accident & Emergency departments at both the Royal Liverpool University and Aintree Hospitals,

5 Further examples and more detailed information about Mersey Care's achievement for 2018/19 can be found on the Trust's website at https://www.merseycare.nhs.uk/our-services/good-news-stories/

6 Further information about the CQC's Inspection Report can be found on the Trust's website by clicking here.

v) since joining the Trust from the former Liverpool Community Health NHS Trust, and as a new component of their statutory / mandatory training, some 90% of staff have completed their Level 1 suicide awareness training,

vi) through the *paperlight programme*, continuing to develop the delivery a single electronic patient record for service users of the division, including agile working technology for clinical staff to access these records on the move;

c) within the ***Local Services Division*** examples include:

i) in January 2018 the Trust started building a new 40-bed mental health facility and integrated community mental health hub in Southport adjacent to our Boothroyd Unit (on the former Southport General Infirmary site). To be called the ***Hartley Hospital***, it will replace the Boothroyd Unit and the Hesketh Centre as the base for our services in Southport. Work continues to progress well and we hope to open this new £21m facility by the autumn of 2019,

ii) through effective case and bed management of the Trust's mental health inpatient beds, the division achieved 486 days by the end of March 2019 without any service user requiring an inpatient bed being transferred *out of area* for a bed (excluding psychiatric intensive care beds). In a time when it is being widely reported that mental health patients are being transported the length and breadth of the country for an inpatient bed, this is something both the division and Trust are rightly proud of. However the division recognises it needs to keep a focus on this each and every day in order to ensure the best care for our patients and their carers to ensure a speedy recovery,

iii) in Sefton the local council has commissioned *Light for Life*, a voluntary organisation, to provide a range of services for homeless people. Recognising a small group of rough sleepers in Southport needed support for drug and alcohol addiction issues, the council secured funding from the Government's Rough Sleepers Initiative to fund some integrated outreach work between *Light for Life* and the Trust's drug and alcohol team. Since January 2019 a clinical nurse prescriber from this team joined *Light for Life's* outreach services every week to help support this small group of rough sleepers by undertaking assessments, handing out prescriptions and helping them access services,

iv) together with North West Ambulance Service NHS Trust (NWAS), the division is helping to pilot a mental health response car operating across Merseyside. This is on top of the mental health triage car service operated by the division with Merseyside Police over the last few years and the more recent car service established with the British Transport Police and Merseytravel,

v) the Trust's specialist perinatal care service, which is part of the Cheshire and Merseyside specialist service, continues to expand. This means that not only can the team support more services users and their families but it has also been able to provide awareness raising training not only across the Trust but also to other local NHS organisations as well;

d) within the ***Secure Division*** examples include:

i) in April 2018 the Trust started building a new £60m mental health and learning disability Medium Secure Unit at the Maghull Health Campus. To be called the ***Rowan View***, the new build will replace the mental health secure unit at Scott Clinic, Rainhill, and the learning disability secure unit at Woodview, Whalley. It is expected that this 123-bed medium secure unit will be open by September 2020,

ii) recruited 76 new nursing staff into the division and seconded a number of staff to undertake nurse associate or nurse training, so creating the qualified workforce the division needs in the future,

iii) as part of the goal of a zero approach to long term segregation introduced in 2017, there has been a 38% reduction in patients in long-term segregation in 2018/19,

iv) since reducing physical restraint (No Force First) was introduced in 2015/16, their has been a 36% reduction in the use of physical force and, within just the last 12 months, a 37% reduction in assaults on staff causing harm,

v) in conjunction with service users the division has developed a *person safety training to reduce restrictive practice* mandatory training package, which was introduced in January 2019,

vi) since providing the mental health services at HMP Liverpool (from April 2018), the division has been working closing with the prison authorities, NHS England (commissioner) and Spectrum Healthcare CIC (the main prison healthcare provider, who sub-contracts the provision of mental health service to the Trust) through the prison's Health Partnership Board to improve the healthcare services. This work has been recognised in the Care Quality Commission's latest inspection of Mersey Care's services at HMP Prison[7], which took place in October 2018, and noted a range of improvements to the service being provided;

e) within the ***Specialist Learning Disabilities Division*** examples include:

i) one of our Low Secure wards at Whalley (Maplewood 3) has been selected to take part in a national quality improvement project by the Royal College of Psychiatrists in respect of reducing restrain and seclusion,

7 Published on 27 December 2018 and available on the CQC's website at https://www.cqc.org.uk/location/RW4X6

ii) the women's Low Secure wards at Whalley (Coniston and Grasmere) experience a 3-month period of zero restraint and zero seclusion following the introduction of multi-disciplinary team huddles,

iii) the service user's *Making a Difference: No Force First* group developed an easy read resource for the wards to help develop new ideas, including a 'welcome box' for people newly admitted to these secure services,

iv) the Specialist Treatment, Assessment and Recovery (STAR) unit in Liverpool for people with a learning disability or autism, which transferred to this Division in 2018, has seen its CQC rating improved across all 5 domains from *requires improvement* to *good* in the latest CQC Inspection Report,

v) a Complex Case and Recovery Management (CCaRM) delivery framework was to be rolled out across the division following a pilot across 3 services. CCaRM is a service platform that aims to assist clinical teams with the development of consistent, valued outcomes through collaborating both with service users and a wider constituency of stakeholders also known as the service delivery network. The 'valued outcomes' are principally what matters to the services users, so allow staff and other agencies to understand service users needs when developing and delivering care;

f) within our ***Corporate Services*** examples include:

i) our ***finance team*** has been recognised, the Trust achieved Level 3 ('consistently excellent') as part of the finance staff development accreditation in the NHS, part of the *Future Focused Finance* initiative. Mersey care is one of the few trusts in the north west to have achieved this highest rating,

ii) our ***HR and organisational effectiveness / learning team*** has been recognised - for example through the HPMA's Social Partnership Award, the Institute of Organisational Development's best team and best practitioner (Joanne Davidson, head of service) of the year 2019 awards, and the Positive Practice in MH Award for workforce well-being - for their work, including:

- continuing to support the development and embedding of a just and learning culture across the Trust
- doubling the capacity of the Trust's leadership development programmes (THRIVE and SHRIVE) - especially important in training 100 community leaders in the first 100 days of the Trust acquiring the former Liverpool Community Health NHS Trust
- providing coaching to over 200 people
- designing and delivering the new apprenticeship standards ensuring all pathways were truly employer led, meeting the needs of our workforce along all academic levels

- in line with the People Plan, designing and supporting (through the Practice Education Team) a new preceptorship programme with the Nursing Directorate available to all newly qualified registered nurses and nurse associates, and
- supporting divisions so as to ensure the Trust is in the top 20 nationally of NHS organisations for people completing e-learning courses as part of the Trust's statutory and mandatory training requirements,

iii) within the digital arena the ***Centre for Perfect Care's research team*** have helped with:
- the development of a new suicide prevention mobile phone app
- using Smart Meter technology to determine if changes in patterns of electrical appliance usage are linked to progression of cognitive decline in patients with dementia
- the use of state-of-the-art machine learning and object detection to grade and report on the characteristics of each stage of a pressure ulcer,

iv) the ***Medicines Management Teams*** have:
- through the opening of the new £1m Medicines Management Building on the Maghull Health Campus site at the end of March 2019, ensured the safer supply of medicines through use of the robotic dispensing system at the heart of this new facility
- following a period of testing, continued to roll out the Electronic Prescribing and Medicines Administration (EPMA) system across our secure estate and are developing plans for its roll out across the Local Division's inpatient services in the coming year
- been working with community teams and local GPs across Liverpool to promote the safe, evidence-based and cost-effective use of medicine through introducing a Direct Patient Ordering System with NHS Liverpool Clinical Commissioning Group, saving nearly £1m across the Liverpool health economy, and
- again working with local GPs across Liverpool, completing 9,000 medication reviews and 30,000 other interventions that led to changes in medication, monitoring or referral to other services so as to improve patient safety by stopping medicines that may have unneeded side effects,

g) and, finally, across ***Our Wider Service Offer*** examples include:

i) the Trust has opened its third Life Rooms in January 2019, in conjunction with Hugh Baird College in Bootle. The Life Rooms in Walton, Southport and Bootle provide centres for learning, recovery, health and wellbeing as well as a base for our Recovery College and Social Prescribing Service. Over the past 12 months the Life Rooms received over 40,000 visits by people for advice, support, social inclusion and college activity. In the next 12 months we are planning to develop a Life Rooms at Ashworth

Hospital as well as make our Life Rooms offer more accessible to central and south Liverpool,

ii) 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 2017 we launched the Zero Suicide Alliance 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-minute free online training course on suicide prevention – by the end of March 2019 over 148,000 people have taken the training. ***Save a life and take the training*** at www.zerosuicidealliance.com,

iii) in September 2017 the Board approved the Funding Agreement with NHS England which meant that Mersey Care started a programme to become a Mental Health 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 digitally mature NHS organisations who are committed to becoming world class exemplars for the harnessing of technology and innovation from which other organisations can learn. To date the Trust has implemented:

- a new clinical information system and bed management system for the local services
- an electronic prescribing system to reduce prescription errors
- advanced analytics in community services for identifying those most at risk of a mental health crisis.

The Trust is also involved in research with artificial intelligence and the use of machine learning in suicide prevention and the use of avatar technology in psychological services.

CHAPTER 2 – RISK MANAGEMENT

11. 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.

12. The Board of Directors and its supporting Board committees are detailed in the Annual Governance Statement (see Chapter 16).

13. The Medical Director is the Executive Lead for risk management, 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.

14. 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.

15. Risks that were listed in the Board Assurance Framework as at March 2019 are shown in the following table and the Board Assurance Framework (March 2019) 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 2018/19 has seen:

    a) approval by the Board of Directors of a revised Risk Management Strategy in January 2019;

    b) the introduction of a new type of monthly risk report, rather than specific committee-based reports to give better oversight of the high scoring risks across the Trust to all committees;

    c) the risks identified by the former Liverpool Community Health NHS Trust in respect of the community services provided in South Sefton and Liverpool, have been reviewed and are now fully integrated into the Mersey Care risk management system;

d) risks now grouped and tagged by their root cause on the risk management system in order to better identify risk trends;

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.

16. The continued 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 is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board*".

17. The Board Assurance Framework discussed by the Board of Directors at its meeting in March 2019 can be found in Table 16 (see paragraph 304 of Chapter 16 – Annual Governance Statement.

PART B – PERFORMANCE REPORT

CHAPTER 3 – EXECUTIVE PERFORMANCE REPORT

18. The Executive Performance Report provides the Board of Directors and Board Committees with high level information relating to Trust performance across a number of key areas.

19. The Trust's Strategic Priorities for 2018/19 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.

20. 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.

21. The Executive Performance Report provides the Board of Directors and Board Committee members with information about the Trust's performance. The Executive Performance Report is a standing item on the agendas of the:

    a) Board of Directors;

    b) Performance, Investment and Finance Committee – chaired by a Non-Executive Director and reporting to the Board of Directors;

    c) Quality Assurance Committee – chaired by a Non-Executive Directors and reporting to the Board of Directors;

    d) Executive Committee – chaired by the Chief Executive and reporting to the Board of Directors.

22. A summary of the performance issues facing the Trust is also shared with the Council of Governors through a report to each of their meetings.

23. The Executive Performance Report is supported by a number of detailed documents and considered at other meetings:

a) 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. Reviews identify areas of performance improvement and actions either required or being undertaken to achieve targets;

b) each of the four clinical divisions within the Trust is subject to a Quarterly Performance Review, a quarterly meeting with executive level membership, where performance is both presented and scrutinised. The group's primary purpose is to provide assurance on the delivery of all aspects of operational, quality and financial performance, alongside risks and mitigating actions affecting the organisation. Additionally, service-specific deep dives are undertaken in order that the group gains a comprehensive understanding of all aspects of service delivery performance requirements.

24. As **Table 1A** shows, during 2018/19 Mersey Care in its Mental Health, Secure and Specialist Learning Disability Services provided care, treatment and support to 39,190 service users, broken down as follows for each of the following three clinical divisions.

Table 1A: Number of Service Users – Local, Secure and Specialist Learning Disabilities Divisions – 2018/19

Clinical Division	No. of Service Users
Local Services Division	37,169
Secure Division	309
Specialist Learning Disability Division	1,712

25. As **Table 1B** shows, during 2018/19 Mersey Care in its Community Services Division received 166,782 distinct referrals, broken down as follows for each geographical area.

Table 1B: Number of Referrals to the Community Division, 2018/19

Community Services Division	No. Referrals
South Sefton services	41,359
Liverpool services	125,423

26. During 2018/19 Mersey Care provided services from 124 sites (freehold - 81, Leasehold - 44) [8] and, as at 31 March 2019, had 766 inpatient beds. The Trust also had 1,864,968 outpatient attendances, community contacts or domiciliary visits. A breakdown of this activity by service line is provided in the **Table 1C** below.

[8] The number of sites Mersey Care provides services from has increased from 53 in 2017/18 to 124 sites in 2018/19 following the acquisition of the former Liverpool Community Health NHS Trust on 1 April 2018.

Table 1C: Outpatient, Community Contacts, Domiciliary Visits by Service Line, 2018/19

Service line	Activity Type	2018/19
Adult mental health services	Outpatient	10,988
	Community	188,342
Assessment services	Outpatient	-
	Community	17,963
Complex care services	Outpatient	3,230
	Community	87,069
Specialist services	Outpatient	1,451
	Community	59,251
Low secure services	Outpatient	-
	Community	2,860
Medium secure services	Outpatient	-
	Community	1,836
Offender health	Outpatient	22
	Community	6,435
Community Division (South Sefton)	Outpatient	53,398
	Domiciliary	209,655
Community Division (Liverpool)	Outpatient	645,843
	Domiciliary	571,840
Other service lines	Outpatient	269
	Community	4,516
Total		**1,864,968**

27. 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.

28. Further information on the Trust's performance against the Single Oversight Framework can be found in Chapter 15, with a list of the strategically significant risks available in Table 16, (paragraph 304 of the Annual Governance Statement).

	22 May 2019
Joe Rafferty **Chief Executive**	**Dated**

CHAPTER 4 – ENVIRONMENT & SUSTAINABILITY

Sustainability and Carbon Management

29. In response to the NHS Sustainability Development Unit (SDU) objectives to embed sustainability into all areas of the NHS, the Trust had previously a Carbon Management Plan through assistance provided by the Carbon Trust but this has now been replaced with a Sustainable Development Management Plan (SDMP) and associated delivery plan that has been approved by the Board of Directors.

30. 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.

31. 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.

32. As can be seen by **Table 2B** below this year has seen an increase in carbon emissions relating to Scope 1 and Scope 2 emissions from previous, this being attributed to the Trust expanding due to the acquisition of services from the former Liverpool Community Health NHS Trust.

33. 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 SDMP.

34. **Table 2A** provides a summary of the carbon emissions for the past 5 years as compared to the base line year is provided below:

Table 2A: Summary of Carbon Emissions over 5 Years compared to the Baseline

Carbon Emissions (electricity & gas) - CO_2e tonnes						
2009/10 (Base Year)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
11,222	10,028	9,748	9,835	8,684	6,894	7,220

35. The energy consumption and carbon emission figures for the current year along with a comparison of the previous year are detailed in the **Table 2B** below.

Table 2B: Energy Consumption & Carbon Emission Figures (2017/18 – 2018/19)

Greenhouse Gas Emissions Indicator		Consumption *(MWh)*		Emissions *(CO_2e tonnes)*	
		2017/18	2018/19	2017/18	2018/19
Scope 1 (Direct) Emissions - gas consumption		20,164	24,876	3,075	4,576
Scope 2 (Indirect) Emissions - electricity consumption		8,003	9,340	3,819	2,643
		Distance Travelled *(Miles)*		Emissions *(CO_2e tonnes)*	
		2017/18	2018/19	2017/18	2018/19
Scope 3 – official business travel emissions	Air travel	46,365	119,868	7.33	20.82
	Road travel	2,551,769	3,989,514	747.98	1,078.70
	Rail travel	217,187	239,573	16.61	17.35

36. Scope 3 emissions through Air, Road and Rail Business Travel show a marked increase on the previous years. Notably Air Travel emissions have increased by some 184% and Road Travel emissions have increased by some 45%. Rail Travel emissions remain fairly consistent although still increasing. This is in part is because the Trust has expanded with the acquisition of community physical health services provided by the former Liverpool Community Health NHS Trust.

37. It is proposed that 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 a focused review of the staff travel policies and to set objectives to reduce these emissions within the SDMP.

Table 2C: Financial Indicators for Energy (2017/18 – 2018/19)

Financial Indicator for Energy	2017/18	2018/19
Cost of Scope 1 & Scope 2 consumption (£)	2,607,750	2,971,980

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 2019.

39. Through the Backlog Maintenance budget further energy saving schemes have been completed during this year including heating boiler replacements and associated plant upgrades across the Trust's estate.

Water Consumption & Management

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

41. 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.

42. **Table 2D** shows that water consumption for the current year has shown an increase on the previous year, again in part as a result of the acquisition of the former Liverpool Community Health NHS Trust. Costs have also increased due to higher usage charges being levied by the water supplier.

Table 2D: Water Usage & Costs (2016/17 – 2018/19)

Finite Resource Consumption Indicator	2016/17	2017/18	2018/19
Water consumption (m^3)	85,805	153,986	172,464
Total expenditure – Water (£)	414,659	738,401	871,313

Waste Management

43. 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 comingled and 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.

44. 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.

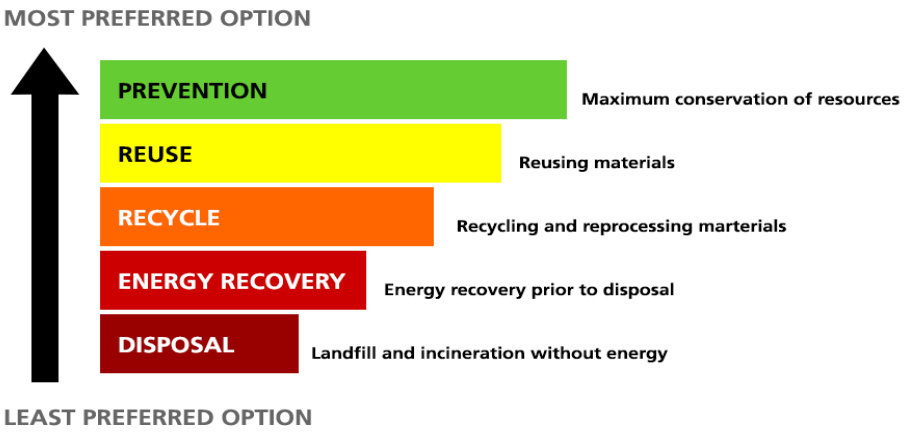


Table 2E: Waste Management (2016/17 – 2018/19)

Waste minimisation and management indicators (tonnes)	2016/17		2017/18		2018/19	
	Tonnes	%	Tonnes	%	Tonnes	%
Waste recycled/reused	357	54	213	32	242	34
Waste incinerated (clinical waste)/energy from waste	261	40	430	65	468	65
Waste to landfill	39	6	16	3	4	1
Total waste arising (tonnes)	657	100	659	100	714	100

Table 2F: Cost of Waste Management (2016/17 – 2018/19)

Financial indicators on waste	2016/17	2017/18	2018/19
Cost of waste incinerated/energy from waste (clinical waste) £	20,975.27	33,285.30	44,484.02
Total expenditure on waste arising £	163,997.67	168,858.09	170,881.36

45. 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.

46. Emphasis in the last year has been placed on the sorting of waste at source where possible. Although this has not reduced the overall volumes of waste, it has reduced the volumes of residual waste and tonnages landfilled to less than 1%. Newly agreed contracts for the forthcoming financial year will look again to reduce residual and incinerated waste tonnages and strive to improve reuse and recycling rates. A by-product of this should facilitate some cost savings across all waste streams in the forthcoming 12 months.

CHAPTER 5 – EQUALITY, DIVERSITY AND HUMAN RIGHTS

47. 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. The expansion of Mersey Care, as a result of taking responsibility for Liverpool and South Sefton's community physical health services over the last two years, has led to the Trust to developing and engaging on a new strategic approach to embedding equality and inclusion across everything the Trust does.

48. Our developing strategy has identified the following equality objectives for 2019 to 2021:

a) to improve year on year the reported employee experience for protected groups;

b) to embed high quality analysis through the use of data into the design, delivery of services including our decision-making processes;

c) to reduce health inequalities for protected groups by improving access to all services (includes accessible information standard);

d) to improve year on year the reported patient / service user experience for protected groups.

49. The strategy will be supported by a trust-wide Equality & Inclusion Action Plan, progress against which will be monitored by the Equality & Inclusion Group, which reports to the Board of Directors via the Quality Assurance Committee. The Group is chaired by a Non-Executive Director (Aislinn O'Dwyer). The Board of Directors receives a number of key equality driven performance reports within its routine business alongside equality and inclusion specific reports.

50. As part of this strategy review, together with the Trust's Workforce Race Equality Standard (WRES) results, we have re-launched of the Black, Asian and Minority Ethnic (BAME) Staff Network. The BAME Staff Network is working with the Trust on projects that aim to improve race equality, including our respect and civility workstream.

51. In 2018/19 the Trust also:

a) became a patron of the Mandela 8 charity including membership of a steering group, with other local organisations including Liverpool City Council, the Steve Biko Housing Association and trade unions, working to improve health and employment opportunities for Liverpool's BAME communities;

b) as a result of the re-launch of the BAME Staff Network, the Trust also launched staff networks for disabled, women and LGBTQI+ staff;

c) the Women's Staff Network celebrated International Women's Day with a self-care workshop and meeting held at Aintree Racecourse;

d) 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;

e) following engagement with our deaf and hearing-impaired patients, changed the Trust's British Sign Language (BSL) supplier to their supplier of choice.

CHAPTER 6 – COMPLAINTS AND COMPLIMENTS

52. The Trust uses learning from complaints and compliments as a further means of measuring performance. From 1 April 2018 to 31 March 2019, a total of 338 formal complaints were received, compared with 415 for the same period in 2017/18. Overall the Trust has seen a reduction of approximately 23% in the number of complaints received during 2018/19 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.

53. 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 1405 compliments in 2018/19 through a mix of verbal, written and face to face from service users, carers, families and external organisations. This figure has significantly increased from

2017/18 when we recorded 359 compliments. This increase is largely due to the Community Divisions 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 – FREEDOM TO SPEAK UP

54. In 2015 Sir Robert Francis produced his *Freedom to Speak Up Review* which, amongst a range of recommendations and principles, called for all NHS organisations to appoint a Freedom to Speak Up (FTSU) Guardian to improve the way organisations deal with concerns raised by their staff as part of the process of fostering "a culture of safety and learning in which all staff feel safe to raise concerns" (available by clicking here). In accordance with guidance issued by NHS Improvement and the National FTSU Guardian's Office[9], a trust's annual report should contain high level, anonymised data relating to FTSU and the actions a trust is taking to support a positive speaking up process.

55. Oversight and assurance in respect of the Trust's FTSU activities is undertaken by the Audit Committee, reporting to the Board of Directors (each receiving a bi-annual report on FTSU activities). The Lead Non-Executive Director overseeing FTSU is the Senior Independent Director (Gerry O'Keeffe). The Lead Executive Director is the Executive Director of Communications and Corporate Governance, supported by the Director of Patient Safety who oversees the FTSU Guardians.

56. The Trust's first FTSU Guardian commenced work in the organisation in October 2016. Two FTSU Guardians are now employed by the Trust so as to provide cover across the Trust, with one Guardian working four days per week and the other two days per week. Both work closely together and flexibly across services to meet staff shift patterns and working arrangements. The FTSU Guardians visit staff on and off Trust premises and, when required, provide unsocial hours cover. The FTSU Guardians work closely with the Just and Learning Culture programme (see paragraphs 248 to 253).

57. In 2018/19 a total of 162 staff have spoken up. The majority of staff speaking up have either done so in confidence or 'owned' (i.e. they have identified themselves), 19 staff raised their concerns anonymously[10]. Of these 16 contacts, 89 contacts have been closed while 73 cases remain open as at 31 March 2019.

58. Whilst the majority of cases are reviewed and effectively dealt with by the FTSU Guardians, to the satisfaction of the staff raising the initial concern(s), there have been seven cases where it has been necessary for the Director of Patient Safety to commission an external independent review. These are cases that are very complex and have involved:

9 *Guidance to NHS trust and NHS foundation trust boards on Freedom to Speak Up*, available by clicking here.

10 Although some concerns are raised collectively by a team / group, they have to be recorded individually by the FTSU Guardians, although reviews / action taken may be on a team / group basis.

a) a member of staff concerned at the treatment they have received from the Trust;

b) two separate concerns raised about the quality and safety of care at Clock View;

c) concerns raised by six district nursing team operating across South Sefton;

d) concerns about the management within one of the corporate teams.

59. The underpinning themes that have emanated from staff raising FTSU concerns have included:

a) communication, i.e., staff feeling they are not being listed too;

b) poor response times and consistency, i.e., staff feeling that Trust policies and procedures are not consistently applied;

c) bullying;

d) lack of confidence in management;

e) staff feeling unsafe; and

f) patient safety concerns.

60. The Trust has recognised that it has multiple ways for staff to report concerns – through the Freedom to Speak up Guardian, by following the whistleblowing policy, using 'tell Joe' (an email address for the chief executive) or through their staff side representative. An independent review has been commissioned by the lead Executive for with the aim of identifying if the process can be streamlined to make it easier for staff to raise a concern and to ensure that the Trust is adhering to national and local guidance.

61. In their recent well led review the CQC found that the Trust's FTSU policy met the standards set out in NHS Improvement's 'freedom to speak up: raising concerns (whistleblowing)' policy (2016). The CQC found that the FTSU had the training and experience to be able to perform their roles and that they raised awareness through the Trust's website/intranet, posters (many of which they saw during their inspection) and by visiting service sites.

62. The CQC found that staff they spoke with during the inspection, including focus groups, knew who at least one of the FTSU Guardians were and said that they felt confident to approach them with any concerns. Staff also told the CQC that they knew how to use the whistleblowing process and felt confident to raise concerns without fear of retribution.

63. The Trust undertook seven whistleblowing investigations in 2018. The CQC reviewed five of them and found that investigations were thorough and objective. Outcomes and lessons learned were shared with relevant individuals, including the original whistle-blower where their identity was known.

64. The FTSU Guardians have quarterly meetings with the Chairman and the Chief Executive, as well as meeting regularly with the Lead Non-Executive, the Lead Executive and the Director of Patient Safety with the aim of sharing current issues being raised and solving / discussing any complex issues. The FTSU Guardian(s) also meets with the Head of Human Resources as part of the process to ensure that all work undertaken meets national and local HR policy and procedure. The FTSU Guardians can meet with Chief Executive at short notice to raise a concern if it is felt this level of intervention is required.

65. In order to promote speaking up positively the FTSU Guardians visit wards and teams formally and informally during training sessions, team meetings, and reflective practice sessions to raise awareness of their role, discuss any concerns they may have and to gain an understanding of the general experiences of staff on those departments. The FTSU Guardians vary theses visits between both day and night shifts to increase visibility.

66. The FTSU Guardians and Director of Patient Safety review the number and type of issues raised via the FTSU process. These are shared with the Head of Human Resources and with clinical divisions via their surveillance processes. Issues raised are triaged with other related data and appropriate improvement action put in place.

67. The FTSU Guardians aim to work closely with the Just & Learning Committee to dovetail FTSU and just and learning messages. Key themes are emerging including that many staff who raise concerns via the FTSU route have already tried to raise them locally beforehand, and report going off sick with work related stress / illness or have attended their GP or Occupational Health department to help them cope.

CHAPTER 8 – EMERGENCY PLANNING, RESILIENCE AND RESPONSE

68. 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 Assurance Process. The Trust also contributes to the work of both the multi-agency Local Resilience Forum and to the NHS Local Health Resilience Partnership.

69. The Executive Director of Nursing and Operations is the Trust's Accountable Officer for Emergency Planning, Resilience and Response, supported by the Director of Patient Safety. Following the publication of the Department of Health & Social Care's *EU Exit Operational Readiness Guidance* at the end of December 2018, the Executive Director of Finance was appointed as the Trust's Senior Responsible Officer in respect of the Trust's EU Exit preparedness, taking responsibility for assessing risks associated with the EU Exit and ensuring appropriate mitigation and business continuity plans are in place.

CHAPTER 9 – FINANCE DIRECTOR'S REPORT

Summary

70. Over recent years Mersey Care has grown significantly, increasing the Trust's income from £206.9m in 2014/15 to £392.6m in 2018/19. The increase in turnover has largely been achieved through delivery of the Trust's Growth Strategy which has seen the acquisition of other health organisations, most recently the former Liverpool Community Health NHS Trust in April 2018 and the former Calderstones Partnership NHS Foundation Trust, together with being awarded contracts to provide South Sefton community health services (June 2017) and mental health services at HMP Liverpool (April 2018).

71. During this period of growth, the Trust has sustained strong financial performance including delivery of NHS Improvement control totals whilst maintaining a strong commitment to service quality. Strategic plans to integrate and transform new and existing services will ensure the trust continues to make progress in delivering perfect care within a financial sustainable delivery model.

72. Over the next year the Trust is planning a breakeven financial position. Achievement of this position will ensure the Trust receives an allocation from the Provider Sustainability Fund of £3.7m. The efficiency programme for the year is consistent with the recommendations of the Carter Review with regards to corporate and non-clinical saving opportunities. This approach, along with the 2019/20 contractual settlement, will allow the Trust to invest in front line service delivery whilst avoiding the need to reduce costs in those frontline services.

73. Maintaining our track record of strong financial performance will ensure the cash balances required to support essential capital investments to improve our estate and digital infrastructure are available in future years.

Financial Overview

74. In 2018/19, the Trust has achieved a £16.1m surplus and a Use of Resources rating of 1. Financial performance for the year included £3.6m of planned core Provider Sustainability Fund (PSF) along with a further incentive and bonus PSF allocation of £6.7m (i.e. £10.3m PSF in total).

75. The financial position has also been supported through the delivery of a £6.5m cost improvement programme (CIP) which as in the previous financial year was focused on cost reduction opportunities in non-clinical corporate areas of the trust.

76. Key financial risks have continued to be monitored against improvement plans during the year. Particular focus has been on cost pressures in medical staffing and the delivery of the corporate CIP programme. Both areas of risk have been effectively mitigated in 2018/19 but are expected to continue in 2019/20.

77. In 2018/19, the Trust was a victim of a sophisticated fraud resulting in the loss of cash to the organisation (£0.9m). The Trust has recovered £0.2m back from NHS

Resolution under the Fidelity Guarantee Scheme and the incident remains under investigation by NHS Counter Fraud Authority.

78. Measures to protect the Trust against such frauds have been strengthened and assurance on the implementation and effectiveness of these measures has been scrutinised by the Audit Committee on behalf of the Board of Directors.

79. The financial year has seen significant levels of financial investment across clinical services. Most notable has been the investment in the on-going quality, service improvement journey for the Community Services (i.e., the Liverpool and South Sefton community physical health services) following the recommendations of the Kirkup Review. Investments in this area included assessment of Trust incidents, organisational development programmes and development of community service delivery model.

Capital Investments

80. If the Trust manages resources effectively it will generate a surplus. This surplus can be carried forward year on year and used to invest in capital. Capital expenditure in 2018/19 totalled £44.204m and included the following key areas of investment as shown in **Table 3A** below.

Table 3A: Capital Expenditure in 2018/19

Scheme	Description	Capital Investment £m
Rowan View	New medium secure facility based at Maghull Health Park.	18.2
Hartley Hospital	New mental health facility at the existing Boothroyd Mental Health Unit site.	14.6
Global Digital Exemplar	Delivering improvements in the quality of care, through the world-class use of digital technologies and information.	2.5
Ashworth Hospital	Agile workspace in the OER Building and bathroom upgrades.	0.9
Macauley Ward	Refurbishment of ward.	0.6
Low Secure Unit	Development of a business case for new Low Secure Unit.	0.5

Income

81. The Trust received income of £392.6m in 2018/19 which was generated from a number of sources as set out in **Figure 1** below.

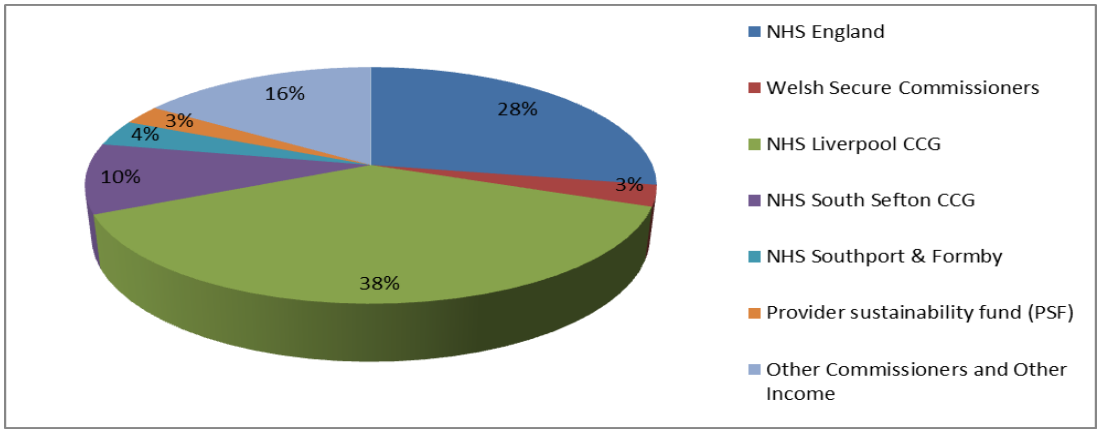


Figure 1: Analysis of Trust Income for 2018/19

Operating Expenditure

82. The Trust has invested the income received to fund the cost of services provided. The major areas of cost are summarised in **Figure 2** below with more than 70% of costs relating to staff.

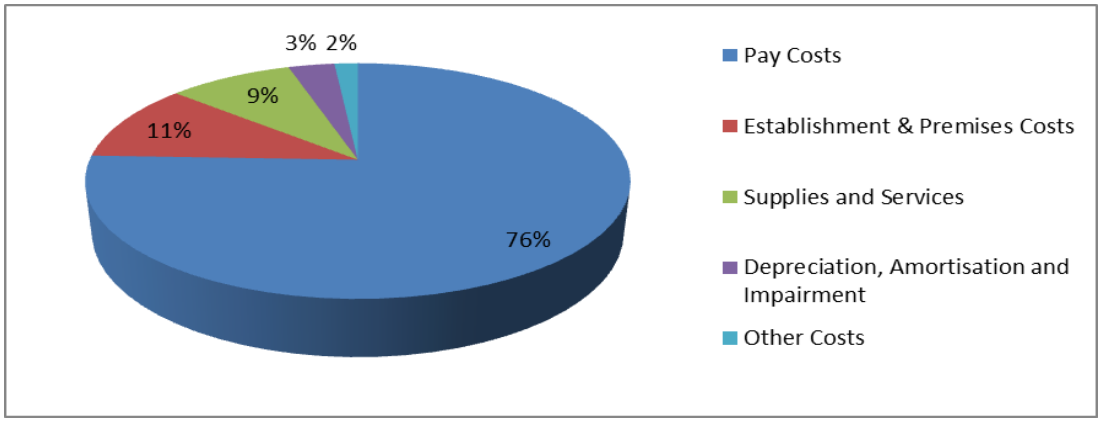


Figure 2: Analysis of Trust Expenditure for 2018/19

Better Payments Practice Code

83. 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. **Table 3B** provides a summary of the Trust's performance for 2018/19.

Table 3B: Performance against the Better Payment Practice Code 2018/19

	Invoices Paid			
	Within 30 days		Outside 30 days	
	Number	%	Number	%
NHS	2,675	99.3	19	0.7
Non NHS	55,545	97.2	1,607	2.8

84. During 2018/19 the Trust made payments of £0.008m under the late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015.

Payments Code

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

86. The Trust has signed up to the code and is committed to pay all invoices relating to small and medium businesses and individuals within 10 days.

Going Concern

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

88. 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 has adequate resources to continue in operational existence for the foreseeable future with no necessity of liquidation or ceasing operations. Accordingly, 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. Therefore, these accounts have been prepared on a going concern basis.

Trust Auditors

89. The Trust's external auditor is Grant Thornton UK LLP. They provide audit services in relation to the statutory audit duties as required by the Department of Health and Social Care in providing an independent audit opinion. The audit fee received for work carried out during 2018/19 on the financial statements and opinion was £0.061m. The breakdown of expenditure is detailed in **Table 3C** below.

Table 3C: External Audit Fees for 2018/19

	£
Financial statements and value for money	54,180
Other services (including the trust's Quality Account)	6,840
TOTAL	**61,020**

Longer Term Outlook

90. The Trust is in the process of refreshing its long term finance and investment strategy that will support delivery of the Trust's Strategic Plan. The finance and investment strategy will be finalised in summer 2019 and will be consistent with the vision set in the NHS Long Term Plan, seeking to deliver on the opportunities presented by the national £20.5bn investment in health over the next 5 years.

91. The Trust will focus on ensuring continued delivery of a financial sustainable service that ensures surplus delivery continues and generates cash resources to support on-going capital investment. The Trust will continue to seek to protect front line services and generate financial efficiencies from non-clinical services.

92. The Trust's future financial plans will be reflective of the national commitment to work closer with other system health and social care providers and commissioners. This commitment to work as an Integrated Care System (ICS) will be reflected in a combined financial plan for the ICS late in 2019. As such the Trust will continue to proactively engage and influence the local planning programme.

2019/20 Financial Year

93. The Trust has been set a financial control total of breakeven for 2019/20. Achievement of this position will ensure the Trust receives the full Provider Sustainability Fund (PSF) allocation of £3.7m, improving performance to a £3.7m surplus for the year. The financial plan reported to the Board of Directors has demonstrated an ability to deliver this position.

94. In 2019/20 Clinical Commissioning Groups (CCG's) should continue to invest in mental health services, in line with the national Mental Health Investment Standard (MHIS). This requires CCGs to increase spend by at least their overall programme growth allocation plus an additional percentage increment. In most cases this commitment has been reflected by commissioners in 2019/20 contracts.

95. Positive cash balances are forecast for the year with forecast cash at 31st March 2020 expected to be £24.8m. This forecast cash position is after a capital investment programme for the year of £46.8m.

Conclusion

96. The Trust continued to deliver a strong financial position during a challenging economic climate during 2018/19. I would like to thank all staff who worked hard to deliver the planned surplus and who have supported our investment priorities which has included our continued work on Hartley Hospital, Rowan View and the Global Digital Exemplar. These developments will continue in 2019/20 as the Trust plans to spend £46.8m across the capital programme. This would not be possible without the commitment to delivery of the financial plans each year.

PART C – ACCOUNTABILITY REPORT

CHAPTER 10 – DIRECTORS' REPORT

97. The Directors' Report has been prepared under direction issued by Monitor[11], 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 Financial Reporting Manual (FReM);

d) Additional Disclosures as required by NHS Improvement.

Membership

98. As a Foundation Trust, Mersey Care is required to have a membership which is representative of the population that it serves - which is reflected in the three main constituencies shown in **Table 4A** below.

Table 4A: Membership Constituencies

Constituency	Description	Areas / Classes
Service User and Carer	Those individuals (aged 14 and over) who at the time of applying to be a member are currently accessing, or have accessed any of the clinical / care services provided by the Trust in the last three years (and who consider themselves a service user) as well as those individuals who are caring for a current service user, or have cared for an individual who has accessed Mersey Care services in the last three years (and who consider themselves a carer).	This constituency has no areas or classes
Public	Any individual who apples to be a member (aged 14 or over) who resides in one of the three areas specified as an area for public constituency (see next column)	1. Liverpool, Sefton or Knowsley 2. Ribble Valley 3. The rest of England and Wales
Staff *(Note – whereas other constituents apply to be members, staff are automatically members unless they opt out.)*	Staff membership is open to anyone who is employed by the Trust under a contract of employment which has no fixed term, or who has been continuously employed by the Trust under a contract of employment for at least 12 months. Staff are eligible to join one of four classes of staff (see next column)	1. Medical Staff 2. Nursing Staff 3. Other Clinical / Clinical Support Staff 4. Non-Clinical Staff

[11] Monitor is commonly referred to as NHS Improvement.

99. The membership help the Trust build and maintain effective links with the community that it serves.

100. The Council of Governors is responsible for reviewing, contributing to and supporting the ***Membership Strategy*** and making recommendations to the Board of Directors, for approval of revisions to the strategy. The implementation of the Membership Strategy is monitored by the Membership and Engagement Working Group of the Council of Governors, which is chaired by a Governor.

101. The Trust expects its membership to grow in line with the targets. To achieve this growth, the Trust will keep under review changes to its membership profile, as members leave and new members are recruited, as well as the demographics of the population for the areas that it serves. Any gaps in its membership profile shall be considered and targeted recruitment activities undertaken to address such gaps.

102. The Trust's plans for its membership in 2018/19 included:

a) adding those staff transferred from the former Liverpool Community Health NHS Trust (LCH) to the Trust's membership;

b) recognising that upon acquisition the former LCH did not have a membership, advertising the availability of Mersey Care's membership scheme across the former LCH premises;

c) holding another Members Meeting in addition to the Annual Members Meeting (in future we plan to hold four Members Meeting, including the Annual Meeting, each year), which provide an opportunity for the Trust and its Governors to engage with its members;

d) participation in community projects to promote the Trust as a membership organisation, with the support of the Council of Governors;

e) promoting the membership at all Mersey Care events (e.g., opening of new services / buildings, consultation events);

f) directly targeting those groups identified in the Membership Strategy as under-represented across the Trust's membership; and

g) continuing the checking exercise to ensure the Trust's existing membership information was up-to-date.

103. Communications with members is through the Trust's dedicated membership magazine – *MC Magazine* – which is either sent to members electronically or by post (based on the members' preference). In addition, staff are updated on issues via the weekly newsletter – *yourNews* – which is emailed to all staff. The Trust's stakeholders are also emailed a monthly newsletter providing a monthly roundup of all the news involving Mersey Care.

104. The Members Annual General Meeting (July 2018) and the Members Meeting (February 2019) provided an opportunity to update members on the delivery of the Trust's Strategy and the progress made on major projects currently underway,

including the Medium Secure Unit and Southport new build. Members were able to speak to Governors on their role and information was available regarding the nominations for elections to the Council of Governors.

105. **Table 4B** below provides a breakdown of the membership by constituency, providing a comparison between the end of March 2018 and the end of March 2019.

Table 4B: Breakdown of Membership by Constituency

Constituency	As at 31 March 2018	As at 31 March 2019	Increase/ Decrease (%)
Public	4,833	4,639	(0.4)%
Service User/ Carer	2,250	2,151	(0.5)%
Staff	4,641	6,940	49.5%
Membership	**11,724**	**13,730**	**48.6%**

106. If you wish to become a member of Mersey Care then please:

a) go the Trust's website at https://www.merseycare.nhs.uk/getting-involved/become-a-member/;

b) email the Membership Office at membership@merseycare.nhs.uk;

c) ring the Membership Office on **0151 471 2303** for further information; or

d) write to: The Membership Office
c/o the Executive Office
Mersey Care NHS Foundation Trust
V7 Building
Kings Business Park
Prescot
Merseyside
L34 1PJ

The Council of Governors

107. 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. Further amendments to the Constitution have been agreed from time to time by the Board of Directors and the Council of Governors, including changes to the membership of the Council of Governors associated with the acquisition of the former Liverpool Community Health NHS Trust.

108. 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

109. 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 2018/19.

110. It is intended that the Council of Governors meets four times a year. However, as can be seen from the list of meeting below, an extraordinary meeting was held in September 2018 in respect of the appointment of a Non-Executive Director:

a) Thursday 12 April 2018;

b) Friday 3 August 2018;

c) Wednesday 12 September;

d) Thursday 18 October 2018;

e) Thursday 17 January 2019.

111. 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 make recommendations which need to be approved by the full Council. Key decisions made by the Council of Governors in 2018/19 include:

a) election by the Governors of a new Lead Governor (Paul Taylor);

b) extending the terms of office of the Chairman (Beatrice Fraenkel) and an existing Non-Executive Director (Nick Williams), both until 30 April 2022;

c) approving commencement of the recruitment process to appoint two new Non-Executive Directors (Murray Freeman and Aislinn O'Dwyer) for 3-year terms;

d) considering the Operation Plan for 2019/20 and the Quality Report for 2017/18;

e) selecting the indicator for testing by External Auditors as part of the Quality Report for 2018/19;

f) receiving the Annual Report and Accounts for 2017/18 and external audit opinion;

g) approving changes to the Trust's Constitution;

h) approving the process for and considered the outcome of the Chairman's and Non-Executive Directors appraisal process.

112. Governor elections were held in 2018 and 2019 (the results being issued on 12 September 2018 and 22 March 2019) and then a process was undertaken to ensure the eligibility of Governors. An induction and training programme was undertaken for new and existing Governors in 2018, taking into account the experience of existing Governors of the induction programme undertaken in 2016 and 2017. The induction and training programme is underway for those Governors elected in March 2019.

113. A list of Governors can be found in **Table 4C** below, which shows those Governors who have left or joined the Council of Governors over the 2018/19 reporting period. Details of Governors attendance at Council meetings can be found in **Appendix A**.

Table 4C: Council of Governors in Post during 2018/19

Constituency (as at 1 April 2018)	Governor	Term of Office	
		From	To
Public Constituencies (Elected Governors – 8)			
Liverpool, Sefton and Knowsley (5 posts)	Jayne Moore	01/05/16	30/04/19
	Helen Casstles	01/10/18	30/09/21
	Susan Martin	01/10/18	30/09/21
	Paul Smith	01/10/18	30/09/21
	Mary Sutton	01/10/18	30/09/21
	John Mousley*	01/05/16	30/09/18
Ribble Valley (1 post)	Vacant	-	-
Rest of England (2 posts)	Garrick Prayogg	01/11/17	30/09/20
	Alex Till	01/10/18	30/09/21

Constituency (as at 1 April 2018)	Governor	Term of Office	
		From	To
Staff Constituencies (Elected Governors – 8)			
Medical (1 post)	Sayed Ahmed	01/11/17	30/09/20
Nursing Staff (3 posts)	Maria Tyson	01/05/16	30/04/19
	Tracey Cummins	01/11/17	30/09/20
	Cheryl Barber	01/10/18	30/09/21
	Scott Parker*	01/05/16	30/09/18
Other Clinical, Scientific, Technical and Therapeutic Staff (3 posts)	Sara Finlayson	01/05/16	30/04/19
	Paul Allen	01/11/17	30/09/20
	Gie Peneche	01/10/18	30/09/21
	David Kitchen*	01/05/16	30/09/18
Non Clinical Staff (1 post)	Vacant	-	-
	Mike Jones	01/05/16	30/04/19
Service User and Carer Constituencies (Elected Governors – 8)			
Service Users and Carers (8 posts)	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
	Matt Copple	01/10/18	30/09/21
	Julie Dickinson	01/10/18	30/09/21
	Debbie Riozzie	01/10/18	30/09/21
	George Allen*	01/05/16	30/09/18
	Brian Murphy*	01/05/16	30/09/18
	Hilary Tetlow*	01/05/16	30/09/18
Appointed Governors - 5			
Academic (Edge Hull University)	Clare Austin	01/05/16	30/09/19
The Unions and Other Staff Representative Bodies formally recognised by the Trust	Mandi Gregory	01/04/18	31/03/21
Local Authority (Sefton Council)	Veronica Webster	01/04/18	30/03/21
Local Authority (Ribble Valley Council)	Vacant	-	-
Voluntary Sector (Sefton Carers)	Vicky Keeley	1/08/2017	30/04/19

Note – the table above shows (i) those Governors in post at 31 March 2019 and (ii) those Governors(*) in post until 30 September 2018 (when their term of appointment ended).

114. 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.

115. As a result of the acquisition of the former 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 was 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.

116. The overall effect of these changes is to reduce the number of Governors from 35 to 29 from 1 April 2018.

117. Governors can be contacted via one of the following methods by emailing MerseycareCoG@merseycare.nhs.uk and clearly state the name of the Governor you wish to contact.

The Board of Directors

118. The Board of Directors is a unitary board, which means that the both the Non-Executive Directors 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;

one other director attends the Board in a non-voting capacity (the Director of Strategy.

119. 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.

120. 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 377 (Table 17) 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 16 – Annual Governance Statement.

121. 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.

122. Details about the membership of the Board may be found in **Table 4D** (see paragraph 124) below.

123. During the reporting period of this Annual Report, 2018/19, the following changes have occurred with the Board of Directors:

a) Non-Executive Directors:
   i) Murray Freeman – appointed 8 May 2018,
   ii) Aislinn O'Dwyer – appointed 11 October 2018,
   iii) Cath Green – resigned 11 July 2018;

b) Executive Directors:
   i) Trish Bennett – took up post of Executive Director of Nursing *and* Operations from 1 April 2018,
   ii) Mark Hindle – resigned as Executive Director of Operations from 30 June 2018.

124. A full list of the Board of Directors is provided in **Table 4D** overleaf. Further details regarding the directors' skills, expertise and experience is available from in paragraph 126 below.

Table 4D: The Board of Directors for the Year Ending 31 March 2019

Name	Title		Term of Office	
			From	To
Chairman and Non-Executive Directors		**Time in Office (at end of current term)**		
Beatrice Fraenkel	Chairman	6 years	01/04/08	30/04/22
Gerry O'Keeffe	Non-Executive Director	4 years	18/04/13	17/04/20
Matt Birch	Non-Executive Director	2yrs 9 mths	05/09/12	31/03/19 (Resigned)
Nick Williams	Non-Executive Director	6 years	01/01/14	30/04/22
Pam Williams	Non-Executive Director	4yrs 1 mths	15/06/15	14/06/20
Cath Green	Non-Executive Director	1 yr 5 mths	02/02/17	11/07/18 (Resigned)
Gaynor Hales	Non-Executive Director	3yrs	23/05/17	22/05/20
Murray Freeman	Non-Executive Director	3yrs	08/05/18	07/05/21
Aislinn O'Dwyer	Non-Executive Director	3yrs	11/10/18	10/10/21
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. the 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
Trish Bennett	Executive Director of Nursing & Operations		01/03/18	N/A
Ray Walker	Executive Director*		20/06/11	Seconded (28/2/17)
Mark Hindle	Executive Director of Operations		01/05/16	Resigned (30/06/18)
Other Directors (Non-Voting)				
Louise Edwards	Director of Strategy		12/11/12	N/A
In Attendance (Statutory role, Non-Voting)				
Andy Meadows	Trust Secretary		21/03/14	N/A

* Ray Walker resigned from his post as Executive Director of Nursing at the end of February 2018. Ray is currently on secondment with Health Education England, which means that although Ray retains Executive Director status with the Trust, he is not a member, nor does he attend or vote at Mersey Care Board meetings.

Register of Interests

125. 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 interests – 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.

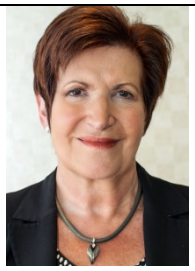
Skills, Expertise and Experience of Board of Directors

126. 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

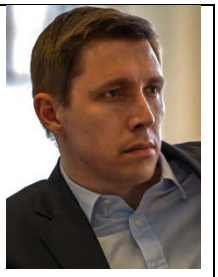
Chairman: Beatrice Fraenkel



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 ***and resigned on 31 March 2019***. 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 ***and resigned on 11 July 2018***. 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.

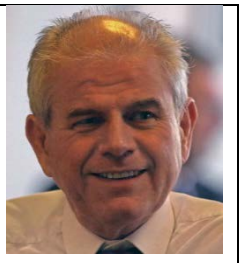
Qualifications: Fellow of Chartered Institute of Housing, Honorary Fellowship Award for Services to Vocational Education in Oldham from University Campus Oldham.

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)

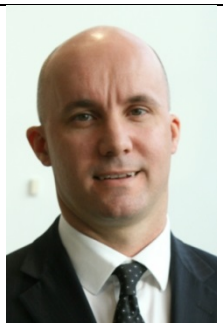


Gerry was appointed on 18 April 2013. Currently retired, he worked for CSC from 2000 until 2014 and was their Chief Operating Officer from 2011, reporting to the CEO for UK & Ireland, responsible for ensuring P&L, Client Satisfaction and revenue growth were delivered by all parts of the business. Other 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.

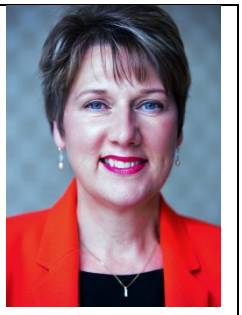
Non-Executive Director: Nick Williams



Nick was appointed on 1 January 2014. Currently Managing Director, Commercial & Business Transformation (January 2018-present) at Lloyds Banking Group. Previously he was Consumer Digital Director at Lloyds Banking Group (2014-January 2018); 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).

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: Murray Freeman

Murray was appointed on 8 May 2018 and his term ends on 7 May 2021. Murray has been a GP in Wirral since 1981. As well as being a GP has been involved in a whole range of NHS organisations, committees and activities including: Special Adviser to the Care Quality Commission, Clinical Investigator at NHS England (March 2018 – present), previous Non-Executive Director at Wirral Community NHS Foundation Trust. Murray has also held the role of GP Executive Board Member at Wirral Health Commissioning Consortium, Lead for Cancer & End of Life Care for the NHS Wirral / Merseyside & Cheshire Cancer Care Network and Medical Director for Wirral Community Healthcare NHS Trust (1994 – 1996).

Qualifications: Doctor of Medicine.

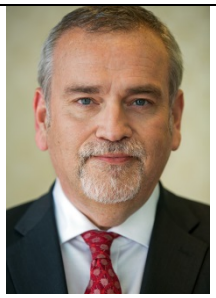
Non-Executive Director: Aislinn O'Dwyer

Aislinn was appointed on 11 October 2018.
Aislinn is a public health professional with a community nursing background with more than 25 years strategic management experience across both the NHS and local government, including as a Public Health Consultant with UK Med, Lancashire County Council, Cumbria & Lancashire SHA and North West RHA, as well as Director of Public Health at Blackburn with Darwen PCT, West Lancashire PCT. Aislinn is a Fellow of the Faculty of Public Health and is the Vice Chair of Savera UK, a Liverpool-based charity

Qualifications: RGN, District Nurse, Health Visiting, Masters in Public Health, Diploma in Humanitarian Assistance

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 and Operations: Trish Bennett

Note - Trish took up this post on 1 March 2018 as Executive Direct of Nursing, then assumed responsibility as Executive Director of Nursing & operartion from 1 April 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	

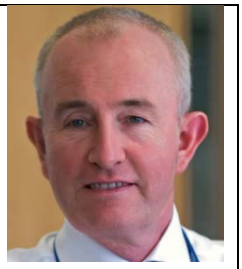
Executive Director of Workforce – Amanda Oates

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



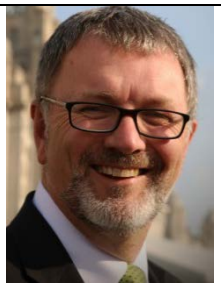
Appointed September 2004, Neil assumed the Deputy Chief Executive portfolio in 2013. Neil was previously the Executive Director of Finance and Performance, Mersey Care NHS Trust (2004-2013).

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: 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).

Executive Director of Operations: Mark Hindle

Mark was appointed in July 2016 and ***resigned on 30 June 2018***.
Mark 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.

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

127. **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 130 and 131 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.

128. 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-Executive Directors (which is the responsibility of the Council of Governors). A further independent Board Skills Review is planned in the next financial year.

129. **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 Very 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

130. 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 Governor. 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.

131. 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

132. Details of the Board of Director's remuneration are provided in the Remuneration Report (see Chapter 13).

Better Payment Practice Code

133. Details of the Trust's compliance with the Better Payment Practice Code can be found in the Finance Director's Report (see Chapter 9, paragraphs 83 – 84).

The Late Payment of Commercial Debts (Interest) Act 1998

134. There were several claims for late payment made against the Trust, the majority of which relate to the former Liverpool Community Health NHS Trust, totalling £7,825.53.

Cost Allocation and Charging

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

Financial Instruments

136. There were no risks arising from the use of financial instruments (see also the Annual Accounts for 2018/19).

Stakeholder Communications

137. The Trust continues to use established methods of communication to engage with service users, patients, staff and carers and has also developed new processes and enhanced our use of social media.

138. The main staff communications channels are:

a) *yourBrief* which is circulated to all staff to provide an accessible summary of the main issues discussed at the Board of Directors meetings

b) a weekly staff newsletter via email;

c) a weekly blog to staff and stakeholders from the Chief Executive,

d) *yourSpace* - the staff intranet and *yourBrief* which is circulated to all staff to provide an accessible summary of the main issues discussed at the Board of Directors meetings.

139. For stakeholders, *MC Magazine*, a quarterly magazine, is sent to Trust members, Trust sites, community centres, libraries, council offices and GP practices. The *Stakeholder Briefing* is issued 11 times a year to Governors, GPs, MPs, local councillors and local Clinical Commissioning Groups. The Trust, as a founder member of the Zero Suicide Alliance (ZSA), has overseen activities including training accessed by over 135,000 people. The external website has over a million and a half “hits” in the last year and provides information on services as well as links to self-help guides and a curated collection of online apps for service users and staff to access.

140. In respect of 2018/19 communication activities:

a) internal communications - 9 out of 10 staff say that they’re happy with how they’re communicated with and feel that they’re kept up to date with Trust wide news; twice-monthly staff induction on reputation and communication to more than 30 people per session;

b) the Trust’s website (www.merseycare.nhs.uk) – 1.6 million views;

c) direct contacts - 4,800 including ‘tell Joe’ (direct questions to the Chief Executive) and Freedom of Information Act enquiries;

d) social media – 1,944 posts and 2.4 million impressions on Twitter including an increasing number of short form video packages;

e) media contacts – 156 press briefings;

f) in-house design – designed and delivered some 240 posters, leaflets, banners and other promotional materials, staff campaigns including flu inoculations and Just and Learning Culture;

g) *MC Magazine* – produced four print editions with 8,500 hard copy distribution and development to our online versions;

h) estates – the team is supporting the Trust's Estates Strategy and has communication plans and activities in place around the new Hartley Hospital in Southport, Rowan View in Maghull and the Life Rooms developments;

i) service users – the team maintain close links with the Life Rooms, Whalley Media Crew, arts projects, Family and Carer groups and many other groups;

j) governors – the team supports communications with governors, which have included a staff video message from the Lead Governor, blogs and at events;

k) national recognition – for the communications team specifically for National Engage Award, PR Moment and a Northern Digital Award, plus nominations in other categories, and supporting wins for the Trust's services at many other events.

Partnership Working

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

142. The Trust continues to participate in the Cheshire and Merseyside Health and Care Partnership (the new name for the Sustainability and Transformation Partnership), including 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).

143. 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.

144. The Trust is also involved in a range of multi-agency arrangements to facilitate partnership working and risk management across the wider health and social care system, including:

a) the Chief Executive chairing 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 Liverpool;

b) the Chief Executive chairing the Sefton Provider Alliance a meeting that brings together representatives from NHS providers in Sefton together with local GPs, Sefton Council, Clinical Commissioning Groups and representatives of the voluntary sector to address the integration of health and social care across Sefton;

c) membership of the Transformation 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;

d) 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;

e) membership of the Local Health Resilience Partnership.

Additional Disclosures Required by the Finance Reporting Manual (FReM)

145. Accounting policies for pensions and other retirement benefits are set out in note 1.5 to the Annual Accounts and details of senior employees' remuneration can be found in the Remuneration Report (see Chapter 13).

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

146. 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

147. 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.

Compliance with the NHS Foundation Trust Code of Governance

148. During 2018/19 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 the Nolan principles, 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 Strategy
viii) Freedom to Speak Up Policy
ix) Fit and Proper Persons Policy

together with the Safety Framework in respect of the safety and quality of services;

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 4D**);

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 125);

j) an effective infrastructure, including the provision of high quality reports (informed by an annual cycle of business) and minutes to support the Council of Governors and its working groups, including a Membership Strategy reported to the Council of Governors;

k) an effective infrastructure, including the provision of high quality reports (informed by an annual cycle of business) and minutes to support the Board of Directors and its subcommittees. These allow the Board of Directors to measure and monitor the Trust's effectiveness, efficiency, and economy together with the quality of healthcare safety and delivery;

l) mechanisms to regularly review of the effectiveness of the Board of Directors through both independent reviews and independent well-led reviews commissioned by the Trust (see paragraphs 381 to 388);

m) an annual process for the election of the Lead Governor by the Governors;

n) robust Audit Committee arrangements, including the Council of Governors appointing the external auditor;

o) separate Remuneration (and where applicable Nominations) Committees to oversee the remuneration / appointment / re-appointment of Non-Executive Directors and Executive Directors, with membership drawn appropriately to ensure nobody is involved in determining their own remuneration / terms and conditions of services;

149. The Board of Directors confirms that the Trust has complied with the Code of Governance. Although the Code explicitly calls at least half the Board of Directors, excluding the Chair, to comprise of Non-Executive Directors (Principle B.1.2), Mersey Care also seeks to apply this requirement to its Board Committees, with the exception of:

a) the Audit Committee, which the Code (Principle C.3.1) states should draw its membership from Non-Executive Directors;

b) the Performance, Finance and Investment Committee which, although the Non-Executive Directors are in a minority, has established a mechanism to ensure an equal number of Non-Executive Directors to Executive Director has a vote; and

c) the Executive Committee which does not have any Non-Executive Directors. This is chaired by the Chief Executive and provides a mechanism for the Executive Team to oversee the operational management of the Trust. Assurance is also provided through the Quality Assurance Committee and the Performance, Investment & Finance Committee to the Board of Directors on operational delivery.

Directors' responsibility for preparing financial statements

150. 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

151. 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.

152. 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

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

CHAPTER 11 – STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

154. 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.

155. 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.

156. In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's 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 and Social Care's *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;

e) confirm that 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 NHS Foundation Trust's performance, business model and strategy; and

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

157. 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.

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

	22 May 2019
Joe Rafferty **Chief Executive**	**Dated**

CHAPTER 12 – AUDIT COMMITTEE

Role of the Audit Committee

159. 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, at the end of March 2019, two other Non-Executive Directors (Gerry O'Keeffe and Nick Williams) as members[12]. The Audit Committee met on six occasions in 2018/19 and all meetings were quorate (details of members' attendance can be found in **Appendix B**).

160. 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 2018/19 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.

161. 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.

162. 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 2018/19

Internal control and risk management

163. The Committee, having reviewed relevant disclosure statements for 2018/19 and other appropriate independent assurance, together with the Director of Internal Audit Opinion, external audit opinion (at its May 2019 meeting), considers that the 2018/19 Annual Governance Statement is consistent with the Committee's view on the Trust's system of internal control. Accordingly the Committee supported the 2018/19 Annual Governance Statement for approval by the Board of Directors.

164. The Audit Committee receives regular assurance on the Trust's risk management processes through the Executive Lead for risk (Medical Director), supported by the Risk Management Group. Further work has taken place over the last year to embed

[12] For a few meetings the Audit Committee in addition to the Non-Executive Director Chair (Pam Williams) had three other Non-Executive Director members (Gerry O'Keeffe, Nick Williams and Murray Freeman), but this was reduced to two other members (Gerry O'Keeffe and Murray Freeman) at March 2019's Board of Directors meeting as a result of changes to Non-Executive Directors' committee membership following the resignation of a Non-Executive Director.

risk management across the Trust, including the integration of the risks relating to the former Liverpool Community Health NHS Trust's services, acquired by the Trust on 1 April 2018.

165. Risk priority areas for 2018/19 included:

a) following a significant fraud incident in August 2018, the Audit Committee has sought a range of assurance from the Executive Director of Finance, the Trust's Anti-Fraud Specialist, Mersey Internal Audit Agency (MIAA) and the NHS Counter Fraud Agency on the response to this incident and the adequacy of financial controls and arrangements going forward;

b) a range of other issues including *Freedom to Speak Up* issues (whistleblowing), clinical audit arrangements, management of service user leave and the Agenda for Change human resources processes.

Internal audit

166. 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.

167. 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 regular reports on follow-up actions from internal audit reviews undertaken, including those of the former Liverpool Community Health NHS Trust.

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

169. The Committee reviewed and approved the internal audit plan and detailed programme of work for 2018/19 at its April 2018 meeting. This included reviews of combined financial systems, clinical information systems, information governance toolkit, workforce planning, corporate governance compliance and the assurance framework.

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

Anti-Fraud

171. The Committee reviewed and approved the counter fraud policy and work plan for 2018/19 at its April 2018 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. In light of the sophisticated fraud the Trust was subject to, the Committee has received assurance on the implementation and effectiveness of those measures put in place to protect to the Trust against such frauds.

External audit

172. 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. The Trust has a three-year contract with Grant Thornton for external audit subject to regular effectiveness reviews. The Trust has procedures for considering any non-audit services provided by external audit.

173. 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

174. 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 2018/19 management assurance outside of the audit action plans was received in respect of the prioritisation framework to support review of the Trust's Disposal Policy (surplus land and buildings) and the corporate performance reporting process.

Financial Assurance

175. 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

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

Review of Audit Committee Effectiveness

177. The Audit Committee undertakes an annual review of its effectiveness using the self-assessment tools provided in the NHS Audit Committee Handbook. These were completed in August 2018 (Committee processes) and February 2019 (Committee effectiveness). No significant areas for improvement were identified in either of these assessments.

P. J. Williams	22 May 2019
Pam Williams **Chair of the Audit Committee**	**Dated**

CHAPTER 13 – REMUNERATION REPORT

What this report covers

178. 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 2018 to 31 March 2019;

b) provides tables of information showing details of the salary and pension interests of all Directors for the financial period 1 April 2018 to 31 March 2019;

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 (SI 2008/410) ("the Regulations"); Parts 2 and 4 of Schedule 8 of the Regulations as adopted by Monitor (NHS Improvement) 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 and Operations
- Executive Director of Communications and Corporate Governance
- Executive Director of Workforce;

ii) Other Directors (non-voting):
- Director of Strategy and Planning.

Board of Directors' Remuneration and Terms of Service Committee

179. **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.

180. **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 16 – Annual Governance Statement.

181. The work of the Remuneration and Terms of Service Committee during 2018/19 has included:

a) approval of a request of an individual staff member to withdraw from the Mutually Assured Resignation Scheme (MARS), and the approval of funding for a previously declined application;

b) approval of the request to implement a MARS scheme for non-clinical staff and the associated funding to support the scheme, subject to the Performance, Investment and Finance Committee receiving appropriate assurance in relation to the overall financial position;

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

d) noted correspondence received from NHS Improvement regarding the Very Senior Manager inflation uplift against set criteria for the financial year 2018/2019;

e) approved the appointment of the Director of Corporate Transformation as a role subject to Very Senior Manager pay arrangements and approved maintaining the salary range and associated benefits of the post-holder's existing remuneration and inclusion of this role as part of the executive independent pay review;

f) noted the financial cost of the consultancy work undertaken by the former Executive Director of Operations and agreed to fund the extension of this consultancy work until 31 December 2019 to a maximum of £70,000;

g) approval of a series of redundancy proposals resulting from the acquisition of the former Calderstones Partnership NHS Foundation Trust;

h) approved the special severance settlement for a staff member and write off of associated overpayments (subject to HM Treasury approval) based on legal advice;

i) agreed the key principles in respect of an Executive Pay Review;

j) approved the implementation of NHS Improvement's recommendation in respect of Very Senior Managers pay, backdating the award of £2,075 per annum to 1 April 2018.

Remuneration for the Chairman and Non-Executive Directors

182. 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 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-Executive Directors - £13,000 per annum.

Remuneration for Executive Directors / Other Board Directors

Employment Contracts

183. 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 5**).

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

Table 5: 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
Patricia (Trish) Bennett (1)	Executive Director of Nursing and Operations	01/08/2016	Permanent (6 months)	None
Elaine Darbyshire	Executive Director of Communications and Corporate Governance	01/06/2013	Permanent (6 months)	None
Louise Edwards	Director of Strategy and Planning	12/11/2012	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
Amanda Oates	Executive Director of Workforce	01/08/2013	Permanent (6 months)	None
Mark Hindle (2)	Executive Director of Operations	01/07/2016	Permanent (6 months)	None
Ray Walker (3)	Executive Director of Nursing	20/06/2011	Permanent (6 months)	None

Notes

1 Appointed as Executive Director of Nursing with effect from 1 March 2018, role changed to become Executive Director of Nursing & Operations from 1 April 2018

2 Resigned as Executive Director of Operations on 30 June 2018.

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 since 1 March 2018.

Remuneration Process for Executive Directors / Other Board Directors

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

186. Starting salaries for Executive Directors / Other Board 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. This Committee also considers the notice periods (normally 6 months) as part of the approval of the remuneration package for Executive Directors / Other Board Directors.

187. Progression is determined by the Board of Directors' Remuneration 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.

188. Executive Directors / Other Board 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.

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

Future Process on Remuneration of Executive Directors / Other Board Directors

190. 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[13] – employer and employee contributions as specified by NHS Pension Agency unless the senior manager opts out;

d) Additional benefits[14] - tax-free childcare voucher scheme, salary sacrifice lease car scheme, salary sacrifice home electronics scheme, cycle to work scheme.

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

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

192. 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

193. 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.

194. 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 2019

195. 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.

196. In compliance with Article 21 of the General Data Protection Regulation (GDPR) each member of the Board, detailed in the tables below, have given their consent for their information to be included.

197. **Tables 6 to 9** below provide details of the salaries and / or allowances for the Chairman / Non-Executive Directors and the Executive Directors / Other Board Directors for both 2017/18 and 2018/19. **Table 10** provides details of the Pension Benefits.

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

Table 6: Executive Directors / Other Board Directors Salaries (April 2018 to March 2019)

		2018-2019					
		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	30			0	215 - 220
David Fearnley – Medical Director		255 - 260	83			30.0 - 32.5	295 - 300
Neil Smith – Executive Director of Finance / Deputy Chief Executive		145 - 150	62			0	130 - 135
Elaine Darbyshire - Executive Director of Communications and Corporate Governance.		125 - 130	29			20.0 - 22.5	150 - 155
Amanda Oates - Executive Director of Workforce		115 - 120	57			17.5 - 20.0	140 - 145
Louise Edwards - Director of Strategy and Planning		115 - 120	52			20.0 - 22.5	140 - 145
Trish Bennett - Executive Director of Nursing and Operations	**2**	125 - 130	16			47.5 - 50.0	175 - 180
Ray Walker - Executive Director (seconded to Health Education England)	**3**	125 - 130	0			7.5 - 10.0	135 - 140
Mark Hindle - Executive Director of Operations	**4**	35 - 40	0			0	15 - 20
Jim Hughes - Director of Informatics and Performance Management	**5**	0	0			0	0
Band of Highest Paid Director's Total Remuneration (£'000)		295 - 300					
Median Total Remuneration of all staff		30,070					
Pay Multiple Ratio		8.6					

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).

Note – explanatory text in support of the notes shown in column 2 above can be found at the end of Table 9 below.

Table 7: Chairman / Non-Executive Directors Allowances (April 2018 to March 2019)

		2018-2019					
		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		45 - 50	11				45 - 50
Matt Birch		10 - 15					10 - 15
Gerry O'Keefe		15 - 20					15 - 20
Catherine Green	**6**	0 - 5	1				0 - 5
Pamela Williams		15 - 20	9				15 - 20
Nicholas Williams	**7**	0					0
Robert Beardall	**8**	0					0
Gaynor Hales		10 - 15	6				10 - 15
Murray Freeman	**9**	10 - 15					10 - 15
Aislinn O'Dwyer	**10**	5 - 10					5 - 10
Brenda Roe	**11**	0					0

Note – explanatory text in support of the notes shown in column 2 above can be found at the end of Table 9 below.

Table 8: 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	£'00	£'000
Executive Directors							
Joseph Rafferty - Chief Executive	**1**	210 - 215	49			0	215-220
David Fearnley – Medical Director		255 - 260	64			90.0-92.5	350-355
Neil Smith – Executive Director of Finance / Deputy Chief Executive		145 - 150	55			37.5-40.0	185-190
Elaine Darbyshire - Executive Director of Communications and Corporate Governance.		120 - 125	53			32.5-35.0	160-165
Amanda Oates - Executive Director of Workforce		115 - 120	97			52.5-55.0	180-185
Louise Edwards - Director of Strategy and Planning		110 - 115	35			47.5-50.0	165-170
Trish Bennett - Executive Director of Nursing and Operations	**2**	115 - 120	23			57.5-60.0	175-180
Ray Walker - Executive Director (seconded to Health Education England)	**3**	125 - 130	56			20.0-22.5	150-155
Mark Hindle - Executive Director of Operations	**4**	145 - 150				2.5-5.0	150-155
Jim Hughes - Director of Informatics and Performance Management	**5**	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					

Note – explanatory text in support of the notes shown in column 2 above can be found at the end of Table 9 below.

Table 9: 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	£'000		£'000	£'00	£'000
Non Executive Directors							
Beatrice Fraenkel - Chairman		45 - 50	19				45 - 50
Matt Birch		10 - 15					10 - 15
Gerry O'Keefe		15 - 20					15 - 20
Catherine Green	**6**	10 - 15	12				10 - 15
Pamela Williams		15 - 20	9				15 - 20
Nicholas Williams	**7**	0					0
Robert Beardall	**8**	10 - 15					10 - 15
Gaynor Hales		10 - 15	6				10 - 15
Murray Freeman	**9**	0					0
Aislinn O'Dwyer	**10**	0					0
Brenda Roe	**11**	0 - 5					0 - 5

Notes:

1 Joseph Rafferty (Chief Executive) ceased contributions into the NHS Pension Scheme on 1 April 2017.

2 Trish Bennett was appointed as Executive Director of Nursing with effect from 1 March 2018. Her role changed to become Executive Director of Nursing and Operations from 1 April 2018.

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.

4 Mark Hindle resigned as Executive Director of Operations on 30 June 2018.

5 Jim Hughes retired from the post of Director of Informatics and Performance Management on 31 August 2017.

6 Catherine Green resigned as a Non-Executive Director with effect from 11 July 2018.

7 In accordance with his contract of employment, Nicholas Williams (Non-Executive Director) received no remuneration from the Trust.

8 Robert Beardall resigned as a Non-Executive Director with effect from 5 March 2018.

9 Murray Freeman was appointed as a Non-Executive Director with effect from 8 May 2018.

10 Aislinn O'Dwyer was appointed as a Non-Executive Director with effect from 11 October 2018.

11 Brenda Roe resigned as a Non-Executive Director with effect from 31 May 2017.

Pension Benefits

198. 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 10** below shows the pension benefits received by the Executive Directors / Other Board Directors.

Table 10: Executive Directors / Other Board Directors Pension Benefits (April 2018 to March 2019)

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 31.03.19 (bands of £5000) £'000	Lump sum at pension age related to accrued pension at 31.03.19 (bands of £5000) £'000	Cash Equivalent Transfer Value at 01.04.18 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31.03.19 £'000	Employers Contribution to Stakeholder Pension £'000
Joseph Rafferty - Chief Executive*	0	0	0	0	0	0	0	0
David Fearnley – Medical Director	2.5-5.0	0.0-2.5	50-55	145-150	831	146	1002	20
Neil Smith – Executive Director of Finance / Deputy Chief Executive	0.0-2.5	0.0-2.5	60-65	180-185	1204	129	1369	21
Elaine Darbyshire - Executive Director of Communications and Corporate Governance	0.0-2.5	0	20-25	0	256	59	326	18
Amanda Oates - Executive Director of Workforce	0.0-2.5	0	25-30	55-60	390	76	478	17
Louise Edwards - Director of Strategy and Planning	0.0-2.5	0	20-25	35-40	261	58	329	17
Trish Bennett - Executive Director of Nursing and Operations	2.5-5.0	7.5-10.0	35-40	110-115	683	139	843	18
Ray Walker - Executive Director of Nursing	0.0-2.5	2.5-5.0	25-30	75-80	540	80	636	18
Mark Hindle - Executive Director of Operations	0	0	70-75	220-225	1585	134	1766	6

* Joseph Rafferty (Chief Executive) ceased contributions into the NHS Pension Scheme on 1 April 2017.

Note: The factors used to calculate the Cash Equivalent Transfer Value (CETV) increased on 29 October 2018. This increase is reflected in the calculations used in the above table.

Cash Equivalent Transfer Values (CETV)

199. 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

200. 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

201. 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.

202. The banded remuneration of the highest paid director in Mersey Care NHS Foundation Trust in the period April 2018 to March 2019 was £257,739 (2017/2018, £256,270). This was 8.57 times (2017/2018, 9.31) the median remuneration of the workforce, which was £30,070 (2017/2018, £27,540).

203. For the period April 2018 to March 2019, 0 (zero) employees (2017/2018, 0) received remuneration in excess of the highest-paid director (in 2017/18 the number was also 0 [zero] employees). Remuneration ranged from £17,652 to £257,739 (2017/2018, £14,120 to £256,270).

204. 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.

205. The average number of full-time equivalent staff for the period April 2018 to March 2019 was 6,589 (2017/2018, 4,483) which generated a pay multiple of 8.57 (2017/2018, 9.31). The reduction in the pay multiple is mainly driven by the increase in the number of staff following the acquisition of the former Liverpool Community

Health NHS Trust in April 2018. The highest earning director's salary has changed very little, however the increase in the number of staff has changed the median salary value. This has resulted in a reduction in the pay multiple when compared to the previous year.

Reporting of Other Compensation Schemes – Exit Packages

206. NHS Foundation Trusts are required to disclose summary information of their use if exit packages in the year.

Exit Packages

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

208. **Table 11A** discloses details of all exit packages, analysed between compulsory redundancies and other – non-compulsory – departures. The values of these exit packages are analysed by cost band. Comparative information for 2017/18 is included.

Table 11A: Exit Payments by Type and Cost Band for 2018/19 and 2017/18

Exit Package Cost Band	Payments for 2018/19			Payments for 2017/18		
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Less than £10,000	0	24	24	10	29	39
£10,000 to £25,000	2	13	15	16	16	32
£25,001 to £50,000	14	6	20	22	5	27
£50,001 to £100,000	3	4	7	4	2	6
£100,001 to £150,000	0	0	0	2	0	2
£150,001 to £200,000	1	0	1	0	0	0
Total number of exit packages by type	**20**	**47**	**67**	**54**	**52**	**106**
Total resource cost	**£886,000**	**£819,000**	**£1,706,000**	**£1,742,000**	**£690,000**	**£2,432,000**

209. Redundancy costs have been paid in accordance with the provisions of the NHS Scheme. Other departure costs have been paid in accordance with the provisions of the NHS Scheme/Trust's Mutually Agreed Redundancy Scheme (MARS). Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included within this table.

210. In respect of **Table 11A** above, please note:

a) this table reports the number and value of exit packages agreed in the year;

b) the expense associated with these departures may have been recognised in part or in full in a previous period.

Non-Compulsory Departures

211. **Table 11B** discloses details the number of non-compulsory departures which attracted an exit package in the year and the values of the associated payment(s) by individual type. Comparative information for 2017/18 is included.

Table 11B: Non-Compulsory Departures attracting Exit Payments for 2018/19 and 2017/18

	For 2018/19		For 2017/18	
	Number of agreements	Total value of agreements	Number of agreements	Total value of agreements
Voluntary redundancies including early retirement contractual costs	0	£0	0	£0
Mutually agreed resignations (MARS) contractual costs	25	£718,000	29	£613,000
Early retirements in the efficiency of the service contractual costs	0	£0	0	£0
Contractual payments in lieu of notice	42	£102,000	51	£77,000
Exit payments following Employment Tribunals or court orders	0	£0	0	£0
Non-contractual payments requiring HM Treasury approval	0	£0	0	£0
Total	**67**	**£819,000**	**80**	**£689,000**

212. As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in **Table 11B** which will be the number of individuals.

213. In respect of **Table 11B** above, please note:

a) any non-contractual payments in lieu of notice are disclosed under “non-contractual payments requiring HM Treasury approval”;

b) includes any non-contractual severance payment made following judicial mediation, and relating to non-contractual payments in lieu of notice;

c) Nil non-contractual payments (£0) were made to individuals where the payment value was more than 12 months’ of their annual salary;

Approved by:

	22 May 2019
Joe Rafferty **Chief Executive**	**Dated**

CHAPTER 14 – STAFF REPORT

Analysis of Average Staff Numbers

214. **Table 12A** below shows information on the number of staff employed by the Trust by whole time equivalents (WTE)

Table 12A: Average Staff Numbers (WTE)

Staff Group	Permanent (wte)	Other (wte)	Total (wte)
Medical and Dental	169.70	-	169.70
Nursing	2,098.94	-	2,098.94
Scientific, Therapeutic & Technical	834.53	-	834.53
Health Care Support staff	1,866.63	-	1,866.63
Admin and Estates	1,619.51	-	1,619.51
Agency and contract staff	-	127.22	127.22
Bank Staff	-	396.89	396.89
All Staff Groups	**6,589.31**	**524.11**	**7,113.42**

Staff Breakdown by Gender

215. **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 Gender and Role as at 31 March 2019 (WTE)

Title	Female	Male	Total
Non-Executive Directors	4	4	8
Executive Directors	3	3	6
Other Employees	4,630	1,914	6,544
Total	**4,637**	**1,921**	**6,558**

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

216. **Table 12C** 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 12C: Staff by Disability and Role as at 31 March 2019 (WTE)

Title	Yes	No	Not Stated	Total
Non-Executive Directors	-	8	-	8
Executive Directors	-	6	-	6
Other Employees	364	5,659	521	6,544
Total	**364**	**5,673**	**521**	**6,558**

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

217. **Table 12D** 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 12D: Staff by Ethnicity and Role as at 31 March 2019 (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	-	-	-	-	-	-	8	8
Executive Directors	-	-	-	-	-	-	6	6
Other Employees	118	114	43	87	135	91	5,956	6,544
Total	**118**	**114**	**43**	**87**	**135**	**91**	**5,956**	**6,558**

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

218. **Table 12E** 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 12E: Staff by Sexual Orientation and Role as at 31 March 2019 (WTE)

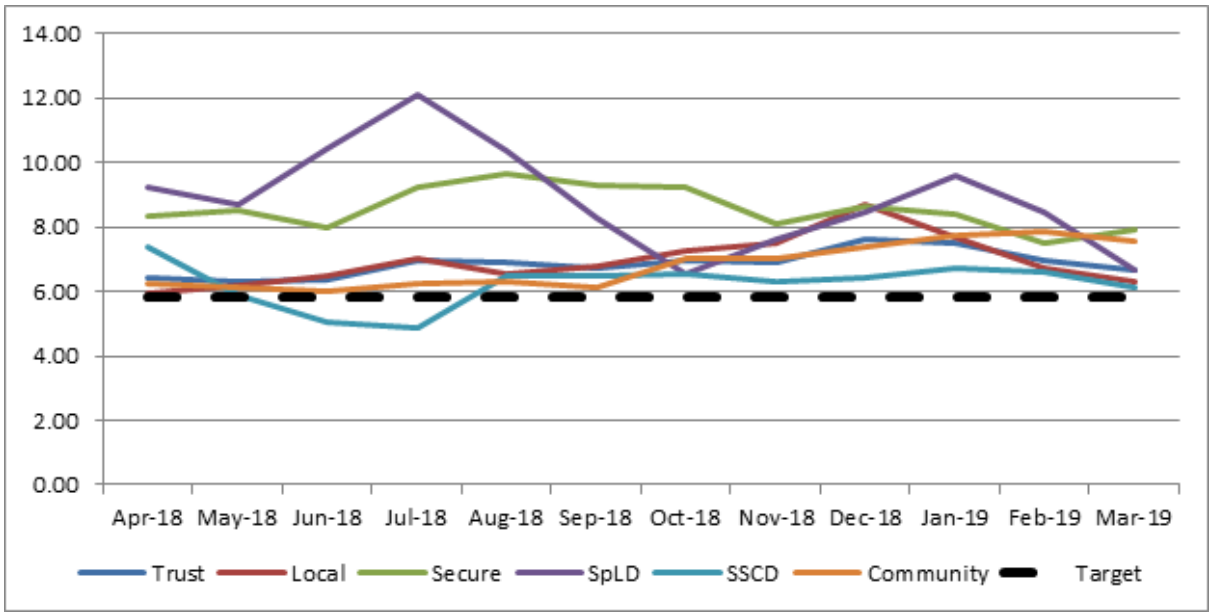
Title	Bisexual	Gay/Lesbian	Hetero-sexual	Not Stated / Disclosed	Undefined	Total
Non-Executive Directors	-	-	8	-	-	8
Executive Directors	-	-	5	1	-	6
Other Employees	38	115	5,551	573	267	6,544
Total	**38**	**115**	**5,564**	**574**	**267**	**6,5584**

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

219. **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)



220. To support the reduction of sickness absence, the Trust has developed a Sickness Absence Reduction Plan which is centred around the Department of Health & Social Care's 5 High Impact Changes. Training for managers on the application of the Supporting Attendance Policy (HR07) has taken place during 2018/19. Throughout 2018/19 the Trust has been working with NHS Improvement, together with several other NHS organisations in the surrounding area, to reduce absence in the NHS.

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.

221. Mersey Care is recognised as a 'Disabled Positive' 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.

222. 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.

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

224. The Recruitment 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.

225. 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.

226. 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. In addition, 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.

227. 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

228. 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.

229. 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.

230. 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. The Trust has in place a range of communication channels including the Chief Executive's blog, *yourNews* (a weekly email update), Birthday Breakfasts with the Chief Executive, bi-annual divisional road shows and leadership forum meetings where the Chief Executive updates his managers and senior leaders.

231. 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.

232. The Trust's appraisal process (Personal Achievement and Contribution Evaluation-PACE) continues to be enhanced and embeds the Trust values, helping staff to understand their role in delivering the Trust's performance and also encouraging and empowering 'leadership' at every level.

233. 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

234. The 2018/19 National Staff Survey for Mersey Care was conducted on line and was sent to all staff.

235. The National Staff Survey is conducted independently from the Trust so as to assure staff regarding the confidentiality of their responses. The Trust always provides feedback to staff on both the results and how the Trust intends to address any issues raised via divisional actions plans.

236. Mersey Care's response rate for the National Staff Survey for 2018 was 51%, which is above the national average of 45%.

237. The results are now presented in 10 Themes which are scored on a 01 to 10 point scale, where 10 is always more positive. Mersey Care has met or exceeded the national average in 6 out of these 10 themes.

238. Given the changes to the Trust's organisational structure following the acquisition of the former Liverpool Community Health NHS Trust (LCH), the independent provider has not been able to provide fully comparable data that allows the Trust to assess Staff Survey result for this year with those from previous years. The Trust has attempted to undertake this analysis internally where possible, so as to indicate trends from previous years in order to inform future action plans. To this effect 2018 will become 'Year Zero' of the new integrated organisation and the new reporting format to provide the benchmark for future results.

239. The Trust's results for this year are encouraging in terms of comparison against national average and against 2017's results. The Trust is either meeting or above average in 6 out of the 10 key themes. When the Trust compares our results by question with the previous year, the results are shown in **Table 13** below.

Table 13: 2018 National Staff Survey compared against 2017 Survey

Number of questions where the Trust has improved	59
Number of questions where the results are the same as the previous year	12
Number of questions where the Trust has seen a slight deterioration	11
Number of questions which are new so as to have no direct comparator	8

240. In relation to Overall Staff Engagement the Trust has achieved a score of 7.0 which meets the national average for our comparator group. All clinical divisions have seen improvements in relation to engagement.

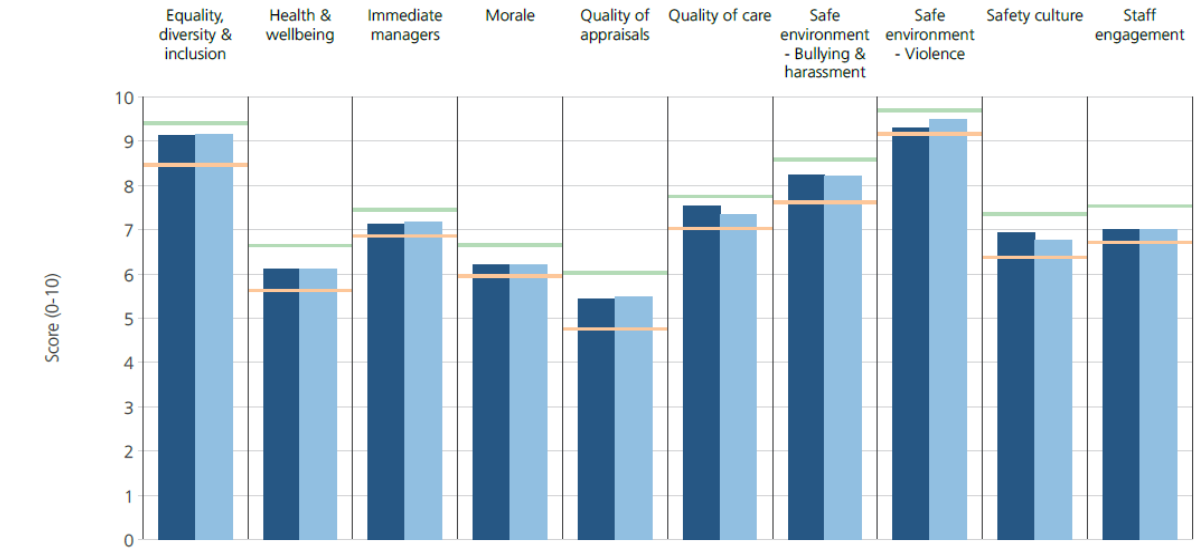
241. The Trust has also seen notable improvements in each of the questions that make up the Safety Culture, which has been a key area of focus for the Trust in line with the Just and Learning Culture work. Particular improvements were noted in the Community Division, which undertook the survey for the first time as part of Mersey Care following the acquisition of Liverpool Community Health NHS Trust in April 2018.

242. These results were presented to the Board of Directors in March 2019, as well as cascaded through divisional workforce groups. Results will be shared with front line staff as part of the Spring Roadshows taking place in April and May and used to generate discussion between staff and senior manager about their experience at work.

243. The Trust's People Plan has previously identified 5 key priorities that will improve staff experience and ensure Mersey Care is an employer of choice. These 5 areas directly link to the 10 new themes of the Staff Survey, on-going progress of actions will be monitored by the Board and by the Strategic Workforce Group. Divisional action plans in response to findings are being developed and will be presented to the relevant Operational Management Boards (which oversee the work of the four clinical divisions).

244. **Figure 4** below outlines the key findings from the National Staff Survey

Figure 4: Analysis of Mersey Care's Key Findings from the 2018 National Staff Survey



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	9.1	6.1	7.1	6.2	5.4	7.5	8.2	9.3	6.9	7.0
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7

245. Note – as part of the Annual Report requirements Trusts show at least two years data from their Staff Surveys. Due to Mersey Care acquiring the former Liverpool Community Health NHS Trust, comparable data is not available prior to April 2018.

Staff Survey Action Plans

246. Each division has been tasked with the creation of a tailored Staff Survey Action Plan in response to the 2018 National Staff Survey, which will be presented to the Trust's Board of Directors meeting in July 2019.

247. Divisional action planning will concentrate on the areas where the Trust scores are worse than the 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 following approval by the Trust's Board of Directors in July 2019.

Embedding "A Just and Learning Culture"

248. 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.

249. During 2018/19 the Trust set the following objectives:

a) **Objective 1 – 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:**

i) PACE (appraisal) process is the main mechanism for assessment and development planning against the Trust values / behaviours and competence,

ii) a leadership competency framework was developed and incorporated within the 2018/19 PACE process,

iii) 82% of people at Band 7 and above have had completed PACE and therefore been assessed, had feedback and have agreed their development priorities and plans with their line manager in accordance with our Just and Learning Culture,

iv) for managers previously employed by the former Liverpool Community Health NHS Trust (LCH) who have not used PACE, the approach has been different. Assessment has been undertaken as part of the THRiVE process and will be aligned to PACE upon implementation later this year. To date 46 former LCH managers (i.e., Band 7 and above) have or are completing THRiVE,

v) an evaluation and review of progress to date is being conducted. Those yet to complete this process have been identified and plans to support will be agreed and put in place to ensure 100% of those in scope meet the Just and Learning Culture objective. In the meantime, the refresh of Mersey Care's values has been undertaken, with these revised and updated values incorporated into the PACE process for 2019/20 – which all staff will be using;

b) **Objective 2 – to support colleagues' psychological safety through the development of bullying awareness for staff based on a preventative approach to recognise bullying behaviour and development of a process to resolve issues:**

i) the Trust has a group, made up of representatives from across Mersey Care, to support this important piece of work. Ben Towell from this group was asked to speak at the launch of The Positive Practice in Mental Health Collaborative / National Collaborating Centre for Mental Health's event at the Houses of Parliament in March 2019 to launch their *A Happy, Healthier Workplace* report,

ii) the group has also produced two videos for staff on the topics of anti-bullying and harassment to raise awareness across the Trust,

iii) the Trust took part in the anti-bullying week, including that National Odd Socks Day in November 2018, to raise awareness across Mersey Care,

iv) the Trust has signed up to the *collective call to action* from the Social Partnership Forum for all NHS organisations to create positive workplace cultures and tackle bullying in the NHS;

c) **Objective 3 – to develop a standardised framework to support learning from incidents including supporting staff, how to debrief effectively, 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:**

i) several engagement events have been held to inform the on-going development of a standardised framework to support learning,

ii) as a result a number of frameworks have been considered and being evaluated, including:

- a just and learning review meeting where staff – both qualified and unqualified - can raise patient safety issues
- the high risk complex case escalation mechanism – a framework for staff to draw organisational support for complex cases that challenge the limits of their expertise
- focussing on contemporaneous learning
- learning from what is working well

iii) to coordinate the different patient safety frameworks and forums effectively – safety huddles, debrief, post incident reviews and other processes;

d) **Objective 4 – 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:**

i) this year there has been a large expansion of the 'always on' resources on the Just and Learning microsite. Linking in with the civility work stream which has examined and tuned that sharing of responsibilities with events, publicity materials and videos, the microsite acts as a resource for staff across the whole service and has been discussed with service users in different divisions,

ii) there have been a number of initiatives focussed on introducing and demonstrating shared responsibilities, particularly in the Community Division established in April 2018, with presentations and ward visits from Professor Dekker and his team. Work in the Medical Senate in particular has illustrated and demonstrated the culture of change with support from the Medical Director and Deputy Medical Director, as well as a number of clinicians contributing to parallel work streams.

Just and Learning Ambassadors

250. We have now appointed 55 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.

251. 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

252. 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.

253. 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 2018/19

254. The staff Friends and Family Test is a regulatory requirement and is carried out during quarters 1, 2 and 4 of each year. It is not carried out in quarter 3 as this is when the National Staff Survey takes place. The two core questions check the likelihood of staff recommending Mersey Care as:

    a) a place to receive treatment; and

    b) as a place to work.

255. Despite the survey taking just a couple of minutes to complete, the Trust's 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 always scores less than the "place to receive treatment".

256. Our last results were as follows:

    a) recommend as a place to receive care – 74%;

    b) recommend as a place to work – 59%.

257. During 2018 the Trust launched an in-house staff engagement test called *The Culture of Care Barometer* across the Local, the Specialist Learning Disabilities and the Secure Divisions. This is based on an NHS England tool that allows trusts to measure staff engagement quarterly, report down to a team level. This provides Mersey Care with much more useful and dynamic information that allows the Trust to tailor its approach to staff engagement and work proactively with teams who may be at risk of becoming dis-engaged. The roll out of the tool will continue in 2019 as the Trust launches it within the Community Division.

Staff Engagement Plan 2018/19

258. In the past the Trust had a stand-alone Staff Engagement Plan. This has now been incorporated into the *People Plan 2018 – 21*. The People Plan establishes five strategic key priorities within a framework that provides meaningful connections between our staff and our delivery plans.

259. The five strategic key priorities are interlinked and together deliver the 'Our People' strategic objectives, which will support the delivery of the Trust's strategy and operational plan and will further embed our values and behaviours. Engaging staff in this work is critical.

260. Our values, practices and behaviours are at the heart of this and how our staff do things is as important as what we do. Mersey Care's values and Staff Charter were co-produced in 2013/14 through an extensive engagement process with colleagues across the trust, service users and carers. These values are the golden thread within the Trust's aspiration to deliver *perfect care* and have been embedded within all of our people management and development policies and practices. The values were refreshed and updated during 2018 to reflect the changing nature of the Trust following the acquisition of Liverpool Community Health NHS Trust.

261. All staff engagement interventions are outlined in the People Plan and are measured, monitored and governed via the Strategic Workforce Group, which provides assurance to the Board of Directors via the Executive Committee.

Time Spent on Trade Union Duties

262. In line with the Trust's Partnership Agreement with its recognised staff representative bodies, in 2018/19 the Trust provided the following supported time for its recognised staff representative bodies per week;

a) Unison – 22.5 days;

b) the Royal College of Nursing – 8 days;

c) Unite – 7 days;

d) the POA (The Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers) – 6.5 days.

Expenditure on Consultancy

263. 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 & Social Care's *Group Accounting Manual 2018/19* as "the provision to management of objective advice and assistance to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives". It includes the provision of external advice and assistance in relation to 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 and programme and one-off projects. The expenditure incurred in the period 1st April 2018 to 31st March 2019 was £2,704,000.

Off-Payroll Engagements

264. Following the *Review of the tax arrangements of public sector appointees* published by the Chief Secretary to the Treasury in 2012, 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).

265. **Table 14A** below shows, all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months

Table 14A: Off-Payroll Engagements as at 31 March 2019

	Number
Number of existing engagements as of 31 March 2018	3
Of which, the number of staff that have existed:	
• for less than one year at the time of reporting	2
• for between one and two years at the time of reporting	1
• 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

266. **Table 14B** below shows all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months.

Table 14B: All New Off-Payroll Engagements between 1 April 2018 and 31 March 2019

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	3
Of which:	
• number assessed as caught by IR35	1
• number assessed as not caught by IR35	2
• number engaged directly (via PSC contracted to department) and are on the departmental payroll	1
• 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

267. **Table 14C** below shows any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019.

Table 14A: Off-Payroll Engagements for Board Members / Senior Officials between 1 April 2018 and 31 March 2019

	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 figure must include both on payroll and off-payroll engagements.	7

Reporting of Other Compensation Schemes – Exit Packages

268. NHS Foundation Trusts are required to disclose summary information of their use if exit packages in the year. To avoid duplication this information has been provided in the Remuneration Report included in this Annual Report (see Chapter 13, specifically paragraphs 207 – 210).

CHAPTER 15 – SINGLE OVERSIGHT FRAMEWORK

269. 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).

270. 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 2019, 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).

271. The Trust's ***Finance and Use of Resources*** score for the period ending 31 March 2019 is a ***1*** overall (on a scale of 1 to 4, where 1 reflects the strongest performance).

NHS Improvement Single Oversight Framework

Table 15: Single Oversight Framework

Theme	Type	Measure	Freq-uency	Threshold/ National Median	Latest Data	Date of Latest data	Position Compared to 2017/18	Source
Quality of Care	Caring	Written Complaints - Rate	Quarterly	National Median: 18.25	6.69	Q3 2018-19		NHS Digital
Quality of Care	Caring	Staff FFT % Recommended	Quarterly	No Threshold/ National Median Applied	73.78%	Q2 2018-19	Not Applicable	NHS England
Quality of Care	Safe	Occurrence of Never Events	Monthly (6-month rolling)	Green = 0, Red = 1 or more	0	March-2019		Mersey Care Internal Reporting
Quality of Care	Safe	Patient Safety Alerts not completed by deadline	Monthly	Green = 0, Red = 1 or more	0	March-2019		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-2019		Mersey Care Internal Reporting
Quality of Care	Safe	Potential under-reporting of patient safety incidents	Monthly	No Threshold/ National Median Applied	32.77	May 2018	Not Applicable	NHS Improvement
Quality of Care	Caring	Mental health scores from FFT - % positive	Monthly	No Threshold/ National Median Applied	90.82%	March-2019	Not Applicable	Unify Return
Quality of Care	Caring	Community scores from Friends and Family Test - % positive	Monthly	No Threshold/ National Median Applied	98.14%	March-2019	Not Applicable	Unify Return
Quality of Care	Organisat-ional Health	CQC Community Mental Health Survey	Annual	Lower Limit Range - 6.37 Upper Limit Range - 7.30	7.05%	2018		Care Quality Commission

Theme	Type	Measure	Freq-uency	Threshold/ National Median	Latest Data	Date of Latest data	Position Compared to 2017/18	Source
Quality of Care	Effective	Care Programme approach follow up within 7 days	Monthly	Green =>95% Red <95%	98.94%	Q4 2018-19	▲	Unify Return
Quality of Care	Effective	% clients in settled accommodation	Monthly	National Median: 64%	41%	January-2019	▼	NHS Digital via MHSDS
Quality of Care	Effective	% clients in employment	Monthly	National Median: 8%	3%	January-2019	▼	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 (Part A)	Monthly (3-month rolling)	Green =>53% Red <53%	68.35%	March 2019 (rolling 3 months)	▲	Unify Return
Operational Performance	Operational Performance	People with a first episode of psychosis begin treatment with a NICE recommended care package within 2 weeks of referral (Part B)	Monthly (3-month rolling)	Green =>53% Red <53%	65%	January 2019	▲	Mental Health Services Data Set Return
Operational Performance	Operational Performance	IAPT – waiting time to begin treatment (from IAPT minimum data set) within six weeks	Monthly (3-month rolling)	Benchmark 75%	95.69%	March-2019	▼	NHS Digital
Operational Performance	Operational Performance	IAPT – waiting time to begin treatment (from IAPT minimum data set) within 18 weeks	Monthly (3-month rolling)	Benchmark 95%	100%	March-2019	◀▶	NHS Digital
Operational Performance	Operational Performance	Inappropriate out-of-area placements for adult mental health services (OBDS) - External only	Monthly	Q4 2018-19: 169	0	March 2019	◀▶	Clinical Audit Platform – NHS Digital
Operational Performance	Operational Performance	IAPT - proportion of people completing treatment who move to recovery (IAPT minimum dataset)	Quarterly	Benchmark 50%	50.54%	Q4 2018-19	▲	NHS Digital
Operational Performance	Operational Performance	Data Quality Maturity Index (DQMI) - MHSDS Dataset Score	Quarterly	Green =>95% Red <95%	97.80%	Q2 2018-19	▲	NHS Digital

Theme	Type	Measure	Freq-uency	Threshold/ National Median	Latest Data	Date of Latest data	Position Compared to 2017/18	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%	46.24%	2017-18 2018-19 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%	15%	2017-18 2018-19 data to be available in June 2018	Not Available	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%	19.80%	2017-18 2018-19 data to be available in June 2018	▲	Royal College of Psychiatrists
Operational Performance	Operational Performance	Accident and Emergency Maximum waiting time of four hours from arrival to admission/ transfer/ discharge	Monthly	Green =>95%Red <95%	100%	March 2019	Not Available	NHS England
Leadership & Improvement	Leadership & Improvement	NHS Staff Survey	Annual	National Median: 3.74	3.77	2018-19	▲	NHS England
Leadership & Improvement	Leadership & Improvement	Proportion of Temporary Staff	Monthly	National Median: 4.21%	4.26%	March 2019	▼	Provider Return
Leadership & Improvement	Leadership & Improvement	Staff Sickness	Monthly	National Median: 5.08%	6.60%	March 2019	▲	Mersey Care Internal Reporting
Leadership & Improvement	Leadership & Improvement	Turnover	Monthly	National Median: 1.06%	1.25%	March 2019	▲	Mersey Care Internal Reporting

CHAPTER 16 – ANNUAL GOVERNANCE STATEMENT

SCOPE OF RESPONSIBILITY

272. 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

273. 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 Mersey Care NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Mersey Care NHS Foundation Trust for the period ending 31 March 2019 and up to the date of approval of the annual report and accounts.

CAPACITY TO HANDLE RISK

Leadership

274. 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, the Medical Director, who is supported by the Risk Management Group.

275. 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.

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

277. 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.

278. The accountability arrangements for risk management in 2018/19 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 (which is supported by the Liverpool Community Services Transition Sub Committee, specifically in relation to the services acquired from the former Liverpool Community Health NHS Trust) 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 risk management processes and Risk Management Strategy;

f) the Medical Director, as the Lead Executive Director, 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 and Operations is accountable for CQC registration.

279. 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

280. 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.

281. 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.

282. 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.

283. 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.

284. 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.

285. 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.

286. 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.

287. 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

288. 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.

289. 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) Liverpool Community Services Transition Sub Committee;

b) Remuneration and Terms of Reference Committee;

c) Mental Health Act Managers Sub-committee;

d) Operational Management Boards;

e) Health & Safety Sub-committee;

f) Infection Control Sub-committee;

g) Mortality Committee;

h) Drugs & Therapeutics Sub-committee;

i) Digital Board;

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

k) Safeguarding Group;

l) Risk Management Group;

m) Weekly Divisional Safety Huddle meetings;

n) Weekly Executive Safety Huddle meetings.

Risk Management Strategy

290. 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 from 2017 to 2019[15];

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 regularly reviewed by the Board of Directors;

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.

291. 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.

292. 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

[15] The Board of Directors approved an updated Risk Management Strategy, including an action plan for 2019/20, at the March 2019 Board Meeting.

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.

293. 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.

294. Each Division has governance arrangements in place with a governance lead 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.

295. Embedding risk management as a core activity within the organisation is achieved through many systems and processes. 2018/19 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 Risk Management Strategy to take account of the acquisition of the former Liverpool Community Health NHS Trust from 1 April 2018;

c) 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;

d) the inclusion of discussion of all strategically significant risks, on a rolling basis, as part of the weekly Executive Safety Huddle meetings;

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

f) continued development and scrutiny of risks within the Clinical Divisions, including additional support for the Community Services Division (incorporated the Liverpool and South Sefton community health services provided by the former Liverpool Community Health NHS Trust);

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.

296. 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 is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board"*

Risk Appetite

297. 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.

298. 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.

299. The Risk Appetite Statement is due for review by the Board of Directors in 2019/20.

Risk Assessment

300. 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 Community Services Division following the acquisition of Liverpool's physical community health services from the former Liverpool Community Health NHS Trust on 1 April 2018;

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 Safety Framework;

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 Medical Director in 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;

301. 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.

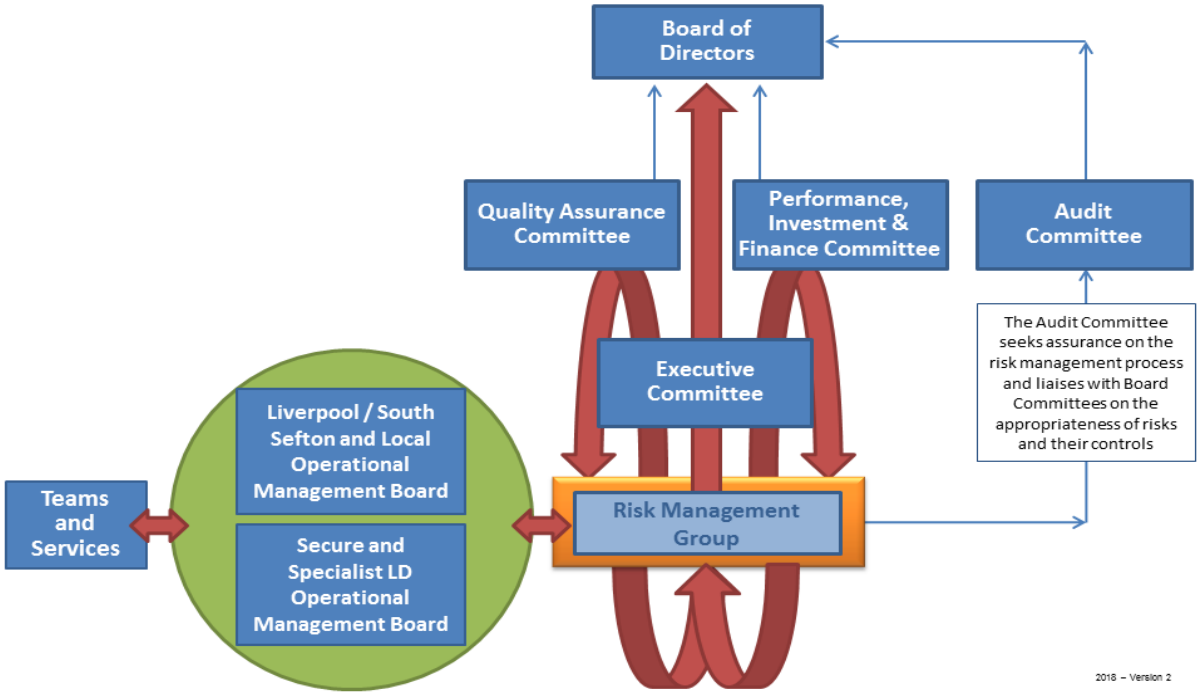


Figure 5: Risk Escalation Process

Strategically Significant Risks in 2018/19

302. 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 2018, with risks added in respect of the Liverpool physical health community services during the six month of the year, in line with the Community Services Improvement Programme (which has also taken account of the Post Transaction Implementation Plan) established following the acquisition of the former Liverpool Community Health NHS Trust on 1 April 2018 (now part of the Community Services Division). Updates on the Community Services Improvement Programme have been regularly provided to the Liverpool Community Services Transition Sub Committee, the Quality Assurance Committee, the Executive Committee and the Board of Directors throughout 2018/19.

303. 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.

304. **Table 16** below highlights the 27 strategically significant risks the Board considered at its meeting in March 2019, against the Trust's four main strategic objectives and listed by those risks identified:

a) by the Board (11 risks);

b) by the divisions (13 risks);

c) by specific programmes (2 risks).

Table 16: Strategically Significant Risks on the Board Assurance Framework (March 2019)

Risk Description	Score	Exec. Lead
Strategically Significant Risks Identified by the Board of Directors		
The CIP target associated with Corporate services both for Mersey Care and the acquisition of LCH equates to £12m over 3 years (£5m for 2018/19). If this is not delivered recurrently, there is a risk the trusts control total will not be achieved. (Strategy Objective – Our Future)	20	Finance Director
If the organisations' strategic options are not progressed effectively as a partnership with other organisations, then opportunities for achieving efficiencies and delivering care out of hospital will be lost. (Strategy Objective – Our Future)	9	Strategy Director
If the organisation's strategic plans are not informed by the Cheshire and Merseyside Sustainability and Transformation Plan, leading to a loss of influence for the Trust and opportunities for growth and development being compromised. (Strategy Objective – Our Future)	8	Strategy Director
If the organisation does not successfully operationalise Community Services which have transferred into the Trust, leading to mental health and primary care failing to integrate, resulting in non delivery of improvement in the quality of care & performance. (Strategy Objective – Our Future)	12	Nursing & Operations Director
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)	12	Workforce Director
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. (Strategy Objective – Our People)	9	Finance Director
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)	6	Finance Director
If the organisations' 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 Resources)	8	Comms & Corporate Governance Director
If the Trust does not deliver its Action Plan in response to the Kirkup Review recommendations, leading to deterioration in the quality of care, regulatory action and damage to the Trust's reputation. (Strategy Objective – Our Services)	12	Nursing & Operations Director
If the Trust does not implement the Local transformation programme 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)	8	Nursing & Operations Director
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)	6	Comms & Corporate Governance Director
Strategically Significant Risks Identified by a Division and Considered by the Board		
If the NWAS delay responding to an incident within the Walk -In Centres with limited emergency equipment and medication, causing the patient's condition to deteriorate and increase stress on staff.	20	Nursing & Operations Director

Risk Description	Score	Exec. Lead
If a lack of robust systems and processes causes children to be classified as "untraceable" creating a risk that they will not be able to access Healthy Child Programmes such as vaccination and immunisations and be given assurance around safeguarding.	16	Nursing & Operations Director
If there is a major public health outbreak the Trust would not be able to provide assurance that the immunisation levels in specific schools are sufficient to contain the spread of the disease, leading to an increase in preventable cases.	16	Nursing & Operations Director
If Supported Living Services (SLS) and DISH services are in breach of the Working Time Regulations 1997 then this may pose a risk to the health and safety of both patients and staff and is likely to have a detrimental effect on the health and wellbeing / work life balance of staff.	20	Nursing & Operations Director
If the Trust is unable to decommission Sefton SLS & DISH Services in a robust fashion then there could be potential harm to service users.	20	Nursing & Operations Director
If the mobilisation of Park Lodge Community Mental Health Team is not progressed then the Trust may receive a CQC notice and the privacy and dignity of service users, safety of staff and compliance with DDA regulations may be comprised.	20	Nursing & Operations Director
If there is a reduction in funding from the Long Term Planning Guidance then the CQUIN programmes and roles may be negatively impacted upon.	16	Nursing & Operations Director
If the ADHD Service is not appropriately funded then service users' clinical needs may not be met due to insufficient resources and delays in assessment	16	Nursing & Operations Director
If Talk Liverpool is unable to recruit to vacancies then service users may encounter delays in obtaining therapy and the service could fail to meet the agreed access target of 19%.	16	Nursing & Operations Director
If there is insufficient leadership and expertise within the Division out of hours then business contingency strategies may not be implemented resulting in reduced staffing numbers and service users' care being compromised	16	Nursing & Operations Director
If service users are not adhering to the Trust Smoke Free Policy then there is an increased risk of fires occurring	15	Nursing & Operations Director
If the number of physical restraints continues to increase, in particular T-supine restraint, then there is a risk of injury and psychological trauma to staff and service users.	16	Nursing & Operations Director
If the Children in Care service is not delivered in line with the Trust's statutory health responsibilities, it may lead to the harm of a child due to deterioration in care, and associated reputational and financial implications for Mersey Care.	16	Nursing & Operations Director
If the Local Division continues to see an overspend in senior medical staffing through the use of locums (£2.2 M for 2018/19), there is a risk that Trust's control total will not be achieved.	16	Medical Director
Strategically Significant Risks Identified by a Project and Considered by the Board		
If capital funding is unavailable to re-provide LSU services off Whalley, this will conflict with NHS England commissioning intentions and result in the loss of the LSU contract for Specialist LD services.	20	Finance Director
Risk that key programme dates for the clinical model implementation will be delayed due to commissioners / NHS England not being able to meet critical deadlines	16	Nursing & Operations Director

305. 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 reports to the Executive Committee;

b) regular scrutiny and challenge of relevant risks by the appropriate Board Committee (with the Liverpool Community Services Transition Sub-Committee supporting the Quality Assurance Committee in respect of risks associated with the community services acquired from the former Liverpool Community Health NHS Trust);

c) receipt of changes to risk review dates and target scores by the Audit Committee on a regular basis;

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

e) 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;

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

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

Public Stakeholders Involvement in Managing Risks

306. 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.

307. 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.

308. In 2018/19 the Trust continues to participate in the Cheshire and Merseyside Health and Care Partnership (the new name for the Sustainability and Transformation Partnership), including 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).

309. 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.

310. 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.

311. 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.

312. In addition the Trust is involved in a range of multi-agency arrangements which assist with the management of risks across wider health and social care systems, including:

a) the Chief Executive chairing 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 Liverpool;

b) the Chief Executive chairing the Sefton Provider Alliance a meeting that brings together representatives from NHS providers in Sefton together with local GPs, Sefton Council, Clinical Commissioning Groups and representatives of the voluntary sector to address the integration of health and social care across Sefton;

c) membership of the Transformation 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.

313. 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.

314. Although the Trust hosts Informatics Merseyside (which provides IT services to a range of local NHS organizations), 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, St Helens & Knowsley Teaching Hospitals NHS Trust.

315. In addition, the Trust has a Major Incident Plan in place which ensures involvement in system-wide emergency planning and business continuity arrangements, including the Local Resilience Forum and the Local Health Resilience Partnership.

Provider License

316. 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). The Trust monitors compliance with the Provider License through a range of mechanisms, including the Executive Performance Report, the Quality Report and a range of reports to various parts of the Trust's governance mechanisms.

Corporate Governance Statement

317. 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 2018/19 at its Board meeting in May 2019. In the course of approving the Corporate Governance Statement, the Board has had regard to supporting evidence, in addition to details of the risks and mitigations the statement made.

Quality Governance

318. Over the last four years the Trust has developed a framework to oversee the quality, safety and clinical governance of the services it provides, so as 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, including the escalation of matters from wards / teams to the Board and from the Board to wards / teams.

319. The latest version, which is now called the *Safety Framework*, was approved by the Quality Assurance Committee in November 2018 following an engagement process which included the Board of Directors. It builds on the lessons the Trust has learnt from implementing these frameworks both to its original core services and the services it has acquired, as well as being updated to take account of the Trust's changing strategic direction, most notably the development of a just and learning culture approach. The *Safety Framework* is outlined in **Figure 6** below.

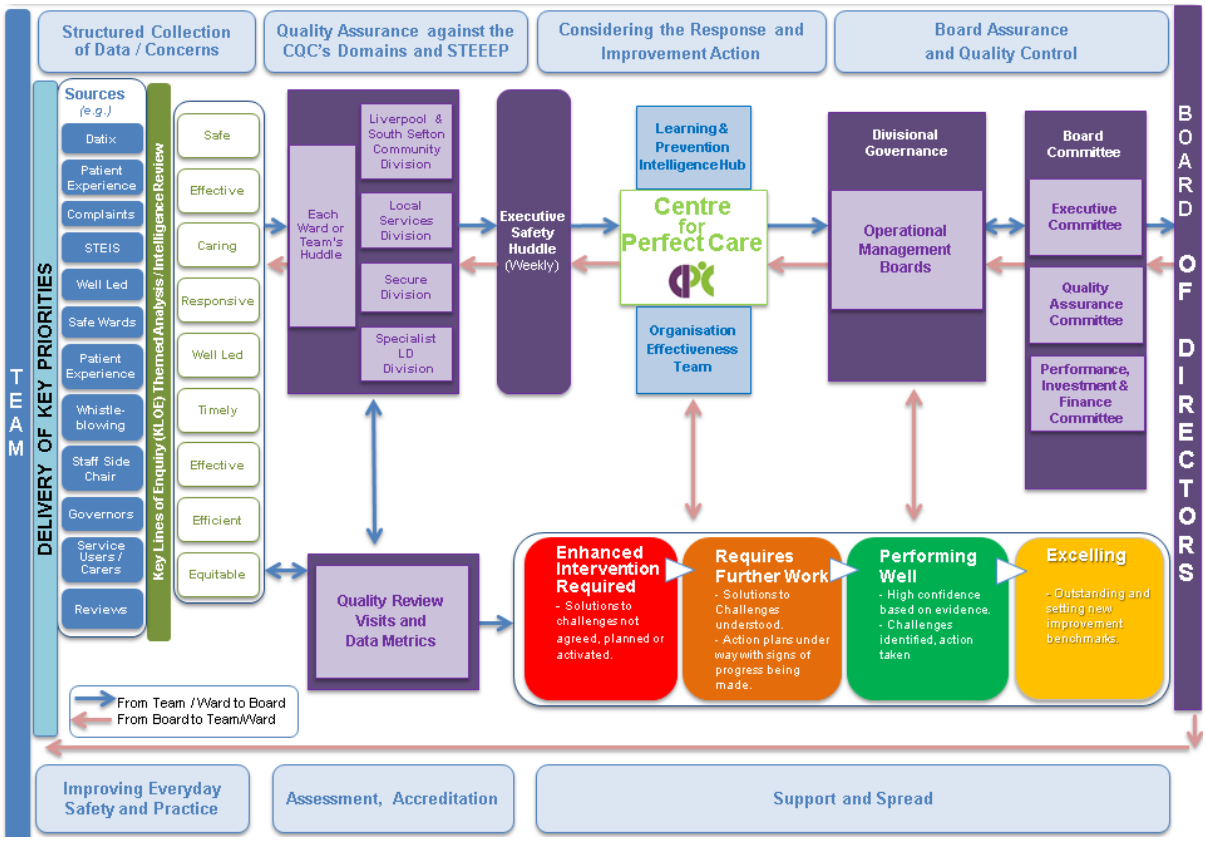


Figure 6: Safety Framework Process

CARE QUALITY COMMISSION REGISTRATION REQUIREMENTS

320. The *Safety Framework* provides mechanism to regularly and routinely monitor compliance with Care Quality Commission (CQC) requirements. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

SERIOUS INCIDENTS

321. The Board of Directors receives information pertaining to all serious incidents through the Governance of Quality Report (which was replaced by the Safety Report in November 2018, 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.

LEARNING FROM DEATHS

322. 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 August 2018 the Trust updated its Learning from Deaths Policy (SA45) and has a Non-Executive Director lead for Learning from Deaths (Dr Murray Freeman). 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.

DATA QUALITY

323. 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 through a range of policies and mechanisms, with assurance provided to the Audit Committee.

324. 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

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

Just Culture

326. 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.

327. 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 one of the priorities for the Trust for 2018/19 and therefore is reflected in our Annual Quality Report.

Performance and Quality Risks

328. 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.

EQUALITY AND INCLUSION

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

330. 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.

DEVELOPING WORKFORCE SAFEGUARDS (SAFE STAFFING)

331. The Trust continues to follow the National Quality Board (NQB) requirements, endorsed by the Care Quality Commission, and is committed to review in practice against the recently published draft guidance for Safe, Sustainable and Productive Staffing publication in February 2018.

332. The Trust going forward for 2018/19 has aligned the safe staffing review process with the new guidance from NHS Improvement "Developing Workforce Safeguarding. Supporting providers to deliver high quality care through safe and effective staffing" published October 2018.

333. The guidance articulates for all Trust Board's accountability in respect of Safe Sustainable and Productive Staffing and recommends that the Board should have processes in train to provide assurance that the right staff with the right skills are in the right place at the right time. **Figure 7** below refers:

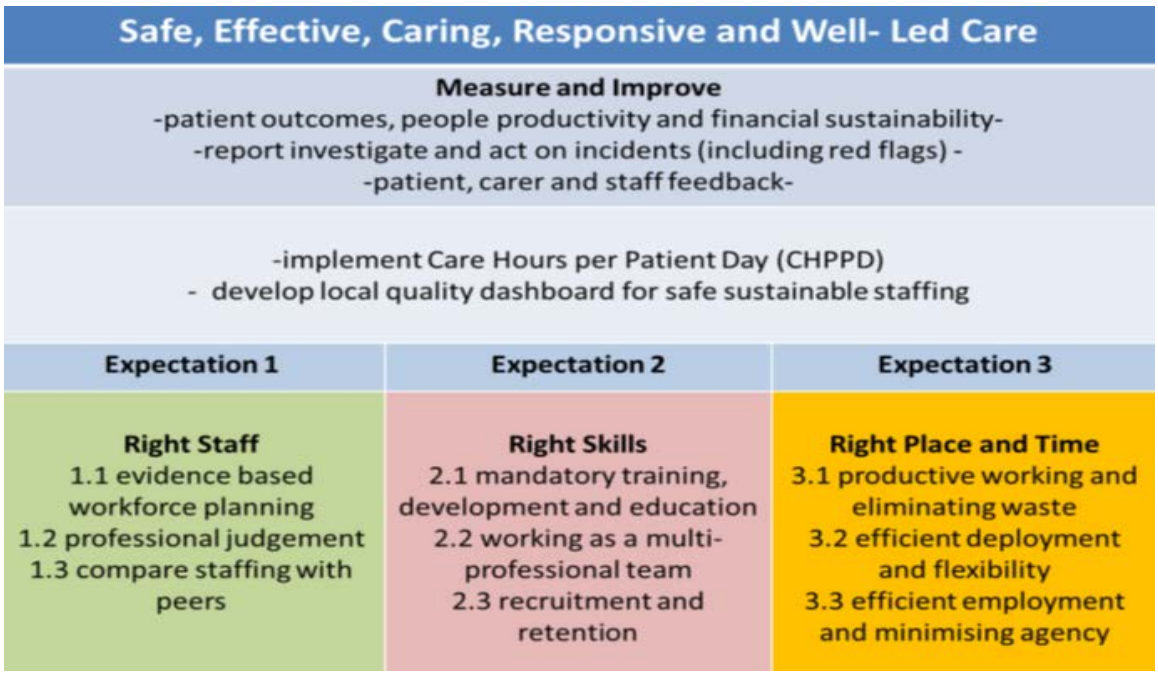


Figure 7: Safe Staffing Overview

334. The Trust complies with recommended guidance by presenting two papers a year to the Board of Directors:

a) the Annual Strategic Staffing Review determines the required establishment, demonstrated by a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times; and

b) a Comprehensive Staffing Report after six months, to confirm that the workforce plans are still appropriate for the skill mix required for the is still e being achieved.

335. All service change / role change have a Quality Impact Assessment completed and signed off from the Medical Director and the Executive Director of Nursing and Operations.

336. In line with national guidance the Trust also reports via UNIFY (a reporting system to NHS England) each month the Care Hours per Patient Day (CHPPD) data.

REGISTER OF INTERESTS

337. As an employer Mersey Care requires all staff – in line with the Trust's *Standards of Business Conduct* (policy F04) - to disclose relevant interests, especially if they are involved in decision-making (i.e., normally the Board of Directors, staff in posts above Agenda for Change Band 8A and those staff working in the procurement team[16]). This policy takes account of the *Managing Conflicts of Interests in the NHS* guidance published by NHS England.

338. The Trust maintains a live Register of Interests using an online website that all members of the Board of Directors and employees are required to use and make declarations. Members of the Board and employees are regularly reminded of the need to maintain their own information on this register. Known at the *Staff Declarations Website*, this online Register of Interests is accessible to the public and staff at https://merseycare.mydeclarations.co.uk/home. If you have any problems accessing this Register of Interests please do not hesitate to contact the Corporate Governance Team at the Trust's Headquarters.

NHS PENSION SCHEME

339. 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.

CLIMATE CHANGE

340. The Trust has undertaken risk assessments and has a Sustainable Development Management Plan in place which takes account of the UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

[16] A definition of decision-making staff is included in chapter 7 of the Trust's Standards of Business Conduct policy.

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

341. 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.

342. Annual budgets are approved by the Board of Directors following sign-off by delegated budget holders. There is comprehensive reporting (e.g., via the Executive Performance Report and the Safety 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, the Executive Performance Report is scrutinised at every meeting of the Performance, Investment & Finance Committee, the Quality Assurance 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, and the Quality Assurance Committee undertake detailed scrutiny of the Safety Report.

343. Cost Improvement Plans, whilst developed by directorates and clinical divisions in conjunction with the Finance Team, are scrutinised by both the Medical Director and Executive Director of Nursing & Operations 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 reviewed by both the Quality Assurance Committee and the Performance, Investment & Finance Committee on behalf of the Board of Directors.

344. 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 cannot be funded are 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.

345. 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.

INFORMATION GOVERNANCE AND DATA SECURITY

346. The Trust utilises the Data Security & Protection 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.

347. 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 Joint Chief Information Officer and teams.

348. 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, hosted by Mersey Care NHS Foundation Trust, and through regular Information Security reviews.

349. The Trust experienced the following issues in respect of 16 information governance incidents which occurred in 2018/19 and met the Information Commissioner's Office (ICO) reporting criteria:

a) a service user attending the Sexual Health Clinic obtained another service user's contact details and contacted them. Both service users had the same name and date of birth. A full Root, Cause analysis investigation was conducted with new operational procedures implemented within the Clinic. Service users advised of the incident and supported by Clinical team. The case was closed by the ICO;

b) a member of staff circulated an email to staff and service users to promote a careers event – this was not sent "blind carbon copy" and therefore email addresses for five service users in the group email were visible. 1:1 information governance training provided to employee who circulated the email and completion of Data Security Awareness Training module. Service users notified of incident and apology provided by Trust. The case was closed by the ICO;

c) an employee accessed a service user's record that they had no legitimate purpose to do so. Full investigation undertaken – employee resigned from Trust. Incident reported to the ICO and closed by them;

d) copies of personal identifiable information contained on Section 117 leave papers in respect of two service users on escorted leave found by a member of public in Whalley and returned to the Trust's site. Full investigation undertaken – incident reported to, and closed down by the ICO;

e) a statement of care letter had been dictated by a clinician without the unique identification number or NHS number being stated. The transcriptionist typing up the letter accessed the clinical information system and selected an incorrect service user with the same name. The incorrect recipient contacted the Trust and reported the incident. 1:1 information governance training provided to member of staff. Incident closed by ICO;

f) a service user's record was accessed by a member of a Community Services Team who knew the service user and noticed a decline in the service user's mental health status, which they had cause for concern and wished to contact the key worker for the service user in order to raise concerns. Whilst the access was not malicious the employee was not part of the service user's immediate care team and a written warning was issued. The case was closed by the ICO;

g) the Liverpool Echo contacted the Trust regarding an incident that had occurred at Ashworth Hospital requesting a statement. It transpired that information from an adverse incident report had been sent to the Liverpool Echo. The information did not contain any personal identifiable information relating to patients or employees. Although an IT forensic investigation is on-going by the Trust, the ICO have closed the incident down as no personal information was disclosed;

h) section 17 papers for a patient on escorted leave to attend a hospital appointment left in the hospital restaurant in a bag. The escort returned to restaurant and bag was missing. The bag was retrieved by Security Staff at the hospital site with papers intact. New operational process implemented resulting in section 17 papers no longer taken off site. Incident closed by the ICO;

i) a spreadsheet was mistakenly sent by the Safeguarding Team to a member of staff at Warrington & Halton Hospitals NHS Foundation Trust (via secure email) instead of to a Trust member of staff. The recipient reported to Mersey Care NHS Foundation Trust and confirmed its deletion. Liverpool City Council was notified of the incident as the spreadsheet originated from the Council who confirmed no further action required. The incident was closed by the ICO;

j) an internal email intended for one senior nurse manager was sent to a senior nurse group distribution list. The email was then circulated to a wider distribution group list of Trust staff – although the email contained limited

service user personal identifiable information, it also contained personal identifiable information relating to four members of staff going through the Trust's disciplinary process. The email was printed and posted to the four employee's home addresses. Service users and employees were notified in respect of the data incident. Internal investigation on-going. In response a communication was sent to all staff, attached to payslips, reminding staff of their duty of confidentiality, the Chief Executive released statement in the Trust's weekly emailed newsletter and new guidance was circulated across the Trust to all members of staff. Incident closed down by ICO;

k) an allegation of unauthorised access by a member of staff to their relative's clinical record. A privacy audits and investigation was undertaken and completed – this confirmed the member of staff did not have access to Trust clinical information systems. Member of staff interviewed during which Trust policies re-enforced. Incident closed by the ICO;

l) a complaint was received from Volunteer Counsellor alleging a breach of confidential information by a member of staff, who also works for another organisation as volunteer counsellor. Root cause analysis investigation currently being completed. Incident closed by the ICO;

m) a telephone call was received from a service user who had received a letter addressed to them, however content of the letter related to another service user. Root cause analysis investigation undertaken and new operational processes within the service implemented. Service users notified of the incident and supported by clinical team. Incident closed by the ICO;

n) unauthorised disclosure of medical diagnosis divulged during a visit to a school by the vaccination & immunisation team, as a result of a conversation overheard by teacher at school. Root cause analysis investigation currently being completed. The incident has been closed by the ICO;

o) a member of staff's occupational health report was sent to an incorrect recipient, who in turn notified the Trust. Investigation commenced and the incident reported to the ICO (Trust awaiting contact from the ICO at the time of writing this report); and

p) an appointment letter was sent to a service user which had an assessment attached to it relating to a different service user. The service user who received the information returned it to the Trust. The clinical team notified correct service user of incident and is supporting them. A root cause analysis investigation has commenced and the incident reported to the ICO (Trust awaiting contact from the ICO at the time of writing this report).

350. 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 Joint SIRO 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 two of these incidents.

351. The Trust received 'substantial assurance' in respect of the Data Security & Protection Toolkit which was submitted at 31 March 2019.

352. 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. 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. These reports are shared with the Board of Directors. This is especially important as the Trust hosts Informatics Merseyside which provides IT services to many local NHS organisations and represents the Trust on the Cheshire & Merseyside Health and Social Care Partnership's cyber security work stream.

ANNUAL QUALITY REPORT

353. 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.

354. The annual Quality Report is published as part of the Trust's Annual Report. The Quality Account for 2018/19 has been developed in accordance with national guidance with its development being led by the Executive Director of Nursing and Operations.

355. 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.

356. 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

357. The quality priorities within the report have been presented to and monitored by the Quality Assurance Committee throughout the year, the minutes and chair's 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 Annual Quality Report via its External Auditors. The Trust has consulted and sought the feedback of the Council of Governors regarding the quality priorities for 2019/20.

Policies and plans

358. The Trust had put controls in place to ensure the quality of care provided and accuracy of data used in the Annual 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

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

Systems and processes

360. 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 reports to the Board of Directors, 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.

361. 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 Agency, 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

362. The Annual Quality Report has been shared with senior managers across the Trust, members of the Executive Team and the Quality Assurance Committee, the Executive Committee and the Board of Directors to ensure all of the information

contained within is accurate. To determine the quality improvement priority areas for 2018/19 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

363. 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

364. 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 Annual 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.

365. 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.

366. 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).

367. The Audit Committee plays a key role in receiving assurance on the Trust's systems of internal control. As at the end of March 2019 the Audit Committee has three Non-Executive Director members[17] and receives assurance from officers of the trust, the

[17] For a few meetings the Audit Committee had four Non-Executive Director members, but this was

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.

368. 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.

369. At the Audit Committee in May 2019, the Director of Audit Opinion and Annual Report 2018/19 from Mersey Internal Audit Agency (the Trust's internal auditor) provided significant assurance for the period 2018/19 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 "*is structured to meet the NHS requirements [and] is visibly used by the Board and clearly reflects the risks discussed by the Board*".

370. In respect of clinical audit 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.

371. 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.

372. 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

373. 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.

374. 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.

375. The terms of reference for all Board Committees were reviewed, updated and then approved by the Board of Directors in May 2018, as part of the annual review of

reduced to three at March 2019's Board of Directors meeting as a result of changes to Non-Executive Directors' committee membership following the resignation of a Non-Executive Director.

terms of reference. These changes also took account of changes to membership as a result of the acquisition of the former Liverpool Community Health NHS Trust and its services (see paragraphs 379 – 380 below).

376. 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.

377. The committee structure, to support achievement of the Trust's strategic objectives, is outlined in **Table 17** 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 17: 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
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

Committee	Role
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

378. 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).

Acquisition of Liverpool Community Health NHS Trust

379. A significant change for Trust's governance arrangements came about as a result of the acquisition of the former Liverpool Community Health NHS Trust on 1 April 2018. As this acquisition was regarded a 'significant' transaction it was subject to a full assessment process by NHS Improvement[18] and required the approval by both the Board of Directors and Council of Governors of the submission of a joint application to acquire Liverpool Community Health NHS Trust. This was approved by both the Board and the Council at the end of March.

380. 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 then proposed acquisition of Liverpool Community Health NHS Trust. As a result of the approval of the acquisition application by NHS Improvement, the following leadership and governance arrangements came into effect from 1 April 2018:

a) the creation of an Executive Director of Nursing and Operations role to oversee the activities of all 4 clinical divisions[19];

[18] In line with the *Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions* (NHS improvement, November 2017).

[19] Trish Bennett took up post as Executive Director of Nursing & Operations on 1 April 2018. Mark Hindle, the then Executive Director of Operations, left his role with the Trust at the end of June 2018. During his last 3 months in post Mark Hindle supported Trish Bennett in her new role.

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[20];

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.

BOARD AND ORGANISATIONAL REVIEWS

381. 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, in March 2017 (report published in June 2017) and in November / December 2018 (report published in April 2019). The report of the 2018 inspection, which included a well-led inspection, were considered by the Board of Directors at its May 2019 meeting. The detailed scrutiny of the Trust's action plan will be led by the Quality Assurance Committee on behalf of the Board of Directors;

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 acquisition of Liverpool Community Heath NHS Trust (from 1 April 2018).

382. **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

[20] The South Sefton Community Services Division, created in June 2017 following the transfer of South Sefton's community physical health services to the Trust, was merged into the new Liverpool and South Sefton Community Division on 1 April 2018.

Dr Murray Freeman (a GP) and Aislinn O'Dwyer (a nurse and public health specialist) as Non Executive Directors, and extended the terms of office for Beatrice Fraenkel (Chairman) and Nick Williams (Non Executive Director).

383. **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".*

384. The report of the March 2017 Care Quality Commission inspection was published 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"*

385. The report of the November / December 2018 Care Quality Commission inspection was published in April 2019. The Trust received an overall rating of 'good' as a result of the inspection. The reports noted that:

> *"the Trust has the leadership and capacity and capability to deliver high quality, sustainable care. The Board was well-established and stable, with a broad range of experience and skills"* and that *"there was a robust, realistic strategy for achieving the priorities and delivering good quality, sustainable care."*

386. Both the Board of Directors and the Council of Governors particularly welcomed:

a) the achievement of a 'good' rating for the safe domain, the previous two inspections having rated the Trust as 'requires improvement' for the safe domain;

b) being rated as 'outstanding' for the well-led domain – which reflects the strong accountability and leadership across the whole of the Trust.

387. 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 Constitution (with the Council of Governors), Standing Financial Instructions and Scheme of Reservation and Delegation of Powers.

388. The results of all these reviews have informed the continuing review and development of the Trust's governance and risk management arrangements, together with the Trust's strategic priorities.

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

389. 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*) - 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.

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

391. Although the report focussed on former Liverpool Community Health NHS Trust, many of the recommendations of the Kirkup Review impact on those NHS providers that now provide the services previously provided by the former Liverpool Community Health NHS Trust. Mersey Care now provides the majority of services that were at different times the responsibility of the former Liverpool Community Health NHS Trust, including:

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

b) the former Liverpool Community Health NHS Trust's services for Liverpool since 1 April 2018;

c) mental health services at HM Prison Liverpool from 1 April 2018[21].

[21] 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 1 April 2018 the contract to provide prison healthcare services has

392. Mersey Care has developed a Community Services Transformation Programme to respond to the Kirkup Review, which has been scrutinised by the Liverpool Community Services Transition Sub Committee, the Quality Assurance Committee and the Board of Directors, including updates to the Council of Governors, throughout 2018/19.

SIGNIFICANT GAP IN CONTROL DUE TO FRAUD

393. In 2018/19 the Trust was the victim of a sophisticated fraud which resulted in a loss of circa £900,000 of Trust funds. The fraud has been notified to the Council of Governors and the Board of Directors, as well as NHS Improvement, the NHS Counter Fraud Authority, the police and the Trust's auditors.

394. The fraud is currently under active investigation by the NHS Counter Fraud Authority which means the Trust is limited as to the information that can be in the public domain at the time of writing this report. Measures to mitigate the Trust against similar frauds have already been put in place, with assurance on the implementation and effectiveness of these measures being scrutinised by the Audit Committee on behalf of the Board of Directors.

CONCLUSION

395. The overall opinion is that, apart from the sophisticated fraud identified above, no other 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:	22 May 2019

been awarded to Spectrum Healthcare Community Interest Company, who have sub-contracted the provision of mental health services to Mersey Care

APPENDICES

APPENDIX A – ATTENDANCE AT COUNCIL OF GOVERNORS MEETINGS

Governors

Constituency	Name	12 Apr 2018	03 Aug 2018	12 Sep 2018	18 Oct 2018	17 Jan 2019
Governor - Public Liverpool, Sefton and Knowsley	Jayne Moore	×	×	×	×	✓
Governor – Public, Liverpool, Sefton and Knowsley	Helen Casstles*	Not in Post			✓	×
Governor – Public, Liverpool, Sefton and Knowsley	Susan Martin*	Not in Post			×	✓
Governor – Public, Liverpool, Sefton and Knowsley	Paul Smith*	Not in Post			✓	✓
Governor – Public, Liverpool, Sefton and Knowsley	Mary Sutton*	Not in Post			×	×
Governor – Public, Liverpool, Sefton and Knowsley	John Mousley~	×	✓	✓	End of Term	
Governor – Public, Rest of England	Alex Till*	Not in Post			✓	×
Governor – Public, Rest of England	Garrick Prayogg	✓	×	✓	✓	×
Governor - Staff Medical	Sayed Ahmed	✓	×	×	×	✓
Governor - Staff Nursing	Scott Parker	✓	✓	✓	End of Term	
Governor - Staff Nursing	Maria Tyson	×	✓	✓	×	✓
Governor - Staff Nursing	Tracey Cummins	×	✓	×	×	✓
Governor - Staff Other Clinical, Scientific, Technical and Therapeutic	Cheryl Barber*	Not in Post			✓	✓
Governor - Staff Other Clinical, Scientific, Technical and Therapeutic	Sara Finlayson	✓	×	✓	×	×
Governor - Staff Other Clinical, Scientific, Technical and Therapeutic	David Kitchen~	✓	×	✓	End of Term	
Governor - Staff Other Clinical, Scientific, Technical and Therapeutic	Paul Allen	✓	✓	✓	×	×

Constituency	Name	12 Apr 2018	03 Aug 2018	12 Sep 2018	18 Oct 2018	17 Jan 2019
Governor - Staff Other Clinical, Scientific, Technical and Therapeutic	Gie Peneche*	Not in Post			×	✓
Governor - Staff Non Clinical	Mike Jones	✓	✓	✓	✓	✓
Governor - Service Users & Carers	Johanna Birrell	✓	✓	×	×	✓
Governor - Service Users & Carers	Debra Doherty	×	✓	×	✓	✓
Governor - Service Users & Carers	Mark McCarthy	✓	✓	×	✓	✓
Governor - Service Users & Carers	Martin Murphy	×	×	×	×	×
Governor – Service Users & Carers	Deb Riozzie*	Not in Post			×	✓
Governor - Service Users & Carers	Paul Taylor	✓	✓	✓	✓	✓
Governor - Service Users & Carers	Matthew Copple*	Not in Post			✓	✓
Governor – Service Users & Carers	Julie Dickinson*	Not in Post			✓	✓
Governor - Service Users & Carers	George Allen~	✓	✓	×	Not in Post	
Governor - Service Users & Carers	Brian Murphy	✓	Resigned from Post / Term ended 30 Sep 2018			
Governor - Service Users & Carers	Hilary Tetlow~	✓	✓	✓	Not in Post	
Appointed Governors	Clare Austin	×	×	✓	×	✓
Appointed Governors	Veronica Webster	✓	✓	✓	✓	✓
Appointed Governors	Amanda Gregory	✓	×	×	✓	×
Appointed Governors	Vicky Keeley	×	×	✓	×	✓

Notes: * = took up post in October 2018 ~ = term of office ended 30 September 2018

APPENDIX B – ATTENDANCE AT THE BOARD OF DIRECTORS AND BOARD COMMITTEE MEETINGS

Board of Directors

Constituency	Name	24 May 2018	30 May 2018	25 Jul 2018	26 Sep 2018	28 Nov 2018	30 Jan 2019	27 Mar 2019
Chairman	Beatrice Fraenkel	✓	✓	✓	✓	✓	✓	✓
Non Executive Director	Matt Birch	×	✓	×	×	✓	✓	✓
Non Executive Director	Murray Freeman	×	✓	✓	✓	✓	✓	✓
Non Executive Director	Gerry O'Keeffe	✓	×	✓	✓	✓	×	✓
Non Executive Director	Cath Green	×	✓	Resigned from Post				
Non Executive Director	Gaynor Hales	✓	×	✓	✓	✓	✓	✓
Non Executive Director	Nick Williams	✓	✓	✓	✓	✓	✓	✓
Non Executive Director	Aislinn O'Dwyer	Not in Post				✓	✓	✓
Non Executive Director	Pamela Williams	✓	×	✓	✓	✓	✓	✓
Chief Executive	Joe Rafferty	✓	×	×	✓	✓	✓	✓
Executive Director of Nursing & Operations	Trish Bennett	✓	✓	✓	✓	✓	✓	✓
Executive Director of Communications and Corporate Governance	Elaine Darbyshire	×	✓	✓	✓	✓	✓	✓
Medical Director	David Fearnley	✓	✓	✓	✓	✓	✓	✓
Executive Director of Operations	Mark Hindle	✓	✓	Resigned from Post				
Executive Director of Workforce	Amanda Oates	✓	✓	✓	✓	✓	✓	✓
Executive Director of Finance / Deputy Chief Executive	Neil Smith	×	×	✓	✓	✓	✓	✓
Director of Strategy and Planning	Louise Edwards	×	✓	×	✓	✓	✓	✓

Audit Committee

Members	Apr 2018	16 May 2018	24 May 2018	Aug 2018	Oct 2018	Dec 2018	Feb 2018
O'Keeffe, Gerry	✓	✓	✓	×	✓	✓	✓
Williams, Nick	×	×	✓	×	×	×	✓
Williams, Pam (Chair)	✓	✓	✓	✓	✓	✓	✓

Executive Committee

Members	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Rafferty, Joe (Chair)	×	✓	✓	✓	×	×	✓	×	Meeting Not Held	✓	✓	×
Smith, Neil (Deputy Chair)	×	×	×	×	✓	✓	×	✓	Meeting Not Held	✓	✓	✓
Darbyshire, Elaine	✓	×	✓	✓	✓	✓	✓	×	Meeting Not Held	✓	✓	✓
Fearnley, David	✓	✓	✓	✓	×	×	✓	×	Meeting Not Held	✓	×	✓
Oates, Amanda	✓	✓	✓	✓	✓	✓	✓	✓	Meeting Not Held	✓	✓	✓
Edwards, Louise	✓	✓	×	✓	×	×	×		Meeting Not Held	✓	✓	✓
Hindle, Mark	✓	✓	✓	✓	Resigned from Post							
Bennett, Trish	✓	✓	✓	✓	×	✓	×	×	Meeting Not Held	✓	✓	✓

Performance, Investment and Finance Committee

Member	Apr 2018	Jun 2018	Aug 2018	Oct 2018	Dec 2018	Feb 2019
Non Executive Directors						
Birch, Matt (Chair)	✓	✓	✓	✓	Meeting Not Held	✓
O'Keeffe, Gerry	✓	×	✓	✓	Meeting Not Held	✓
Williams, Nick	×	×	×	×	Meeting Not Held	✓
Green, Cath	×	✓	Resigned from Post			
Executive Directors						
Oates, Amanda	✓	×	✓	✓	Meeting Not Held	✓
Darbyshire, Elaine	✓	✓	✓	✓	Meeting Not Held	✓
Smith, Neil	×	×	✓	✓	Meeting Not Held	✓
Bennett, Trish	×	✓	✓	✓	Meeting Not Held	✓
Hindle, Mark	✓	×	Resigned from Post			

Quality Committee

Member	May 2018	Jul 2018	Sep 2018	Nov 2018	Jan 2019	Mar 2019
Non Executive Directors						
Freeman, Murray	✓	✓	×	✓	✓	✓
Green, Cath	✓	Resigned from Post				
O'Dwyer, Aislinn	Not in Post			✓	✓	✓
Hales, Gaynor (Chair from March 2018)	✓	✓	✓	✓	✓	✓
Executive Directors						
Fearnley, David	✓	✓	✓	✓	✓	✓
Oates, Amanda		×				
Bennett, Trish	✓	✓	✓	✓	✓	×

Remuneration and Terms of Service Committee

Member	Apr 2018	May 2018	Aug 2018	Nov 2018	Jan 2019	Feb 2019	Mar 2019
Beatrice Fraenkel	✓	✓	✓	✓	✓	✓	✓
Robert Beardall	×	×	×	Resigned from Post			
Matt Birch	×	✓	✓	✓	✓	×	✓
Gerry O'Keeffe	✓	×	✓	✓		✓	✓
Gaynor Hales	×	×	×	✓	✓	✓	✓
Nick Williams	×	✓	×	×	✓	×	✓
Pam Williams	✓	×	✓	✓	✓	✓	✓
Murray Freeman	Not in Post	✓	✓	✓	✓	✓	✓
Aislinn O'Dwyer	Not in Post			✓	✓	✓	✓
Cath Green	✓	✓	Resigned from Post				

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Mersey Care NHS Foundation Trust

Quality Report 2018/19

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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (EIP): 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 2018/19' 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 2018/19' 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 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2018/19' 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 2018 to 29 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 29 May 2019;
- feedback from commissioners dated 20 May 2019;
- feedback from governors on 25 April 2019;
- feedback from local Healthwatch organisations dated 23 and 24 May 2019;
- feedback from the Sefton Metropolitan Borough Council Overview and Scrutiny Committee dated 20 May 2019;
- 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 2018;

- the 2018 national staff survey dated 26 February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated March 2019;
- the Care Quality Commission's inspection report dated 5 April 2019; and
- any other information obtained during our limited assurance engagement.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 2019, 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 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 2018/19' 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 and is subject to separate terms and conditions. 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.

Basis for qualified conclusion

The indicator reporting the proportion of people experiencing first episode psychosis or 'at-risk mental state' who wait two weeks or less to start NICE-recommended package of care did not meet the six dimensions of data quality in the following respects:

- Accuracy – Our testing identified that relevant data for August 2018 could not be located and therefore we have been unable to determine that data relating to that period has been accurately included in the performance indicator according to the definitions set out in the applicable guidance.
- Completeness – Our testing identified that relevant data for August 2018 could not be located and therefore we have been unable to determine that the data has been correctly included in the performance indicator according to the definitions set out in the applicable guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 2018/19' 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 2018/19'; and
- the indicators in the 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 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP

Chartered Accountants

Birmingham Office, The Colmore Building, 20 Colmore Circus B4 6AT

29 May 2019

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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 2018/19. 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.

Mersey Care's vision is to provide Perfect Care that enables people with physical health and mental health conditions, learning disabilities and addictions to live longer, healthier lives.

2019 is the first year of a new five year strategy. We will continue our focus on Perfect Care, improving quality and safely reducing cost. But we also need to change our focus for the future. We need to develop more preventative and integrated services for children, young people and adults that enable them to take a more active role in their own health and we must think differently about our workforce models and realise the potential benefits of digital technology.

Our long term strategy is to develop new clinical models to prevent crisis in community settings, enable people to take more control of their own health and integrate services. These exciting new service models, developed using co-production with service users and carers, along with the continued development of a Just and Learning Culture and a focus on quality and inclusion, will make us the employer of choice in our sector.

Delivering our strategy will enable Mersey Care to remain in financial balance, through service redesign that develops more preventative and integrated services, but also through focusing on our main financial risks of medical recruitment, corporate services and community services. We will also invest in improving our digital and physical estate so that Mersey Care has a solid platform to enable our new service models for the future.

Mersey Care cannot rise to the quality, workforce and financial challenges we face by working on our own. The development of partnerships with other providers at neighbourhood, place and Cheshire and Merseyside levels is essential to the future sustainability of our services.

	22 May 2019
Joe Rafferty **Chief Executive**	**Dated**

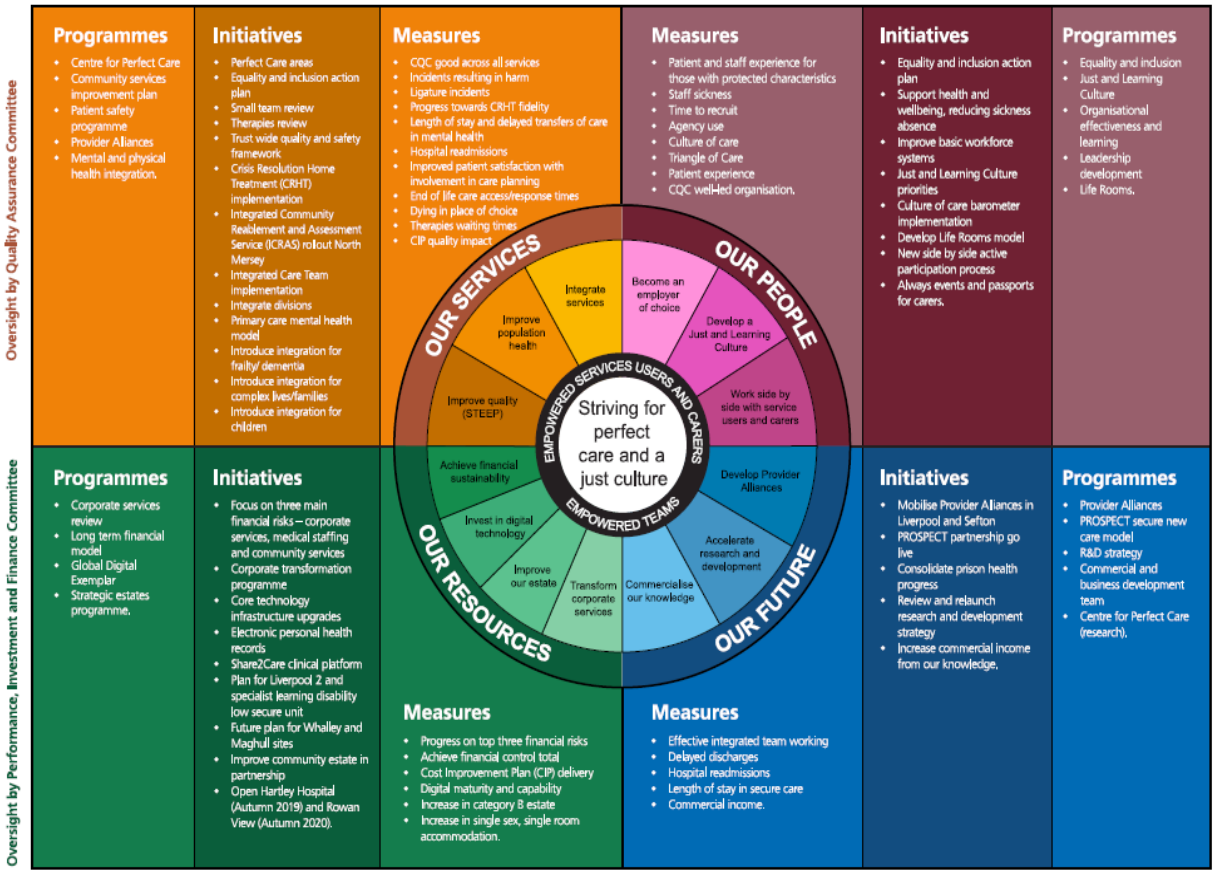
1.2 Our Strategic Direction: Transforming our Trust

1. Public services play a critical role in helping and protecting people, but we know something is not working. Despite having a number of excellent hospitals, a thriving voluntary and third sector and good quality social services, local services are not solving the most intractable health challenges, with huge variation in health outcomes even within neighborhoods of Liverpool. We know that individuals and families with the most complex needs experience multiple interventions from different services and agencies and yet all too often remain trapped in repeating cycles of intervention. People's lives and associated health problems are increasingly complex and require services to work together in order to be effective, but all too often individual organisations offer services in isolation. As is set out in the *Five Year Forward View* and the Cheshire and Merseyside Sustainability and Transformation Plan, the NHS part of this system is not financially or clinically sustainable in its current form.

2. Mersey Care faces a range of challenges and uncertainties in the next five years which will require fundamental redesign of our clinical, workforce and operational models. Doing more 'business as usual' faster and more efficiently is not going to be a sufficient response to these challenges.

3. In summary, our long term strategy is to continue to improve quality and cost in our services, and from this strong platform, develop more preventative, integrated community-based services. In response to the longer term workforce challenges, our strategy is to become an employer of choice, attracting people to work for Mersey Care but also developing and retaining people once they have joined the Trust. Our strategy for guaranteeing the longer term financial sustainability of our services is to develop a more preventative (and thus cost-effective) clinical model and focus on our three key financial risks – medical recruitment, community services and corporate services. Strategic investment is also important to the financial sustainability of our services, and we plan to invest in estate and digital infrastructure so that we have a solid platform for improvement and integration in the future. Our long term strategy also reflects the need for Mersey Care to work as part of a wider system at neighbourhood, place and system levels because the challenges we face require a collaborative effort to overcome them.

4. Our key long-term challenges and solutions are set out in the table below, alongside the initiatives set out in this plan to address those challenges and the associated resourcing/ investment.



Our services	Strive for perfect care
Our people	Become the employer of choice in our sector
Our resources	Develop a solid financial, estate and digital platform for future Integration
Our future	Work with and learn from others to have greater impact.

1.3 Improving Quality

5. 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.

6. Mersey Care has an overall 'Good' rating from the CQC. In 2019, services were rated as 'Good' for being safe, effective, caring, and responsive, and outstanding for well led. This is an improved position since the 2017 inspection when the Trust was rated as Good overall, but 'Requires Improvement' for being safe.

1.4 Pursuing Perfect Care

7. 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).

8. We have set ambitious goals in pursuit of perfect care:

   a) Reducing Restrictive Practice;

   b) zero suicide for those in our care;

   c) physical health for service users;

   d) A just and learning culture;

   e) Zero deterioration of pressure ulcers within our care in 2019/20;

   f) Learning from deaths;

   g) Reducing Delayed Discharges in Mental health.

9. 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 Reducing Restrictive Practice guidance 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 2019/20 AND STATEMENT OF ASSURANCE FROM THE BOARD

2.1 Priorities for Improvement 2019/20

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 2019/ 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 **2019/20** 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 **2019/20** will be:

    a) **Priority 1: Reducing Restrictive Practice**

        i) Full compliance with the reducing restrictive practice guide by March 2020.

        ii) Reduce restraints in SLD services from 2018/19 baseline by 50% in 2019/20.

b) **Priority 2: Towards Zero Suicide**

i) Zero inpatient suicides in 2019/20.

ii) Develop world leading practice guidance on reducing self harm in people with Personality Difficulties by October 2019.

c) **Priority 3: Improvements in Physical Health Pathways**

i) Focus on improving access to End of Life Care for all servicers across Mersey Care.

ii) Develop clear pathway for each Division to access End of Life Care.

iii) 100% Compliance for the physical health pathway (Annual Health Check) for community service users on care programme.

d) **Priority 4: A Just and Learning Culture**

i) Develop a tool / framework to support restorative conversations in practice.

ii) Develop a tool/framework (aligning to our organisational values) that supports civility in practice.

iii) Every team to have a Just and Learning conversations about learning from routine and what goes right , as well as when something doesn't go to plan.

iv) Review the Datix pro-forma, process, pathways and guidance.

e) **Priority 5: Reduction in Community Acquired Pressure Ulcers**

i) Zero deterioration of pressure ulcers whilst under our care

f) **Priority 6: Learning from Deaths**

i) Four thematic reviews will be conducted per year on analysis of mortality figures by March 2020.

ii) Process for undertaking pathway reviews will have been developed and implemented in association with the partner organisation March 2020.

iii) Data from GPs, specifically the cause of death will be used as part of the mortality review process.

g) **Priority 7: Reducing Delayed Discharges in Mental health**

i) Aim for Zero Delay in discharge for patients.

ii) Set clear goals with the Division for reducing length of stay.

13. Following the transaction of Community Health the Trust has a focus on improving child health and delivering the healthy child program. We will particularly focus on two areas to improve care as part of child health.

a) **Education and Health Care Plans**

i) Discharge all of the actions required to address issues identified as part of the 2019 SEND inspection by March 2020.

b) **Lost Contact Process**

i) Delivery of a signed off process for safe management of lost contact population by September 2019.

Ensuring Equality and Tackling Health Inequalities

14. 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.

15. Each priority lead will ensure this is reflected in the work stream reporting framework.

Monitoring and Reporting Arrangements

16. A nominated lead will be identified for each priority and will chair a work stream forum which will coordinate progress and monitor activity.

17. 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.

18. 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 2018/19

19. In June 2018**,** the Trust published its Quality Report reporting on the quality of services against six areas of priority. Following engagement with key stakeholders the following priorities would be the key areas of quality improvement:

    a) Priority 1: Reducing Restrictive Practice

    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

    f) Priority 6: Learning from Deaths

20. Table 1 below summarises the elements of achievements in relation to these priority areas.

Table 1: Quality Report Progress 2018/19

Priority	Description	Delivery
1	Reducing Restrictive Practice	
	• Develop and implement a strategy on rapid tranquilisation and depot administration to reduce prone restraint by 50% from baseline by March 2019; • 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;	Achieved Achieved

Priority	Description	Delivery
	• Review of ligature incidents by June 2018 and develop an implementation plan to address risks using the strategies from the P4P2 project; • Implement Zero Segregation action plan to reduce long term segregation by 20% from the baseline cohort by the end of financial year 2018 – 2019; • By March 2019 a further Research Evaluation of the implementation of the Guide to Reducing Restrictive Practice Guide will be completed; • Compile and publish good practice stories on reducing restrictive practice from across the Trust by December 2018	Achieved Achieved Achieved Achieved
2	**Towards Zero Suicide**	
	• 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; • targeted suicide prevention interventions to be provided to teams that have experienced a suicide or near fatal event as an on-going intervention; • 100% of former Liverpool Community Health staff will complete Level 1 Suicide Awareness Training by March 2019; • 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; • Centre for Perfect Care to provide an analysis of post incident reviews of suicides to identify key targeted areas for improvement by March 2019.	Partially Achieved Partially Achieved Achieved Partially Achieved Achieved
3	**Improvements in Physical Health Pathways**	
	For clinical staff to recognise the deteriorating patient through NEWS2 to ensure prompt intervention to treatment required; <u>Measures:</u> • 100% of inpatient wards have implemented NEWS2 • 100% of inpatient wards have implemented the sepsis pathway • Physical health community division implemented NEWS2; By March 2019, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented.	Achieved Achieved Achieved Partially Achieved

Priority	Description	Delivery
4	**Just And Learning Culture**	
	• 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; • 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; • 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; • 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.	Achieved Achieved Achieved Achieved
5	**Reduction of Community Acquired Pressure Ulcers**	
	• Raise awareness training for managing pressure ulcers in the mental health in patient wards; • Reduction plan in place with a target trajectory for reduction of Grade 2 and 3 pressures ulcers; • Zero grade 4 pressure ulcers.	Achieved Achieved Not Achieved
6	**Learning from Deaths**	
	• Scope for reviewing individual community deaths will have been agreed and implemented by March 2019; • Scope for reviewing individuals in mental health care will have been reviewed and new standards adopted by March 2019. • Single action plan for monitoring completion of learning points will be developed and completion of actions monitored by March 2019; • Four thematic reviews will be conducted per year based on an analysis of mortality figures by March 2019; • Process for undertaking pathway reviews will have been developed and implemented in association with partner organisations March 2019; • Data from GPs, specifically the cause of death will be used as part of the mortality review process.	Achieved Achieved Achieved Achieved Partially Achieved Partially Achieved

Detailed Progress on Quality Report Objectives 2018/19

Priority 1 Progress: Reducing Restrictive Practice

Dr Jennifer Kilcoyne is the Consultant Psychologist is the nominated lead for No Force First.

Priority 1 Objectives for 2018/19

Develop and implement a strategy on rapid tranquilisation and depot administration to reduce prone restraint by 50% from baseline by March 2019

- The trajectory for reductions in prone restraint to administer rapid tranquilisation and depot medication required a Trust total of no more than 5 incidents per month by the end of Q2. The target was achieved during the quarter however, during September the Secure Division did not meet the performance target of (1) as (2) services required IM medication and were placed in the prone position for it to be administered safely. The Personal Safety Service have been in contact with the respective wards and offered additional support and training.
- We have developed a number of work streams to continue to reduce the use of planned prone restraint to support the safe administration of rapid tranquilisation and depot medication through; a) the delivery of PSS Training, ensuring it is only used if there are cogent reasons for doing so b) by exploring alternative sites to administer depot and rapid tranquillisation medication c) engagement sessions to explore the reasons why nursing staff are not considering administering prescribed medication in alternative sites and d) reviewing all prone restraints across the Trust and providing additional support.
- We are also in the process of developing a blended training package to enhance staff confidence in administering depot medication and rapid tranquilisation in alternative sites. We foresee this training being delivered through an e-learning package, clinical skills trainers and the Personal Safety Service.

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 other

- The trajectory for reductions in physical restraint associated with self-harm required a Trust total of no more than 39 incidents per month by the end of Q3. The target was exceeded by some considerable distance throughout the quarter.
- Local division remained marginally above target (n = 7 against a target of 5 by end of quarter) and although Brunswick ward spiked during November. There were no real hot spots in December, with the 7 incidents dispersed across 4 different wards. Brunswick ward have now completed their ‘discovery’ work under the auspices of the self-harm project, and identified priority interventions they will implement to reduce further incidents. This work continues through the ward.
- Specialist LD division were responsible for the majority of incidents during the quarter 1 to 3), with just three wards – 1 Woodview, Newton & Slaidburn and the Star Unit – responsible for almost 90% of incidents by end of quarter. Considerable work has been undertaken to understand this spike in restraints, which would appear to be an unintended consequence of advice given in the wake of a serious incident last year. An action plan has since been implemented to reverse the trend, which, as can be seen,

appears to be having a positive impact. The wards in question are also part of the self-harm project and are currently implementing PDSA cycles which are due to be evaluated at the end of Q4.

Review of ligature incidents by June 2018 and develop an implementation plan to address risks using the strategies from the P4P2 project

- The trajectory for the reduction in ligature incidents required a Trust total of no more than 49 incidents per month by the end of Q3. After recovering the Q2 closing position going into October, another spike ensued, peaking at 138 in December. Local and Specialist LD Divisions accounted exclusively for this total with 121 and 17 incidents respectively.
- In Local division, Dee ward alone was responsible for 55% of all incidents having experienced a significant spike towards the end of the quarter. The vast majority of these incidents were attributed to one particular patient .the patient was admitted in crisis at the end of November, with ligaturing as a long-standing behaviour both in the community and during repeated admissions – and subsequently engaged in the behaviour almost daily, sometimes up to five times per day. The majority of incidents resulted in 'no harm as the ligatures were loosely tied and often removed by the patient themselves. The MDT have since been working hard to secure the patients discharge pathway. The remaining incidents were dispersed across 10 wards with no other obvious 'hot spots' or special cause variations.
- In Specialist LD division the 17 ligature incidents were dispersed across four wards, with three of them – Newton & Slaidburn, 1 Woodview, and Coniston & Grasmere – accounting for 94% of incidents (n = 16). The three wards in question are all involved in the self-harm project and were represented at the 'Sharing the Learning' event at the start of the quarter in October, where potential mitigation strategies were identified. PDSA cycles have subsequently been implemented on all three wards and these are due to be evaluated at the end of Q4.

Implement Zero Segregation action plan to reduce long term segregation by 20% from the baseline cohort by the end of financial year 2018 – 2019

- The trajectory target required of cumulative days of long term segregation was 17848 days by the end of Q2. The target was achieved by 637 days by Q2

<u>Secure Division</u>

- We are currently nursing (28) patients in long-term segregation at Ashworth Hospital. We have recently had an increase in the use of long-term segregation due to a small number of patients relapsing in mental state and new admissions from the Prison Service who are currently acutely unwell, remain a high risk of assaulting others and require intensive care and treatment to stabilise them.
- We have developed a driver diagram below to help translate our high level improvement goal into a logical set of underpinning goals and projects. It captures the entire change programme into a single diagram and also provides a measurement framework for monitoring progress.

Long term segregation – length of stay

Long term segregation – length of stay	April 2018	May 2018	June 2018	July 2018	August 2018	Sept 2018
0-3 months	**13**	**12**	**14**	**7**	**9**	**12**
4-6 months	**4**	**6**	**7**	**5**	**3**	**3**
7-12 months	**3**	**4**	**5**	**5**	**7**	**7**
Over 12 months	**11**	**8**	**8**	**8**	**8**	**8**

Current Progress:

- **13.6%** reduction in cumulative days since April 2018.
- **31%** reduction from patient baseline April 2018 cohort (26) patients nursed in LTS (6) progressed (2) returned to LTS.
- **42%** reduction in length of stay in LTS over 12 months since April 2017.
- During September 2018 we obtained permission from the commissioner for (1) service user in our MSU at Scott Clinic to be transferred to long term segregation from seclusion due to risk, safeguarding issues and to reduce restrictions that was being applied whilst nursed in seclusion.

Specialist Learning Disability Division

- We are currently nursing (1) servicer user in long term segregation in our MSU at Woodview since 15/05/18 (121 days). However, we have ended long segregation for (2) service users since April 2018.

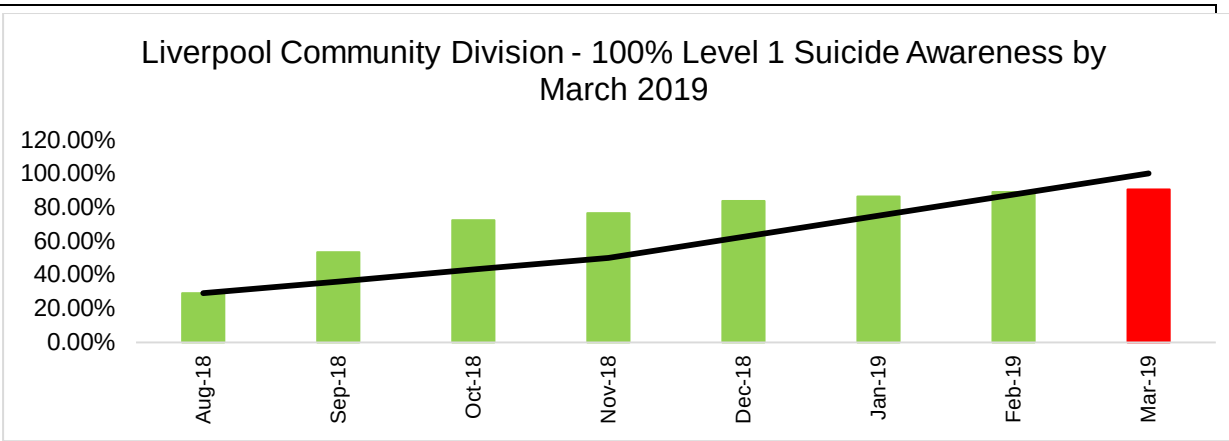
By March 2019 a further Research Evaluation of the implementation of the Guide to Reducing Restrictive Practice Guide will be completed.

- The Trust Research & Development Team are in the process of scoping out a potential independent evaluation with Manchester Metropolitan University with Professor Joy Duxbury

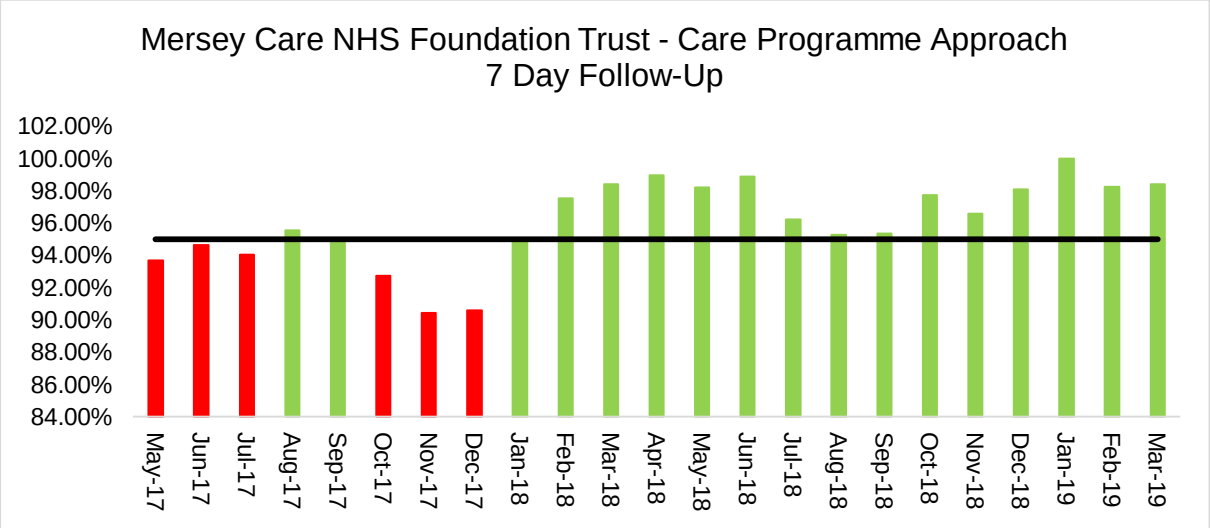
Compile and publish good practice stories on reducing restrictive practice from across the Trust by December 2018.

- We have tasked divisional leads to explore best practice across the Trust in relation to the implementation of the 6 core ward based interventions and evidenced based approaches from the Guide to Reducing Restrictive Practice.
- We continue to engage our service users from across the 3 divisions to obtain their views on the impact this has had on supporting their physical and psychological wellbeing and recovery. We are also planning to develop a video consisting of service users and staff to highlight good practice stories within the Trust

Priority 2 Progress: Zero Suicide
Dr Rebecca 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 2018/19
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
• The reporting tool to monitor safety planning is now available within RiO, although there has been a delay in this being implemented and extracting information from this tool is still being developed. An alert will also be present within RiO to ensure that patients with safety plans are easily identifiable and the safety plan can be easily accessed in times of need. • All adult wards have been offered the safety plan training and in line with the implementation plan champions have been identified by the ward managers for each ward. The Centre for Perfect Care (CfPC) has Quality Improvement staff that are trained in delivering safety plans and will support the champions in the continued roll out. • The CfPC will continue to work alongside the ward champions to identify and update safety plans.
Targeted suicide prevention interventions to be provided to teams that have experienced a suicide or near fatal event as an on-going intervention
• Suicide prevention training has been delivered to the majority of inpatient areas, with the older peoples services being delayed in receiving the training in any aspect of suicide prevention. Plans have been established to deliver the training in these areas. • Additional areas within the community setting such as A and E liaisons, Criminal Justice staff have all been trained in suicide prevention. The development of the new crisis teams has agreed to have suicide prevention as a core learning strategy and we will be training any new staff to this service in due course.
100% of former Liverpool Community Health staff will complete Level 1 Suicide Awareness Training by March 2019
The Suicide awareness training is now available and being accessed by community Division – please see graph on the next page



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



Centre for Perfect Care to provide an analysis of post incident reviews of suicides to identify key targeted areas for improvement by March 2019

- Initial work has been commenced on this area, with a number of topics being highlighted as areas for improvement over the current year. Such as MDT Processes (including Standards and Quality of service), Clinical Interventions (development of risk plans and skills of staff to undertake these), Documentation (effective communication and adequate supervision). The role of Carers and Families to be more involved in the care and treatment of their loved ones; by way of them feeling supported, listened to and informed by staff. Further analysis of themes over previous years is still being completed, but analysis completed to date highlights similar themes in previous years.

Priority 3: Progress Improvements in Physical Health

Jenny Hurst Deputy Director of Nursing is the nominated lead for this priority area. A Trust wide physical strategy group supports and oversees this priority area.

Priority 3 Objectives for 2018/19

For clinical staff to recognise the deteriorating patient through NEWS2 to ensure prompt intervention to treatment required

Measures:

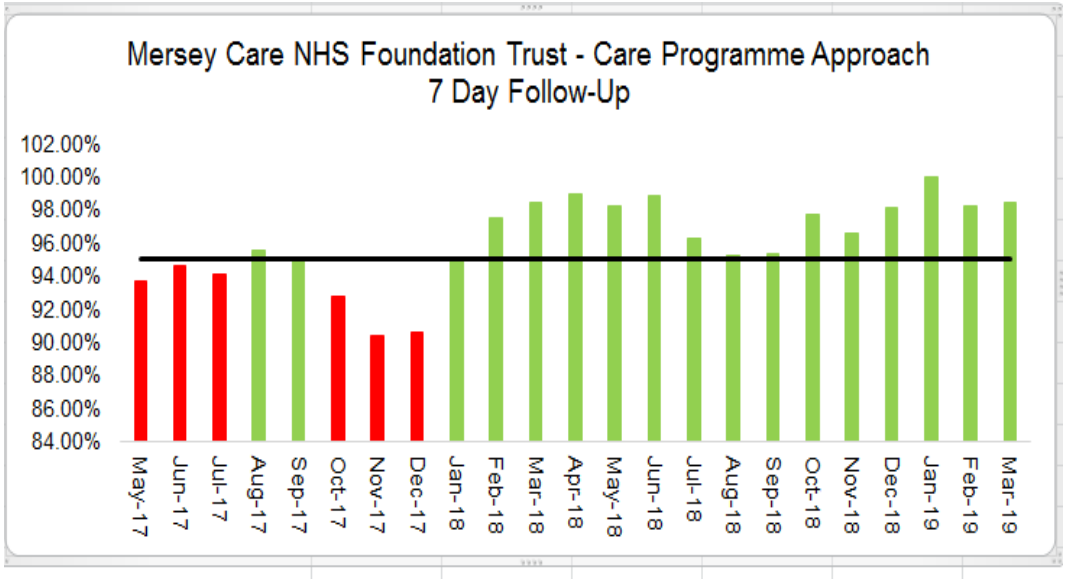
- 100% of inpatient wards have implemented NEWS2
- 100% of inpatient wards have implemented the sepsis pathway
- Physical health community division implemented NEWS2;

All inpatient wards have implemented NEWS2 and sepsis pathway. Community have implemented NEWS2 and sepsis pathway. NEW2 training is mandated from April 19 for all clinical staff band 3 to 8a.
Trust Wide Policy for Recognising the Deteriorating Patient developed and Trust Website

By March 2019, 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.

Percentage of community service users on CPA who have an annual health check – Trust



Priority 4: A Just and Learning Culture
Amanda Oates Executive Director of Workforce is the nominated lead for this priority
Priority 4 Objectives for 2018/19
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
• PACE (appraisal) process is the main mechanism for assessment and development planning against the Trust values / behaviours and competence. • A leadership competency framework was developed and incorporated within the 2018-19 PACE process. • As at end of September 2018 82 % of people at Band 7 and above have had completed PACE and therefore been assessed, had feedback and have agreed their development priorities and plans with their line manager in accordance with our Just and Learning Culture. • For the former Liverpool Community Health managers (LCH) who have not used PACE, the approach has been different. Assessment has been undertaken as part of the THRiVE process and will be aligned to PACE upon implementation later this year. To date 46 former LCH Band 7 and above have or are completing THRIVE. • An evaluation and review of progress to date is being conducted. Those yet to complete this process have been identified and plans to support will be agreed and put in place to ensure 100% of those in scope meet the Just and Learning Culture objective. In the meantime the refresh of Mersey Care values has been approved. The additional value and behaviours associated with Support will be incorporated within PACE 2019-20. By this time all MCT will use PACE.
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
• This will be part of the framework being developed for PACE 2019/20
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
• A guide will be produced 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 will include the development of bullying awareness

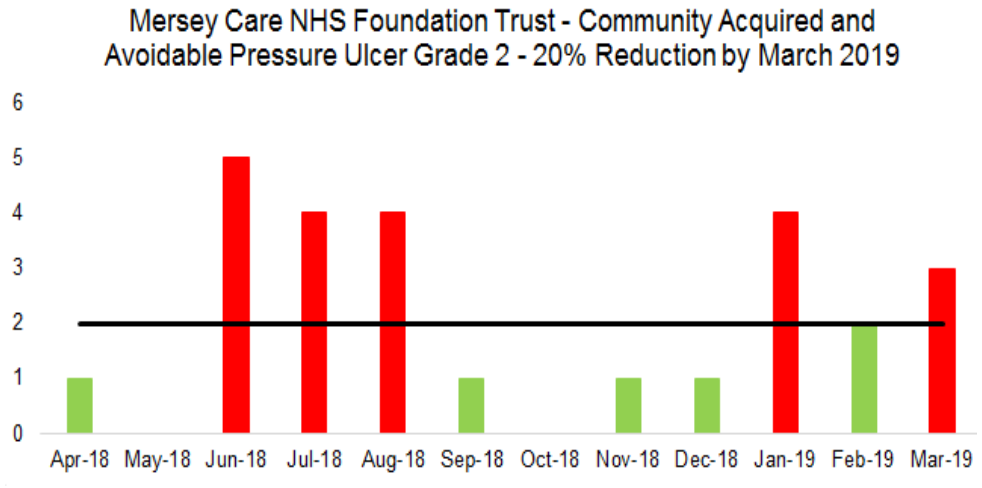
Priority 5: Reduction of Community Acquired Pressure Ulcers
Nicky Ore, Clinical Lead Sefton Locality, is the nominated lead for this priority.
Priority 5 Objectives for 2018/19
• **Raise awareness training for managing pressure ulcers in the mental health in patient wards;** • **Reduction plan in place with a target trajectory for reduction of Grade 2 and 3 pressures ulcers;** • **Zero grade 4 pressure ulcers.**
• The Trust has continued to develop an action plan to reduce pressure ulcers across the community and raise awareness across mental health. We have worked in collaboration with NHS Improvement and perfect care team to implement the reduction program • Pressure Ulcer dashboard at locality/ divisional level is now implemented. • Further work underway to capture deterioration of pressure ulcers on caseload this will be mobilised in Quarter 1 2019/20. • Team level dashboards have been implemented to support monitoring of targets via Pressure Ulcer Reduction Harm Free Care Group, Locality Governance and Performance meetings this across the district nursing workforce. This is to be rolled out to the AHP workforce in 2019-20. • All Pressure ulcers monitored weekly via daily Datix report in the locality, Locality Safety Huddle and Divisional Safety Huddles. The 72 hour review process is fully embedded. As at end of March 2019, performance against targets as follows: • Category 2 Community Avoidable Acquired (CAA) – Target 23 • Category 3 CAA: 27 – Target 29 • Category 4 CAA: 7 – Target 0 • Deterioration of category 2 /3 and category 3/4: Work underway to capture timely data this will be part of the dashboard going forward and will mobilise in Quarter 1 2019/20. Category 4 • Strategy meetings have been delivered to identify immediate learning in relation to Category 4 pressure ulcers. • Following review of all strategy notes gaps in practice have been identified .Quality Improvement Alerts were developed and implemented across the division and wider organisation to support immediate learning. • Category 4 pressure ulcers have been a key area of focus at both the divisional and executive safety huddles and this work continues. • Specialist Tissue Viability Nurse reports implemented in Quarter 3 these are now completed for all CAA Categories 3 and 4 Pressure Ulcers to support Root Cause Analysis (RCA) investigations. Further review has been undertaken to evidence effectiveness of this process and the RCA template is being further adapted to reduce duplication and ensure specialist oversight to support the improvement programme. • Last category 4 reported was 10th January 2019 in Central Locality –85 days without a category 4

The pressure ulcer reduction programme continues to be developed and extended with a work plan and action plan in place to support. The pressure ulcer action plan has been update to reflect aims / objectives and outcomes. Work has now been implemented to understand and support the needs of the other divisions across MCFT in pressure ulcer awareness and prevention.

Target 1 - 20% reduction compared to 2017/18 for Category 2 Community Acquired Avoidable Pressure Ulcers).

The current level of performance against target – Grade 2: 3 (YTD)

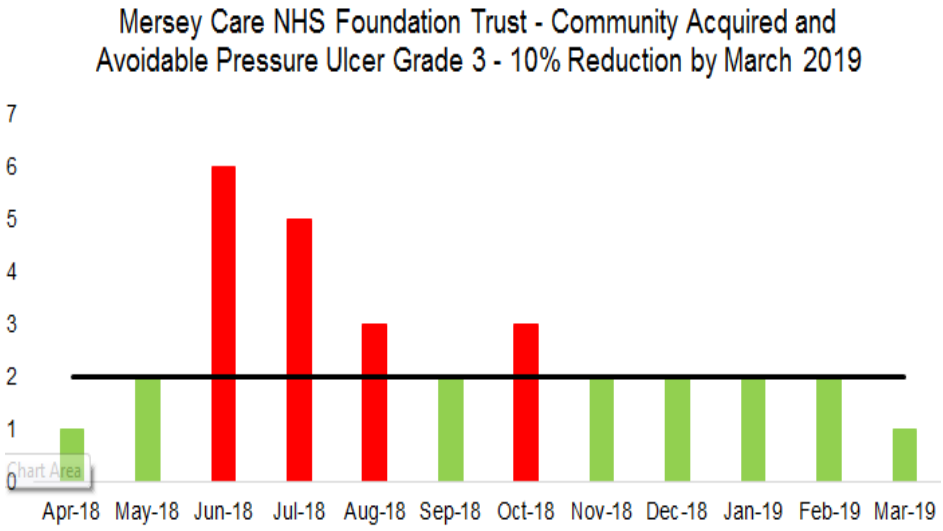
Category 2 Community acquired pressure ulcers



Target 2 - 10% reduction compared to 2017/18 for Category 3 Community Acquired Avoidable Pressure Ulcers.

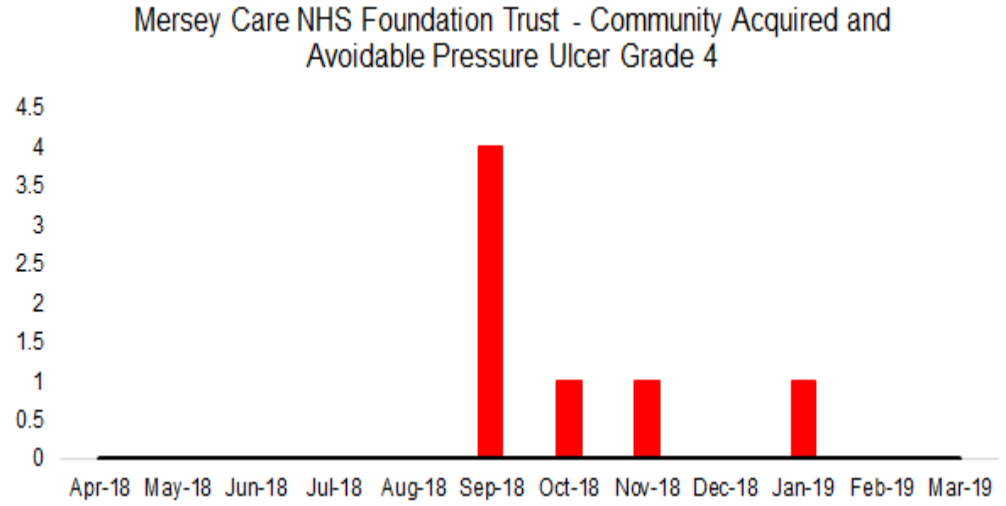
Community acquired grade 3 pressure ulcers YTD.

No of Category 3 community acquired avoidable pressure ulcers



Target 3- Zero Category 4 Community Acquired Avoidable Pressure Ulcers (STEIS).

- Current level of performance Category 4



Priority 6 :- Learning From Deaths
Priority 6 Objectives for 2018/19
Steve Morgan Director For Patient Safety is the nominated lead for this priority
• scope for reviewing individual community deaths will have been agreed and implemented by March 2019; • scope for reviewing individuals in mental health care will have been reviewed and new standards adopted by March 2019. • single action plan for monitoring completion of learning points will be developed and completion of actions monitored by March 2019; • four thematic reviews will be conducted per year based on an analysis of mortality figures by March 2019; • process for undertaking pathway reviews will have been developed and implemented in association with partner organisations March 2019; • data from GPs, specifically the cause of death will be used as part of the mortality review process.
• The scope for agreeing deaths has been agreed for the community division and an implementation is now being put in place. This has included changes being made to the Datix reporting form to enable staff in the community division to report incidents more easily. The scope has been broadened at the request of the Executive Director responsible and will include all deaths of patients who have been receiving clinical care by the division. The new system will commence in November 2018. • A further W.T.E. post has been recruited to and will be fully in place by December 2018 to increase the capacity of the team to undertake the enhanced number of reviews. This post is currently for a year using LCH improvement funding. The Consultant Psychosis role has now been fully appointed too, for two sessions per week, they are taking the lead in providing support and supervision to the Mortality and Incident Practitioners and proffering medical guidance during RCA reviews. • The Trust have asked the CCG to provide support in gaining access to GP information they have agreed to do this and have confirmed that having GPs involved in undertaking reviews of deaths is part of their plan . The Trust has confirmed that they are happy to share information on the process used to undertake reviews if this will help GPs to engage. • The Trust as completed a thematic review into deaths of patient with a diagnosis of Dementia, an action plan is currently being put in place and will be monitored by the Mortality Review Group

2.3 Statements of Assurance from the Board: Review of Services

21. During 2018/19 Mersey Care NHS Foundation Trust provided NHS services to a number of NHS Commissioners, including public health (local authorities).

22. During 2018/19, 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 community services, including pre-birth to 19 services commissioned by Liverpool City Council through the contract

c) NHS Liverpool CCG for addiction services;

d) NHS Liverpool CCG for Improved Access to Psychological Therapies (IAPT);

e) NHS South Sefton CCG, NHS Southport and Formby CCG, NHS Liverpool CCG and Aintree Hospital NHS FT for Sefton community physical health services. Some of these services are sub-contracted to North-West Boroughs NHS Trust

f) 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);

g) NHS England (through its regional and various sub-regional teams) for:
   i) low, medium and high secure services (also provided to 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;

h) Spectrum CIC for provision of mental health services in HMP Liverpool

i) Aintree University Hospitals NHS Foundation Trust for the Liverpool Community Alcohol Service, bariatric support services, Litherland Walk-in Centre and services provided as part of the Liverpool Diabetes Partnership;

j) NHS East Lancashire CCG (and associates) for low and medium secure services and enhanced community support services for specialist learning disabilities services;

k) NHS North Lancashire and South Cumbria CCG for Learning Disability Specialist Support Teams

l) NHS Trafford CCG (and associates) for low and medium secure services and enhanced community support services for specialist learning disabilities services

m) Alder Hey Children's NHS Foundation Trust – CQUIN transition from CAMHS to Adult Mental Health and Learning Disability Service;

n) Liverpool Women's NHS Foundation Trust for Perinatal Mental Health Service (funded till June 2018);

o) Manchester Mental Health and Social Care Trust for psychiatry services to HMP Manchester;

p) National Probation Service for community personality disorder services, Resettle and Psychologically Informed Planned Environment (PIPE) services;

q) NHS East Lancashire CCG for Learning Disabilities Enhanced Support Services

r) Lancashire Care NHS Foundation Trust for Dental services for low and medium secure services. **This is a commissioned service i.e. expenditure**;

s) Lancashire Care NHS Foundation Trust for Speech and Language Services. **This is a commissioned service i.e. expenditure.**

t) Liaison & Diversion service (CJLT) - within secure main contract;

u) Sex Offender Treatment Programme at HM Prison Wymott – within OPD element of main secure contract;

v) Psychiatry service to HM Prison Altcourse (Primecare);

w) National Probation Service / NOMs OPD work in Cheshire.

23. 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 Women's 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

24. Mersey Care has reviewed all of the data available on the quality of care in all of these services

25. The Trust also hosts Informatics Merseyside which provides services to a range of local NHS organisations.

2.4 Participation in National and Local Clinical Audits and National Confidential Enquiries

National Clinical Audit Reports 2018/19

26. During 2018/19 **twelve** 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 83% (n10/12) 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 2018/19 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 EIP Spotlight;

    d) National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation;

    e) Falls and Fragility Fractures Audit programme (FFFAP) National Audit Inpatient Falls

    f) National Audit of Cardiac Rehabilitation

    g) National Clinical Audit of Anxiety and Depression (NCAAD) Core Audit

    h) National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight

    i) POMH: Assessment of side effects of depot and LAI antipsychotic medication;

    j) POMH: Rapid Tranquillisation;

    k) POMH: Prescribing Clozapine;

    l) POMH: Monitoring of patients prescribed lithium.

29. The national clinical audits and national confidential enquiries that Mersey Care NHS Foundation Trust participated in during 2018/19 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 EIP Spotlight;

d) National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation;

e) National Clinical Audit of Anxiety and Depression (NCAAD) Core Audit

f) National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight

g) National Audit of Care at the End of Life (NACEL)

h) National Audit of Intermediate Care (NAIC)

i) POMH: Assessment of side effects of depot and LAI antipsychotic medication;

j) POMH: Rapid Tranquillisation;

k) POMH: Prescribing Clozapine;

l) POMH: Monitoring of patients prescribed lithium.

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 2018/19, 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.

National Audit Title	No of Cases Submitted	No of cases as a % of number required
National Confidential Enquiry into Suicide and Homicide by people with Mental Illness;	73 submitted, 12 returned	100%
Learning Disability Mortality Review Programme (LeDeR);	The Trust has not yet had any targeted feedback from the programme.	
National Clinical Audit on Psychosis EIP Spotlight	200	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation	Case submission not commenced	
National Clinical Audit of Anxiety and Depression (NCAAD) Core Audit	100	100%
National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight	11	18%
National Audit of Care at the End of Life (NACEL)	16	100%
National Audit of Intermediate Care (NAIC)	NA	_
POMH: Assessment of side effects of depot and LAI antipsychotic medication	Sept 18 Not Published	
POMH: Rapid Tranquillisation;	59	100%
POMH: Prescribing Clozapine;	158	100%
POMH: Monitoring of patients prescribed lithium.	Feb19 – March 19 Not published	

31. The reports of 3 national clinical audits were reviewed by the provider in 2018/19 and Mersey Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

a) From the National Clinical Audit on Psychosis (year 1 2017/2018) the actions to improve quality are:-
   i) Continue the development of the 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.
   ii) Review provision and access to psychological therapies;
   iii) Review the record keeping associated with engagement/involvement of service users in prescribing decisions.

b) From the National Audit of Care at the End of Life (NACEL) the actions to improve quality are:
   i) Review of the End of Life Care Plan and include as part of electronic patient record on EMIS;
   ii) To undertake monthly audits to ensure key stages of the pathway are being met;

c) National Audit of Intermediate Care (NAIC) the actions to improve quality is:
   i) The findings from the audit have been included in the review of the Integrated Community Reablement and Assessment Service (ICRAS) across both Liverpool and South Sefton.

Participation in Trust Wide Clinical Audits

32. The reports of 80 completed clinical audits were reviewed by the Trust in 2018/2019 and it intends to take action to improve the quality of healthcare provided (see Annex 3 Actions against the key themes from these local clinical audits reviewed in 2018/19).

33. 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.

2.5 NHS Staff Survey Results 2018

34. The annual NHS Staff Survey was conducted between 5 October and 30 December 2018, the Trust achieved a response rate of 51% which is above national average of 45%. Following the acquisition of Liverpool Community Health NHS Trust (LCH), Mersey Care's Staff Survey responses are now benchmarked against Combined Mental Health/Learning Disability and Community Trusts as its comparator group. There are 30 other organisations within this comparator group.

35. Given the changes to our organisational structure following the acquisition of LCH, there is no comparable data provided by the Survey Co-Ordination Centre. This analysis has been conducted internally where possible for guidance to indicate trends from previous years. To this effect 2018 will become 'Year Zero' of the new

integrated organisation and the new reporting format to provide the benchmark for future results.

36. The Trust's results for this year are encouraging in terms of comparison against national average and against 2017's results. The Trust is either meeting or above average in 6 out of the 10 key themes. When we compare our results by question with the previous year, our results are as follows:

Number of questions where we have improved	**59**
Number of questions where the results are the same as the previous year	**12**
Number of questions where we have seen a slight deterioration	**11**
Number of questions which are new so have no direct comparator	**8**

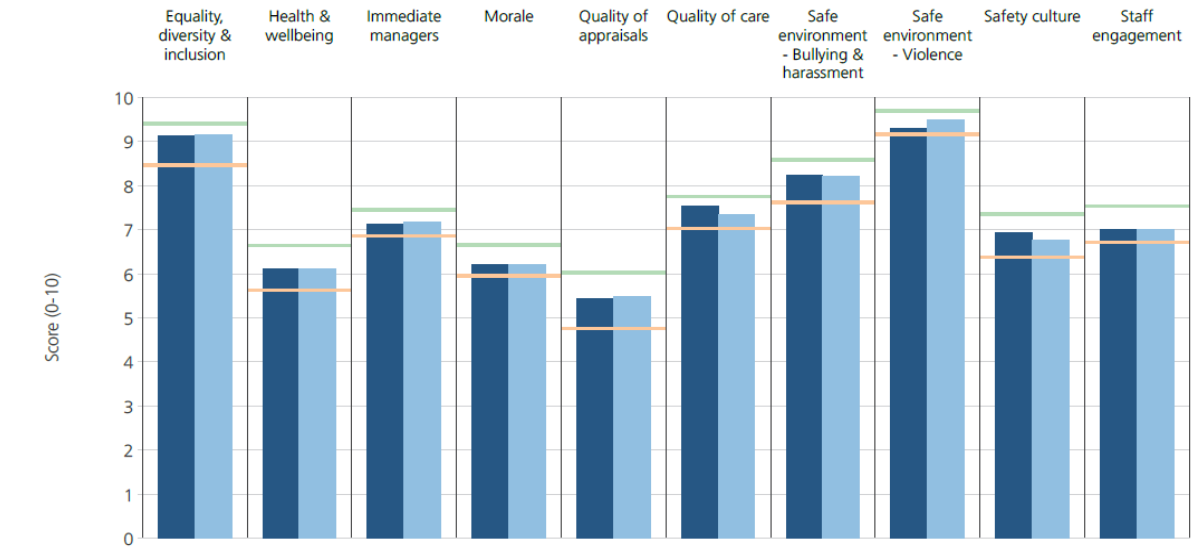
37. In relation to Overall Staff Engagement the Trust has achieved a score of 7.0 which meets the national average for our comparator group. All clinical divisions have seen improvements in relation to engagement. After a decrease in medical staff engagement, this group have seen a notable improvement, reflecting the work undertaken in this area and the implementation of the Medical Senate.

38. The Trust has also seen notable improvements in each of the questions that make up the Safety Culture, which has been a key area of focus for the Trust in line with the Just and Learning Culture work. Particular improvements were noted in the Community Division who undertook the survey for the first time as part of Mersey Care following the acquisition in April 2018.

39. These results were presented to the Trust Board of Directors in March 2019, as well as cascaded through divisional workforce groups. Results will be shared with front line staff as part of the Spring Roadshows taking place in April and May and used to generate discussion between staff and senior manager about their experience at work.

40. The Trust's People Plan has previously identified 5 key priorities that will improve staff experience and ensure Mersey Care is an employer of choice. These 5 areas directly link to the 10 new themes of the Staff Survey; on-going progress of actions will be monitored by the Board and by the Strategic Workforce Group. Divisional action plans in response to findings are being developed and will be presented to the relevant Operational Management Boards.

http://www.nhsstaffsurveyresults.com/local-breakdowns-questions/



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	9.1	6.1	7.1	6.2	5.4	7.5	8.2	9.3	6.9	7.0
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7

2.6 Research and Development

41. This year priority has again been given to supporting NIHR (National Institute for Health Research) adopted studies. A wide range of student, staff and internally generated research studies have also been facilitated. We have supported 117 open studies (including those in set-up, actively recruiting and in write up), of which 58 were adopted NIHR studies and the remaining 59 were student, Trust specific and own account studies.

42. The number of service users recruited during this period to participate in research, approved by a research ethics committee was 899. In addition, 108 staff and 134 carers and 43 others participated in research studies – a total of 1184. Of these, 333 service users, 87 carers and 26 staff and 6 others (a total of 452 recruits) were from NIHR adopted portfolio studies and 732 from non-adopted studies.

43. 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 2018/19 and have again surpassed the recruitment target for the number of people participating in NIHR research.

44. Research effort to support Trust priorities this year has continued, including self-harm, suicide, reducing restrictive practice, physical health.

45. The range of studies being supported continues to be varied including community health, parental mental illness, service users as parents and parenting practice, learning disability, mental health, forensic, genetics, dementia, IAPT, social work, perinatal mental health ,injecting drug users, alcohol abuse and offender personality disorder pathway. The R&D team have supported the trust's first Lewy Bodies Dementia study. We are also supporting the identification of potential dementia participants for an open Phase I clinical trial looking to reduce the production of a

specific protein in the brain which may affect the progression of AD in collaboration with the Royal Liverpool Hospital.

46. The acquisition of Liverpool Community Health NHS Trust (LCH) and the return of services in Liverpool Prison have allowed us to support a wider range of studies. These have included: Rethinking Strategies for Positive New-born screening; improving vaccination amongst Polish and Romanian migrants; Accessing medicines at end of life; trial of a safer sex intervention; Strengths/limitations on District Nursing teams completing Continuing Healthcare Assessments for patients. A new study is being supported in HMP Liverpool looking at dementia and cognitive impairment in the older prison population identifying healthcare needs for older prisoners.

47. The highest recruiting study this year was also our first significant commercial study, generating income to the trust. 106 service users were recruited within both time and recruitment target. This was a single site study looking at the effect of Clozapine and other antipsychotic treatment on circulating B cells with the potential for repurposing this drug. Very positive feedback on our support has been received from the sponsor.

48. Recruitment to a national genomics project (100,000 Genomes Project) which aimed to sequence 100,000 whole genomes from NHS patients to accelerate the development of new diagnostics and treatments has now been completed. The project focused on patients with rare disease and their families. We supported the recruitment of participants with severe learning disabilities with associated congenital malformation and autistic tendencies. Clinicians are now waiting for individual service user results to be fed back from the research team.

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 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.

51. Expansion of a range technology based studies has continued through collaborative links with our academic partners. These have included SWiM (Strength Within Me), a study to develop an algorithmic risk score that is valid in predicting suicide risk. Recruitment within in-patient wards to the pilot feasibility study is now complete with publications being drafted. Phase 2 is in the planning stage. A second Trust study under the GDE work plan is AVERT which is using free text clinical data to investigate the feasibility of conducting sophisticated artificial intelligence (AI) analysis on clinical text data to predict future health outcomes.

52. A common dilemma facing district nurses and community matrons is the grading and classification of pressure ulcers. Investigations have often revealed inconsistencies in how they are recorded, making it difficult to track accurately any improvement or

deterioration. Liverpool and South Sefton Community division's skin team are working with Liverpool John Moores University on a pilot research study to test the efficacy of an automated pressure ulcer management tool. The tool uses state-of-the-art machine learning and objection detection to grade and report on the characteristics of each stage of a pressure ulcer. The study will evaluate the potential of the tool for use in day-to-day clinical practice.

53. 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. The Specialist Learning Disability Division (SLDD) based on the Whalley site have offered service users an opportunity to be involved in the early stages of planning two research studies. Both were in preparation for external funding bids. One was a project using an inclusive participatory approach to explore what the experiences and aspirations for future care transitions of autistic people living in forensic hospitals and how can these help to shape future service delivery with the University of Leeds. The second was a bid to review approaches used to prevent and reduce the use of restrictive interventions on adults with learning disabilities with Manchester Metropolitan University.

54. With the planned closure of LD service provision on the Whalley site, it is imperative that this process is captured and monitored to measure impact and for future reference. The Whalley site is supporting an undergraduate project titled; The *Impact of the Transforming Care Agenda upon inpatient services users within England's last specialist NHS Learning Disability hospital…. A staff perspective.*

55. Working in collaboration with Lancaster University, the Whalley site Research Practitioner and the Whalley site Speech and Language Therapy Lead, are undertaking statistical and qualitative analysis concerning a checklist devised by the Speech and Language Lead. This checklist is measuring the effectiveness of a tool called 'Enhanced Communication Tool'. Colleagues at Lancaster University are assisting in assessing the effectiveness of the tool with the aim of validating it and rolling this out within a number of differing services, including secure LD, Youth Offending and Prison/Probation services/settings.

56. Patient and Public Involvement and Engagement (PPIE): The Whalley site has welcomed a number of academics and visiting researchers who are interested in capturing the views and opinions of both the Service Users who reside at Whalley and the staff who work there. This has largely involved working in partnership with the Media Crew. The Media Crew are a service user led group facilitated by Occupational Therapy services who focus on co-producing and designing accessible information and thus promoting engagement in the development of; posters, leaflets, short films, welcome packs for new service users and story boards. The group also advise on a range of topics including research/service evaluation design, methodology and dissemination. The group meets on a weekly basis and are experts in co-producing materials and planning projects.

57. Working collaboratively within the Research Team, People Participation Team, Trust Legal Services and Service User consultation groups, a Research Volunteer

Agreement has been developed to facilitate and safeguard research volunteers. The purpose of the agreement is to actively engage with any potential Research Volunteers and support them in a safe manner to undertake a range of research activity. Research Volunteers arise in a range of ways and the lack of any formal governance to both support and protect these individuals was identified by the R&D team. Hence, the Research team compiled their own bespoke agreement which is being reviewed prior to formal introduction. Two members of the R&D team are also supporting a group of service users and carers in the Life Rooms encouraging and supporting involvement in research and evaluations.

58. The Health Research Authority (HRA) directs that GDPR has to be included in participant information sheets but the wording and language for some service users is very difficult to understand. The R&D team have worked with service users, Speech and Language therapists and colleagues to develop an easy read which the HRA are keen to review and potentially use nationally.

59. A group of service users and carers have worked in collaboration with the University of Liverpool to develop and deliver their own research project looking into staff perceptions of working with service users with borderline personality disorder. A paper on the findings has been drafted with plans to submit for publication imminently.

60. A service user has been supported in his research application for an MSc in Personality Disorder looking at staff experience of "crisis calls" in a specialist MH service for patients with a diagnosis of emotionally-unstable PD.

61. The R&D Team have continued to promote a national initiative entitled Join Dementia Research (JDR) with the use of a recruitment booth from the JDR team and have achieved the second highest uptake of JDR in the NW Coast region.

62. The R&D team has developed a quarterly research newsletter whose main focus is promotion of research to service users and carers but also to raise the profile of research to staff.

63. The team has introduced thank you letters for service users, carers, staff and teams who support research studies. Continued support for research will support Clinical Divisions evidence facilitation of research, engagement, partnership working and expertise of service user groups to facilitate participation in research as part of future CQC inspections.

64. 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.

65. Development of research skills in the workforce has continued to be supported including training on the legal requirements for clinical trials, Good Clinical Practice training, shadowing opportunities for students, internships, Masters qualifications, and the Comprehensive Research Network (CRN) Advanced Leadership Programme.

66. The R&D team has encouraged an increasing number of medical colleagues to evidence research in their core competencies and has supported clinical teams that have had little research experience previously.

67. Through an established collaboration with the University of Liverpool entitled the ARISE (Applied Research, Innovation and Service Evaluation) 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 :- 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 progressed to stage 2 for funding to test out the delivery of this service in the community – Community Outpatient Psychotherapy Engagement (COPE).

68. Collaboration with R&D colleagues at North West Boroughs Healthcare NHS Foundation Trust (NWBHFT) has continued with the aim of widening access to clinical trials to Service Users.

69. 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.

70. 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, Manchester Met University and Manchester University. High Secure Services have maintained and built upon their longstanding collaboration with UCLAN. 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, Denmark, Netherlands, Switzerland, Sweden, Australia, Maastricht , Old Dominion University, Virginia, USA; University of Western Sydney, Australia. Ashworth Research Centre has also supported students from Germany and Russia. The R&D team continue to work collaboratively with the North West Mental Health Research Alliance.

71. The Trust is one of eleven partners in the Liverpool Health Partners (LHP) initiative which has a vision to promote and grow research in the Liverpool region based around the specific local population health needs. The trust has been working to support the formation of the Joint Research Service (JRS) which will go live in mid

May 2019 with the aim of reducing bureaucracy and set up time for external researchers. The JRS will be formed through the co-location of support staff from across the LHP members. Due to the small R&D team resource, no trust staff will physically move to the JRS base but funding will be provided for a post in the specialist team. We will work closely with the JRS team through sharing expertise and knowledge and contribute fully to the updated data management/performance system. LHP membership will allow the trust to build stronger relationships and collaborations with partner trusts that are skilled in the delivery of clinical trials with high quality clinical trial facilities and resources. It is anticipated that this will give the trust safe and trusted environments to deliver clinical trials collaboratively in the future.

72. The outcomes of several funding bids with academic colleagues from various universities are awaited. One successful bid, with the University of Liverpool, plans to develop a social network Intervention to support recovery for people living with severe mental illness.

73. The R&D team relocated in October 2019 to a base in indigo which supports improved and safer working (e.g. lone working in community/home environments), better collaboration and supports team cohesion.

74. The specialist knowledge and skills within the team have been acknowledged via the Whalley site Research Practitioner being approached by the NIHR to peer review a proposed RCT feasibility study application submitted to the NIHR funding competition

75. Staff projects have lead to successful publication in peer reviewed journals. For example: Zulaikha Khan, Arun Chidambaram, Michaela Thomson, Courtney Hurst, (2019) "An exploration of MDT views on key factors to consider when determining a service users required level of security", Journal of Forensic Practice, Vol. 21 Issue: 1, pp.38-49.

76. A challenge for the coming year will be to deliver our first clinical trial as a site with support from the sponsor - Imperial College London. The study is entitled: *The clinical effectiveness and cost effectiveness of clozapine for inpatients with borderline personality disorder: randomised controlled trial.* Delivery of this study is not anticipated to be easy but it will provide experience to the R&D team and the Principal Investigator. Maintaining the number of adopted NIHR studies is expected to be challenging and unpredictable with an increasing emphasis on delivering Trust specific studies and external funding bids rather than relying on external studies.

2.7 Sign Up to Safety Campaign

77. 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.

78. Mersey Care is committed to Sign Up to Safety and support the philosophy of locally led, self-directed safety improvement.

79. 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.

80. 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.

81. 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.

82. 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. 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.

83. 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

84. The Trust continues to fund a Mortality and Incident Review Team to meet Trust priority 6 for 2019/20. The team has been expanded to allow for the quality and timeliness of reviews undertaken to be maintained. The Trust has used national and Royal College guidance, attendance at local and national conferences, involvement of specialists from MAZARS and support from our commissioners to ensure that the work being undertaken is current and able to meet best practice.

85. The Trust has committed to reviewing all deaths of patients who utilise its clinical services. The scope for reviewing deaths within community services was agreed in 2018/19 and was implemented from November 2018. Reporting to commissioners on these deaths will begin from Q1 2019/20.

86. All deaths that are in scope are reviewed by the Trust using its three stage process:

    a) triage using the agreed review tool;

    b) Structured Judgment Review(SJR)/seventy two hour review;

    c) Root Cause Analysis Review

87. The screening tool used by the team for reviewing deaths has been adapted following the Trust's participation in the pilot of the Royal College of Psychiatrists mortality screening tool. The Trust's Associate Medical Director for learning reviews actively participated in the feedback on this, presenting to the Royal College in London.

88. The screening tool highlights 'red flags' where further more detailed review is warranted. Additional red flags applicable to physical health cases were added in consultation with community services staff and commissioners to ensure that reviews are applicable to all patients under the care of the Trust.

89. The Trust will continue to develop the screening tool to optimise its use in practice and maximise learning from reviews of deaths that are undertaken.

90. The Mortality and Incident Review team is now supported by the Associate Medical Director for learning reviews which allows for an MDT (multi-disciplinary team) approach to be utilised for oversight of reviews undertaken. The team meets weekly to consider any SJR's and is able to source subject matter expertise and engage provider partners if necessary to allow for a fuller review of a patient pathway. Feedback is given promptly to team concerned during the course of the meeting to allow for learning to take place.

91. The Trust continues 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 in those with a dementia diagnosis and a review of Learning disability deaths which was supported by Mazars. Actions that have emanated out of these have included work on advanced care planning for those with dementia which is now underway.

92. 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.

93. To continuously improve the quality of incident reviews the Trust has supported key staff to undertake an academic course facilitated by the University of Central Lancashire, with further places sourced for 2019/20.

94. Additional training on incident reviews has been delivered within the Community Services Division by the Director of Patient Safety to improve the quality of reporting and enhance the resulting learning and improvement opportunities. A member of the Mortality and Incident Review team has also been allocated to support the Division's review process and a 'buddy' system for new reviewers has been established to allow for maintenance of standards and to maximise learning.

95. A process mapping exercise is now underway to consider how the Trust undertakes incident reviews to ensure that a single methodology is used across all its services underpinned by just culture principles.

96. 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.

97. 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.

Supplementary Mortality Data for Quality Account 2018-2019

Item 27.1 - Total number of deaths 2018 – 2019

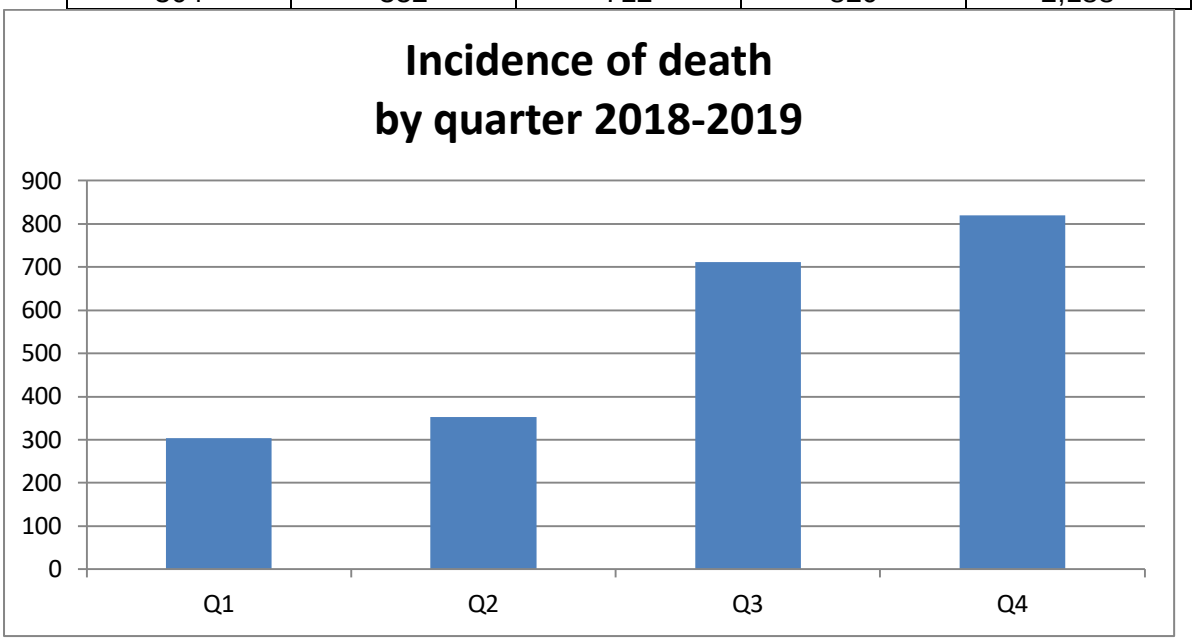
98. Deaths are continuously being reported within the Trust through incident reporting systems. Changes were made within the year in reporting mechanisms with a move to use of a single incident reporting system for mental health and community services from February 2019. Additionally, from November 2018, the Community services division had begun reporting on all deaths of patients who had been in contact with clinical services within the previous 30 days.

99. Deaths are also now reported to the incident reporting system from the mental health services patient administration system, RIO, which pulls this information directly from the NHS spine (national patient data system). Work is underway with the provider of the patient administration system for the Community services division to explore if a similar transfer of data is possible.

100. It should be noted that some Q4 deaths may have been reported in Q1 2019-2020 and will be listed for review during that period, details will not be available on these cases until the next reporting year and this number may increase as deaths are reported.

Total number of deaths by quarter 2018-2019

Q1	Q2	Q3	Q4	Total
304	352	712	820	2,188



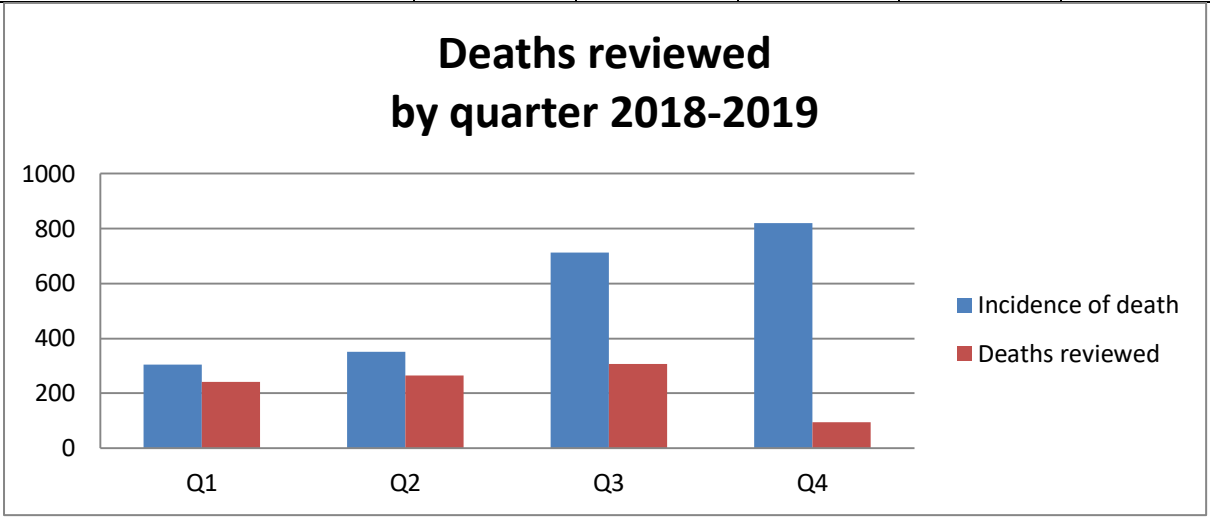
Item 27.2 - **Number of deaths reported and reviewed 2018–2019**

101. There has been an increase in the number of deaths reported and therefore increased demand for review. In mid quarter 3 it was agreed that the organisation would report all deaths that involved patients who it had cared for across all clinical divisions. Currently the Trust is not able to review all cases due to the numbers involved, it is though prioritising review for those deaths that are unexpected, where concerns had been expressed by the treating team, the patient was treated by the organisation on a long term basis and or they were recently admitted or discharged. The team will review its current scope to ensure that its target numbers are met.

102. All deaths of patients with Learning disability reported were reviewed within the year.

103. All child deaths were reviewed via the Child Death Overview Panel process.

Deaths reviewed 2018-2019	Q1	Q2	Q3	Q4	Total
Incidence of death	304	352	712	820	2,188
Deaths reviewed	241	264	306	94	905



Item 27.3 - Proportion of deaths likely attributable to care

104. Problems with care can be identified through the adverse incident and mortality review processes. Deaths from suspected or actual suicide are escalated as Serious Incidents according to the national framework and reviewed by root cause analysis (RCA) investigation.

105. Other deaths are reviewed through the mortality screening process and progress to structured judgement review (SJR) where the mortality team feel that there are concerns for care. During the reporting period the mortality team introduced a 'red flag' system, based on a Royal College of Psychiatrists pilot review tool, to identify key features, aspects of illness or elements of care which warrant further detailed review by SJR. Additional 'red flags' were incorporated into the screening tool applicable to physical health deaths.

106. During the reporting period a mortality multi-disciplinary meeting with Consultant leadership was established to consider SJR's as a team.

107. Of those deaths reviewed during 2018-2019 none of the cases reviewed by SJR during the reporting period were felt to have been more likely than not to have resulted from problems with care.

108. From those deaths investigated through the RCA process, those with root causes suggesting avoidability are shown in the table below.

Deaths linked to care concerns 2018-2019	Q1	Q2	Q3	Q4
Cases	2	0	0	0 (provisional)
% age of deaths occurred	0.65	0	0	0 (provisional)

109. 5 RCA reviews for deaths which occurred in the 2018-2019 reporting period remain in progress at the time of this report. Any attribution to care problems for these reviews will be reserved until full details are known and will be reported in the end of year summary 2019-2020.

Item 27.4 - Key learning from reviews highlighted in 27.3

110. The Trust currently does not have a drafted Bereavement Policy to guide staff in management of a significant loss for patients.

111. The Trust needs to provide training and refresher training in risk assessment of patients in mental health services. This should include preparation for staff to be able to assist service users in developing safety plans.

112. There should be a review of the CPA process to ensure that it is robust and safe

Item 27.5 - Actions as a result of key learning identified in 27.4

113. Creation of a Trust-wide Bereavement policy is on the work plan for the Director of Patient Safety for 2019-2020.

114. Suicide risk training continues to be rolled out across all divisions. Risk assessment training, along with Safety Plan training has been developed and is being rolled out across the Local services division and will continue to be monitored through the Local services division overall Serious Incidents action plan

115. A whole-system review of the CPA process has taken place and the actions are now being monitored through the Local division overall Serious Incidents action plan.

Item 27.6 - Assessment of impact

116. Actions are divisionally led and assurance is provided through divisional governance processes or, where impact is Trust-wide, the Mortality Review Group.

Item 27.7 - Number of reviews completed 2018-2019 for deaths which occurred 2017-2018

117. This detail was not included in the previous reporting period document.

118. It is not possible to draw information from that period for all divisions now within the Trust due to the acquisition of new services and changes to incident reporting systems and new death reporting and review mechanisms which were introduced part way through 2017-2018.

119. On the Trust incident reporting system 34 deaths were reported and reviewed in 2018-2019 which had actually occurred during 2017-2018.

Item 27.8 - Estimate of the number of deaths in 2017-2018 with completed reporting in 2018-2019 likely to be attributable to care

120. Two of the 34 deaths noted in 27.7 above progressed to RCA investigation and noted root causes suggestive of attribution to poor elements of care.

121. There have been changes in the organisation and in Trust mechanisms as noted within 27.1 and 27.7 that make extrapolation of percentages regarding these details for the period problematic.

Item 27.9 - Revised estimation of deaths from previous reporting period 2017-2018 attributable to problems with care

122. It is not possible to present this information as these details were not included in the previous reporting period.

123. **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)

124. Details of the CQUIN Schemes for 2017/19 are provided The Trust will report quarter four CQUIN targets to commissioners on the 30th April 2019 and commissioners are expected to confirm performance in May 2019.

125. The Trust will report 'green' for all CQUIN targets in quarter four, with the following exceptions.

126. The Local Division may fail to achieve the National Physical Health CQUIN. The division is taking the following action to improve performance. A maximum of £0.124m may be identified to reinvest in the service to improve performance:

a) the division continues to monitor compliance with the Inpatient Physical Health Assessment form, in conjunction with PHYSCOC 8 and the Single oversight framework;

b) the division is working with the BI and performance teams to develop performance monitoring systems for community teams. This should enable the division to target areas of underperformance;

c) NHS England has included Early Intervention in Psychosis Teams (EIP) in the NCAP audit for 2018-19 which now included specific indicators for the group to monitor smoking cessation and BMI outcomes. The Modern Matron for Physical Health – Local Division and the EIP service have worked together to ensure that accurate data is provided for audit purposes. Early indications from the trust internal audit team predict a significant improvement in audit performance which is expected to be confirmed once the full NCAP results are published in June 2019;

d) the audit for Inpatient and Community Teams will not be part of the NCAP audit but will revert back to the CQUIN audit undertaken by the Royal College of Psychiatrists. The Local Division Modern Matron for Physical Health has suggested changes to the internal audit process to improve the quality of the data supplied which will include clinical input. These results will be published in June 2019;

e) for the Collaboration with Primary Care Physicians indicator, the Modern Matron for Physical Health – Local Division is in dialogue with commissioners in order to improve communication across Primary and Secondary Care, and to develop a shared care protocol.

127. There is a risk that Liverpool Community Services may not achieve the Personalised Care and Support Planning CQUIN, £0.97m may be identified to be reinvested back in the service for underperformance. The service has an action plan in place in order to address the shortfall in care plans. Commissioners have confirmed that payment for the Personalised Care and Support Planning CQUIN will be paid to the Trust when the annual target of 72 patients has been achieved and the shortfall has been addressed.

128. The South Sefton Community Services Division may fail to achieve the Supporting Proactive and Safe Discharge. Work is currently underway with the Service Lead and

Care Manager to look at ways of achieving the targets in Q4, £0.11m may be identified to reinvest in the service for underperformance.

129. The Staff Survey results, part of the Corporate CQUIN, Improvement of Health and Wellbeing were published in February 2019. The trust has failed the CQUIN targets, under this year's contractual arrangements for the Local and Community Services Divisions £0.228m may be identified to reinvest back into the CQUIN to improve performance. For the Secure and Specialist Learning Disability Divisions, £0.052m may be returned to commissioners for underperformance.

130. NHS England is has reviewed the CQUIN Guidance. From April 2019, both the CCG and Prescribed Specialised Services (PSS) CQUIN schemes will be reduced in value by 50% to 1.25% with a corresponding increase in core prices through a change in the tariff uplift. The CQUIN scheme has been simplified, focusing on a small number of indicators aligned to key policy objectives drawn from the Long Term Plan.

Local Services Division CQUIN Schemes 2018-19

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. Baseline survey is the 2016 staff survey
	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. The improvements made in 2017-18 to be maintained.
	1c. Improving the uptake of flu vaccinations for front line staff within Providers.	1c Joanne Scoltock	**1c** 75 % of frontline staff to have received their flu vaccination by the 28th February 2019.
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% • BMI Outcome indicator – 35% • Smoking outcome indicator –

CQUIN Indicator	Summary:	Lead:	Deliverables
			10% Audit of patient records to take Place in Q4. 90% of patients to have 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.	Jane Chaffer	Where a 20% reduction of attendances for the cohort of frequent attenders was achieved in year 1, the number of attendances in the group remains at least 20% less than the baseline level in 2016/17; or where the 20% reduction was not achieved, the 20% reduction should be achieved. Building on the work in year 1, identify a new cohort of frequent attenders to A&E during 17/18 that would benefit from psychosocial interventions and work to reduce by 20% their attendances to A&E during 2018/19.
Preventing ill	**Part a**. Tobacco screening	Linda Roberts	Trust to demonstrate for all

CQUIN Indicator	Summary:	Lead:	Deliverables
Health by risky behaviours – Alcohol and Tobacco	**Part b.** Tobacco Brief Advice **Part c**. Tobacco referral and Medication Offer **Part d.** Alcohol screening **Part e**. Alcohol brief advice & referral		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).	Phil Laing	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 Schemes 2018-19 (High Secure Services)

CQUIN Indicator	Summary:	Lead:	Deliverables
Increasing Physical Activity for Secure Patients	All patients in HSS to be offered 90 minutes f moderate exercise each week. For patients with specific physical or mental health issues a bespoke activity plan should be offered	Danny Angus	• Improved recording of patients physical exercise uptake • Increase in access to physical exercise for all patients • Increase in uptake of physical exercise by individual patients • Bespoke physical exercise plans for patients who have specific needs • Improved sense of patient well being and motivation

CQUIN Indicator	Summary:	Lead:	Deliverables
Reducing Long Term Segregation	To support HSS in reducing the use of long term segregation in an innovative and systematic way by producing and implementing a strategy to prevent and reduce the use of LTS	Danny Angus	• To reduce long term segregation by an agreed % in the baseline cohort • To demonstrate improved experience, access and inclusion, quality of life and recovery outcomes for those in LTS • To improve the physical health outcomes for patients in LTS • To reduce incidents of conflict • To reduce incidents of physical restraint and Response team interventions • To reduce work related sickness and associated costs to the organisation related to physical restraint and associated stress • To develop high levels of competency and resilience in staff teams
Reducing Psychological and Emotional Impact on Secure Staff	The aim of the CQUIN is to assist staff in the recognition of their own responses and will enhance their capacity to manage the on-going personal and professional challenges inherent in providing relational security for people with wide ranging and long standing needs. The development of trauma informed systems will provide a proactive approach to ensure staff are appropriately supported, trained and cared for.	Frank McGuire	• Enhanced staff well-being • Reduction in the level of absenteeism and sickness • Increased use of supervision • Enhance staff motivation • Increased use of reflective practice • Improved ward environment • Increased awareness of evidence base on developmental trauma • Implementation of trauma specific processes and procedures • Enhanced staff knowledge, confidence and competency (self perception)

Secure Division CQUIN Schemes 2018-19 (Medium / Low Secure Services)

CQUIN Indicator	Summary:	Lead:	Deliverables
National Staff Health & Wellbeing	**1a.** Improving staff health and Wellbeing (staff survey).	**1a**. Melissa Holt	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. Baseline survey is the 2016 staff survey
	1b. Healthy food for NHS staff, visitors and patients.	**1b.** Dale Williams	1b. Changes in catering provision to reduce the fat, sugar and calorie content of food and drink items on trust sites. The improvements made in 2017-18 to be maintained.
	1c. Improving the uptake of flu vaccinations for front line staff within Providers.	**1c** Bridget Clancy	1c 75 % of frontline staff to have received their flu vaccination by the 28th February 2019.
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% • BMI Outcome indicator – 35% • Smoking outcome indicator – 10% Audit of patient records to take Place in Q4.
	2b. Collaboration with primary Care Clinicians.		90% of patients to have 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.
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.

CQUIN Indicator	Summary:	Lead:	Deliverables
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.	Danny Angus	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	Lisa Rens/ Toni Vaughan	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/ Mo Sidat	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 Schemes 2018-19

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.	**1a.** Melissa Holt **1b**.Dale Williams	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. Baseline survey is the 2016 staff survey 1b. Changes in catering provision to reduce the fat, sugar and calorie content of food and drink items on trust sites. The improvements made in 2017-18 to be maintained.

CQUIN Indicator	Summary:	Lead:	Deliverables
	1c. Improving the uptake of flu vaccinations for front line staff within Providers.	**1c** Bridget Clancy	**1c** 75 % of frontline staff to have received their flu vaccination by the 28th February 2019.
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% • BMI Outcome indicator – 35% • Smoking outcome indicator – 10% Audit of patient records to take Place in Q4. 90% of patients to have 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.
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.	Danny Angus	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	Lisa Rens/ Toni Vaughan	This scheme is designed to achieve at least a 10% reduction in the current average length of stay.

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	Dale Williams/ Mo Sidat	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.	Lisa Rens/ Toni Vaughan	To support the transfer of patients on the Whalley site to supported living in the community.

Community Services Division CQUIN Schemes 2018-19 (South Sefton Services)

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.**Amanda Smith 1**c** Joanne Scoltock	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. Baseline survey is the 2016 staff survey 1c 75 % of frontline staff to have received their flu vaccination by the 28th February 2019.
Supporting proactive and safe discharge	Improving the discharge process for patients.	Michelle Bilsbarrow/ Cathy Long	Establish a baseline for the collation of data and then reporting on the timeliness of Fast Track Assessments, Health Needs Assessments and CHC Discharge Support Tool, against locally agreed targets
Improving the assessment of wounds	Improving the assessment of wound care for patients.	Michelle Bilsbarrow/ Jacqueline O'Riley	Target to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.

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	Catherine McGiveron/ Annemarie Howard	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.
Personalised care and Support Planning	Embedding personalised care and support planning for patients with long term conditions.	Michelle Bilsbarrow/ Annemarie Howard	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

Community Services Division CQUIN Schemes 2018-19 (Liverpool Services)

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.**Donna Jones **1c** Joanne Scoltock	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. Baseline survey is the 2016 staff survey 1c 75 % of frontline staff to have received their flu vaccination by the 28th February 2019.
Improving the assessment of wounds	Improving the assessment of wound care for patients.	Karina Woodyer Smith	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	Dave Jones	Trust to demonstrate for all inpatient admissions: • Percentage of adult patients screened for tobacco and alcohol use. • Patient records to include

CQUIN Indicator	Summary:	Lead:	Deliverables
	Part e. Alcohol brief advice & referral		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.
Personalised care and Support Planning	Embedding personalised care and support planning for patients with long term conditions.	Lynda Taylor	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.
School age immunisation workforce development	Workforce development for the school immunisation programme	Lynda Taylor	Two year CQUIN with 2017/18 focusing on the development of the Health Care Assistant role in the delivery of the NHS Universal Childhood Flu vaccination programme.

Financial Statement

131. The trust has seven main contracts which each attract their own National and Local Commissioning for Quality and Innovation (CQUIN) schemes. The total trust CQUIN value for 2018-19 is £7.495m. The National CQUINs are mandated as part of the NHS standard contract local CQUINs are negotiated with commissioners in line with Trust and CCG local priorities. The trust reported quarter four CQUIN performance to commissioners on the 30th April 2019 and commissioners are expected to confirm performance by the end of May 2019.

2.9 Care Quality Commission

Registration and CQC Ratings

132. Mersey Care is required to register with the Care Quality Commission and during 2018/19 there was a number of changes made to register correctly all community services and dental practice locations with CQC, there are no conditions attached to the CQC registration.

133. The Care Quality Commission last inspected the Trust between October and December 2018, and the report following this inspection visit was published on 5 April 2019. The current CQC rating is GOOD following that process of inspection, and the position has strengthened, with the Trust attaining the rating of good for the

Safe, Effective, and Caring and Responsive domains and outstanding for the Well Led domain.

134. The CQC has not taken enforcement action against the Trust during 2018/19 and the Trust has not been subject to any in-depth enquiries or investigations by the Care Quality Commission during the reporting period.

135. CQC undertook an announced focused inspection of Mersey Care NHS Foundation Trust during March 2018 because:

a) there had been a significant change in the Trust's circumstances. The Trust had acquired South Sefton community services from Liverpool Community Health Trust on 1 June 2017 and Liverpool Community Services from the same Trust on 1 April 2018;

b) the inspection was to include the annual Well led inspection of services;

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 2017.

136. During this focused inspection the CQC inspected the following core services provided by the Trust:

a) Acute wards for adults of working age and psychiatric intensive care units;

b) Wards for older people with mental health problems;

c) Wards for people with a learning disability or autism;

d) Long stay/rehabilitation wards for working age adults;

e) Community-based mental health services for adults of working age;

f) Community health services for adults;

g) Community health services for children, young people and families;

h) Community dental services;

i) End of life care.

The CQC also visited three of the trust's walk-in centres: Smithdown Road Children's NHS Walk-in Centre; Liverpool City Centre NHS Walk-in Centre and Old Swan NHS Walk-in Centre.

137. The ratings of these specific services were published following inspection in December 2018 (published April 2019) are as follows

a) Acute wards for adults of working age and psychiatric intensive care units – Good;

b) Wards for older people with mental health problems – Good;

c) Wards for people with a learning disability or autism – Good;

d) Long stay/rehabilitation wards for working age adults – Good;

e) Community-based mental health services for adults of working age – Requires Improvement;

f) Community health services for adults – Requires Improvement;

g) Community health services for children, young people and families – Good;

h) Community dental services – Good;

i) Community End of life care – Requires Improvement;

j) Walk In Centres – Requires Improvement.

Requirement Notices

138. The Trust was issued with a requirement notice in respect of 13 breaches of legal requirements, under the following 3 Regulations. The areas these relate to are summarised as follows:

a) **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment in** *community mental health services for adults of working age***, in** *community health services for adults, in walk-in centres* **and** *end of life care*

b) **Regulation 17 HSCA (RA) Regulations 2014 Good governance in** *end of life care,* and *walk-in centres*

c) **Regulation 18 HSCA (RA) Regulations 2014 Staffing in** *community mental health services for adults of working age, community health services for adults,* and *walk-in centres*

139. 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/AAAJO888.pdf.

140. The Trust will respond as required with a provider action plan due to be submitted by 1 May 2019

Other CQC Activity

141. The Trust has participated in two thematic reviews across partner agencies where CQC look at the 'whole systems approach' to care being delivered.

142. These reviews have consisted of a focussed review of HMP Liverpool, which took place in October 2018 where Mersey Care was the provider of the mental health services and a system wide review of health services for Children Looked After and Safeguarding in Sefton' with Sefton CCG as the lead, This took place in July 2018.

143. From the CQC report received following the review of HMP Liverpool it was noted that the services provided by Mersey Care had improved considerably and although not rated by CQC, there were notably only 3 "should do" recommendations made by CQC to Mersey Care.

144. The report regarding the system wide review of health services for Children Looked After and Safeguarding in Sefton' identified a number of actions identified for healthcare partner organisations. A Task & Finish Group was set up to respond to the actions identified, this was led by Sefton CCG and Mersey Care were actively engaged and involved in this process.

145. During 2018/19 CQC published the review of older people's services in Liverpool that had taken place in February 2018, led by the Local Authority. Again, there was system wide learning identified and Mersey Care have been actively engaged with this approach.

146. Across Mersey Care inpatient services that are registered to provide care to patients under the Mental Health Act (1983) the Trust was subject to 26 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.

147. 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.

148. 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.

149. 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.

150. 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.

Summary of CQC Inspection Findings 2019

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

2.10 Duty of Candour

151. 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). This includes informing people of the incident and providing an apology, truthful information and reasonable support. 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.

152. 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.

153. The Patient Experience/ Duty of candour Lead works closely with all clinical divisions to ensure that all appropriate incidents are identified as requiring the Duty of Candour process. Lead reviewers who are primarily clinical staff are supported by the Duty of Candour lead 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.

154. 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.

155. All actions are recorded on the Trust's Risk Management data base (Datix) as are copies of letters and incident reports.

a) Duty of Candour has been applied to 84 incidents from 1st April 2018 to 31st March 2019

b) there were 34 deaths where there was a full RCA (root cause analysis) review undertaken;

c) there were 11 incidents with severe harm, including 3 self harm, 7 grade 4 pressure ulcers and a homicide;

d) of the 39 moderate harm incidents, 27 related to G3 pressure ulcers, 4 to medication related incidents, 7 relating to care and treatment, and one fall.

e) a family liaison or clinical lead was appointed to all 84 incidents, there were 2 cases where the patient or family declined any further contact.

f) an apology and letter was given all cases apart from 4 were there was no family or contact details

g) of all completed reviews where the patient or family were involved the reports have been share with the patient or family.

	2018/19
Duty of Candour Incidents	**84**
Breakdown of Duty of Candour Incidents	**Total**
Death	**34**
Severe Harm	**11**
Self-harm Incidents	3
Pressure Ulcer G4	7
Homicide Incident	1
Moderate Harm	**39**
Pressure Ulcers G3	27
Medication	4
Care and treatment	7
Fall	1

156. 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.

157. 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.

2.11 Data Quality Improvement Plans

158. 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.

159. Good quality information also enables the efficient management of services, service planning, performance management, business planning, commissioning and partnership working.

160. 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.

161. 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.

162. The importance of Data Quality is also highlighted in Clinical Information Systems training along with the importance of Good Record Keeping.

Quality Report 2018/19

163. Mersey Care NHS Foundation Trust submitted records during 2018/19 to the Secondary Users 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) 99.4% for admitted patient care;
   ii) 99.6% for outpatient care

b) which included the patient's valid General Medical Practice Code was:
   i) 99.9% for admitted patient care;
   ii) 99.8% for outpatient care.

Latest data (SIS DQ dashboard) available from NHS Digital on 4 April 2019 relates to M10 2018/19 (April 2018 to January 2019)

2.12 Information Governance

164. The new Data Security & Protection Toolkit 2018/19 was submitted in March with the Trust being awarded "substantial assurance" status following audit of the Data Security & Awareness 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 2018/19 Nationally Mandated Indicators (Section 2.3)

165. NHS foundation trusts are required to publish the data reported to NHS Digital for each indicator for the reporting period, i.e., the 2018/19 financial year. For some indicators, no data or only partial year data is available for 2018/19. The latest should be published for the last two reporting periods or data covering the minimum of a year.

166. The data reported below relates to the latest information available via the defined data sources as at 2 April 2019. Comparisons are with other mental health / learning disability providers.

Readmissions

167. The Quality Report reporting arrangements for 2018/19 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). To find the percentage of patients aged 0-15 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.

168. To find the percentage of patients aged 16 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.

169. The latest version of both readmission reports were uploaded in December 2013 and the "Next version due" field stages "TBC".

170. As Mersey Care NHS Foundation Trust does not provide inpatient services for under 16 year olds, data for this indicator for the 0 to 15 year old patient group is not included.

171. No data relating to Mersey Care NHS Foundation Trust 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.

172. 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 2018/19 Quality Account.

173. 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 with the next version due June 2017.

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current

3.3 Performance against NHS Improvement's Single Oversight Framework Indicators

174. In preparing the Quality Report for 2018/19, NHS Foundation Trusts are required to report on indicators that appeared in both NHS Improvement's Risk Assessment Framework and the Single Oversight Framework.

175. 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.

176. 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

Indicator	Performance threshold	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Full year position
Accident and Emergency Maximum waiting time of four hours from arrival to admission/ transfer/ discharge	>=95%	100.00%	100.00%	100.00%	100.00%	100.00%
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	>=53%	60.00%	63.27%	63.75%	67.95%	63.74%
Improving access to psychological therapies (IAPT): Proportion of People completing treatment who move to recovery.	>=50%	50.28%	50.47%	47.42%	50.54%	49.68%
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%	96.58%	97.26%	98.42%	95.69%	96.99%
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%	100.00%	100.00%	100.00%	100.00%	100.00%
Inappropriate out-of-area placements for adult mental health services (OBDS) - External only	Q4 2018-19 - 169	0	0	0	18	18

Indicator	Threshold	Q4 – 2016/17	Q4 – 2017/19
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards	>=90% green; <90% red	66.00%	46.24%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services	>=90% green; <90% red	Not Available	15.00%
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%	19.80%

177. The Cardio metabolic indictor audit results are unavailable until June 2019 after the Quality Report is published

3.4 Stakeholder Metrics

178. 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.

COMMISSIONERS

NHS Liverpool Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group
Quality Account Statement 2018-19
Mersey Care Mental Health and Community NHS Foundation Trust

NHS Liverpool, South Sefton and Knowsley CCGs welcome the opportunity to jointly comment on the Mersey Care NHS Foundation Trust Draft Quality Account for 2018-19. 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 Trusts final version of the Quality Account.

We have worked closely with the Trust throughout 2018-19 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 the delivery of 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 2018-19, which were:

- Priority 1: Reducing Restrictive Practice
- Priority 2: Towards Zero Suicide
- Priority 3: Improvements in Physical Health Pathways
- Priority 4: Just and Learning Culture
- Priority 5: Reduction in Community Acquired Pressure Ulcers
- Priority 6: Learning from Deaths

Following consultation with key stakeholders; these six priorities will be carried forward into 2019-20, with an additional priority;

- Priority 7: Reducing Delayed Discharges in Mental Health

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.

The Trust places significant emphasis on its quality and safety agenda and the pursuit of Perfect Care. These quality improvement priorities are consistent with the Trust's Model of Quality 'STEEEP'; Safety of Patients; Timely Care; Effectiveness; Efficient Care; Equitable Care and Positive Patient Experience. This is reflected in the work which the Trust has carried out around seven day follow up and annual health checks for service users on a care programme approach and the process for undertaking pathway reviews in association with partner organisations and obtaining data from GPs in relation to Learning from Deaths.

Through this Quality Account and on-going quality assurance processes, the Trust clearly demonstrates their commitment to improving the quality of care and services delivered.

Of particular note, during 2018-19; the Trust has undertaken work to improve outcomes on the following work streams:

- Physical restraint associated with self-harm has been reduced by 20%.
- 100% of staff who transacted from Liverpool Community Health have completed Level 1 Suicide Awareness Training.
- 100% of inpatient wards have implemented the National Early Warning Score; NEWS2.
- A standardised framework has been developed to support staff and learning from incidents.
- A reduction plan and target trajectory for pressure ulcers is in place.
- Scope for reviewing individual community deaths has been implemented.
- New standards have been adopted for the review of individuals in mental health care, in relation to Learning from Deaths.

Commissioners acknowledge the significant work undertaken by the Trust in relation to the transaction of Liverpool Community Health services, which took place in April 2018 and the ongoing work which is underway to align systems and processes across the Community and Mental Health Divisions. Reducing inpatient suicides to zero; improving Learning from Deaths and reducing the occurrence and deterioration of pressure ulcers are important priorities and focus areas for the Trust in 2019-20.

Commissioners are aspiring through strategic objectives and five year plans 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 & Formby CCG**	**Knowsley CCG**
Ledward	Fiona Taylor	p.p. D. L. Anderson
Jan Ledward **Chief Officer**	**Fiona Taylor** **Chief Officer**	**Dianna Johnson** **Chief Executive**
Date: 20 May 2019	Date: 17 May 2019	Date: 17 May 2019

NHS Blackburn with Darwen Clinical Commissioning Group
NHS East Lancashire Clinical Commissioning Group

Enquiries to: Saba Abid
Contact no: 01282 644882
Email: saba.abid@nhs.net
Our Ref: QA-2018-19/MCFT/SA

Date: 29th May 2019

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Ms J Hurst
Deputy Director of Nursing/Director of Infection Control
Executive Nursing Department
Mersey Care NHS Foundation Trust
V7 Building
Kings Business Park
Prescot
Merseyside
L34 1PJ

Dear Ms Hurst,

Re: Mersey Care NHS Foundation Trust Quality Account 2018/19 (Draft)

East Lancashire and Blackburn with Darwen Clinical Commissioning Groups (CCGs) welcome the opportunity to comment on the draft 2018/19 Quality Account for Mersey Care NHS Foundation Trust (MCFT) as host commissioners for Learning Disability services across Lancashire, South Cumbria and Greater Manchester.

The CCGs are pleased to note the Trust's most recent Care Quality Commission (CQC) rating of "Good" as at December 2018 and commend the "Outstanding" rating for the Well Led domain. The CCGs have continued to work with MCFT to support the delivery of any quality improvement requirements identified via the CQC inspection report and will oversee progress through the quarterly Quality Review Meetings with the Trust.

Priorities for 2018/19:

Within the 2017/18 Quality Account, MCFT identified the following priorities for 2018/19:

- Reducing Restrictive Practice
- Towards Zero Suicide
- Improvements in Physical Health Pathways
- A Just and Learning Culture
- Reduction in Community Acquired Pressure Ulcers
- Learning from Deaths

The CCGs are pleased to note and acknowledge the progress made on "Reducing Restrictive Practice" with achievement of all six of the objectives identified and a reduction in the use of prone restraint by 50% from the baseline. Within the Specialist Learning Disabilities Division, it is noted that there was an increase in the number of restrictive interventions in Quarter(Q)3 and 4 of 2018-19. However, the CCGs note that the number of T-supine restraints have continuously been reducing and MCFT have been successful in introducing Safety Pod restraints for a number of patients.
The CCGs have been in discussions with MCFT with regard to the collection of data to show the intensity and length of incidents and thus providing additional reassurance and intelligence for this priority area. The CCG's continue to monitor this through detailed quarterly incident and restrictive intervention reports as part of the quarterly Quality Review Meetings with MCFT.

With regard to "A Just and Learning Culture", the Trust has achieved all four of the objectives in relation to this priority. In particular, the CCGs note the work by MCFT to develop a standardised framework to support learning from incidents and the preventative approach taken to recognise bullying behaviour and help support psychological safety of staff.

The CCGs note the partial achievement of MCFT's remaining four priorities for 2018/19, "Towards Zero Suicide", "Reduction of Community Acquired Pressure Ulcers", "Improvements in Physical Health Pathways" and "Learning from Deaths". However, it is encouraging to note the 100% achievement rates in relation to the "Improvements in Physical Health Pathways" for clinical staff to recognise deteriorating patients and ensuring prompt intervention to treatment. It is also positive to note that the work ongoing to implement last year's objectives will continue into 2019/20.

With regard to "Learning from Deaths", the CCGs note that MCFT participated in the Learning Disabilities Mortality Review Programme and the draft Quality Account states the Trust have not yet had any targeted feedback from this review. The CCGs recommend the draft Quality Account provides further details on "Learning from Deaths" as per the prescribed information and form of statements as listed in the national reporting requirements for 2018/19.

The CCGs support the "Sign up to Safety" campaign and recognise the continuing work on this agenda within the Trust, particularly with the recent appointment of a lead manager to coordinate all Duty of Candour work resulting in an increase in the quality of work undertaken. Whilst it is disappointing to note that the Quality Account does not detail the different ways in which staff can speak up (as per the national reporting arrangements 2018/19 issued by NHS Improvement), the CCG recognise the excellent work carried out by the Trust's Freedom to Speak Up Guardians which mean the organisation is able to deal with issues and implement remedial actions to enhance the safety and quality of service provision. The CCGs commend the continuing collaboration with Stanford University using Design Thinking Methodology to reduce the number of self-harm incidents.

2018/19 Quality Indicators and CQUIN:

With regard to the Specialist Learning Disability Service commissioned from MCFT by the CCGs on behalf of Lancashire, South Cumbria and Greater Manchester, a small number of queries remain to be resolved in relation to the 2018/19 quality indicators. The CCGs continue to work with the Trust to ensure that the submitted data and information can be reconciled against the indicators, to close the 2018/19 Quality dashboard and provide assurance to stakeholders in terms of compliance with the applicable standards.

Three of the four Commissioning for Quality and Innovation (CQUIN) schemes for 2018/19 have been achieved. The achievement level of "Improving staff health and wellbeing" is yet to be confirmed, dependent on the submission of further updates from MCFT.

During 2018/19, MCFT has participated in 83% (n10/12) of all applicable National Clinical Audits and 100% of all National Confidential Enquiries. The CCGs note that MCFT reviewed three of the national audits and within the Quality Accounts, actions to improve the quality of healthcare from the National Clinical Audit on Psychosis, National Audit of Care at the End of Life and National Audit of Intermediate Care have been detailed.

MCFT has reported a Trust-wide position, for Quarter 4 of 2018/19, of 98.4% of patients on the Care Programme Approach being followed up within 7 days of discharge; the national target is 95%. The CCGs are pleased to note that the commissioned Specialist Learning Disability service achieved performance of 100% for this indicator throughout 2018/19.

In relation to the data quality targets for submission of valid NHS Number and General Practice Code information to NHS Digital (SUS), the Quality Account reports performance for both indicators in excess of 99.4%, for all episodes of care. The CCGs are pleased to note that the commissioned service achieved performance of 100% for valid NHS Number submission throughout 2018/19. In relation to Information Governance, the CCGs note that MCFT was awarded "substantial assurance" status following audit of the Data Security & Awareness Toolkit 2018/19.

With regard to patient experience, the draft Quality Accounts are reporting on results from 2017/18 and therefore the CCGs would recommend that up to date information is made available. It is positive to note the Trust's Friends and Family Test scores have continuously improved over 2018/19, with 77% of participating respondents likely or highly likely to recommend the service to family or friends if they needed care and treatment.

Results of the 2018 National NHS Staff Survey are encouraging, with the Trust either meeting or performing above average in 6 of the 10 key themes. In relation to Overall Staff Engagement, the Trust has achieved a score of 7.0 which is in line with the national average for MCFT's comparator group. The CCGs are pleased to see notable improvements in each of the questions that make up the Safety Culture domain which also aligns to the Just and Learning Culture work undertaken by MCFT.

The draft Quality Account does not reference the rate of patient safety incidents however, the CCGs note that publicly available data shows MCFT's reported rate of patient safety incidents per 1000 bed days, for the period October 2017 to March 2018, was 25 and is consistent with the figure of 22 reported last year. The CCGs engage with MCFT through the quality review process and consistently receive quarterly reports detailing incidents by cause group. In relation to Enhanced Support Services, the number of incidents over Q4 2018/19 was 577 and attributable to an average of 33 service users. Although this figure is high, the CCGs continue to monitor themes and trends and are committed to supporting the Trust to implement learning from such incidents across the Specialist Learning Disabilities division.

Although data on Complaints are not reported in the Quality Account, the CCGs receive quarterly reports through the quality review process and are pleased to note that zero complaints were received in relation to the commissioned Enhanced Support Service during 2018/19.

Priorities for 2019/20:

The Quality Account details MCFT's achievements and challenges whilst setting out clear priorities for 2019/20. The CCGs support these priorities as a continuation of previous work and concerted plans to further improve commissioned services and increase the quality of patient experience. Furthermore, the CCGs are pleased to note the involvement of key stakeholders when consulting on the quality improvement priorities.

The CCGs support MCFT's approach to quality improvement and look forward to continuing to work with the Trust throughout 2019/20 to ensure that the services commissioned for our patients are of the highest quality standards and provide safe, personal and effective care.

Yours sincerely,

pp

Mrs Kathryn Lord
Interim Director of Quality and
Chief Nurse Associate
East Lancashire CCG

HEALTHWATCH

Healthwatch Liverpool welcomes this opportunity to comment on the 2018-19 Quality Account for Mersey Care NHS Foundation Trust.

We base these comments on the contents of a draft Quality Account which was provided to us prior to publication, as well as our ongoing engagement with the Trust and feedback received from a variety of sources including www.careopinion.org.uk, patients and families.

As with all Trusts in Liverpool, we hold annual Listening Events where a team of staff and volunteers from Healthwatch Liverpool visits the hospital to speak to patients and visitors about their experiences. These events are intended to provide a snapshot of what patients and visitors think about the service. The Trust can then use this feedback in conjunction with other patient experience measures to provide valuable insight.

This year's Listening event at community services was at the Liverpool Walk-in Centres in October 2018 and Broadoak Unit for mental health services in November 2018. Feedback overall was positive, although there were suggestions for improvements too; all feedback was shared with the Trust.
Since January 2019 we have been working with Talk Liverpool, Mersey Care's Improving Access to Psychological Therapies (IAPT) service, to gather feedback about some of the group sessions they provide; this will be collated and passed back to the Trust soon.

Mersey Care has seen major change this year, with Liverpool community services that had previously been managed by Liverpool Community Health being incorporated into the Trust. It would be impossible for the Quality Account to provide an overview of the quality of all the services provided, but it is positive to see more detailed explanations about the priorities, and how and why they have, or have not, been met.

The quality priorities for the coming year have been clearly set out. Several of the overarching quality priorities from both community and mental health services are continued from the previous year, with new targets set.
We are pleased to see that work to ensure the sharing of learning from both community and mental health services is ongoing. We also welcome that work will continue on those priorities where less progress was made than hoped, such as the reduction of pressure ulcers and the reduction of restrictive practice.

As part of work around Learning from Deaths, the trust has acknowledged that there are differences in how staff provide care in inpatient areas. We welcome the Trust taking this opportunity to reduce variance and share best practice.

Healthwatch Liverpool is looking forward to ongoing, regular engagement with the Trust in 2019-20. This engagement will cover both community health and mental health services, taking into account quality and equality considerations and with a focus on patient experience.

Mersey Care NHS Foundation Trust
Quality Account 2018-19 Commentary

Healthwatch Sefton would like to thank the Trust for the opportunity to comment on the draft Quality Account 2018-19. We attended the Quality Account session on the 3rd May 2019 at which the Trust presented and this was very useful. In addition, our two representatives on the Sefton MBC Adult Social Care and Health Overview and Scrutiny Committee (OSC) attended a quality account event (10th May) at which the trust also presented.

In reviewing the readability of the report there is no summary of the different services which the trust now provide within the report and this would have been helpful. The trust is our provider for Mental Health and Learning Disability service across the Borough and is the provider of community services for south Sefton.

In reviewing the work to reduce restrictive practice it is positive to see that all of the targets set were achieved, particularly the target to reduce physical restraint by 20%. The words 'restrictive practice' may not resonate with a member of the public reading this document and a summary of what this means would have been helpful. The work undertaken to review ligature incidents was noted and in reviewing the data we noted the spike in incidents during December 2018. However a comprehensive account of the reasons for the increases were provided in the account and it was positive to see that the Trust has been able to identify the wards in which the majority of incidents have occurred.

In looking at the Trusts work towards zero suicide, three of the five areas prioritised were only partially achieved, however the work undertaken is commendable as this is such an important area. The focus on following up patients on the care programme approach within 7 days of discharge from psychiatric in-patient care must also be noted, with the Trusts target just below the national average, quarter 4 showing a higher than national average target.

In reading progress for those areas which relate to improvements in physical pathways, it was great to see the use of the NEWS2 (recognising the deteriorating patient) and the achievements in this area.

The Trusts overall work to reduce pressure ulcers is noted, in particular, the reductions in the number of community acquired and avoidable pressure ulcers. However, we do note that there were Grade 4 pressure ulcers reported during this period and therefore zero tolerance was not achieved. This is an area we will be monitoring and would like to see zero tolerance in the next reporting period. We note the priority set for 'zero deterioration of pressure ulcers whilst under our care' for the coming 12 month period.

We have worked proactively with our community division colleagues in the past 12 months and have established a great working relationship with this division. During the 12 months we have been invited to attend and contribute to the divisions patient experience group and this has been very productive.

In reading the report, we read that the South Sefton Community Services Division may fail to achieve the 'Supporting Proactive and Safe Discharge'. We are aware of the work currently taking place to look at ways of achieving the targets in Q4, and hope that the identified reinvestment to support the service has/will be allocated.

We have regular contact with managers and staff within the community division and we would like to see our relationship with managers and staff from other divisions, improve over the next 12 months. We highlighted this in last years account and our informal meetings with the Trust have come to a halt. We would really welcome a discussion with the Trust and our Healthwatch colleagues about how we can build up this work again.

In reviewing the report from a public perspective, it would be helpful if the report had a glossary to support the reader in understanding abbreviations and terms. We felt that there was a lack of information within the account relating to 'experience'. It would have been useful for us to have been able to read about the work being undertaken to improve feedback and experience on the trusts services, including some case studies, as this area was lacking within the report. Again there was a lack of information within the report relating to equality and equity of service provision.

We would like to congratulate the Trust on its current CQC rating 'Good', with the Trust attaining the rating of good for the Safe, Effective, Caring and Responsive domains and outstanding for the Well Led domain. We however note the areas which have been shared within the report which require improvement and we will be ensuring that we monitor the areas, by asking for up to date information over the next 12 months.

Healthwatch Sefton will continue to work in partnership with the Trust to support the on-going work to improve the overall care and services provided to both patients and their visitors. We will be particularly keen to see progress on the Trusts focus on the integration of physical and mental health.

OVERVIEW AND SCRUTINY COMMITTEE

Sefton Council

Ground Floor
Trinity Wing
Town Hall
Trinity Road
Bootle
L20 7AE

Mr. Joe Rafferty
Chief Executive
Mersey Care NHS Trust
Trust Offices
V7 Building
Kings Business Park
Prescot
LIVERPOOL
L34 1PJ

Date: 20 May 2019
Our Ref: DAC/QAs
Your Ref:

Contact: Debbie Campbell
Telephone Number: 0151 934 2254
Fax Number: 0151 934 2034
email: debbie.campbell@sefton.gov.uk

Dear Mr. Rafferty,

Mersey Care NHS Foundation Trust – Quality Account 2018/19

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 2018/19.

Members of the Committee met informally on 10th May 2019 to consider a small number of Quality Accounts, together with representatives from Healthwatch Sefton and from the local Clinical Commissioning Groups. 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 had also heard from the Provider for services in the north of the Borough.

We received a presentation from the Trust representative outlining the following:-

- CQuin Update;
- Quality Account Priority 2018/19;
- Reducing Restrictive Practice;
- Reduction in Prone Restraint;
- Reduce Physical Restrain Associated with Self-Harm by 20% by March 2019;

- Review of Ligature Incidents by June 2018 and Develop an Implementation Plan to Address Risks;
- Implementation Zero Segregation Action Plan to Reduce Long-Term Segregation by 20% From the Baseline Cohort by end of financial Year 2018-19;
- Current Progress;
- Priority Areas Progress Update 2018/19;
- Zero Suicide - 100% of Former Liverpool Community Health Staff will complete Level 1 Suicide Awareness Training by March 2019;
- Zero Suicide – 7-day Follow-Up;
- Improving Physical Health Pathways;
- Just and Learning Culture;
- Reduction in Pressure Ulcers – Increasing Reporting / Reduced Harm;
- Learning from Deaths;
- Priority Areas for 2019/20;
- Reducing Delay Discharges in Local Division; and
- Next Steps.

We heard about progress made around zero suicide; national early warning scores to improve the detection and response to clinical deterioration, including sepsis; and the development of an open and transparent culture within the Trust that enables staff to raise issues. This latter issue is important, given some of the difficulties encountered by community health staff under their former Trust.

We were advised that there has been an increase in awareness and reporting on pressure ulcers which has led to huge achievements in the reduction of grade 4 pressure ulcers being detected within the community. At the time of our meeting, the Trust had gone 85 days without a grade 4 pressure ulcer being detected. We asked whether incidents of serious pressure ulcers are linked to people being left to stay in bed too long and were advised that the main issue is that senior staff need to go out to assess pressure ulcers, if they occur, the aim being to prevent grade 3 pressure ulcers developing into grade 4 ulcers. Some patients may not accept all the equipment offered them in such instances, although compromises may be reached.

It was reported that connections with GPs would be reviewed this year and opportunities to learn from poor care would be examined. Patients with a mental health diagnosis should have the same access to services as everyone else and clearer pathways for referrals are required.

It was pleasing to hear that the overall summary of the Trust's most recent Care Quality Commission inspection was "good" in all domains, with "Outstanding" under the Well-Led domain.

One of our Healthwatch representatives raised the point that there are a number of Providers within the Borough of Sefton, which can make things difficult from a carer's perspective. He asked how effective communication and integration with other Providers is and it was acknowledged that there are some gaps and that work is on-going to look at pathways to ensure the best possible experience for patients. There is also the possibility of having a district nurse going into the Boothroyd Unit in Southport, which would assist with integration. It was also acknowledged that some information governance systems within the

NHS do not “talk” to each other and the CCG representative reported on on-going strategic work to provide more integrated systems within Merseyside. Healthwatch also pointed out that having to repeat a patient’s story to every Provider can be upsetting for patients and carers, and it was considered that the way in which services are commissioned contributes to this issue. In general, nurses are being told to specialise in their specific area which, in the long run, requires more visits from different Providers. The CCG representative told us that it is a strategic aim to provide a seamless journey for the patient and that patient records should stay with them on their journey. The Trust representative indicated that the Trust will have an overarching co-ordinator in place to progress integration work and she offered to feedback on the issues raised at the meeting.

We very much appreciated the opportunity to scrutinise your draft Quality Account for 2017/18 and were grateful for the attendance at our meeting by the Trust representative. I do hope you find these comments, together with some of the suggestions raised at the meeting, to be useful.

Please accept this letter as the Sefton OSC’s formal response to your draft Quality Account.

Yours sincerely,

Councillor Mhairi Doyle, M.B.E.
Chair, Overview and Scrutiny Committee (Adult Social Care)

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 2018/19 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 1 April 2018 to 28 May 2019,

      ii) papers relating to quality reported to the Board over the period 1 April 2018 to 28 May 2019,

      iii) feedback from commissioners dated 20 May 2019,

      iv) feedback from governors on 25 April 2019,

      v) feedback from local Healthwatch organisations dated 23 and 24 May 2019,

      vi) feedback from the Sefton Metropolitan Borough Council Overview and Scrutiny Committee dated 20 May 2019,

      vii) the Trust's 2017 complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009,

      viii) the national patient survey dated 15 November 2018,

      ix) the 2018 national staff survey dated 26 February 2019,

      x) the Head of Internal Audit's annual opinion over the Trust's control environment dated March 2019,

      xi) the Care Quality Commission's inspection report dated 5 April 2019;

   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;

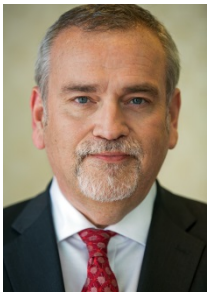
f) the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

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:

Beatrice Fraenkel, Chairman
22 May 2019



Joe Rafferty, Chief Executive
22 May 2019

ANNEX 3 CLINICAL AUDIT REPORT 2018/19	
Audit Theme	**Improvement Activities Arising from Clinical Audit Outcomes**
NICE	• ECT Consent NICE TA59 & CG90 amend consent form to include recording of religion • Autism NICE QS151 improve recording of engagement with carers • Borderline personality disorder CG78 improve timeliness of diagnosis and promote completion of admission checklist • Dementia NG97 improved information from pharmacy about whether memantine added or substituted
Physical Healthcare	• A review of the physical health care pathway for patients with both serious mental illness and first episode of psychosis have been reviewed including additional clinical support and improved documentation within the clinical notes. Re-audit has noted significant improvement. • Repeated attempts with inpatients on mental health adult acute wards around smoking cessation including introduction of controlled access to e-cigarettes • Clozapine assay required further work to investigate the adherence considering after dose change, side effects, smoking cessation or clinical need • Improvement of the diabetes management of inpatients on mental health adult and older people's wards • Expanded reporting of wounds being managed by Podiatry services to explain in more detail the aetiology, introducing a proforma to capture essential information • Improvement of day 1 and day 3 blood samples for patients on IV therapy.
Records Management	• Address the functionality within the clinical records system to enable countersignature of clinical entries • Improved reporting of follow up on actions arising from incident reviews.
Risk Assessment/Patient safety	• Review of the referral process to DVLA around driving restrictions to psychiatric inpatients. • For venous leg ulcers a 'sockit' box was introduced and standardised use of compression hosiery • For pressure ulcer care a Risk Stratification Tool has now been agreed for implementation following testing in divisional pilot sites and recording all moisture-associated skin damage (MASD) within local reporting systems (Datix) in addition to pressure ulcers. The aim of reporting moisture lesions is to capture data in relation to all skin damage

Audit Theme	Improvement Activities Arising from Clinical Audit Outcomes
	• Improve the communication of the Environmental Suicide Risk Audit (ESRA) across ward teams • Review processes within the Patient appointment centre and how the DNA's are communicated to each respective clinical team to discuss as part of the MDT process. • A review of the CPA process Trust wide to ensure a standardised and consistent trust-wide approach to CPA to ensure care plans are service user directed and strengths-based with clear goals to support the service user's recovery. • A review of the process around recording risk assessment before section 17 leave and upon return from leave.
Medicine Management	• Improved compliance with Pan Mersey Anti-Microbial Formulary for Non-Medical Prescribers • Improve the quality of care planning for dual diagnosis patients with opioid dependency • Developing a standardised template as part of discharge communication to provide assurance to GP that discharge medication has been provided. • An alert added to Depot Card and clinical notes to ensure that care coordinators and any other practitioner have a visual reminder of the annual review date • An Aide memoire added to Depot Cards with recommended physical health monitoring requirements •
GP Communication	• Piloting the eDischarge process in the care records to improve the 24 hour/7 day compliance with discharge notification

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Mersey Care NHS Foundation Trust

Annual Accounts 2018/19

Annual Report and Accounts 2018/19

Presented to Parliament pursuant to Schedule 7, paragraph 25(4)(a) 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 2019 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; 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.

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

Financial statements audit

- Overall materiality: £6.4m, which represents 1.63% of the Trust's gross operating income (consisting of operating income from patient care activities and other operating income);
- Key audit matters were identified as:
  - Revenue recognition: contract variations and other operating income
  - Valuation of land and buildings.
- We have tested the Trust's material income and expenditure streams and assets and liabilities.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified two significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (see *Report on other legal and regulatory requirements* section).

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
Risk 1: Contract variations and other operating income Approximately 92% of the Trust's income is from patient care activities and contracts with NHS commissioners and other NHS bodies. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. We have considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue. We have rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We have determined these to be income from: • Block contract income element of patient care revenues. We have not deemed it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue. The block contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in these contracts (e.g. contract variations) are subject to verification and agreement by the commissioners and may include estimates. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. We have therefore identified the occurrence and accuracy of contract variations and other operating revenue (excluding education and training income) and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement and a key audit matter.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition of income from patient care activities for appropriateness and compliance with the Department of Health and Social Care (DHSC) group accounting manual 2018/19 • updating our understanding of the Trust's system for accounting for income from patient care activities and evaluate the design of the associated controls • agreeing on a sample basis income from contracts with commissioners to signed contracts • agreeing a sample of any contract variations to supporting evidence • assessing the Trust's estimates and judgments taken in order to arrive at the income recorded in the accounts • examining variances in income and expenditure and receivables and payables between the Trust and other NHS Bodies of £300k and above • agreeing income to NHSI notifications in respect of Provider Sustainability Funding. **Key observations** We obtained sufficient audit evidence to conclude that: • the Trust's accounting policies for recognition of contract income and other operating revenue comply with the DHSC group accounting manual 2018-19 and have been applied appropriately • income from patient care activities and other operating income and the associated receivable balances are not materially misstated.
Risk 2: Valuation of land and buildings The Trust re-values its land and buildings on a regular basis to ensure that the carrying value is not materially different from current value in existing use. This represents a significant estimate by management in the financial statements. 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, the instructions issued to valuation experts and the scope of their work; • Evaluating the competence, capabilities and objectivity of the Trust's valuation expert; • Discussing with the Trust's valuer the basis on which the valuations were carried out and challenging the key assumptions applied; • Challenging the information used by the valuer to assess completeness and consistency with our understanding; • Testing, on a sample basis, revaluations made during the year to ensure they have been recorded accurately in the Trust's asset register; • Evaluating the assumptions made by management for any assets not revalued during the year and how management has satisfied themselves that carrying value is not materially different to current value in existing use. The accounting policy on valuation of land and buildings is shown in note 1.72 to the financial statements and related disclosures are included in note 15. **Key observations** We obtained sufficient audit evidence to conclude that • the basis of the valuation of land and buildings was appropriate, and the assumptions and processes used by management in determining the estimate were reasonable; • the valuation of land and buildings disclosed in the financial statements is reasonable.

Our application of materiality

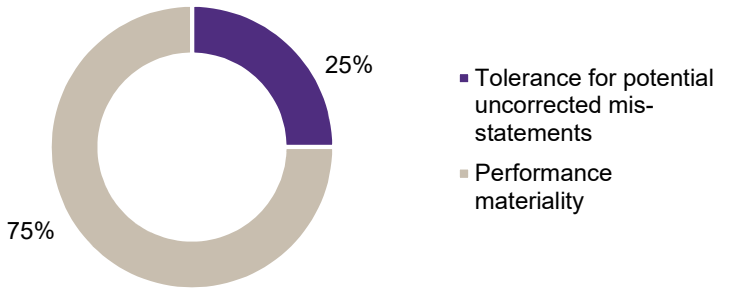
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£6.4m which is 1.75% of the Trust's gross operating income. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust generates its income. Materiality for the current year is at the same percentage level of gross operating income as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	We design our procedures to detect errors in specific accounts balances or disclosures at a lower level of precision. The senior officer remuneration disclosure in the Remuneration Report has been identified as an area requiring lower level of materiality of £5,000 based on the disclosure bandings, due to its sensitive nature.
Communication of misstatements to the Audit Committee	£321,000 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.

Overall materiality – Trust



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. It included an evaluation of the Trust's internal controls including relevant IT systems and controls over key financial systems.

The scope of our audit included:

- obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams
- obtaining supporting evidence, on a sample basis
- obtaining supporting evidence, on a sample basis, for property plant and equipment and the Trust's other material 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**,** other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the

extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit 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 the 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 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given 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 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

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 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by 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 2018/19 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 issue a report 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 refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take 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 the Chief Executive's Responsibilities as the Accountable Officer of the Trust* 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 2018/19, 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 Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

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 2019.

We have nothing to report in respect of the above matter.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks	How the matter was addressed in the audit
Risk 1 Continued integration of community services Upon acquisition of Liverpool Community on 1 April 2018, the Trust embarked on a programme of integration across corporate services, community services and mental and physical health services. This is an ambitious programme and is not without its challenges. In the short term, the Trust will need additional investment in order to maintain momentum and not compromise quality. Unless this additional investment is provided externally, the Trust will be unable to meet its requested break-even position in 2019/20. We continued to monitor the Trust's financial position in the short term and consider the implications that the lack of investment may have on the Trust's financial sustainability.	Our audit work included, but was not restricted to: • monitoring the Trust's financial position throughout 2018/19 • reviewing the assumptions within the Trust's 2019/20 budget, specifically in relation to additional support requirements • assessing the adequacy of the Trust's borrowing facility in the context of the 2019/20 capital programme. **Key findings** No issues have been identified that would suggest that the Trust does not have adequate arrangements in place for delivering economy, efficiency and effectiveness in the use of its resources.
Risk 2 Estates strategy The Trust has in place an extensive capital programme, with an expected £50m of additional capital build to be added to the Trust's asset base by 2020. Whilst the Trust has an agreed £60m capital financing facility, it is expected that the estates strategy will require a further £40m to £50m of investment which will taking the Trust beyond its borrowing limits. With such an ambitious programme in place it is imperative that the Trust's operational and service strategies align with the estates strategy so that planned developments continue to be fit for purpose. We will continue to monitor the strategy development and decisions made to consider the implications that this has on the Trusts financial sustainability and borrowing limits.	Our audit work included, but was not restricted to: • Review of the estates strategy was presented to Board in January 2019 and the linkages into the operational and financial plans for 2019/20 • Review of progress on the supporting strategies • Understanding the partnership working arrangements across the STP **Key findings** No issues have been identified that would suggest that the Trust does not have adequate arrangements in place for delivering economy, efficiency and effectiveness in the use of its resources.

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 2019, 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.

Use of our report

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.

Grant Patterson

Grant Patterson, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham Office, The Colmore Building, 20 Colmore Circus B4 6AT

29 May 2019

Foreword to the accounts

Mersey Care NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 **22 May 2019**

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	361,639	253,293
Other operating income	4	30,936	23,288
Operating expenses	6, 8	(375,308)	(272,407)
Operating surplus from continuing operations		**17,267**	**4,174**
Finance income	11	250	84
Finance expenses	12	(2,587)	(2,495)
PDC dividends payable		(4,346)	(4,303)
Net finance costs		**(6,683)**	**(6,714)**
Other losses	13	(164)	(161)
Gains arising from transfers by absorption	35	18,095	3,554
Surplus for the year from continuing operations		**28,515**	**853**
Surplus for the year		**28,515**	**853**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(6,786)	(6,084)
Revaluations	16	1,470	7,449
Total comprehensive income for the period		**23,199**	**2,218**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	3,284	1,014
Property, plant and equipment	15	230,763	196,383
Investment property	17	1,375	1,375
Receivables	20	116	109
Total non-current assets		**235,538**	**198,881**
Current assets			
Inventories	19	526	377
Receivables	20	32,254	17,312
Cash and cash equivalents	21	27,371	19,497
Total current assets		**60,151**	**37,186**
Current liabilities			
Trade and other payables	22	(29,640)	(20,407)
Borrowings	24	(778)	(670)
Provisions	26	(5,675)	(3,296)
Other liabilities	23	(450)	(143)
Total current liabilities		**(36,543)**	**(24,516)**
Total assets less current liabilities		**259,146**	**211,551**
Non-current liabilities			
Borrowings	24	(49,994)	(28,912)
Provisions	26	(22,112)	(22,561)
Total non-current liabilities		**(72,106)**	**(51,473)**
Total assets employed		**187,040**	**160,078**
Financed by			
Public dividend capital		84,209	80,217
Revaluation reserve		55,989	58,493
Other reserves		59,907	59,907
Income and expenditure reserve		(13,065)	(38,539)
Total taxpayers' equity		**187,040**	**160,078**

The notes on pages 234 to 284 form part of these accounts.

Name
Position Chief Executive
Date **22 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**80,217**	**58,493**	**59,907**	**(38,539)**	**160,078**
Surplus for the year	-	-	-	28,515	**28,515**
Transfers by absorption: transfers between reserves	229	3,179	-	(3,408)	**-**
Other transfers between reserves	-	(367)	-	367	**-**
Impairments	-	(6,786)	-	-	**(6,786)**
Revaluations	-	1,470	-	-	**1,470**
Public dividend capital received	3,763	-	-	-	**3,763**
Taxpayers' equity at 31 March 2019	**84,209**	**55,989**	**59,907**	**(13,065)**	**187,040**

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**
Surplus 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**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care 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.

Other reserves
The 'Other reserves' relate to the equity received when Ashworth Hospital Authority was transferred to the trust in April 2002.

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), South Sefton Community Services (acquired 1 July 2017) and Liverpool Community Health NHS Trust (acquired 1 April 2018).

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus		17,267	4,174
Non-cash income and expense:			
Depreciation and amortisation	6.1	6,546	5,741
Net impairments	7	5,668	9,659
Increase in receivables and other assets		(9,094)	(1,808)
Increase in inventories		(81)	(7)
Decrease in payables and other liabilities		(2,525)	4,551
Increase in provisions		506	(968)
Net cash generated from operating activities		**18,287**	**21,342**
Cash flows from investing activities			
Interest received		250	84
Purchase of intangible assets		(2,721)	(850)
Purchase of property, plant, equipment and investment property		(38,017)	(16,593)
Net cash used in investing activities		**(40,488)**	**(17,359)**
Cash flows from financing activities			
Public dividend capital received		3,763	1,250
Movement on loans from the Department of Health and Social Care	24.1	21,767	-
Capital element of finance lease rental payments		(278)	(257)
Capital element of PFI, LIFT and other service concession payments		(392)	(394)
Interest on loans		(42)	-
Interest paid on finance lease liabilities	12.1	(525)	(524)
Interest paid on PFI, LIFT and other service concession obligations		(1,904)	(1,918)
PDC dividend paid		(3,950)	(4,456)
Net cash generated from financing activities		**18,438**	**(6,299)**
Decrease in cash and cash equivalents	**21.1**	**(3,763)**	**(2,316)**
Cash and cash equivalents at 1 April - brought forward		**19,497**	**21,553**
Cash and cash equivalents transferred under absorption accounting	35	11,637	260
Cash and cash equivalents at 31 March	21.1	**27,371**	**19,497**

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 financial statements have been prepared in accordance with the GAM 2018/19 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 the 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 1.2 Going concern

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

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 1.3 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 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the trust accrues income relating to performance obligations satisfied in that year. Where the trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The majority of contracts with Commissioners are based on block contract values, based on agreed performance obligations. Credit terms are 30 days, therefore invoices are raised prior to the end of each reporting period and payments are made by the 15th of the following month. Therefore the impact of timing of payments has a minimal impact on contract balances.

Revenue from NHS contracts

The main source of income for the trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the trust reflects this in the transaction price and derecognised the relevant portion of income.

The trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the trust's interim performance does not create an asset with alternative use for the trust, and the trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The trust recognises the income on a receipts basis.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

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.

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to 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 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. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

A proportion of the trust's building estate is made available through lease arrangements. When the trust commits to capital investment within such properties the value carried within the capital asset register is reflected at investment cost and depreciated over the lease term. This is deemed the most appropriate way to depreciate the cost of the asset over its useful life and to reflect the current value of the investment over the life of the lease. The value of associated assets is £4.104m at 31 March 2019 (£4.319m 2017/18).

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 an 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 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 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned 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 useful 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is charged to operating expenses as incurred.

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 lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	1	55
Dwellings	34	38
Plant & machinery	10	10
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 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.

Revised Royal Institution of Chartered Surveyors' guidance came into effect in January 2019 but did not impact on the 2018/19 accounts. Based on internal reviews, it is not expected that the revised guidance will have a material impact for the trust in 2019/20.

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.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	3	5

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 at note 20.

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 18.

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. Cash and cash equivalents can be found at note 22.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the 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 assets and financial liabilities

Note 1.13.1 Recognition

instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS. Further information on the trust's financial instruments can be found at note 32.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the trust elected to measure an equity instrument in this category on initial recognition.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the trust recognises an allowance for expected credit losses.

The trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined, distinguishing as necessary between different methods used for different classes of financial asset and the age of the asset.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition

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

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

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. Details of finance leases held by the trust can be seen at note 26.

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

Operating leases

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

Contingent rentals are recognised as an expense in the period in which they are incurred. The trust's operating leases can be seen at note 10.

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's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's 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 27.1.

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 27.2 but is not recognised in the trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 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 28 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 28, 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 organisations. 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 Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 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 1.19 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 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 22.2 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 accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments disclosed in note 33 is 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. Transfers of functions from other NHS bodies can be seen at note 36.

Note 1.23 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's 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 2019 reflect their value in existing use.

Note 1.24 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 Accounting Manual (GAM). Details of impairments are included in note 7.

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 27.1.

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.

Provisions
The amount recognised as a provision is the best estimate at the end of the reporting period of the expenditure required to settle a present obligation or constructive obligation, taking into account risks and uncertainties. Further clarification of the provisions accounting policy is set out in note 27.1.

PPE Leased Properties
A proportion of the trust's building estate is made available through lease arrangements. When the trust commits to capital investment within such properties the value carried within the capital asset register is reflected at investment cost and depreciated over the lease term. This is deemed the most appropriate way to depreciate the cost of the asset over its useful life and to reflect the current value of the investment over the life of the lease. The value of associated assets is £4.104m at 31 March 2019 (£4.319m 2017/18).

Accruals
Accruals are largely based on known commitments and are assessed accurately. Where estimates are made, they are based on historical records, precedence and officers' knowledge and experience. In all cases, the trust adopts a prudent approach to avoid overstating its resources.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.26 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 2018/19. These standards are still subject to HM Treasury *FReM* adoption, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- 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 April 2018 this also includes physical health community services following the acquisition of Liverpool Community Health NHS Trust.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Mental health services		
Block contract income	241,898	232,690
Clinical partnerships providing mandatory services (including S75 agreements)	351	357
Community services		
Community services income from CCGs and NHS England	110,734	20,246
Income from other sources (e.g. local authorities)	3,692	-
All services		
Agenda for Change pay award central funding	4,598	-
Other clinical income	366	-
Total income from activities* **	**361,639**	**253,293**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	108,637	99,910
Clinical commissioning groups	219,789	130,342
Department of Health and Social Care	4,598	-
Other NHS providers	4,725	2,726
NHS other*	-	1,600
Local authorities	6,663	6,020
Injury cost recovery scheme	366	-
Non NHS: other**	16,861	12,695
Total income from activities* **	**361,639**	**253,293**
Of which:		
Related to continuing operations	361,639	253,293

***NHS other** includes non-recurrent income in 2017/18 from NHS Improvement £1.600m

****Non NHS other** includes contractual Secure/Specialised Learning Disability income from Health Commission Wales £11.695m;Secpro income £0.453m; NHS Scotland £0.399m; Brain Injury Support £0.384m; HMP Liverpool £3.500m; Northern Ireland Patient £0.199m

*****Total income from activities** increased in 2018/19 due to the acquisition of Liverpool Community Health NHS Trust on 1 April 2018.

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	195	281
Education and training (excluding notional apprenticeship levy income)	7,904	7,151
Non-patient care services to other bodies	7,942	8,526
Provider sustainability / sustainability and transformation fund income (PSF / STF)	10,346	2,971
Other contract income*	2,217	-
Rental revenue from operating leases**	-	883
Other non-contract income***	2,332	3,476
Total other operating income	**30,936**	**23,288**
Of which:		
Related to continuing operations	30,936	23,288

***Other contract income** includes; Staff Secondments £0.810m; Sefton social services £0.324m; Property Rental £0.308m; Patients shop income £0.298m; Catering income £0.261m; Dental Charges £0.092m; Lease Car Income £0.031m; Staff Counselling Service £0.065m

****Rental revenue from operating leases** includes income received by the trust for land leased on the Maghull Health Park site which expired in July 2017.

*****Other non-contract income** includes; NHS Improvement/NHS England support £1.800m; GDE recharges £0.100m; Staff Counselling service £0.065m; DoH Funding £0.166m

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	143

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2019
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000
within one year	143
Total revenue allocated to remaining performance obligations	**143**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 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:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	309,925	222,822
Income from services not designated as commissioner requested services	51,714	30,471
Total	**361,639**	**253,293**

Note 5.4 Profits and losses on disposal of property, plant and equipment

The trust had no profits or losses on disposals of property, plant and equipment during 2018/19.

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	135	-
Purchase of healthcare from non-NHS and non-DHSC bodies	2,195	2,504
Staff and executive directors costs*	280,301	197,916
Remuneration of non-executive directors	166	141
Supplies and services - clinical (excluding drugs costs)	13,290	3,597
Supplies and services - general	5,700	4,370
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	4,585	3,716
Consultancy costs**	2,704	1,346
Establishment	9,238	9,194
Premises	26,298	21,596
Transport (including patient travel)	712	434
Depreciation on property, plant and equipment	6,259	5,596
Amortisation on intangible assets	287	145
Net impairments	5,668	9,659
Movement in credit loss allowance: contract receivables / contract assets	533	
Movement in credit loss allowance: all other receivables and investments	13	(68)
Change in provisions discount rate(s)	(417)	343
Audit fees payable to the external auditor***		
audit services- statutory audit	59	54
other auditor remuneration (external auditor only)	7	7
Internal audit costs	218	144
Clinical negligence	600	335
Legal fees	480	646
Insurance	715	467
Research and development	736	673
Education and training	3,299	2,754
Rentals under operating leases	4,478	1,034
Early retirements	-	156
Redundancy	3,000	1,582
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	537	482
Car parking & security	1,102	318
Hospitality	12	30
Losses, ex gratia & special payments	1,581	811
Other services, eg external payroll	532	291
Other****	285	2,134
Total***	**375,308**	**272,407**
Of which:		
Related to continuing operations	375,308	272,407

***Staff & executive directors costs** increased due to the acquisition of Liverpool Community Health NHS Trust
****Consultancy costs** includes £0.854m in 2018/19 due to Kirkup Report
*****Audit fees payable to the external auditor** are inclusive of VAT
******Other** includes £0.154m mental health act appeals; £0.121m non clinical recharges received
*******Total** operating expenses increased in 2018/19 due to the acquisition of Liverpool Community Health NHS Trust on 1 April 2018.

Note 6.2 Other auditor remuneration

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	7	7
Total	**7**	**7**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2.000m (2017/18: £2.000m).

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	5,929	9,578
Other	(261)	81
Total net impairments charged to operating surplus / deficit	**5,668**	**9,659**
Impairments charged to the revaluation reserve	6,786	6,084
Total net impairments	**12,454**	**15,743**

The valuation of all specialised property assets is on a Modern Equivalent Asset basis taking into account functional and economic obsolesence. Non specialist assets are valued based on market value for existing use or at fair value if not in use.

The trust's land and buildings were valued by Cushman & Wakefield on 31 March 2019 resulting in net impairments of £12.454m in 2018/19.

The key elements of this net impairment are:
a) impairments £13.570m
b) reversal of economic impairments £0.261m
c) reversal of market impairments £0.862m
d) transfer of ownership £0.007m

Impairments are taken to the revaluation reserve to the extent there is a balance available (£6.786m) with the remainder (£5.668m) charged to operating expenses as seen at note 6.1.

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	226,544	158,944
Social security costs	20,213	14,632
Apprenticeship levy	1,054	754
Employer's contributions to NHS pensions	26,298	18,593
Pension cost - other	40	7
Temporary staff (including agency)	12,125	9,325
Total gross staff costs	**286,274**	**202,255**
Total staff costs*	**286,274**	**202,255**
Of which		
Costs capitalised as part of assets	1,948	1,670

***Total staff costs** increased in 2018/19 due to the acquisition of Liverpool Community Health NHS Trust on 1 April 2018.

Note 8.1 Retirements due to ill-health

During 2018/19 there were 12 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £666k (£313k in 2017/18).

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

Note 9 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 for Health 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.

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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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.

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 trust offers the National Employment Savings Scheme (NEST) as an additional defined contribution workplace pension scheme.

Note 10 Operating leases

Note 10.1 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.

The trust has no remaining leasing arrangements as a lessor in 2018/19. In 2017/18, the trust leased 8.5 hectares of land. No buildings formed part of the lease. The lease expired in July 2017.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Other	-	883
Total	**-**	**883**

Note 10.2 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 and vehicles.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	4,478	1,034
Total	**4,478**	**1,034**

On 1 April 2018 all leases previously held by Liverpool Community Health NHS Trust transferred to the trust.

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	4,389	756
- later than one year and not later than five years;	8,116	3,173
- later than five years.	3,890	710
Total	**16,395**	**4,639**

The additional property leases have the following affect on the future minimum lease commitments of the trust: not later than one year £2.056m; later that one year and not later than five years £3.605m; later than five years £3.590m

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	250	78
Interest on other investments / financial assets	-	6
Total finance income	**250**	**84**

Note 12.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	135	-
Finance leases	525	524
Interest on late payment of commercial debt	1	-
Main finance costs on PFI and LIFT schemes obligations	1,759	1,790
Contingent finance costs on PFI and LIFT scheme obligations	145	128
Total interest expense	**2,565**	**2,442**
Unwinding of discount on provisions	22	53
Total finance costs	**2,587**	**2,495**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	1	-
Compensation paid to cover debt recovery costs under this legislation	7	-

Note 13 Other losses

	2018/19	2017/18
	£000	£000
Losses on disposal of assets	(164)	(161)
Total losses on disposal of assets	**(164)**	**(161)**

Note 14 Intangible assets - 2018/19

	Software licences	Licences & trademarks	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**2,456**	**-**	**2,456**
Additions	2,557	164	**2,721**
Disposals / derecognition	(87)	(164)	**(251)**
Valuation / gross cost at 31 March 2019	**4,926**	**-**	**4,926**
Amortisation at 1 April 2018 - brought forward	**1,442**	**-**	**1,442**
Provided during the year	287	-	**287**
Disposals / derecognition	(87)	-	**(87)**
Amortisation at 31 March 2019	**1,642**	**-**	**1,642**
Net book value at 31 March 2019	**3,284**	**-**	**3,284**
Net book value at 1 April 2018	**1,014**	**-**	**1,014**

Note 14.1 Intangible assets - 2017/18

	Software licences	Licences & trademarks	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**1,982**	**-**	**1,982**
Additions	689	161	**850**
Disposals / derecognition	(215)	(161)	**(376)**
Valuation / gross cost at 31 March 2018	**2,456**	**-**	**2,456**
Amortisation at 1 April 2017 - as previously stated	**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 15.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**26,597**	**151,027**	**1,581**	**8,624**	**10,463**	**1,359**	**5,164**	**2,913**	**207,728**
Transfers by absorption	1,040	10,229	-	174	843	-	-	385	**12,671**
Additions	-	5,257	-	35,116	235	25	815	35	**41,483**
Impairments	-	(14,690)	-	-	(35)	-	-	-	**(14,725)**
Reversals of impairments	-	(217)	-	-	-	-	4	-	**(213)**
Revaluations	-	345	-	-	-	-	-	-	**345**
Reclassifications	-	185	-	(204)	-	-	-	19	-
Disposals / derecognition	-	(95)	-	-	(413)	-	(1,894)	(748)	**(3,150)**
Valuation/gross cost at 31 March 2019	**27,637**	**152,041**	**1,581**	**43,710**	**11,093**	**1,384**	**4,089**	**2,604**	**244,139**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**659**	**-**	**-**	**4,716**	**1,103**	**2,961**	**1,906**	**11,345**
Transfers by absorption	-	1,873	-	-	464	-	-	194	**2,531**
Provided during the year	-	4,213	35	-	950	55	553	453	**6,259**
Impairments	-	(1,085)	(35)	-	(28)	-	-	-	**(1,148)**
Reversals of impairments	-	(1,336)	-	-	-	-	-	-	**(1,336)**
Revaluations	-	(1,125)	-	-	-	-	-	-	**(1,125)**
Disposals / derecognition	-	(95)	-	-	(413)	-	(1,894)	(748)	**(3,150)**
Accumulated depreciation at 31 March 2019	**-**	**3,104**	**-**	**-**	**5,689**	**1,158**	**1,620**	**1,805**	**13,376**
Net book value at 31 March 2019	**27,637**	**148,937**	**1,581**	**43,710**	**5,404**	**226**	**2,469**	**799**	**230,763**
Net book value at 1 April 2018	**26,597**	**150,368**	**1,581**	**8,624**	**5,747**	**256**	**2,203**	**1,007**	**196,383**

Note 15.2 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 - as previously stated	**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 - as previously stated	**-**	**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 15.3 Property, plant and equipment financing - 2018/19

	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 2019									
Owned - purchased	27,637	123,674	1,581	43,710	5,404	226	2,469	799	**205,500**
Finance leased	-	5,658	-	-	-	-	-	-	**5,658**
On-SoFP PFI contracts and other service concession arrangements	-	19,605	-	-	-	-	-	-	**19,605**
NBV total at 31 March 2019	**27,637**	**148,937**	**1,581**	**43,710**	**5,404**	**226**	**2,469**	**799**	**230,763**

Note 15.4 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-SoFP 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 16 Revaluations of property, plant and equipment

The trust's land and buildings were revalued during 2018/19 by Gian Wong (MRICS), a professionally qualified valuer of Cushman & Wakefield. These values were updated on 31 March 2019 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 and Social Care.

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 £10.984m from £189.139m on 31 March 2018 to £178.155m on 31 March 2019. This resulted in an impairment of £12.454m which can be seen at note 7 and an upward revaluation of £1.470m.

The estimated useful lives of the trust's assets are as follows:

	Between Yrs	Yrs
Buildings (excluding dwellings)	1	55
Dwellings	34	38
Plant and machinery	10	15
	Yrs	
Transport equipment	7	
Information technology	5	

The trust has £4.054m fully depreciated assets in use.

Note 17.1 Investment Property

	2018/19 £000	2017/18 £000
Carrying value at 1 April - brought forward	**1,375**	**1,375**
Carrying value at 31 March	**1,375**	**1,375**

Note 17.2 Investment property income and expenses

	2018/19 £000	2017/18 £000
Direct operating expense arising from investment property which generated rental income in the period	(7)	(13)
Total investment property expenses	**(7)**	**(13)**
Investment property income	71	88

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 2018/19, the trust has contributed to the expenses incurred.

Note 19 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	366	231
Consumables	68	75
Energy	68	44
Other	24	27
Total inventories	**526**	**377**
of which:		

Inventories recognised in expenses for the year were £7.836m (2017/18: £5.559m). Write-down of inventories recognised as expenses for the year were £0.000m (2017/18: £0.000m).

Note 20.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	28,173	-
Trade receivables*	-	8,980
Accrued income*	-	4,006
Allowance for impaired contract receivables / assets**	(902)	-
Allowance for other impaired receivables**	(382)	(584)
Prepayments (non-PFI)	2,923	2,565
PDC dividend receivable	288	628
VAT receivable	748	185
Other receivables	1,406	1,532
Total current trade and other receivables* **	**32,254**	**17,312**
Non-current		
Other receivables	116	109
Total non-current trade and other receivables	**116**	**109**
Of which receivables from NHS and DHSC group bodies:		
Current	24,138	11,720

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

***Contract receivables** includes core Provider Sustainability Funds (PSF) income £1.275m and incentive PSF income of £6.703m for 2018/19.

The **allowance for impaired receivables increase is due to a previous organisational acquisition

****Total current trade and other receivables** increased in 2018/19 due to the acquisition of Liverpool Community Health NHS Trust on 1 April 2018.

Note 20.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**584**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	369	(369)
Transfers by absorption	-	195
New allowances arising	533	77
Reversals of allowances	-	(64)
Utilisation of allowances (write offs)	-	(41)
Allowances as at 31 Mar 2019	**902**	**382**

Note 20.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**652**
Increase in provision	263
Unused amounts reversed	(331)
Allowances as at 31 Mar 2018	**584**

Note 20.4 Exposure to credit risk

The trust has low exposure to credit risk. The maximum exposure as at 31 March 2019 are in contract receivables invoiced to customers, as disclosed in the trade and other receivables note 21.1.

	31 March 2019	31 March 2018
Contract receivables	**£000**	**£000**
Contract receivables - invoiced	16,488	8,937
Contract receivables non-invoiced	11,985	4,049
Total	**28,473**	**12,986**

	31 March 2019	31 March 2018
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	29	1,000
30-60 Days	4	72
60-90 days	56	14
90- 180 days	239	20
Over 180 days	957	786
Total	**1,284**	**1,892**

	31 March 2019	31 March 2018
Ageing of non-impaired financial assets past their due date	**£000**	**£000**
0 - 30 days*	11,511	4,737
30-60 Days	1,665	1,267
60-90 days	339	53
90- 180 days	523	510
Over 180 days	1,166	478
Total	**15,204**	**7,045**

*On 31 March 2019, 0-30 days includes £6.000m due from NHS England for transitional support.

Note 21.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**19,497**	**21,553**
Transfers by absorption	11,637	260
Net change in year	(3,763)	(2,316)
At 31 March	**27,371**	**19,497**
Broken down into:		
Cash at commercial banks and in hand	89	112
Cash with the Government Banking Service	27,282	19,385
Total cash and cash equivalents as in SoFP	**27,371**	**19,497**
Total cash and cash equivalents as in SoCF	**27,371**	**19,497**

Note 21.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the 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 2019	31 March 2018
	£000	£000
Bank balances	1,501	1,605
Total third party assets	**1,501**	**1,605**

Note 22.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	8,078	3,266
Capital payables	3,947	474
Accruals	17,287	13,208
Receipts in advance (including payments on account)	-	390
Social security costs	53	185
Other taxes payable	93	245
Other payables	182	2,639
Total current trade and other payables*	**29,640**	**20,407**
Of which payables from NHS and DHSC group bodies:		
Current	3,571	3,685

***Total current trade and other payables** increased in 2018/19 due to the acquisition of Liverpool Community Health NHS Trust on 1 April 2018.

Note 22.2 Early retirements in NHS payables above

There were no outstanding payables in relation to early retirements at 31 March 2019.

Note 23 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income*	450	143
Total other current liabilities	**450**	**143**

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

Note 24 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	93	-
Obligations under finance leases	300	278
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	385	392
Total current borrowings	**778**	**670**
Non-current		
Loans from the Department of Health and Social Care	21,767	-
Obligations under finance leases	6,564	6,864
Obligations under PFI, LIFT or other service concession contracts	21,663	22,048
Total non-current borrowings	**49,994**	**28,912**

Note 24.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC*	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	-	**7,142**	**22,440**	**29,582**
Cash movements:				
Financing cash flows - payments and receipts of principal	21,767	(278)	(392)	**21,097**
Financing cash flows - payments of interest	(42)	(525)	(1,759)	**(2,326)**
Non-cash movements:				
Application of effective interest rate	135	525	1,759	**2,419**
Carrying value at 31 March 2019	**21,860**	**6,864**	**22,048**	**50,772**

*The trust has a loan facility with DHSC for £51.325m of which £21.767m has been drawn down in 2018/19 to finance the building of Rowan View.

Note 25 Finance leases

Note 25.1 Mersey Care NHS Foundation Trust as a lessor

During 2018/19, the trust has no finance lease arrangements where Mersey Care NHS Trust is the lessor

Note 25.2 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 2019 £000	31 March 2018 £000
Gross lease liabilities	**13,594**	**14,267**
of which liabilities are due:		
- not later than one year;	819	797
- later than one year and not later than five years;	3,436	3,341
- later than five years.	9,339	10,129
Finance charges allocated to future periods	(6,730)	(7,125)
Net lease liabilities	**6,864**	**7,142**
of which payable:		
- not later than one year;	300	278
- later than one year and not later than five years;	1,415	1,328
- later than five years.	5,149	5,536
Contingent rent recognised as an expense in the period	(145)	(128)

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2018	**4,595**	**19,286**	**488**	**1,327**	**161**	**25,857**
Transfers by absorption	-	-	230	-	1,172	**1,402**
Change in the discount rate	(41)	(376)	-	-	-	**(417)**
Arising during the year	290	705	425	2,734	167	**4,321**
Utilised during the year	(424)	(873)	(256)	(92)	(164)	**(1,809)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-
Reversed unused	(114)	(747)	(403)	(250)	(75)	**(1,589)**
Unwinding of discount	4	18	-	-	-	**22**
At 31 March 2019	**4,310**	**18,013**	**484**	**3,719**	**1,261**	**27,787**
Expected timing of cash flows:						
- not later than one year;	427	881	484	3,719	164	**5,675**
- later than one year and not later than five years;	1,798	3,709	-	-	1,097	**6,604**
- later than five years.	2,085	13,423	-	-	-	**15,508**
Total	**4,310**	**18,013**	**484**	**3,719**	**1,261**	**27,787**

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.

Injury Benefits - amounts 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.

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 a reduction to clinical services by the trust.

Other - £1.097m relates to dilapidations contained within property leases to return the property to its original state on vacation. £0.164m relates to the Carbon Reduction Commitment Energy Efficiency Scheme.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions

Note 26.2 Clinical negligence liabilities

At 31 March 2019, £2,097k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Mersey Care NHS Foundation Trust (31 March 2018: £985k).

Note 27 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(239)	(185)
Gross value of contingent liabilities	**(239)**	**(185)**
Net value of contingent liabilities	**(239)**	**(185)**

The future contingent liabilities of £0.239m relate to potential legal claims. These figures have been provided by NHS Resolution.

Note 28 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	39,029	78,596
Total*	**39,029**	**78,596**

*Total contractual capital commitments in 2018/19 includes £29.088m for Rowan View at Maghull Health Park, £4.277m for the refurbishment of Macaulay Ward at Ashworth Hospital and £3.920m for Hartley Hospital.

Note 29 Defined benefit pension schemes

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

Note 30 On-SoFP 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 30.1 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 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**51,614**	**53,766**
Of which liabilities are due		
- not later than one year;	2,113	2,151
- later than one year and not later than five years;	8,354	8,435
- later than five years.	41,147	43,180
Finance charges allocated to future periods	(29,566)	(31,326)
Net PFI, LIFT or other service concession arrangement obligation	**22,048**	**22,440**
- not later than one year;	385	392
- later than one year and not later than five years;	1,767	1,713
- later than five years.	19,896	20,335

Note 30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**86,397**	**88,991**
Of which liabilities are due:		
- not later than one year;	2,878	2,842
- later than one year and not later than five years;	11,838	11,680
- later than five years.	71,681	74,469

Note 30.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**2,848**	**2,799**
Consisting of:		
- Interest charge	1,759	1,790
- Repayment of finance lease liability	392	395
- Service element and other charges to operating expenditure	493	470
- Capital lifecycle maintenance	15	4
- Revenue lifecycle maintenance	44	12
- Contingent rent	145	128
Total amount paid to service concession operator	**2,848**	**2,799**

Note 31 Financial instruments

Note 31.1 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 19. 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 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

The Trust has loans and LIFT/PFI schemes, with the public and private sector respectively. All financial arrangements are subject to clauses within each individual agreement. The trust does not consider these arrangements to carry any credit risk.

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 £22.047m to £43.551m.

Note 31.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	28,411	**28,411**
Cash and cash equivalents at bank and in hand	27,371	**27,371**
Total at 31 March 2019	**55,782**	**55,782**

	Loans and receivables	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**
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**

Note 31.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analysis.

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	21,860	**21,860**
Obligations under finance leases	6,864	**6,864**
Obligations under PFI, LIFT and other service concession contracts	22,048	**22,048**
Trade and other payables excluding non financial liabilities	29,494	**29,494**
Total at 31 March 2019	**80,266**	**80,266**

	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
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**

Note 31.4 Fair values of financial assets and liabilities

The trust measures financial assets and liabilities at book value which is a reasonable approximation of fair value.

Note 31.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	30,272	17,618
In more than one year but not more than two years	1,211	685
In more than two years but not more than five years	5,277	2,356
In more than five years*	43,506	25,871
Total	**80,266**	**46,530**

Note 32 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	17	906	23	15
Bad debts and claims abandoned	41	39	5	4
Total losses	**58**	**945**	**28**	**19**
Special payments				
Ex-gratia payments	55	45	35	12
Total special payments	**55**	**45**	**35**	**12**
Total losses and special payments	**113**	**990**	**63**	**31**
Compensation payments received		230		-

Details of cases individually over £300k

In 2018/19, the trust was a victim of fraud resulting in the loss of cash to the organisation (£0.904m). The trust has recovered £0.230m back from NHS Resolution under the Fidelity Guarantee Scheme.

Note 33.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Note 33.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The application of IFRS 15 has had no impact for the trust.

Note 34 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 35 Transfers by absorption

On 1 April 2018, the trust acquired Liverpool Community Health NHS Trust.

The following assets and liabilities have been recognised in the accounts at the date of acquisition:

	£000
Non Current Assets	10,140
Current Assets	17,956
Current Liabilities	(8,829)
Non Current Liabilities	(1,172)
	18,095

Note 36 Events after the reporting date

There have been no events after the reporting period.