Mersey Care NHS
NHS Trust

Annual Report 2013/14

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Welcome to our annual report for 2013 to 2014

We have spoken many times of the importance of talking and listening to people, but the past year must be etched out as one of the most significant periods for Mersey Care when you talked, we listened and took positive action as a result.

The 'Your Voice Your Change*' programme went through the whole organisation and hundreds of hours in open supportive discussions brought forward ideas and themes of how we can make Mersey Care better. It was the realisation that together we can craft the best, most effective solutions of doing more, safely and with less.

One of the biggest changes to come out of these conversations was the issue of the organisation's complexity. Both service users and staff struggled to understand and find their way around the six clinical business units (CBUs) structure, so we simplified these into three divisions – one for local services, one for secure mental health services, and a third for corporate services.

It was also right that we worked hard to improve staff engagement in addition to embarking on a new process to involve service users, carers and volunteers through the creation of a People Participation framework. Both these responses recognise the fact that Mersey Care is all about its 'people.'

One lesson to come out of listening and sharing stories is that we understand what is important to service users and carers. By seeing things through the eyes of our 'customers' who rely on all of our services we can not only empathise but also strive to improve their experience.

Last year we set ourselves a bold target as an NHS organisation working towards becoming a foundation trust that we would go 'from good to great.' We have made considerable progress towards achieving this and believe the steps put in place now and into the future will see big inroads on that journey.

Some improvements of course are already very visible, such as the start of construction of our new £25 million Clock View hospital in Walton. As it progresses it will become a state-of-the-art mental health facility providing each patient with a single room with en suite bathroom in a therapeutic and healing environment.

Other gains may be less tangible to see and may take more time to achieve, such as our vision of 'perfect care.' To kick-start this process we listened to some of the world's experts and have embarked on a concerted programme under our 'Centre for Perfect Care and Wellbeing', which supports our model for quality improvement and uses evidence to provide the best treatments and therapies.

All of this is only possible with the best people in place right across the trust that are passionate about mental health and a number of appointments took place to strengthen the executive team, making our big decisions.

Supporting our vision is a strong strategy to keep us on track – its four core components are quality, better services, our organisation and partnerships. Although there are considerable challenges ahead, now is the time to act and embed changes which will improve care beyond anything that any of us have previously known.

Beatrice Fraenkel, Chairman

Joe Rafferty, Chief Executive

* Your Voice Your Change is part of a national pioneer approach which focuses on empowering staff to make changes they want to see, to fundamentally shift the way we work and deliver change. It's not just a programme or quick-fix project but more of a philosophy based on becoming a high quality, safe organisation that we all own and are proud of, an approach that places our staff at the heart of decision-making and change.

STRATEGY FOR SERVICE DEVELOPMENT

Mersey Care continues to be a high performing organisation. The trust achieved both its key service and financial performance targets by continuing to improve quality and increase the value of the services we provide. We built on significant developments to make excellent progress in delivering our objectives, ensuring that the principles of equality and human rights underpin everything we do.

Examples of significant progress made in line with the trust's strategy for service development are highlighted below:

To improve quality and increase the value of services

The 'Francis Inquiry*' outlined ways in which the NHS can improve care following poor levels of care witnessed at Mid Staffordshire NHS Foundation Trust. Of the 290 recommendations made, 80 were identified by the trust as requiring review and potential action. Staff, service users, carers and staff side were involved at every stage, from identification of recommendations to implementation of identified actions. The Board, in particular the chairman and director of nursing and secure services, hosted 'hearing events' with small groups of staff. Board members were required to hear but not comment. This proved more difficult than directors had anticipated but made for powerful sessions that allowed staff to share how they felt. We based our actions on themes from the Government response; 'Patients First and Foremost**':

- Preventing problems
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated.

Our annual review of nurse staffing levels, undertaken prior to the publication of the Francis Report, resulted in an extra 98 whole time equivalent posts being identified and filled. Our six monthly staffing reviews will this year be extended to include medical and allied health professional staff. We have signed up to the Nursing Times 'Speak out Safely' Campaign and the 'See Something, Say Something' Campaign to encourage staff to report their concerns.

Weekly unannounced mock Care Quality Commission visits by teams of multi-professional, service user and carer representatives are providing an assurance of openness, transparency, and candour. Areas are identified for visits by an internal Quality Surveillance Group. Quality Surveillance meetings have been established to consider soft intelligence and data on staffing, incidents, complaints and patient tracker feedback and ensure themes and trends regarding quality of care concerns are addressed and reported. Some 45 visits to wards and services took place throughout the year. Reports are produced on first impressions on arrival in an area, information displayed and how a visit is received and managed as well as overall care standards, the environment, facilities and activity programmes. They include how well people are listened to and look for evidence that this translates into action by services. There has been learning and sharing of good practice across services – good ideas and practices seen on one area are recommended on visits to other areas and services have shared outcomes and solutions to issues with each other. The visits also serve to prepare services for future unannounced visits by the CQC. Members of the trust board took part in some of the visits, both in core hours and at weekends and nights, supporting the 'Board to Ward' agenda in which front line staff and service users can talk about their daily experience and board members can gain a greater insight into how services are delivered. Staff have reported that they feel more confident in what to expect and in how to demonstrate how they are achieving CQC standards.

We have developed a 'Health Care Assistant (HCA) Pathway in Practice' foundation programme, 'Compassion and Care in Practice' that considers the key attributes required for the role, and addresses the benefits of using reflective practice. Following completion of the foundation programme, every HCA will have two days per year of protected time, during which they will build a portfolio of evidence based on the 'Ward Stars' programme.

We worked closely with local universities to ensure that the important voice of student nurse feedback is fed into our assurance mechanisms. A 'Mentor and Practice Placement Charter' was launched in June to ensure learners are supported and embrace the trust values.

Our actions in relation to the Francis Inquiry will continue to be reviewed and reported to the Trust Board on a six monthly basis.

* Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, London: The Stationery Office, February 2013.
** The initial Government response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Department of Health, March 2013.

Our 'Recovery College', launched in September, helps people to become experts in self-care by offering a range of recovery focussed courses that develop a person's knowledge and skills and identify talents to reach their goals and aspirations. The College uses an educational model and is underpinned by the principles of co-production, in which every aspect, from conception to delivery, is co-developed and co-produced by people with lived experience and staff who offer professional experience. The programme, which includes some accredited courses, is designed to complement and enhance the effectiveness of traditional therapeutic approaches. Graduates include 14 students from a Peer Support Worker Course, delivered in partnership with the Institute for Mental Health, who gained level four qualifications through the Open University. A job seekers' toolkit helps students to gain meaningful, paid employment, regardless of their condition. We will continue to collaborate to provide an all encompassing recovery programme and to tackle the issue of stigma of mental health in the community with local employers and schools.

The new South Sefton Neighbourhood Centre opened on 29 November 2013, bringing integrated community based services to people in South Sefton. A hub and spoke model for the building, based upon shared care principles, has produced a specialised, single managed multidisciplinary team that provides GPs, service users, families and other care providers with specialised assessment, consultation, education, support, treatment and interventions. Different approaches within this new community recovery model are making it easier for more people to use the service and to better meet clinical needs and aid recovery. Staff have been supported to operate 'virtually' through the provision of ipads.

A review of our corporate services has established a blueprint for ensuring the best possible support to front-line patient care and delivering the savings required by the trust over the next five years. A feasibility study into developing supporting financial information and purchase order processing systems was completed in preparation for procurement in 2014/15.

Significant progress has been made in the development of a 'Patient Level Costing System', improving the trust's understanding of its cost base and the efficiency of individual service lines in preparation for the introduction of Payment by Results in mental health that will form the basis of future contracting arrangements.

We established a corporate intelligence function and ensured compliance with the Francis Report with improved processes and lines of reporting and the appointment of a Chief Clinical Information Officer. We introduced a 'Programme Management Office' which supports key trust capital and business change projects and monitors process for tracking achievement of key targets, and we introduced standard central systems for project documentation.

The year also saw the development of an investment strategy and the implementation of a method for prioritising investments, agreed by the Trust Board. This has allowed the trust to concentrate key resources on viable projects. Allied to this were substantial improvements in the managing and monitoring of capital projects, including a system of post-project reviews.

Informatics Merseyside, a service that is hosted by Mersey Care, successfully rolled out a new Radiology Information System (RIS) and Picture Archiving and Communications System (PACS) across 11 trusts in Cheshire and Merseyside. The new system enables radiologists to report their findings rapidly, allowing clinicians on wards and in clinics to access patient images along with expert opinions, in a timely manner. Consortium trusts now share images seamlessly, saving over 150,000 hours of administration time per annum.

Mersey Care became the first NHS trust in the country to achieve the highest 'Triangle of Care' award from the Carer's Trust. All inpatient and community teams now use this tool to develop their partnerships with service users and carers to deliver high quality person-centred care. We were also commended for implementing the same standard in addiction, learning disability and mental health services.

Our occupational health team was accredited by the Royal College of Physicians under its 'Safe Effective Quality Occupational Health Standards 2010 (SEQOHS)' meeting standards in six core services: prevention, timely intervention, rehabilitation, health assessments for work, promotion of health and wellbeing and teaching and training. Our Staff Support Services was awarded a place on the Occupational Health and Wellbeing Framework for NHS Shared Business Services and retained a contract with Liverpool Community Health. The High Secure Services Recovery Champions were recognised in the 2014 Cygnet National Service User Awards when Ashworth Hospital received two highly commended awards. The hospital also received a Prison Service Audit score of 98%, the highest score across the three high secure hospitals for the second year running.

The trust won the healthcare section of the BREEAM (BRE Environmental Assessment Method) Awards 2013 for the 85 bedded unit developed under the TIME (To Improve Mental health Environments) inpatient unit serving the communities of North Liverpool, Kirkby and South Sefton. Having the recognition of BREEAM ensures we have a sustainable design which benchmarks our future generation of facilities among the best.

To consolidate, develop and expand the range of services we provide

Mersey Care won the contract to neuropsychiatry and neuropsychology services to the Cheshire and Merseyside Rehabilitation Network. Rebuild will also provide psychology services to the community specialist rehabilitation service for Liverpool and Sefton, which provides rehabilitation and support when people return to their own homes or to services in the community. In addition the trust has been asked to provide additional psychology to the Regional Trauma Network across eight other north west hospitals.

The trust has been asked to lead a year long pilot project to provide dedicated specialist support services for patients in Sefton with Asperger's Syndrome, drawing on its extensive experience of service delivery within this specialism and its role as co-ordinator of a network of services that help people with Asperger's Syndrome to live valued lives.

Our Criminal Justice Liaison Team (CJLT) has received a share of £25 million Department of Health funding for a Liaison and Diversion pilot in which mental health nurses and other mental health professionals work with police stations and courts so that people with mental health and substance misuse problems get the right treatment as quickly as possible, and which helps reduce re-offending. The extended service will involve police custody suites and courts across Sefton, Liverpool and Kirkby and the development of an all-age service with practitioners with relevant skills and expertise. The team will work collaboratively with youth offender service partners and the extended structure will include a veteran's worker and support workers with knowledge of drug and alcohol services and housing issues.

Mersey Care has been chosen as the health provider for an innovative prison-based assessment and treatment service for personality disordered offenders at HMP Garth, in Leyland, Lancashire, following a rigorous competitive tendering process. The service, part of the National Offender Personality Disorder Strategy, draws on Mersey Care's expertise and experience in the field of forensic personality disorder. NHS England and the National Offender Management Service were not only impressed by the clinical model proposed, but also recognised Mersey Care's specialist expertise, commitment to partnership working and shared goals to engaging with offenders with a personality disorder in a safe and secure environment. The service will be delivered by a multi disciplinary team within a highly specialised psychological support environment with the aim of improving psychological wellbeing and reducing risk of prisoners committing further offences.

The 'Year of Dementia Awareness' campaign in Liverpool provided an opportunity for Mersey Care and partner Everton in the Community to create and expand 'Pass on the Memories'– an innovative programme which uses sporting memories as a significant theme in providing a new community based service for people with memory loss conditions. Other stakeholders include Sporting Memories Network, Life Story Network, Liverpool Hope University, the Everton Former Players Foundation and the Heritage Lottery Fund. We have also recently replicated this programme within the North Sefton area working in partnership with Southport Football Club. The project has played a significant role in raising awareness of dementia across Merseyside and nationally. The strength of the partnership with the trust also creates a powerful synergy between the clinical expertise they bring to the project and the frontline intervention methods implemented by Everton in the Community practitioners.

A new hub was established to bring together our approved mental health professionals (AMHP), who were previously dispersed across Liverpool and locate them in one central base at Broadoak Unit. The hub now provides the central contact point for the AMHP service in Liverpool, supporting AMHPs by sharing information and skills and improving communication with partner services. The development of the hub has also seen a reduction in the number of Mental Health Act referrals being sent to the out of hours AMHP service, enabling this service to focus on critical or urgent referrals. Communication between the out of hours and core hour AMHP service has improved, supported by a standardised approach to how information and referrals are shared between the two areas of the 24 hour AMHP service.

To enhance partnership arrangements to deliver a better range of quality services

A new People Participation Team launched in April 2013 is dedicated to promoting the active participation of all service users, carers and volunteers. Under the leadership of a newly created Deputy Director and working closely with the Chief Executive and Executive Director of Nursing and Secure Services, the team hosted nine special listening events across the organisation for service users and carers. These events enabled service users and carers to share their experiences of our services and set the agenda for service development. The success of the events and the value of the insights led to the formal establishment of a 'Service User and Carer Assembly' launched in January 2014 as a mechanism for two-way corporate engagement. The assembly is run by service users and carers for service users and carers and its members are now leading work on GP engagement, training for police and A&E staff and carer support programmes.

Our Addictions services have been involved in projects aimed at delivering a better range of quality services with our partners. The sharing of information across the trust and the wider Liverpool health economy will be of great benefit not only to service users but the population of the city as a whole. These projects have included:

- Sharing of information on 'legal highs' and developing clinical guidelines and agreed pathways to work in partnership with A&E departments and hospital admissions to acute services.
- Expanding volunteer and service user involvement, and providing opportunities for volunteers to access accredited mentor training and become recovery mentors.
- Increasing understanding, prior to admission, of inpatient services, detailing positive expectations within information packs.
- A commitment for all staff in addiction services to undertake recovery training. To date 83% of staff have been trained.
- Development and implementation of a tool to support service users through the new strength based assessment.
- An anti-craving prescribing clinic for service users who have attended detox within a community or inpatient setting. This continuation of care is consultant-led in conjunction with GP prescribing.

The 'Imagine Your Goals' football based programme now engages with more than 200 participants per week from various mental health services. The programme targets several ambitious objectives based on the themes: participation, competition, raising awareness, inclusion and exit routes, volunteering, employment and research. Service users are meeting friends and making social contacts which are vital for people who may have traditionally lost friends during periods of illness and have become isolated. As a team, 'Imagine Your Goals' has achieved tremendous success both locally and nationally as they continue to grow and develop.

The partnership between Mersey Care and Everton in the Community adheres to a stringent recovery model. Care coordinators and identified community staff feedback regularly to care teams about their service users. Pre and post involvement reviews compare admission rates, use of prescribed medication and attendance at appointments. Monitoring also ensures that service users who may be relapsing can be identified early and encouraged to seek help. Inspiring success stories have emerged of participants going onto higher education and paid employment and overcoming challenges in their lives. The positive impacts on actual symptoms and reliance on medication were highlighted in a three-year evaluation study conducted by the NHS Service User Research and Evaluation Group.

Informatics Merseyside was involved in a pioneering new service using innovative technology to harness the potential to help people stay more independent. 'Mi – More independent' – is a partnership of organisations, working together to transform lives through technology. It will introduce the concept of telehealth and telecare and the associated products, allowing people to try to buy technology for the first time. Gadgets and tools are available to support people who want to take control of their own lives, and their health.

A joint venture between Mersey Care and 4D Creative uses a combination of technology and human interaction to promote recovery and provide respite from the day to day routine of the ward for people with dementia. Immersive Space, in the lounge at Clarence Ward, Stoddart House, offers a four dimensional immersive experience created through LED lighting, giant projection and surround sound. Using simple touch screen and unique software, users can instantly change the mood, atmosphere and location of the room. The impressive element is how ward staff, service users and families interact within this space.

To become a better organisation by building on our involvement with stakeholders and strengthening our governance

The trust's approach to person-centred care has been further enhanced by the implementation of the 'No Force First' Initiative and 'One Page Profiles' in which information about the individual and things important to them are documented to help build relationships and ensure consistent support.

Informatics Merseyside was the first NHS IT service desk in the North West and only the third in the UK, to secure the Service Desk Institute (SDI's) Service Desk Certification. The rating was awarded following a six month rigorous auditing programme. Certification at this level, against an international framework of standards, demonstrates the organisation's commitment to enhancing both the quality of the service delivered and the overall experience for staff and users.

Rebuild, our service for people with learning disabilities, rehabilitation for people with enduring mental health problems and patients with an acquired brain injury, achieved 82% of its key performance indicators, gained accreditation from Headway and Aims and has received positive Care Quality Commission (CQC) and Patient Led Assessment of Care Environment reviews. Regular monitoring of every aspect of the service and focus on areas where performance might be declining has been key to maintaining standards. Timely and relevant data and direct feedback from service users enabled managers to address issues effectively and provide staff training or corrective action where necessary.

Staff from Rebuild services co-authored the human rights sections of the Department of Health 'Positive and Proactive Care: reducing the need for restrictive interventions', Department of Health, 2014, and were also part of the expert reference group which developed this document. Advice is also being provided to assist in the transfer of people from out of area treatment to local areas.

The CQC has invited Rebuild staff to provide advice on how human rights work can be incorporated into CQC assessments. Input has also been provided to national documents and policy forums around best practice in supporting people with challenging behaviour; human rights in healthcare (with Department of Health (DoH) and British Institute of Human Rights (BIHR)). South London and Maudsley NHS Foundation Trust has sought permission to use human rights tools and has requested training in these approaches.

Mossley Hill Hospital's memory service was accredited as Excellent by the Royal College of Psychiatrist's Memory Services National Accreditation Programme, the first service in the country to achieve this on three successive rounds of accreditation.

The 'Speaking-Up-for-Myself' groups continue to play an integral part in developing key initiatives aimed at embedding human rights based approaches in healthcare locally, nationally and internationally.

The trust's eating disorders service met its targets for assessment and therapy in 2013/14. Though demand is high, staff are committed to ensuring the needs of patients are met. The monthly support group for carers is well attended and a new skills based carers group has been launched to teach the families and carers of service users skills to support loved ones who are experiencing an eating disorder. The service continues to work with Aintree Hospitals NHS Foundation Trust to provide assessment, therapy, supervision and consultation to Aintree weight management service and Aintree LOSS as well as the Aintree Bariatric Collaborative for patients referred from Merseyside, Cumbria and Lancashire.

Fact File

Mersey Care provided:

- Care, treatment and support to 36,401 service users in 2013/14 (35,525 in local services and 876 in secure services).
- Is dispersed across over 32 sites both of its own and premises rented from others.
- Had 674 inpatient beds as at 31 March 2014.
- Had 522,757 outpatient attendances and contacts in 2013/14.

Mersey Care provides:

- Adult and older people's mental health services
- Learning disability services
- Addiction services
- Psychological services
- Low secure services
- Cheshire and Mersey forensic psychiatry (medium secure) services
- High secure services (HSS).

STAFF IN POST AS AT 31 MARCH 2014

Division	Divisional breakdown	Full Time Equivalent	Headcount
Corporate	Additional staffing	0.00	404
	Capital expenditure	0.68	1
	Corporate	416.08	530
Corporate Total		**416.76**	**935**
Informatics Merseyside	Informatics Merseyside	236.31	248
Informatics Merseyside Total		**236.31**	**248**
Clinical Business Units	Addiction services	138.34	149
	Liverpool	581.67	619
	Positive Care Partnerships	531.99	574
	Rebuild	331.88	359
	High Secure services	914.32	944
	SaFE Partnerships	310.41	330
	Capital expenditure	11.00	11
CBU Total		**1235.73**	**1285**
Medics	Hosted St Helens and Knowsley	46.50	47
Grand Total		**3519.18**	**4216**

The figures above include bank staff. They also include capital staff who are part of the workforce.

INFORMATION AND CONSULTATION WITH EMPLOYEES

In 2013/14, Mersey Care undertook a number of consultations with staff. The process followed the trust's 'Organisational Change Policy' and involved consultation with staff side representatives and affected staff in the areas listed in the business units below.

SaFE Partnerships

- Reduction in numbers of band 4 secretaries
- Low secure unit reduction in occupational therapists.

Positive Care Partnerships

- Administrative and clerical staff in South Sefton Neighbourhood Centre
- Learning and development team
- Admin and clerical staff in Stoddart House
- Modern matrons/8a posts
- Integration of home treatment in Community Neighbourhood Team, Southport
- Relocation of staff to South Sefton Neighbourhood Centre (base move).

Liverpool

- Out of hours hub
- Integration of crisis resolution home treatment team into community mental health teams
- Integration of assertive outreach team into community mental health teams
- Criminal justice liaison team changes to shift patterns
- Early intervention teams reduction in managers.

Rebuild

- Reduction in support workers in the community
- Reduction in posts in supported living service management.

Informatics Merseyside

- Review of on-call arrangements for out of hours service desk
- Leads and allowances review within IM
- Relocation of service desk staff from Wavertree to Bluebell House, Aintree University Hospital Foundation Trust
- Relocation of staff from V7 Building, Kings Business Park, and Bluebell House, Aintree sites to Switch House
- Organisational change – review of Registration Authority Manager role (resulted in redundancy)
- Transfer of Undertakings (Protection of Employment) (TUPE) of some IM staff to Royal Liverpool and Broadgreen Hospitals NHS Trust (Service desk, registration authority and voice and data)
- Tupe of some IM staff to Aintree University Hospital NHS Foundation Trust (Desktop, training team, service delivery).

High Secure Services

- Reduction of admin manager
- Leads and allowances
- Mailroom and transport review.

Corporate Services

- Transport and mailroom reduction in numbers in local services
- Communications Team review of service
- Safeguarding Team reduction in numbers
- Delivering Assisted Lifestyles Living at Scale (DALLAS) – Tupe out
- Leads and allowances (undertaken in conjunction with HSS)
- Patient Safety Team review of service and reduction in posts
- Corporate services review.

EQUALITY, DIVERSITY AND HUMAN RIGHTS

Mersey Care's Recruitment and Selection Policy specifically refers to equal opportunities and the requirement on the trust to promote equality of opportunity in employment as well as complying with the 'Two Ticks' commitments. This is further confirmed in the Supporting Disabled Employees Policy.

The trust has continued its commitment to establishing equality of opportunity and tackling inequality within the services it provides and to the people it employs. We have continued to meet the equality objectives set by the Trust Board which included an extensive equality monitoring process. This has been completed to provide quality data that will support the trust in ensuring we provide services to all the communities we serve effectively and support all the staff employed by the trust equally.

The Equality and Human Rights Policy and Supporting Disabled Employees Policy have been reviewed and updated following changes to legislation. Other key pieces of policy such as respect at work and supporting staff who experience abuse, discrimination and violence at work have been reviewed and updated. All policies can be found on the trust website www.merseycare.nhs.uk

The development of strategic aims for Mersey Care included the objective: 'Ensure every individual is treated fairly in our organisation'. This objective, supported by the equality data improvements made, is an important part of the new structures across the trust to improve quality and provide perfect care.

In working towards this aim the trust was able to reach 'achieving' status for 12 of the 18 elements within the 'Equality Delivery System'. The focus of these developments has been in connecting the activities across the trust to improve the quality of service we provide, ensuring we identify and tackle areas where inequalities may occur.

As well as the focus on improving systems, the trust has undertaken a patient experience programme enabling people to report their thoughts and feelings on the services that they are receiving at the point of care. The information includes details to ensure we are able to understand the thoughts and feelings of a representative group of the people that we serve.

Mersey Care continues to work in partnership across Liverpool, Sefton and Kirkby to improve the experiences for people with mental health issues in receipt of both care and services. This has included: a practitioner's guide to support people seeking asylum, guides to understanding learning disabilities and brain injury from an Islamic perspective, working with black and minority ethnic elder communities to understand dementia and improving support to women who experience domestic abuse.

This shared working is part of the trust's commitment to improve the lives of people who may experience inequalities and the recognition of the impact of that on their wellbeing.

Further information on equality can be found on our website.

The trust was successful in becoming sixth in the Stonewall Healthcare Equality Index.

SUSTAINABILITY AND ENVIRONMENTAL MANAGEMENT

In response to the NHS Sustainability Development Unit objectives to embed sustainability into all areas of the NHS, the trust has a Carbon Management Plan but recognises the need to consider 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. 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. The trust is looking at a sustainable management plan in 2014/15.

Carbon Management

The trust is continuing to work to the commitments set out in its five-year Carbon Management Plan. This sets out an ambitious target to reduce carbon emissions, attributable to electricity and gas, by 30% by 2015, against a baseline year of 2009/10. The drivers for this commitment are achieving reductions in environmental impact, improving the health of the people of Merseyside and reinvesting the savings made into therapeutic improvements for our service users.

This year has seen a fall in carbon emissions from previous. This can be attributed to the disposal of a number of buildings across the trust and due in part to the warmer winter period compared to last year. Funding has been allocated to install a Building Management System in high secure services during 2013/14 and within a further six sites across the trust which will help measure and control our gas and electricity usage. Nonetheless, it is recognised that there is a need for significant capital investment in carbon projects going forward if the trust is to maintain the momentum needed to achieve the increasingly tough targets within the Carbon Management Plan.

The priority for the year ahead is to undertake a more thorough assessment of the total carbon footprint for the trust, as well as procuring feasibility studies to assess the options for future, cost effective carbon reduction projects, including renewable energy sources in the form of solar photovoltaics installations and heat recovery systems.

Carbon Emissions (electricity and gas)	2009/2010 (base year)	2010/2011	2011/2012	2012/2013	2013/2014	Target by 2014/15
CO_2e tonnes	11,222	11,175	10,306	10,787	10,028	7,855

Carbon Emissions savings (electricity and gas)	2010/2011	2011/2012	2012/2013	2013/2014
Actual CO_2e tonnes	47	869	-481	759
Annual target CO_2e tonnes	327	796[1]	1,039[2]	2,195[3]
Percentage achievement of annual target	14%	109%	-46%	35%

1 Target for 11/12 increased on the original Carbon Management Plan (CMP) target in line with under-achievement of the 10/11 target
2 Target for 12/13 reduced on the original CMP target in line with over-achievement of 11/12 target
3 Target for 13/14 reduced on the original CMP target in line with trust's Integrated Business Plan, however, this ambitious target was not achieved.

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

Greenhouse Gas Emissions Indicator		Consumption (MWh)		Emissions (CO_2e tonnes)	
		2012/13	2013/14	2012/13	2013/14
Scope 1 (Direct) emissions - gas consumption		31,475	27,796	5,806*	5,104
Scope 2 (Indirect) emissions - electricity consumption		9,137	9,572	4,981*	5,178
		Distance Travelled (Miles)		Emissions (CO2e tonnes)	
		2012/13	2013/14	2012/13	2013/14
Scope 3 - official business travel emissions	Air travel	14,588	34,302	3.09	9.21
	Road travel	2,656,161	2,821,422	180.56	871.42[1]
	Rail travel	99,420	121,370	9.20	11.34

1Carbon emissions for road travel increases are due in part to the conversion factors published in 2013 by DEFRA as compared to the conversion factors published in 2012.

It can be seen from the figures above that air travel has almost doubled since last year, rail travel has also increased by 18% during this year, and road travel has also increased by 6%. A number of objectives and targets will need to be set during the coming year to address these increases and it is advised that this could be achieved through the implementation of the trust's Sustainable Development Management Plan (SDMP).

Financial Indicator for Energy	2012/13	2013/14
Cost of Scope 1 and Scope 2 consumption (£)	1,719,416	1,841,030

Although energy consumption has decreased on the previous year, the cost of energy has increased slightly (7% on previous year) this is due in part to the increases in 'pass through charges' imposed by the energy suppliers across a few of the trust's sites.

Projects successfully implemented in the current year have included the refurbishment of Ruskin ward in high secure services with energy efficient measures (including LED lighting, replacement boiler, insulation and double glazing) to a BREEAM* 'Very Good' standard. The ward refurbishment programme continues into 2014 with the upgrading of Newman ward.

The cost of the trust's carbon reduction committment (CRC) Energy Efficiency Scheme allowances for the 2013/14 year will be £120,362 based on carbon emissions of 10,028 tonnes CO^2e. Carbon allowances currently cost the trust £12/tonne CO^2e, but this rises to £16.40/tonne CO^2e from next year as part of Phase 2 of the CRC Energy Efficiency Scheme and will rise year on year with the rate of interest after that.

As part of meeting the trust's CRC obligations, the energy management function has been outsourced to the trust's BES (Building and Engineering Services) provider. This provides the trust with bill validation, energy usage monitoring, collation of consumption patterns and compilation of the trust's annual carbon footprint report as required under statutory CRC Energy Efficiency Scheme obligations.

The trust engaged consultants 'Carbon Credentials' to conduct a stage 2 audit of the trust's performance under the CRC Energy Efficiency Scheme, in line with Environment Agency requirements, in June 2013. All areas audited achieved a 100% compliance result with no recommendations for improvement.

* An environmental assessment method and rating system for buildings

Water Consumption and Management

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

Water consumption is being continually monitored across all trust sites and night usage baselines established, and wherever practical, reduced or removed in order to eliminate unnecessary water usage.

A number of new water meters have been installed at trust sites in order to replace older and inefficient meters which will help improve monitoring in the future.

Water consumption for the current year has shown a 5% fall on the previous year. However, costs have increased due to increased charges being levied by the supplier.

Finite Resource Consumption Indicator	2011/12	2012/13	2013/14
Water consumption (m^3)	155,000	149,004	141,379
Total expenditure - water (£)	472,661	497,546	506,336

Waste Management

Currently the trust has an integrated waste and recycling contract across all its sites, operated by an independent waste contractor. Recyclable wastes are collected within the general waste containers and separated out into recyclable fractions (different material types) at a transfer station off site. The convenience of the system makes it easier to engage both service users and staff in recycling activity. On average between 75 to 90% of general waste collected from sites (not including clinical waste) is now sent for either recycling or energy recovery through incineration.

The production of clinical and hazardous waste by the trust involves the commitment of significant financial resources to ensure statutory responsibilities are met. To meet this challenge the trust is working towards a concept of total waste management, with waste prevention and reduction at its heart, to reduce pollution and maximise cost savings that can be diverted to patient care.

Details of the wastes arising for the current year along with a comparison of the previous year are detailed within the table below.

Waste Minimisation and Management Indicators	2011/12		2012/13	
	Tonnes	%	Tonnes	%
Waste recycled/reused	667	70	575	69
Waste incinerated (clinical waste)/energy from waste	52	5	20	2
Waste to landfill	224	24	245	29
Total waste arising (tonnes)	943	100	840	100

Financial Indicators on Waste	2012/13	2013/14
Cost of waste incinerated (clinical waste)/energy from waste (£)	30,444	45,770
Total expenditure on waste arising (£)	185,499	111,990

As can be seen from the financial indicators above, the overall cost of disposing of the waste that the trust generates has fallen significantly but the cost associated with waste being incinerated/converted to energy has risen compared with the previous year. However, the quantities of waste being disposed of through recycling/reuse and incineration have reduced but waste being disposed to landfill has increased slightly as compared to the previous year. An objective for the coming year will need to be set to achieve a reduction in the waste being sent to landfill.

During the last year the trust has supported the national NHS Sustainability Day by holding a 'Sustainability Week' providing awareness of a number of environmental themes each day, including: energy and carbon, waste, transport, food and water.

The week was well supported by staff, service users and visitors who were engaged in the daily awareness sessions and took part in competitions that saw over 200 service users in the 'Design a Logo' event which required them to design a logo to be printed onto a T-shirt. The winning design was awarded to Poplar (female ward) at Scott Clinic.

Other highlights included a 'graffiti wall' based in the trust offices, V7 building at Prescot where staff and visitors were encouraged to write suggestions for improving the sustainability of the trust. A wide range of good ideas came from this activity which will be developed upon over the next year. A final event on the actual NHS Sustainability Day was held on the Aintree site at which two trees were planted at 2pm as part of the NHS Forest 2@2 Campaign.

Other events during the last year saw the trust join up with the First Ark Group, Knowsley Council's Business Travel Advice Team and Merseytravel to mark 'Green Office Week' and 'Walk to Work Week' that were held at the V7 building. Information provided at these events focused on green transport, the environment and health, with short workshops taking place with different themes being offered each day. Activities included competitions, health walks, 'taster' bus passes, health checks, recycling tips, bike repairs, plug-in vehicles and more.

EMERGENCY PLANNING

The trust has continued to develop its arrangements for dealing with major incidents and other emergency situations throughout this year. A full review of the trust Major Incident Plan has been undertaken and the plan amended to reflect internal changes and the changes to the wider NHS. The plan was also audited by commissioners and found to be compliant with national guidelines.

The plan has been tested on several occasions with exercises and real time situations.

The plan is supported by a plethora of other contingency plans and guidance documents that relate to events including winter related events, fuel shortage, pandemic influenza, heatwave and floods. These are all supported at divisional level with robust business continuity plans, which are designed to ensure the continued provision of services in the event of a major incident whether that is internal or external to the trust.

Ownership for the development of the trust's major incident and contingency plans lies with the Emergency Planning Forum which has continued to meet throughout the year. Chaired by the Head of Quality and Risk the group is responsible for:

- Developing and reviewing the trust's internal plans and arrangements
- Disseminating plans across the organisation
- Reviewing and assessing the lessons learned from both internal and external incidents and exercises
- Ensuring that identified weaknesses are rectified and recommendations for improvements are implemented.

Each of the clinical services from the divisions is represented on the Emergency Planning Forum as are representatives from the various corporate services.

Emergency planning, however, is only successful if the plans of the trust are linked in to those of the wider health economy and to this end the trust is an active member of the NHS Merseyside Health and Social Care Group. With representatives from all trusts across Merseyside this group, represented by the Head of Quality and Risk for Mersey Care, ensures that plans are not written in isolation but are done so with the cooperation and involvement of key partners and stakeholders, essential in any emergency situation where assistance may be required. At executive level the trust is actively involved in the pan Merseyside Local Health Resilience Partnership that meets quarterly.

RISK MANAGEMENT

Risk management enables individuals and the trust to deal competently with all key risks, clinical and non-clinical, providing confidence that the trust will achieve its objectives.

The Quality Assurance Committee and Performance and Investment Committee, as well as the Executive Committee, are the trust's overarching committees responsible for managing risk and providing advice and expertise to the board on risk management issues.

They are supported by the following board and board sub-committees:

- Audit Committee
- Remuneration and Terms of Service Committee
- Foundation Trust Project Board
- Mental Health Act Manager's Committee
- Health and Safety Sub Committee
- Infection Control Sub Committee
- Drugs and Therapeutics Sub Committee
- Information Governance and Caldicott Sub Committee
- Research Governance Sub Committee
- Clinical Senate.

The Head of Quality and Risk is responsible for implementing effective systems and processes of risk management across the organisation, the identification, management and monitoring of risks; providing reports, information and training as appropriate. Other senior trust staff, managers and individual staff members as well as executive and non-executive directors, clinical directors, 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.

Each service has established governance arrangements in place and the local governance lead is responsible for implementing the corporate risk management processes locally and in addition facilitating the sharing of best practice.

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

- overarching strategic aims for risk management
- the trust's Risk Management Strategy and policy
- organisational risk management objectives
- the framework for achieving risk management objectives
- the organisational process for risk identification and analysis
- a definition of significant risk and acceptable risk within the organisation
- organisational risk management structures
- the development and application of risk registers within the organisation
- incident reporting
- the accountability and responsibility arrangements for risk management
- the Board Assurance and Escalation Framework.

Embedding risk management as a core activity within the organisation is achieved through many systems and processes and 2013/14 has seen:

- a fully revised Board Assurance and Escalation Framework
- the procurement and implementation of electronic risk management software
- implementation, development and scrutiny of divisional risk registers
- work to improve the systems and processes that support the Board Assurance and Escalation Framework
- changes to organisational committee structures to improve effectiveness and ensure all committees actively support the risk agenda
- continued compliance with NHS Litigation Authority (NHSLA) risk management standards
- plans implemented to achieve full compliance with the Care Quality Commission (CQC) Essential Standards of Quality and Safety
- the continued development of the Emergency Planning Forum including development and ratification of a revised Major Incident Plan
- reviews of and improvements to the complaints, claims and adverse incident functions
- significant development of organisational policies, particularly relating to the NHSLA standards
- registration from the Care Quality Commission.

The development of the Board Assurance and Escalation 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 objectives. An opinion on the assurance framework has been provided by Mersey Internal Audit Agency. The opinion (review) states that *"An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principle risks identified by the organisation"*.

COMPLAINTS

The trust works within the principles set out in the Parliamentary and Health Service Ombudsman 'Principles for Remedy' as follows:

Getting it right

Mersey Care sets strict timescales for responding to complainants regularly reporting adherence to the Trust Board. The trust provides open and transparent responses to complainants both in writing and/or through meetings with senior clinicians and managers. Where deficits in care have been identified, an apology will be provided with details of how the problems will be corrected.

Being customer focused

The trust aims to make all investigations into complaints as robust and independent as possible by ensuring staff are qualified in root cause analysis methods and where appropriate using external staff and service users and carers to add an independent perspective. All reports and response letters are scrutinised prior to finalisation to confirm that they answer the questions set. The trust offers complainants the opportunity to challenge its findings and will review the response based on any further concerns raised. Staff aim to be helpful and supportive to people raising a complaint with the aim of helping them gain resolution and correcting any problem they have.

Being open and accountable

Both the process undertaken and the findings from complaint investigations are fully shared with complainants. Where recommendations have been made to improve service provision based on the findings, these are also shared with the complainant. Contact details are provided so that an update on the implementation of these recommendations can be obtained at a later date if desired.

Acting fairly and proportionately

The way in which the trust offers remedies to complaints is fair and proportionate to the concerns that have been raised.

Putting things right

The trust considers all possible forms of remedy with the aim of 'putting things right'. This could be an apology, an explanation, remedial action or financial compensation.

Seeking continuous improvement

The trust uses lessons learned from complaints to ensure that issues relating to care and treatment do not recur. Complaints information is recorded on a database and reports are produced which help to identify themes or trends across the organisation which require remedial action. Learning is also shared throughout the trust by the use of: Dare To Share, Quality Practice Alerts and Oxford Model Events.

The total number of complaints received in Mersey Care in 2013/14 was 371 with 365 responded to within timescales agreed with the complainant. 6 complaints remain open and are still within timescales agreed with the complainant. These figures include 150 complaints in local services where 145 were responded to within agreed timescales and 221 in high and medium secure services where 220 were responded to within timescales agreed with the complainant.

	Local services (inc low secure)		Medium/high secure services		Trustwide	
	No of complaints received	Cleared in agreed timescale	No of complaints received	Cleared in agreed timescale	No of complaints received	Cleared in agreed timescale
April – June 2013	40	40 (100%)	42	42 (100%)	82	82 (100%)
July – Sept 2013	38	38 (100%)	68	68 (100%)	106	106 (100%)
Oct – Dec 2013	36	36 (100%)	53	53 (100%)	89	89 (100%)
Jan – March 2014	36	31 (86%)	58	57 (98%)	94	89 (95%)
Total	150	145 (97%)	221	220 (99%)	371	365(98%)

Health Service Ombudsman

Eight complaints were sent to Health Service Ombudsman for consideration of independent review. Of these:

	Requests received	Outcome No Further Action	Outcome Further Action	Outcome Awaiting Outcome
Local services (inc low secure)	2	1	1	0
Medium/high secure services	6	5	1	0
Totals	8	6	2	0

Comparison with 2012/2013

- The number of complaints received by the trust has increased from 343 during the period 1 April 2012 to 31 March 2013, to 371 during the last 12 month period.
- The number of complaints referred to the Parliamentary and Health Service Ombudsman has reduced from 10 to 8 during the last 12 month period.

Service Improvements

As a result of complaints, the following changes to service provision have been made:

- A complaint was made after a service user presented at a hospital in Liverpool in a distressed state. Following investigation it was found that there was confusion and lack of communication between the trust and external agencies which caused a delay in her receiving appropriate treatment. As a result of this complaint, a recommendation was made that a shared care protocol should be developed between Crisis Resolution Home Treatment Team and community services, and that two staff should attend any future situations where the service user is reported as distressed and agitated.
- Family members raised a number of concerns that included the treatment afforded to a service user whist being cared for on a ward with dementia. The investigation identified concerns regarding the structure of ward meetings, inadequate recording of information, incomplete records and poor care. A detailed action plan has been implemented and included:
    - The provision of senior staff to support the staff team on the wards
    - Develop specialist care pathways
    - Provide training in dementia care
    - Deliver support and training to enhance the quality of the physical health care provided by staff
    - Set standards in relation to the management of Multi-disciplinary team reviews and meetings
    - Enhance the communication provided to carers with the aim of providing improved support.
- A relative complained about the level of support her brother received in attending to his personal care on the ward. The ward manager met with the complainant, apologised and put a plan in place to address all the issues raised. It was agreed that the service user's named nurse would contact the family on a weekly basis to give them the opportunity to discuss any concerns they may have.
- The partner of a service user complained that when his care coordinator was absent from work due to illness, he was not replaced. As a result of the complaint the community mental health team manager took action to ensure that all multi-disciplinary teams covered sickness absence by reallocating their caseload to other care coordinators. Their concerns would also be shared with staff during their team meeting.
- A patient complained that a member of staff's attitude towards him was unprofessional. This was upheld as the staff's style of approach was found to be compounding the patient's belief that he was being singled out and treated differently. A number of recommendations were made relating to the individual nurse and a further recommendation was made that consideration is given to developing a robust training package aimed at enhancing the role of the nursing assistant, with specific focus on promoting awareness into mental health issues.
- A relative complained that the allocated visiting time was reduced by 30 minutes due to a shortage of staff available to escort patients to the visit. The ward manager met with staff to ensure that future staffing cover is appropriately planned to prevent a recurrence of this problem.
- A patient alleged that he saw a nurse secreting medication. As part of the investigation process, CCTV footage was reviewed which clearly indicated that this did not occur. It did however find that the nurse did not follow the appropriate procedure when administering medication and this matter was addressed with the nurse involved.

The complaints team continues to record complaints relating specifically to protected characteristics and during the last 12 month period, two complaints were received from patients regarding discrimination issues. Both concerns were formally addressed under the trust's Complaints Procedure.

Serious Untoward Incidents

Clinical Business Units	Type	Total
Addiction services	Suicide Involvement in homicide Homicide	2 1 1
Addiction services total		**4**
High secure services	Assault Serious self harm Breach of confidentiality Accident Allegation against staff Mental Health Act error Fire Unexpected death	22 7 3 2 2 1 1 1
High secure services total		**39**
Liverpool	Suicide Allegation against staff Accident Unexpected death Serious self harm Under 18 Homicide Serious assault Absent without leave (AWOL) Death natural causes Breach of confidentiality Mental Health Act error	8 4 4 2 2 2 1 1 1 2 1 1
Liverpool total		**29**
Positive Care Partnerships	Suicide Under 18 Serious self harm Homicide Allegation against staff Accident Absent without leave (AWOL) Assault Serious assault Death from self medication Death natural causes	14 6 3 2 2 2 1 1 1 1 1
Positive Care Partnerships total		**34**
Rebuild	Unexpected death Sexual assault	1 1
Rebuild total		**2**
SaFE Partnerships	AWOL Trading on ward Financial abuse	1 1 1
SaFE Partnerships total		**3**
Specialist Management Services	Breach of confidentiality	7
Specialist Management Services total		**7**
Total		**118**

The trust monitors changes in incident trends, spikes in types of incidents and in particular areas. These trends are analysed through local governance mechanisms within services, the trustwide Patient Safety meeting and at a weekly Quality Surveillance Group.

Improvements in the way data is captured via Datix and ePex and then analysed in relation to serious untoward incidents, according to protected characteristics, have been made, and systems are currently undergoing a programme of development.

Actions undertaken and completed following reviews into serious untoward incidents include:

- Anti-ligature work has been undertaken across acute inpatient units throughout the trust with further work agreed in high secure services and Windsor House. Further anti-ligature assessments are being undertaken as part of an annual rolling programme.
- Mersey Care has taken the lead in coordinating the Section 136 project both strategically and operationally, and by giving clear focus and vision to all stakeholders involved in dealing with Section 136 service users. The trust, and partners Merseyside Police, Liverpool City Council, Sefton Council and the acute hospital trusts, conducted a multi-agency review of the strategic, clinical and operational systems, with the aim of improving the experience for the service user. This collaboration ensures no one waits more than two hours for an assessment. The Section 136 rapid response team is working hand in hand with the police to ensure timely and appropriate assessment and placement of people requiring a place of safety.
- Recruitment of nurses in the Criminal Justice Liaison Team.
- Dual diagnosis training for staff and regular trust network events provide learning for both trust staff and those from neighbouring trust/non statutory agencies. Topics have included: sharing the review into dual diagnosis at Mersey Care, legal highs, alcohol and partnership working.
- A review of care programme approach processes and electronic record keeping is ongoing and its aims include increased communication, coordination and continuity of care.

The trust has developed an ambitious goal in developing and building on the introduction of perfect care which states there will be 'no suicides for those in our care'. Integral to achieving this aim is the development of an integrated depression care pathway from community to inpatient services. Level 2 suicide prevention training has been commissioned and will be rolled out to ward staff.

The quality practice alerts system (QPAs) has been used to disseminate information following incident reviews and compliance is monitored by the trustwide Patient Safety Group. These alerts have included:

- Safeguarding information sharing
- Emailing of confidential information
- Care planning
- Methadone prescribing.

No force first is being rolled out across the trust. Initial pilot sites, Gladstone ward and STAR Unit, have shown demonstrable decreases in restrictive practices - primarily the reduction in physical restraint. This programme promotes recovery and enhances service user involvement at all levels. A national 'No force first' conference, organised and hosted by the trust, will take place in May 2014. 'No force first' is an integral part of the perfect care model.

There has been a marked increase in admissions for under 18 year olds this year. The trust named nurse for safeguarding children has alerted the Clinical Commissioning Group (CCG) to this increase. On all occasions, beds have been unavailable at the Maple Unit in Chester although the trust has beds commissioned for this purpose. This has also been discussed at the weekly Quality Surveillance meeting as an ongoing concern.

Last year, Mersey Care's relationship with commissioners was strengthened including discussing admission pathways. The trust has maintained an open pathway with the young persons centre out of hours, with their team providing assessment during 9.00am to 9.00pm Monday to Friday and 1.00pm to 9.00pm at weekends. A transitions practitioner is in post who links with under 18's not known to services as well as supporting the wards where young persons have been admitted to ensure their needs are considered.

The trust is also working proactively to look at prevention of admission and readmission through case reviews. As part of this it has been possible to negotiate more timely pathways to specialist child and adolescent mental health services (16 to 18 years) input and look at new models of care which in the future may meet the needs of this group and prevent admission. The following work has also been undertaken by the Safeguarding Team to strengthen safeguarding systems:

- In relation to generic safeguarding referrals across local services, both the trust safeguarding adult lead and named nurse for safeguarding children receive email alerts for every incident recorded onto the Datix system that has a safeguarding element. From this, the team can ensure that appropriate action has been taken by trust staff to keep service users and children safe.
- The introduction of safeguarding ambassadors across the trust will further ensure safeguarding risks are identified and appropriately actioned.
- The safeguarding campaign across the trust commenced in June 2013 – this highlighted that safeguarding is everybody's business and aimed at bring safeguarding to the forefront of practice.
- There has been an increased uptake in safeguarding training at all levels since the introduction of a safeguarding training drive which coincided with the safeguarding campaign.

During 2013/14 a number of initiatives were implemented in order to mitigate risk against emerging trends relating to data loss/data breach incidents. The trust led a benchmarking exercise in respect of data loss/data breach incidents during 2013 with local mental health trusts to collate comparative data. Two serious incidents occurred in July and August linked to emails and guidance was written on keeping information confidential as well as top tips for using email. These were posted on the trust intranet and the trust information governance webpages.

All data loss/data breach incidents are reviewed by the Senior Information Risk Owner and members of the Information Governance and Caldicott Sub Committee at each meeting. Reports are available via Datix to designated staff from each of the divisional teams who are responsible for reporting the information to the teams and investigating further. A divisional team outcome report is returned to the Senior Information Risk Owner and Information Governance and Caldicott Sub Committee for review. The following actions have been taken:

- In November 2013 the trust launched an information governance campaign which involved the distribution of leaflets trustwide, pop-up reminders on computer screens, and information posted on the trust intranet site and the information governance webpages.
- The trust commissioned an external audit in relation to information governance that was concluded in December 2013. Two recommendations were highlighted; firstly to look at the introduction of a document classification scheme and secondly to implement an IT solution to limit the volume of emails or flag up an alert message.
- A number of bespoke training events were held during 2013/14 relating to the Data Protection Act, Confidentiality and Sharing Information guidance and the Freedom of Information Act.
- In order to meet the information governance toolkit requirements, all staff are required to complete information governance training on a mandatory basis and the trust is required to attain a compliance level of a minimum of 95%. At the end of March 2014, the trust had ensured that 97% of staff had completed the required training.
- A letter outlining the importance of information governance for staff was written by the Senior Information Risk Owner and attached to employee payslips in April 2014.

FINANCE DIRECTOR'S REPORT

Summary

The trust is operating within a challenging financial climate. The culture of sound financial management throughout the trust has enabled the delivery of quality services along with the achievement of a strong financial performance again in 2013/14.

All financial duties have been delivered as set out below.

Financial Duties

1. To achieve a balanced position on the income statement. The trust made a surplus before impairment of £4.8m million at the year end.
2. To operate within the Capital Resource Limit (CRL). The trust delivered a capital programme of £7.3m to achieve its CRL.
3. To operate within the External Financing Limit (EFL). The trust had a duty to hold a minimum cash balance of £18.1m at the end of the year and achieved this.
4. To achieve a 3.5% return on the net assets owned by the trust. This target was achieved with a 3.5% return on net assets.

The trust had an income budget of £207.9m in 2013/14. A cost improvement programme of £10.7m was delivered across the trust which supported the delivery of the planned surplus of £4.8m. The surplus delivered each year provides funds to support capital investment for the benefit of service users and the local population.

Monitor will use a continuity of services risk rating to assess the financial risk of the trust. The continuity of services risk rating incorporates two common measures of financial robustness.

Liquidity: days of operating costs held in cash.

Capital servicing capacity: the degree to which the organisation's income covers its financing obligations.

The trust's continuity of services risk rating is 4 (1 is the lowest rating and 4 the highest).

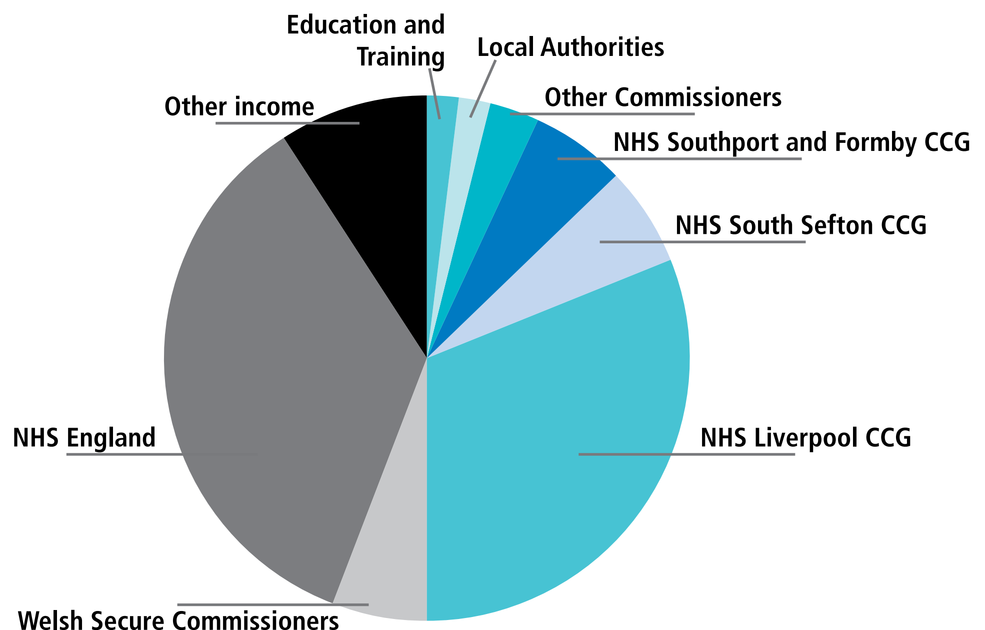
The trust had capital funding of £7.3m available in 2013/14 and spent this in total during the financial year. Capital investment in 2013/14 includes:

- Ruskin ward upgrade in high secure services
- Replacement boilers and ground floor windows at the Boothroyd Unit
- TIME project
- Building management system for high secure services
- Completion of South Sefton Resource Centre
- Demolition of former trust offices on the Maghull site.

Income

The trust received income of £207.9m in 2013/14 which was generated from a number of sources as set out in Chart 1. The information contained in Chart 1 shows the transfer of funding in 2013/14 from primary care trusts to local clinical commissioning groups (CCGs).

CHART 1
ANALYSIS OF INCOME



Operating Expenditure

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

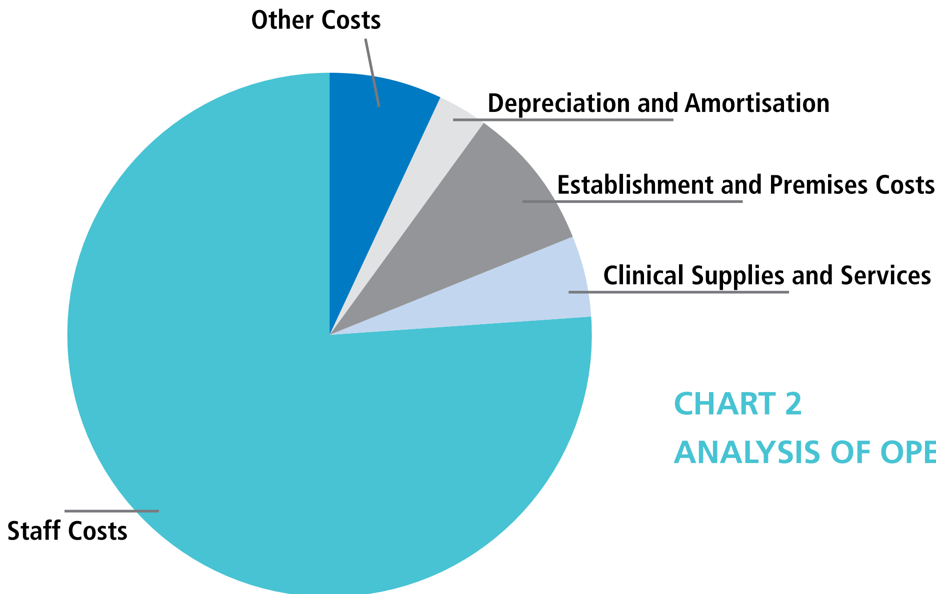


CHART 2
ANALYSIS OF OPERATING EXPENDITURE

Better Payments Practice Code

The 'Better Payments Practice Code' (BPPC) requires the trust to pay all valid invoices within 30 days of receipt of goods. In 2013/14, the trust achieved an average of 98%.

Prompt Payments Code

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

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

A guide for suppliers and contractors regarding the code is available on the trust website within the financial policies and procedures section.

Trust Auditors

The external auditor for the trust was Grant Thornton UK LLP, who provides audit services in relation to the statutory audit duties as required by the Department of Health in providing an independent audit opinion. The fee for work carried out during 2013/14 was £93,310 (2012/13 was £85,810) detailed as

	£
Financial statements, value for money and Quality Accounts	85,810
Other services	7,500
	93,310
Rebate of Audit Fees (Commission's Audit Practice)	(11,743)
	81,567

Longer Term Outlook

In March 2014, the Trust Board approved a financial framework that will support the delivery of the trust's strategic framework. The key elements of the framework are:

1. Maintain sound financial performance

Ensuring the trust maintains sound financial performance provides a stable platform which will support the trust's strategic aims. Mersey Care exists to provide the highest quality of care for its patients. The trust aims to be the best mental health provider within the UK. It has developed a comprehensive strategic framework that sets out clear aims for the forthcoming years. The concept of 'perfect care' is well supported and will ensure that quality of care is improved.

An annual surplus of circa £4m will be delivered, supported by a cost improvement programme of £45.7m over the period 2014/15 to 2019/20. Plans have been agreed by multi-disciplinary teams and all budget holders within each division. The multi-disciplinary teams include directors, clinicians, other staff and service users and carers. The plans are risk assessed by divisions for their impact on the quality of care using the six national domains of quality. The plans have been reviewed by the Medical Director and the Executive Director of Nursing and Secure Services. They have been presented to and discussed by the Clinical Senate and discussed at the Quality Assurance Committee and the Performance and Investment Committee.

2. Service transformation

The trust has agreed an ambitious service transformation plan that seeks to realise savings through the redesign of services. This will enable traditional services to be re-provided through new service models, providing highly effective and efficient services. The consequence will be to move away from traditional cost improvement plans (CIPs) focused on reducing cost to a process that generates cost savings as a consequence of improving service quality and productivity.

The trust has identified three key work programmes designed to deliver this change and generate the improvements required. The three areas are:

- Local services – redesign of services based on pathways of care.
- Secure services – integration and growth of services supported by a move to a secure campus on the Maghull site.
- Corporate services – integration of traditional corporate services to reduce duplication and increase economies of scale.

3. Provide more cost effective/efficient services

The trust has previously been recognised as a relatively high cost provider of services when using the Reference Cost Index (RCI) as a measure of efficiency. The trust has been successful in improving its RCI each year from 121 in 2005/06 to 88 in 2012/13 (an RCI of 100 is the national average score). It is important that we achieve an RCI below the national average of 100 to ensure income received will exceed costs should it be required to operate within a national tariff system (Payment by Results - PbR).

NHS acute trusts are funded by PbR. A national price list is used to make payment depending upon which services/procedures are provided. The national price list is known as the tariff. Mental health trusts are not funded by PbR but are paid on a block contract basis.

National work has outlined proposals for a mental health PbR system based on clusters of care. A date for the move from block contracts to PbR has not yet been confirmed but in 2014/15, it has been mandated that income contracts are monitored using clusters of care. The trust should use national developments in this area to test and refine service design but at this stage financial planning does not assume income growth from a new payment system.

QUALITY ACCOUNT

In preparation for our Quality Account for 2013/14 the trust has undertaken a process of involvement and engagement with key stakeholders to establish their views on what our key priorities for 2014/15 should be. Representatives from the following groups have been engaged and invited to provide feedback on our priorities and the draft Quality Account:

- Healthwatch for Liverpool, Sefton and Knowsley
- Local Overview and Scrutiny Committees
- NHS England (Merseyside) Local Area Team
- NHS Liverpool Clinical Commissioning Group
- NHS Sefton Clinical Commissioning Group
- NHS Knowsley Clinical Commissioning Group
- Mersey Care NHS Trust Members' Council
- Local service user groups
- The Executive Team
- Clinical Senate
- Mersey Care AQuA Group
- Trust Board.

Equality should be taken into account in relation to the development of improvements within the Quality Account. Equality and the Quality Account are linked via the NHS Equality Delivery System.

In addition to the above, the Mersey Care AQuA Group has considered suggestions for 2014/15 quality improvement priorities and has agreed that there would be significant benefits in linking our 2014/15 priorities to the six key elements of quality:

- Patient safety
- Clinical effectiveness
- Patient experience
- Timely care
- Efficient care
- Equitable care.

Many ideas and thoughts were shared, not just by staff and the Mersey Care AQuA Group, but by service users, Healthwatch and other stakeholders and these have all been given due consideration.

After consultation and discussion with the Trust Board the areas of quality improvement for 2014/15 will be:

- Priority 1: No Force First – roll out the initiative across the organisation
- Priority 2: The development of a depression pathway/ reduction in suicides
- Priority 3: Improvement in physical health – focus on body mass index (BMI)
- Priority 4: Reduction in the number of falls and the implementation of revised falls protocols
- Priority 5: Reduction in harm as a result of violence in inpatient settings
- Priority 6: Development of outcome measures for recovery.

The above priorities are all aligned to the trust's Strategic Framework and ensure quality remains at the forefront of our agenda.

Perfect Care

Perfect Care is all about our people. It was our people who managed the transition from big mental health hospitals in the 1980s to the community-based care that we provide today. It is our people who strive on a day by day basis to provide the best possible care for patients. And it is our people who will improve our services based on their knowledge, and who will innovate to create models of care in mental health and wellbeing for the future.

Imagine what we could achieve if we were all pulling in the same direction because we all care about providing the best possible care for the people we serve?

We know that delivering the best possible care is what our people really care about. Through our new 'Centre for Perfect Care and Wellbeing' we are going to support their commitment to patient care so that they can improve the services we provide today, but also to innovate in the services of tomorrow.

Perfect Care means:

- Setting our own stretching goals for improvements in care rather than aiming to meet minimum standards set by other organisations
- Getting the basics of care right every time
- Making improvements to the care we provide because we know it's the right thing to do for patients and because we care about the care that we provide.
- Helping people to try improvements, learn from their mistakes, and apply what works more rapidly.
- Helping our people to innovate in ways that create better quality and outcomes for the people we serve whilst reducing cost. We know from listening to people that they feel we already have many targets and this can feel like pressure to comply with minimum standards that aren't relevant to the care provided. We also know our people are really committed to improving the care provided but sometimes don't have enough time or support to make the improvements that could make a big difference for those we serve.

There is a big difference between targets that feel like minimum standards and that are pushed on us, and goals that we agree and are motivated to achieve. Sometimes having goals really helps motivate people to achieve more than we think is possible.

- Review progress of care clustering as part of Payment by Results (PbR) for mental health, focusing on transition between clusters, and care pathways for recovery and co-existing physical health needs
- Set up 'Mersey Care AQuA' as a successor to the Quality Steering Group, to help stimulate a quality improvement culture
- Quality reviews of cost improvement plans to be held with clinical business unit (CBU) directors and specialist management services managers at the extended executive team meetings in 2012/13.

Following extensive engagement with key stakeholders, it was decided that further to the excellent work that had been undertaken to achieve these targets, six specific areas would be our key areas of quality improvement for 2012/13:

- To ensure the people in our care live for longer
- To ensure carers receive the best level of support available
- To provide care that reduces the need for admission to hospital
- To ensure peoples' experience of our services is recognised nationally as best in class
- To be the safest mental health provider in the country
- To ensure every individual is treated fairly in our organisation
- To ensure people are able to access care when they need it.

With the commitment and dedication of its staff, the trust has made excellent progress in all of these areas.

No Force First

One of the key success stories of the year, and linked to our objective of being the safest mental health provider in the country, is the No Force First initiative.

No Force First set an ambitious goal of eliminating incidents of physical restraint from inpatient facilities across Mersey Care. Sponsored by the Medical Director, and with the help of a project group that included staff, service users and key managers, the initiative, which originated in the United States, was introduced to five pilot wards.

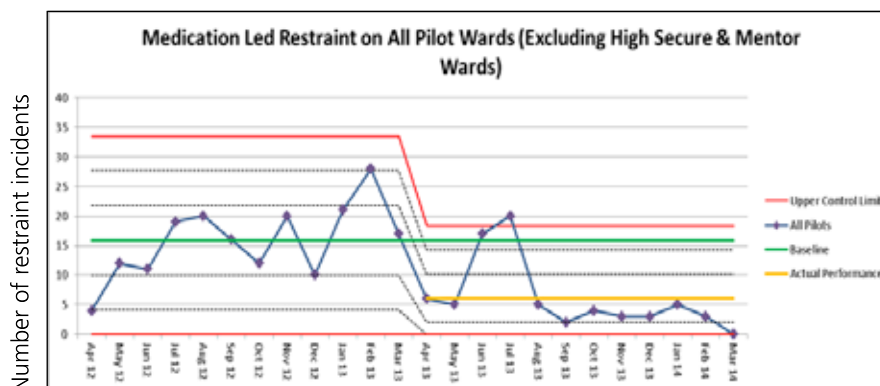
The wards were in different services as well as different geographic areas of the trust and have contributed to staff engagement events and other communications which have attempted to change the culture on the wards to one where restraint is viewed as a treatment failure.

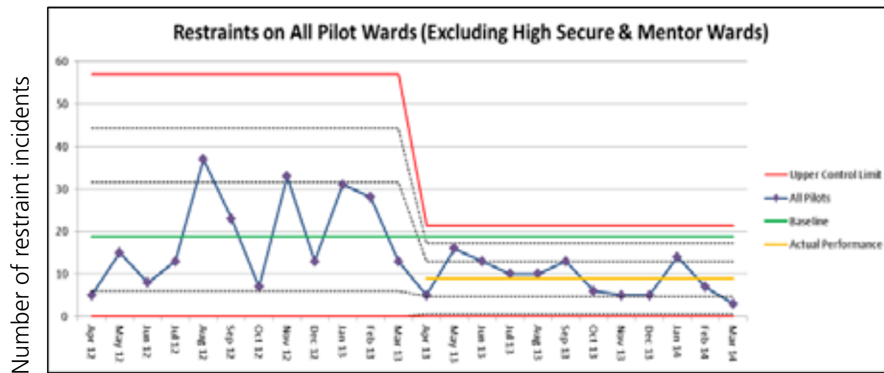
The results have been extremely encouraging, see charts below and opposite, with a reduction of over 50% from the baseline position since the initiative started.

Perfect care will set goals to focus our 'pull' for improvement on goals that our people care about. Working towards these goals will mean working together to try new ways to improve care, learning from our mistakes, and preventing the same mistakes happening over and over again.

In June 2013, the trust published its fourth year of Quality Accounts reporting on the quality of services in 2012/13 against the following areas of priority:

- Improving access to services, especially at times of crisis, and for psychological therapy, by clinical audits of current access and the availability of evidence based interventions
- Promote harm free care through the use of the National 'Safety Thermometer' and continued analysis of incidents and complaints
- Develop a Quality Dashboard for use at individual, team, CBU and Board level. This will include the measures for harm free care, patient experience and effectiveness, and gather key quality metrics for wide dissemination and learning.





The core features of 'No Force First' include:

- Describing the use of force and coercion as a treatment failure
- De-briefing, including the service user, whenever force is used
- Relationships with service users are risk sharing partnerships rather than risk management control
- Use of peer support
- Effective use of advance statements
- Trauma informed care
- Positive, recovery focused communication
- Delivery within a recovery framework.

We will continue in 2014/15 to spread the success of this initiative across the organisation.

Key Area of Improvement 1: To ensure the people in our care live for longer

Whilst improvements in performance have been observed since quarter 3 in 2013/14, both local services and secure services continue to underperform in terms of the completion of annual health checks for community service users on Care Programme Approach (CPA). Both local and secure divisions are now achieving the 95% target for the percentage of long term inpatients who have had their physical health needs reassessed within the last six months.

A performance improvement deep dive exercise in respect of physical health key performance indicators has been completed and the action plan is being implemented.

Key Area of Improvement 2: To ensure carers receive the best level of support available

The trust achieved the highest Triangle of Care award for our work on carer engagement in April 2014. The first gold star award was given for 80% implementation of the Triangle of Care self assessment process within inpatient and crisis services. The second gold star was awarded for implementing the Triangle of Care across all mental health services (inpatient and community). The trust also received special commendation for implementing the same process and standard within our addictions and learning disability services. High secure services also received a special citation.

The trust is now achieving a score of 81% for inpatient services and 69% for community services and continues to work towards 100% compliance across both inpatient and community services into 2014/15.

Key Area of Improvement 3: To provide care that reduces the need for admission to hospital

• Advancing Quality – Psychosis

Plans are in place to achieve the target by 31 March 2014. The trust has strengthened internal project management arrangements to support ongoing delivery of the advancing quality targets into 2014/15.

• Advancing Quality – Dementia

The trust continues to perform well and is consistently surpassing the target. The trust has strengthened internal project management arrangements to support ongoing delivery of the advancing quality targets into 2014/15.

• Gatekeeping – Admissions

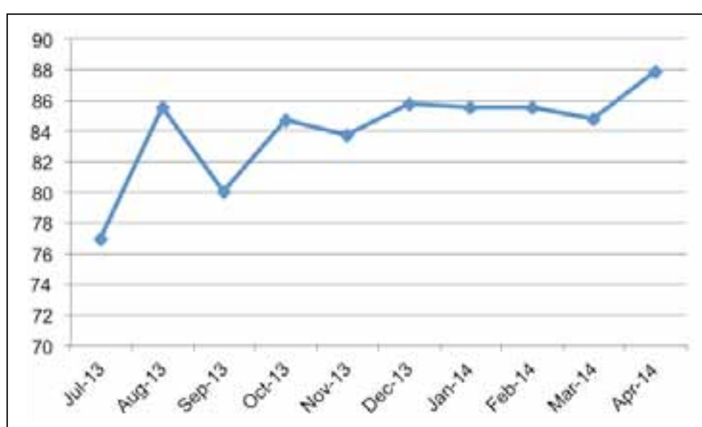
The Local Services Division has consistently met the gatekeeping target during 2013/14.

Key Area of Improvement 4: To ensure peoples' experience of our services is recognised nationally as best in class

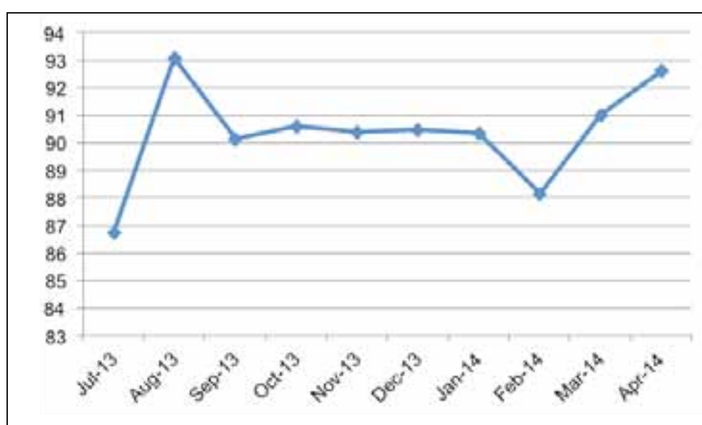
Patient experience is not just about the care received but how we communicate, how our environments impact on the service delivery and experience, and it is essential to ensure that services are developed and improved as a result of patient opinions and feedback. Service users and carers need to see evidence that their views have been listened to. It is essential that information gathered and lessons learned are reported through governance arrangements to ensure that they affect change. The patient experience surveys underpin this and give a trustwide perspective.

Inpatient Local Services overall score by month (1494 responses)

Inpatient Secure Services overall score by month (846 responses)



Community Services overall score by month (2865 response)



The survey questions were written in consultation with service users and carers and are linked to local and national standards such as National Institute for Health and Care Excellence (NICE) quality standards, CQC Essential Standards, NHSLA, NHS Constitution, NHS Outcomes Framework and includes the protected characteristics and the Friends and Family Test.

Technology is used to support patient experience with the use of iPads and has been well received by service users. This has enabled speedy access to the results with instant download capability and access to the data through Sharepoint and accessed through the BiT (Business Intelligence Today). They are available at ward/team level by theme or specific question. Analysis can act as an early warning indicator, influence service improvements and prompt a rapid response when required or identify areas of high performance, significant improvement or the impact of service change or redesign.

The results are accessible in real time with instant reporting as a result of the use of technology and systems built to support the process. The results are reported monthly enabling services to highlight areas of/or for quality improvements and provide evidence of any improvements or impact of service change. The Trust Board receives quarterly reports as part of the Quality Dashboard.

Key Area of Improvement 5: To be the safest mental health provider in the country

• Reporting Rates

Incident reporting rates continue to increase with the trust now achieving the internally set target for inpatient services of 40 incidents per 1,000 bed days during quarter 4 2013/14. The community target of 2.50 incidents per 1,000 community contacts continued to be exceeded.

• Harm

During 2013/14, the trust has consistently achieved lower levels of incidents resulting in harm than the national benchmark used to set the 2013/14 targets.

Key Area of Improvement 6: To ensure every individual is treated fairly in our organisation

Listening

"Do you believe that the views of service users and carers are taken into account to improve how services are provided and delivered?"

There has been continuous improvement in this area and the score is now only 1.1% short of the target of 90%. For community services, performance is now 7.65% short of the target of 90%. A series of mega conversations took place at the beginning of quarter 3 led by Michael Crilly and fronted by the Chief Executive and Executive Director of Nursing and Secure Services. Further focus on how we ensure community service users are appropriately involved in decisions around how services are provided and delivered is necessary to deliver the required improvements in this area.

The ability to understand the service user experience in relation to protected characteristics is vital. This is important where people feel they have had a poorer service.

Key Area of Improvement 7: Access

The trust continues to underperform against the 'psychotherapy: treatment commencing within 18 weeks of referral' indicator at 44% at the end of March 2014. This is a deterioration on the position of 46% reported in quarter 3 2013/14. Skill mix and access to psychological therapies is a key component of the Local Services Division care strategy implementation.

THE TRUST BOARD

Year ended 31 March 2014

Included in executive directors and senior staff at 31 March 2014	Position	New in year	Date of leaving or change
Joseph Rafferty	Chief Executive		
Kim Crowe	Executive Director of Service Integration		11.09.13
David Fearnley	Medical Director		
Neil Smith	Executive Director of Resources / Deputy Chief Executive		
Ray Walker	Executive Director of Nursing and Secure Services		
Elaine Darbyshire	Executive Director of Governance and Communications	01.06.13	
Christine Hughes	Director of Communications and Engagement		30.11.13
Amanda Oates	Director of Workforce	01.08.13	
Non-executive directors and chairman			
Beatrice Fraenkel	+ Chairman		
Brian Lawlor	+*		
Neil Willcox	+*		
Matt Birch	+*		
Marco Longhi	+*		01.11.13
Gerry O'Keeffe	+*		
Brenda Roe	+*	16.05.13	
Nicholas Williams	+*	01.01.14	
Advisory board member			
Christopher Dowrick	*		
Other senior staff			
Paul Weare	Director of Security		27.06.13
John Doyle	TIME Project Director		

+ Member of the Remuneration and Terms of Service Committee

* Member of the Audit Committee (Chairman, Neil Willcox)

REGISTER OF INTERESTS

Name	Job Title	Declaration 2013/14
Beatrice Fraenkel	Chairman	• Liverpool City Councillor • Director, Normal Properties Ltd • Chair, Architects Registration Board • School Governor, The King David High School • Fellow, Royal Society of Arts • Trustee, St Georges Hall • Board Member, Business Improvement District (BID Board) • Member, Public Chairs Forum • Member, Labour Party • Member, The Council of the University of the South Bank, London • Council Member, Edge Hill University
Brian Lawlor	Non-executive director	• Partner, Morecrofts LLP Solicitors • School Governor, Melling Community School • Trustee, Royal School for the Blind (Liverpool) Ltd • Vice Chairman, Marine Football Club • Director, Rossett Park Land Company Ltd • Company Secretary, Northern Premier Football League Limited
Neil Willcox	Non-executive director	• Director, Resman Ltd • Axon Resourcing Limited are a mutual provider for both Mersey Care Limited and Resman Limited
Matt Birch	Non-executive director	• Director of Sainsbury's Retail and Property Finance
Gerry O'Keeffe	Non-executive director	• Chief Operating Officer, CSC Computer Science Ltd
Brenda Roe*	Non-executive director	• Professor of Health Research, Edge Hill University • Fellow, Queens Nursing Institute • Fellow, Royal Society of Public Health • Executive Member, North West People in Research Forum • Steering Committee Member, North West Evidence Synthesis Network • Editor, Journal of Advanced Nursing
Nicholas Williams*	Non-executive director	• Nil Return

Name	Job Title	Declaration 2013/14
Christopher Dowrick	Advisory Board Member	• Part-time General Practitioner, Aintree Park Group Practice • Professor of Primary Medical Care in the University of Liverpool • Honorary President, Compass Counselling Services
Joseph Rafferty	Chief Executive	• Advisory Board, Hunter Healthcare (Recruitment and Advisory Service) • Director of Mersey Care Limited
David Fearnley	Medical Director	• Nil Return
Neil Smith	Executive Director Resources / Deputy Chief Executive	• Nil Return
Ray Walker	Executive Director of Nursing and Secure Services	• Nil Return
Elaine Darbyshire*	Executive Director of Governance and Communications	• Nil Return
Amanda Oates*	Director of Workforce	• Nil Return

Name	*Note
Brenda Roe	Commenced in post 16 May 2013
Nicholas Williams	Commenced in post 1 January 2014
Elaine Darbyshire	Commenced in post 1 June 2013
Amanda Oates	Commenced in post 1 August 2013

SENIOR MANAGER'S REMUNERATION REPORT

1. What this report covers

This report to stakeholders:

- Sets out the trust's remuneration policy
- Explains the policy under which the chairman, executive directors, and non-executive directors were remunerated for the year ended 31 March 2014
- Sets out tables of information showing details of the salary and pension interests of all directors for the year ended 31 March 2014.

2. Role of the Remuneration Committee

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

3. Membership of the Remuneration and Terms of Service Committee

The members of the committee are the chairman and all non-executive directors. Committee meetings are considered to be quorate when the chairman and three non-executive directors are present.

The chief executive may also attend in an advisory role except when his or her own remuneration or other terms of service are under discussion.

4. Service contracts

All executive directors have service contracts. Contracts are usually awarded on a permanent basis, unless the post is for a fixed period of time. Directors have a three month notice period within their contracts of employment, with the exception of the chief executive who has a six month notice period.

Termination payments are made in accordance with contractual agreements.

5. Remuneration policy for executive directors

Directors' posts are currently evaluated by the Business Services Authority, and signed off by NHS England prior to final ratification by the Department of Health. Any pay awards are agreed by the Remuneration and Terms of Service Committee.

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.

The trust does not operate a performance related pay scheme.

6. Remuneration policy for the Chairman and non-executive directors

Increases in the remuneration of the chairman and non-executive directors are agreed nationally by the Department of Health and implemented locally by the trust.

7. Directors' salaries, allowances and benefits for the year ended 31 March 2014

Directors	Notes	Salary (bands of £5,000) £000s	Other Renumeration (bands of £5,000) £000s	Termination Payments (bands of £5,000) £000s	Long Term performance pay & bonus payments (bands of £5,000) £000s	Expense Payments taxable to nearest £100 £000s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000)
Joseph Rafferty - Chief Executive	1	170 - 175				52	92.5 - 95.0	270 - 275
Alan Yates - Chief Executive	2							
Kim Crowe – Executive Director of Service Integration	3	50 - 55				44	(10.0) - (7.5)	45 - 50
David Fearnley – Medical Director	4	90 - 95	105 - 110		35 - 40	37	15.0 - 17.5	250 - 255
Neil Smith – Executive Director of Resources / Deputy Chief Executive	5	135 - 140	5 - 10			29	105.0 - 107.5	245 - 250
Ray Walker - Executive Director of Nursing & High Secure Services		115 - 120				39	15.0 - 17.5	135 - 140
Kath Davies - Director of Workforce	6							
Elaine Darbyshire - Executive Director of Corporate Governance & Communications	7	100 - 105					25.0 - 27.5	125 - 130
Amanda Oates - Director of Workforce	8	65 - 70					47.5 - 50.0	110 - 115
John Doyle - TIME Project Director		95 - 100				44	5.0 - 7.5	115 - 120
Christine Hughes - Director of Corporate Affairs / Communications	9	45 - 50		70 -75		65	(5.0) - (2.5)	120 - 125
Lindsey Dyer - Director, Service Users and Carers	10							
Band of Highest Paid Director's Total Remuneration (£'000)					235 - 240			
Median Total Remuneration of all staff					29,701			
Pay Multiple Ratio					8.0			

Directors' salaries, allowances and benefits for the year ended 31 March 2013

Directors	Notes	Salary (bands of £5,000) £000s	Other Renumeration (bands of £5,000) £000s	Long Term Performance Pay & bonus Payments (bands of £5,000) £000s	Expense Payments taxable to nearest £100 £000s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s
Joseph Rafferty - Chief Executive	1	95 - 100			49	5.0 - 7.5	105 - 110
Alan Yates - Chief Executive	2	70 - 75			34	(27.5) - (30.0)	40 - 45
Kim Crowe – Executive Director of Service Integration	3	115 - 120			37	(20.0) - (22.5)	95 - 100
David Fearnley – Medical Director	4	85 - 90	100 - 105	35 - 40	34	(12.5) - (15.0)	210 - 215
Neil Smith – Executive Director of Resources / Deputy Chief Executive	5	120 - 125			26	(15.0) - (17.5)	105 - 110
Ray Walker - Executive Director of Nursing & High Secure Services		115 - 120			40	25.0 - 27.5	140 - 145
Kath Davies - Director of Workforce	6	100 - 105			40	30.0 - 32.5	130 - 135
Elaine Darbyshire - Executive Director of Corporate Governance & Communications	7						
Amanda Oates - Director of Workforce	8						
John Doyle - TIME Project Director		95 - 100			39	(10.0) - (12.5)	85 - 90
Christine Hughes - Director of Corporate Affairs / Communications	9	70 - 75			57	47.5 - 50.0	115 - 120
Lindsey Dyer - Director, Service Users and Carers	10	60 - 65			16	(32.5) - (35.0)	30 - 35
Band of Highest Paid Director's Total Remuneration (£'000)				230 - 235			
Median Total Remuneration of all staff				28,044			
Pay Multiple Ratio				8.2			

Benefits in kind are the taxable gains on lease cars and salary sacrifice schemes.

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 and age 65 for members of the 2008 section).

Directors' salaries, allowances and benefits for the year ended 31 March 2013

Non Executive Directors (inc Advisory Board Member*)	Notes	Salary (bands of £5,000) £000s	Other Renumeration (bands of £5,000) £000s	Bonus Payments (bands of £5,000) £000s	Expense Payments taxable to nearest £100 £000s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s
Beatrice Fraenkel - Chairman		20 - 25					20 - 25
Brian Lawlor		5 – 10					5 – 10
Elizabeth Powell	11						
Michael Shields	12						
Marco Longhi	13	0 - 5					0 – 5
Matt Birch	14	5 – 10					5 – 10
Gerry O'Keefe	15	5 – 10					5 – 10
Neil Willcox		5 – 10					5 – 10
Brenda Roe	16	5 – 10					5 – 10
*Christopher Dowrick		5 – 10					5 – 10

Directors' salaries, allowances and benefits for the year ended 31 March 2013

Non Executive Directors (inc Advisory Board Member*)	Notes	Salary (bands of £5,000) £000s	Other Renumeration (bands of £5,000) £000s	Bonus Payments (bands of £5,000) £000s	Expense Payments taxable to nearest £100 £000s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s
Beatrice Fraenkel - Chairman		20 - 25			1		20 - 25
Brian Lawlor		5 – 10					5 – 10
Elizabeth Powell	11	0 - 5					0 - 5
Michael Shields	12	0 - 5			1		0 - 5
Marco Longhi	13	5 - 10			1		5 – 10
Matt Birch	14	0– 5					0 – 5
Gerry O'Keefe	15	0 – 5					0 – 5
Neil Willcox		5 – 10			1		5 – 10
Brenda Roe	16						
*Christopher Dowrick		5 – 10					5 – 10

Emoluments

Notes:

1 Joseph Rafferty was appointed Chief Executive on 1 September 2012.

2 Alan Yates left the trust on 12 September 2012.

3 Kim Crowe left the trust on 11 September 2013.

4 The bonus payments relate to clinical excellence awards.

5 The other remuneration is pay arrears from 2012/13.

6 Kath Davies left the trust on 31 March 2013.

7 Elaine Darbyshire was appointed Executive Director of Governance and Communications on 1 June 2013.

8 Amanda Oates was appointed as Director of Workforce on 1 August 2013.

9 Christine Hughes left the trust on 30 November 2013.

10 Lindsey Dyer left the trust on 31 January 2013.

11 Elizabeth Powell retired as a non-executive director on 30 September 2012.

12 Michael Shields retired as a non-executive director on 31 August 2012.

13 Marco Longhi left the trust as a non-executive director on 1 November 2013.

14 Matt Birch was appointed as a non-executive director on 11 July 2012.

15 Gerry O'Keefe was appointed as a non-executive director on 10 September 2012.

16 Brenda Roe was appointed as a non-executive director on 16 May 2013.

17 Nicholas Williams was appointed as a non-executive director on 1 January 2014.
In accordance with his contract of employment, he receives no remuneration from the trust.

Pension benefits

Name Title	Real increase/ (decrease) in pension at age 60 (bands of £2500) £000s	Real increase/ (decrease) in lump sum at age 60 (bands of £2500) £000s	Total accrued pension at age 60 at 31.03.14 (bands of (£5000) £000s	Total accrued lump sum at age 60 at 31.03.14 (bands of (£5000) £000s	Cash Equivalent Transfer Value at 31.03.14 £000s	Cash Equivalent Transfer Value at 31.03.13 £000s	Real increase in Cash Equivalent Transfer Value £000s	Employers Contribution to Stakeholder Pension £000s
Joseph Rafferty – Chief Executive	5 - 7.5	15 - 17.5	45 - 50	145 - 150	904	771	117	0
Kim Crowe – Executive Director of Service Integration	(2.5) - 0	(2.5) - 0	45 - 50	140 - 145	0	968	0	0
David Fearnley – Medical Director	0 - 2.5	2.5 - 5.0	30 - 35	95 - 100	506	460	35	0
Neil Smith – Executive Director of Resources / Deputy Chief Executive	5 - 7.5	15 - 17.5	45 - 50	145 - 150	875	740	119	0
Ray Walker – Executive Director of Nursing & High Secure Services	0 - 2.5	2.5 - 5.0	15 - 20	50 - 55	341	299	36	0
Elaine Darbyshire - Executive Director of Corporate Governance and Communications	0 - 2.5	0	10 - 15	0	109	95	9	0
John Doyle – TIME Project Director	0 - 2.5	0 - 2.5	35 - 40	105 - 110	702	652	36	0
Christine Hughes – Director of Corporate Affairs / Communications	0 - 2.5	0 - 2.5	20 - 25	60 - 65	385	365	8	0
Amanda Oates – Director of Workforce	0 - 2.5	2.5 - 5.0	10 - 15	40 - 45	219	172	29	0

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's 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

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.

8. Pay multiples

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.

The banded remuneration of the highest paid director in Mersey Care NHS Trust in the financial year 2013/14 was £236,525 (2012/13, £230,507). This was 8.0 times (2012/13, 8.2) the median remuneration of the workforce, which was £29,701 (2012/13, £28,044).

In 2013/14, 0 (2012/13, 0) employees received remuneration in excess of the highest paid director. Remuneration ranged from £14,311 to £236,525 (2012/13 £13,903 to £230,507).

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.

The number of full time equivalent staff has decreased from 4,040 to 3,820. The pay multiple has decreased to 8.0.

9. Reporting of other compensation schemes – exit packages

Exit package cost band (including any special payment element)(a)	Number of compulsory redundancies (b)	Number of other departures agreed (c)	Total number of exit packages by cost band (total cost) (d)	Number of departures included in (b) and (c) where special payments have been made (special payment element (totalled) (e)
<£10,000	0	44	44 (£273,327)	0
£10,001 - £25,000	1	48	49 (£764,570)	0
£25,001 - £50,000	0	25	25 (£875,274)	0
£50,001 - £100,000	0	5	5 (£360,357)	0
£100,001 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,000	0	0	0	0
Total number of exit packages by type (total cost)	1 (£18,805)	122 (£2,254,723)	123 (£2,273,528)	0

Approved by:

Signed: Chief Executive

Date: 28.05.14

Off-payroll engagements

For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	18
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	6
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	5

For all new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements between 1 April 2013 and 31 March 2014	5
Number of new engagements which include contractual clauses giving Mersey care NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	5
Of which:	
assurance has been received	5
assurance has not been received	0
engagements terminated as a result of assurance not being received, or ended before assurance received.	0

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

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

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

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

NB: sign and date in any colour ink except black

Signed: Chief Executive

Date: 28.05.14

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

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

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

NB: sign and date in any colour ink except black

Date: 28.05.14 Chief Executive

Date: 28.05.14 Finance Director

GOVERNANCE STATEMENT

Scope of Responsibility

1. The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

2. The Trust Board is ultimately accountable for the management of all risks in the organisation. The Chief Executive, supported by Board Members, has responsibility for the implementation of the Risk Management Strategy. These responsibilities are met in a variety of ways.

3. I, as Chief Executive, with overall responsibility for risk within Mersey Care, ensure the work of the Performance and Investment Committee and other specialist sub-committees is reviewed by the Trust Board. The Chief Executive has overall responsibility for having effective risk management systems in place within the trust, and for meeting all statutory requirements and adhering to guidance issued by the Department of Health and the NHS Trust Development Authority in respect of risk and governance.

4. The Trust Board has overall responsibility for consideration of the Board Assurance and Escalation Framework and resource allocation relating to the 'significant risks' of the trust. The recommendations of the Performance and Investment Committee and relevant sub-committees are made to the Trust Board where competing priorities are debated and agreed or accepted.

5. The accountability arrangements for risk management in 2013/14 involved the following:

    a) The Medical Director had overall responsibility across the organisation for medicines management and as the Accountable Officer (Controlled Drugs) for the trust, research and development and was the identified Caldicott Guardian. In addition to these key functions the Medical Director was accountable for Safeguarding Children and Adults and the regulation requirements relating to registration with the Care Quality Commission as the Nominated Individual. The Medical Director is also the Responsible Officer for medical revalidation.

    b) The Executive Director of Service Development and Delivery had delegated specific responsibilities for the day to day operational management of key risk areas and for ensuring that the trust had sound and effective systems for the management of patient safety, complaints, claims and adverse incidents until the end of May 2013.

    c) The Executive Director of Corporate Governance and Communications became responsible for the management of patient safety, complaints, claims and adverse incidents from June 2013.

    d) The Executive Director of Nursing and High Secure Services was responsible for the strategic management of risk within the secure services.

    e) The Deputy Director of Nursing, as Director for the Prevention and Control of Infection (DIPC), was accountable for the management and prevention of healthcare associated infection.

    f) The Executive Director of Resources (Deputy Chief Executive) was responsible for ensuring that the trust had sound financial as well as information governance arrangements that were controlled and monitored through robust audit and accounting mechanisms and in addition, was the designated Senior Information Risk Officer (SIRO).

6. The development of effective and appropriate risk management processes within Mersey Care has been monitored by the Trust Board and through the various performance review processes of the NHS. The Board Assurance and Escalation Framework, Corporate Risk Register, Clinical Business Unit (CBU) risk registers and Risk Management Strategy have collectively been presented and approved by various review processes, which include health economy partner organisations. The trust's strategic intentions, policies, procedures and supporting documentation are openly accessible via the Mersey Care website to internal and external stakeholders for comment, scrutiny and reference.

7. During 2013/14, the trust contracted with:
   a) NHS Liverpool Clinical Commissioning Group (and associates) and NHS Sefton Clinical Commissioning Group (and associates), for local mental health and learning disability services across the Liverpool, Sefton, Knowsley, Halton and St Helens areas.
   b) Liverpool, Sefton, Knowsley, Halton, St Helens, Wirral and Blackpool Local Authorities for addiction services.
   c) NHS England (Cheshire, Warrington and Wirral Area Team) for low, medium and high secure services and colleagues from NHS Wales in respect of high secure services.
   d) NHS England (Lancashire Area Team) for mental health and addictions services in HMP Liverpool.
   e) NHS England (South Yorkshire and Bassetlaw Area Team) for services at HMP Garth.
   f) Aintree University Hospitals NHS Foundation Trust for the Liverpool Community Alcohol Service and psychological support for Weight Management and Bariatric Services.
   g) Walton Centre NHS Foundation Trust for Neuropsychology and Neuropsychiatry services.
   h) Manchester Mental Health and Social Care Trust for psychiatry services to HMP Manchester.

8. Formal contract monitoring meetings and strategic commissioning meetings were established between commissioners and the trust, where risks relating to the contract and/or the performance and delivery of services were addressed.

9. Commissioners were notified, and involved in the monitoring (as appropriate), of all serious incidents relating to circumstances involving service users of trust services.

10. The trust is an active member of the Merseyside NHS Health Response Group responsible for directing emergency planning/business continuity arrangements across Merseyside on behalf of the Local Health Resilience Partnership.

11. The trust has a fully functioning Infection Control Committee chaired by a Consultant Microbiologist from Aintree University Hospitals NHS Foundation Trust who is employed on a sessional basis to undertake the role of Infection Control Doctor.

12. The trust attends the Overview and Scrutiny Committees (OSC) operating in Liverpool, Sefton and Knowsley where issues relating to service change, service development and matters of interest/concern to the OSC's are discussed and/or information provided.

The Governance Framework of the Organisation

13. The governance framework of the organisation is designed to manage operational and strategic risk and minimise the risk of failure to deliver the trust Strategy.

14. The Trust Board is responsible for providing strategic leadership to the organisation and ensuring that the trust exercises its functions effectively and efficiently. The Trust Board 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.

15. Following a series of reviews conducted by Ernst and Young and KPMG to assess the trust's preparedness for foundation trust status, steps have been taken to further develop the Trust Board's governance arrangements in line with the actions arising from both reviews. This included the establishment of a Performance and Investment Committee, a Quality Assurance Committee and an Executive Committee, the terms of reference for which were approved by the Trust Board in December 2012.

16. This revised committee structure, which was embedded throughout 2013/14, has:
    a) Strengthened the accountability of directors to the Board for their operational management of the trust
    b) Allowed for non-executive directors to focus more time on the delivery of strategic objectives together with scrutinising the robustness of the trust's underpinning reporting systems
    c) Provided for much greater focus by non-executive directors on matters pertaining to the quality of services provided by the trust.

17. The committee structure, to support achievement of the organisation's strategic objectives, is outlined below.

Committee	Role
Audit Committee	• Acts as the central means by which the Trust Board is assured that effective internal control arrangements are in place as part of its annual work plan • Provides a form of independent check upon the executive arm of the Trust Board • Provides independent verification to the Board on internal financial controls based on reports from internal and external auditors • Ensures effective organisational controls and risk management
Performance and Investment Committee	• Provides assurance that the key performance and outcome measures for assessing delivery of the trust's Strategy and annual operating plans are appropriate and that performance is consistent with those measures • 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 • Commissions in-depth scrutiny of strategic risk in line with an annual schedule (from August 2014)
Quality Assurance Committee	• Provides assurance to the Trust Board that the quality of service provision across the organisation is of the highest standard and in doing so, scrutinises risks to quality of services at each of its meetings
Executive Committee	• Supports the Trust Board in setting and delivering the organisation's strategic direction and priorities • Oversees the effective operational management of the trust and delivery of continuous improvement in quality and assesses and controls risk
Foundation Trust Project Board	• Oversees the project being undertaken to ensure delivery of the trust's ambition to be an NHS foundation trust • Keeps under review the plans to mitigate risks associated with this project
Remuneration and Terms of Service Committee	• Determines the policy on executive remuneration • Approves contracts of employment for executive directors and agreement of arrangements for termination of 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
Members' Council	• Acts as an advisory committee to the Trust Board in order to provide learning prior to the trust achieving foundation trust status and establishing its Council of Governors • Responsible for representing and presenting to the Trust Board, the interests of the membership, partner organisations and local health economy

18. Each of the Board committees have formally approved terms of reference, which are reviewed and updated on an annual basis as part of the annual review of governance prior to approval by the Trust Board, as well as an annual cycle of business.

19. The chairs of the Board committees routinely present written and verbal reports to the Trust Board, to highlight any key issues, concerns and decisions at their meetings. Approved minutes of each sub-committee meeting are also presented at public Board meetings.

20. At the Audit Committee in April 2014, the Director of Internal Audit's opinion provided significant assurance for the period 2013/14 that 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 designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

Attendance at Board and Board Committee Meetings

21. The Board met a total of five times in public in 2013/14 (in May, September, November 2013 and January, March 2014). Attendance was monitored throughout the year and is detailed in the table attached at Annex 1.

22. The Board achieved an average attendance level of 93% by its members in 2013/14, with the various Board committees achieving average attendance levels of between 70% to 95% by their members in 2013/14.

23. The one exception, which only achieved an average attendance level of 49%, was the Members Council. Although an advisory Board committee with no delegated decision-making powers, this level of attendance is disappointing with attendance impacted by organisational change in the NHS and the delay in the trust's application for foundation trust status. The development of the Members Council, and its basis as a Council of Governors should the trust be successful in its foundation trust application, has been identified as an important issue to be addressed for 2014/15.

Assessing Board Effectiveness

24. As part of its assurance processes, the Trust Board commissioned an external evaluation of its effectiveness which has informed its recruitment of members and the Trust Board's development plan.

25. In addition, the performance of individual Board members has been assessed through the implementation of the Directors Appraisal Scheme in which executive directors and non-executive directors are subject to regular appraisal. The trust's Chairman is subject to an independent appraisal process by the NHS Trust Development Authority.

26. 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. In addition, the Board undertakes an annual review of its delegated arrangements through a review of its Scheme of Reservations and Delegations.

27. Mersey Care is committed to effective corporate governance. As an aspirant foundation trust, an assessment has been undertaken of the trust's level of compliance with the NHS Foundation Trust Code of Governance, where this is applicable to the governance of a NHS trust.

Risk Assessment

28. In 2013/14 the Quality Assurance Committee and the Performance and Investment Committee were the Board's overarching committees responsible for scrutinising the arrangements in place for managing risk. The Executive Committee also played a key role in the identification and management of risk. These committees are supported by the following Board committees and sub-committees/groups:
    - Remuneration and Terms of Reference Committee
    - Foundation Trust Project Board
    - Clinical Senate
    - Mental Health Act Managers Sub Committee
    - Health and Safety Sub Committee
    - Infection Control Sub Committee
    - Drugs and Therapeutics Sub Committee
    - Information Governance and Caldicott Sub Committee
    - Research Governance Committee
    - Safeguarding Group.

29. 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 organisation; and the systems and processes to ensure identification, management and control of risk.

30. Mersey Care 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 of the trust and its employees take part in.

31. The Head of Quality and Risk is responsible for implementing the effective systems and processes of risk management across the organisation, the identification, management and monitoring of risks; providing reports, information and training as appropriate. Other senior trust staff, managers and individual staff members in addition to executive and non-executive directors, clinical directors, 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.

32. All executive directors 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 (particularly in regard to standards set by the National Health Service Litigation Authority (NHSLA), 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.

33. Each Clinical Business Unit has established governance arrangements in place and the local governance lead is responsible for implementing the corporate risk management processes locally and in addition facilitating the sharing of best practice.

34. Risk management is the responsibility of every individual member of staff. Providing the skills and knowledge to underpin this process is an organisational priority, and is achieved through:
    a) effective induction of all trust staff
    b) the effective implementation of any new systems, procedures or equipment
    c) critical learning provision
    d) the identification of specific needs of staff via personal development plans following the appraisal process
    e) the identification of specific needs by service areas following risk assessment
    f) by providing information leaflets and bulletins to raise awareness of policies and hazard/risk warnings in induction packs, staff handbook and dissemination across the trust.

Major Risk in 2013/14

35. Strategic risks, assessed as having a risk score of 12 and above, were included in the Board Assurance and Escalation Framework, which was regularly considered at public Board meetings throughout 2013/14. The table highlights the major risks facing the trust in 2013/14 and shown in the Board Assurance and Escalation Framework considered by the Board (with new risks for 2013/14 suitably identified).

Major Risk	New for 2013/14
Impact of CIPs upon the delivery of local and national performance targets 2014/2018 and the National Outcomes Framework	
Impact of local authority financial pressures on the service user experience and care pathway	
Implementation of the divisional restructure results in non-delivery of key targets/objectives	
Failure to reduce sickness absence levels impacts on the quality of care and investment in service developments	
The trust ceases to exist if it does not achieve foundation trust status	
The implications of acting as host for Informatics Merseyside negatively impacts upon the trust from a financial and reputational perspective	
Failure of trust payroll provider to deliver transactional HR and payroll services as per contract, impacting on staff morale and provision of safe services	NEW
Delays in agreeing the model of care will impact on the efficiency and effectiveness of services	
CQC issue a warning notice or more severe sanctions that have a negative impact on commissioner confidence resulting in services being commissioned elsewhere	
Data loss/breach resulting in adverse publicity or financial penalty	NEW
Impact of the Governmental welfare reforms increase the incidence of mental illness beyond trust capacity	NEW

36. Three incidents have been reported to the Information Commissioner in respect of data loss/data breaches, further information on which can be found in paragraphs 53 – 57 below.

The Risk and Control Framework

37. The development of effective risk management across the organisation is underpinned by clear processes and procedures which include:
    - overarching strategic aims for risk management
    - the trust's Risk Management Strategy and Policy
    - organisational risk management objectives
    - the organisational process for risk identification and analysis
    - a definition of significant risk and acceptable risk within the organisation
    - organisational risk management structures
    - the development and application of risk registers within the organisation
    - incident reporting
    - the accountability and responsibility arrangements for risk management
    - the Board Assurance and Escalation Framework.

38. Embedding risk management as a core activity within the organisation is achieved through many systems and processes. 2013/14 has seen:
    a) A fully revised Board Assurance and Escalation Framework developed, along with work to improve the systems and processes that support its production.
    b) Introduction of the Quality Surveillance Group as a sub-committee of the Executive Committee.
    c) The procurement and roll out of an electronic solution for the management of the trust's risk portfolio.
    d) The establishment of a Risk Management Group, as a sub-committee of the Executive Committee, to undertake additional analysis of strategic risk, to develop mitigation plans and ensure in-depth reviews of key risks.

e) Implementation, development and scrutiny of Clinical Business Unit risk registers.

f) Changes to organisational committee structures to improve effectiveness and ensure all committees actively support the risk agenda.

g) Maintenance of compliance with the Care Quality Commission Essential Standards of Quality and Safety and the introduction of mock Care Quality Commission visits to further support compliance.

h) The continued development of the Emergency Planning Forum including development and ratification of a revised Major Incident Plan.

i) Reviews of and improvements to the complaints, claims and adverse incident functions including detailed policy reviews in each area.

j) Significant development of organisational policies, particularly relating to the National Health Service Litigation Authority Standards.

k) Continued registration, without improvement conditions, from the Care Quality Commission.

39. The development of the Board Assurance and Escalation 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:

"An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation".

Quality Governance

40. The trust has developed a Quality Account for 2013/14 that highlighted the quality improvements made across the trust in 2013/14 and the priorities for quality improvement in 2014/15. The Quality Account has been shared with members of the Mersey Care AQuA Group, trust directors and the Trust Board to ensure all of the information contained within it is accurate. Internal audit has also performed a review in year of an element of the data quality contained within the Quality Account and further analysis of the quality of data will be undertaken by external audit as part of their annual plan.

41. To determine the quality improvement priority areas for 2013/14 the trust engaged in extensive consultation and this included the Mersey Care AQuA Group, internal groups and committees, service users and carers, Healthwatch and commissioners. The agreed priorities following the consultation were:

- to ensure the people in our care live for longer
- to ensure carers receive the best level of support available
- to provide care that reduces the need for admission to hospital
- to ensure peoples' experience of our services is recognised nationally as best in class
- to be the safest mental health provider in the country
- to ensure every individual is treated fairly in our organisation
- to ensure people are able to access care when they need it.

42. The above priorities were all linked to the trust's Strategic Framework and ensured that the key domains of quality i.e. safety, effectiveness and experience remained at the top of our agenda.

43. Our success against these priority areas will be captured in full for the Quality Account, but in summary we have:

a) Developed a Quality Dashboard to enable reports on quality at every Board and Members Council meeting.

b) Focused on improving the physical health of our service users – meeting NICE standards.

c) Completed a comprehensive analysis of capacity and access to local services.

d) Piloted the No Force First programme on five wards covering high secure services, learning disabilities, medium secure, older people's mental health and adult acute.
Results so far show evidence of sustained reduction in physical restraint overall in 4 pilot wards, with a 50% reduction from the mean achieved by the end of September 2013.

e) Engaged with nearly 1000 staff as part of Your Voice Your Change programme and made a series of practical improvements to care and the staff experience as a result of staff feedback.

f) Developed and implemented a community services version of the Triangle of Care, developed a resource package for staff and mechanisms to monitoring compliance in all service areas.

g) Developed our information systems and processes to enable the Trust Board and teams within the trust to scrutinise patient experience information down to ward/ team level.

44. As part of the aforementioned consultation exercise, the trust will be seeking the views of service users, staff and other stakeholders with regard to what our priority improvement areas for 2014/15 will be. These priorities should build on our achievements in 2013/14 and may include:
    - No Force First – roll out across the organisation
    - the development of a depression care pathway/reduction in suicides
    - improvement in physical health, particularly regarding Body Mass Index
    - reduction in the number of falls and the implementation of revised falls protocols
    - reduction in harm as a result of violence in inpatient settings
    - development of outcome measures for recovery
    - development of a consistent approach to care planning.

45. The trust is compliant with Care Quality Commission essential standards of quality and safety and remained registered with the Care Quality Commission throughout 2013/14 without conditions.

Other Regulatory Requirements

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

47. 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.

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

49. The trust also complies with the requirements of the Corporate Governance Code of Good Practice published by HM Treasury and the Cabinet Office.

Review of the Effectiveness of Risk Management and Internal Control

50. As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance and Escalation Framework and on the controls reviewed as part of internal audit's work. The overall opinion for 2013/14 is that there is 'significant assurance' (i.e. there is a generally sound system of internal control designed to meet the organisation's objectives, and controls are generally being applied consistently). Responsible managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance and Escalation Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

51. My review is also informed by:
    - external audit activities, including an audit of the Quality Account and the information governance arrangements
    - Care Quality Commission inspections and compliance requirements
    - Care Quality Commission's Quality and Risk Profile
    - Care Quality Commission compliance declaration
    - internal audit work including:
      (a) financial systems assurance
      (b) assurance framework
      (c) safeguarding
      (d) risk management processes
      (e) clinical quality
      (f) information governance toolkit review
    - Local Health Resilience Partnership review of emergency planning arrangements
    - service performance.

52. The Board and its committees have advised me on the implications of the result of my review of the effectiveness of the system of internal control.

Significant Issues

Information Governance

53. The trust experienced the following significant issues in respect of four information governance breaches which occurred in 2013/14:

    a) Three, which were self-reported by the trust to the Information Commissioner, related to personal identifiable data being sent out inappropriately (one via electronic mail and two by inadvertently sending patient identifiable information by Royal Mail instead of the internal mail system).

    b) The fourth, brought to the attention of the trust by the Information Commissioner, related to a failure to respond within the prescribed timescales to a single request from an individual for information covered by both the Data Protection Act and the Freedom of Information Act.

54. The trust undertook appropriate internal investigations, including root cause analysis, for each of these incidents. All data loss/data breach incidents were reviewed at meetings of the Information Governance and Caldicott Sub-Committee, with further reviews undertaken by the relevant service to provide a full report back to the Senior Information Risk Owner (the Executive Director of Resources).

55. To mitigate the possibility of incidents reoccurring the trust has:

    a) Instigated an Information Governance campaign to raise staff's awareness of their responsibilities, which is continuing throughout 2014/15.

    b) Committed to ensuring that all staff complete Information Governance training upon induction and thereafter on an annual basis.

56. In addition, the trust commissioned an external and independent audit from Grant Thornton on the trust's information governance arrangements, which provided significant assurance on the trust's systems and processes and led to the development of an action plan.

57. The trust is currently seeking a technical solution to mitigate the risk of information being disclosed via large group emails and looking to implement a corporate records classification system on corporate documents.

Fraud

58. In 2012/13 the trust was the victim of fraud undertaken by a dishonest member of staff inappropriately using the organisation's NHS Supply Chain system account to order printer cartridges and then sell them privately. This fraud was detected in December 2012 and was subsequently reported to the Police, following referral in accordance with the trust's counter fraud arrangements. It was not reported in our 2012/13 annual governance statement as the member of staff in question was not convicted until February 2014, following which the incident was formally closed by our Counter Fraud Lead.

59. Mitigating actions, which where undertaken in 2012/13 and reported to April 2014's Audit Committee, included:

    a) A full review of members of staff (approvers and requisitioners) authorised to use the NHS Supply Chain system was undertaken and access to the system was rationalised to manage self-approved orders.

    b) NHS Supply Chain have revised their reporting tool to enable the trust's Procurement Department to monitor any staff self-approving orders (which is permitted under the NHS Supply Chain system, but is not in line with Trust policy).

60. In addition, the trust's Procurement Department has developed an internal monitoring system to manually check whether any self-approved orders have occurred within the NHS Supply Chain system, contrary to the trust's internal procedures. This audit is undertaken monthly and those identified are contacted and reminded of the correct procedures. Failure to respond is escalated to line managers.

Accountable Officer: Dr Joe Rafferty Chief Executive

Organisation: Mersey Care NHS Trust (RW4)

Signature:

Date: 28.05.14

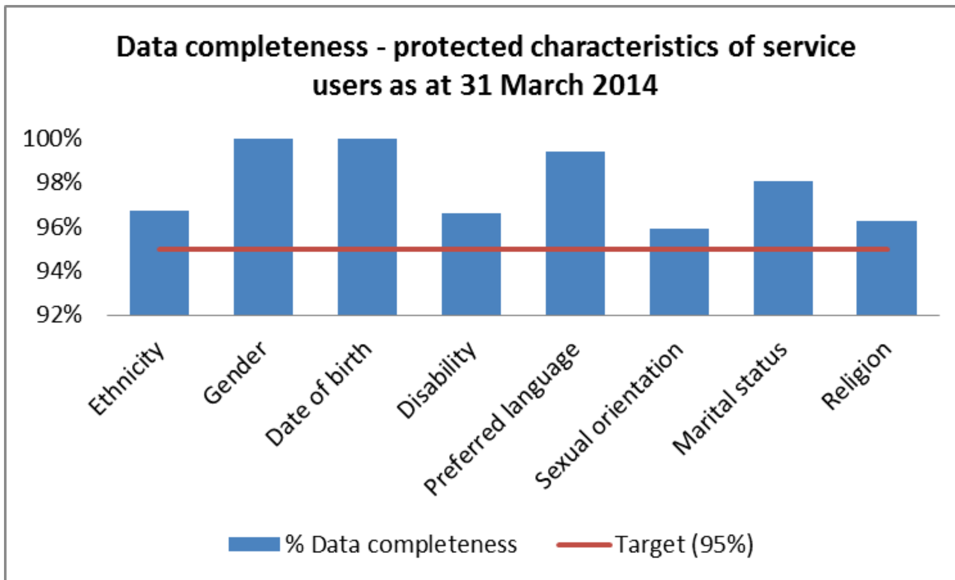
Annex 1 – Attendance at Board and Board Committee Meetings

		Trust Board	Audit Committee	Quality Assurance	Performance and Investment Committee	Executive Committee	Remuneration and Terms of Service Committee	Foundation Trust Project Board
B Fraenkel	Chairman	5/5	-	-	-	-	3/3	10/11
N Willcox	Non Executive Director	5/5	6/6	-	-	-	3/3	10/11
B Lawlor	Non Executive Director	4/5	-	4/6	-	-	3/3	9/11
M Birch	Non Executive Director	5/5	4/6	-	9/9	-	2/3	6/11
B Roe*****	Non Executive Director	5/5	1/1	3/4	2/3	-	3/3	9/10
G O'Keeffe	Non Executive Director	4/5	-	4/6	7/9	-	3/3	10/11
N Williams*	Non Executive Director	2/2	1/1	-	-	-	2/2	2/2
M Longhi**	Non Executive Director	1/2	-	-	6/6	-	1/1	5/5
C Dowrick	Board Advisor	3/5	2/6	4/6	-	-	0/0	3/11
J Rafferty	Chief Executive	5/5	-	-	-	9/12	-	7/11
N Smith	Executive Director	5/5	-	-	8/9	10/12	-	10/11
D Fearnley	Medical Director	5/5	-	6/6	5/9	9/12	-	9/11
R Walker	Executive Director	5/5	-	6/6	7/9	12/12	-	8/11
E Darbyshire***	Executive Director	4/4	-	5/6	-	9/12	-	8/11
K Crowe****	Executive Director	1/1	-	-	-	2/2	-	-
Amanda Oates******	Director of Workforce	4/4						
Average Attendance		**93%**	**70%**	**80%**	**80%**	**82%**	**95%**	**77%**

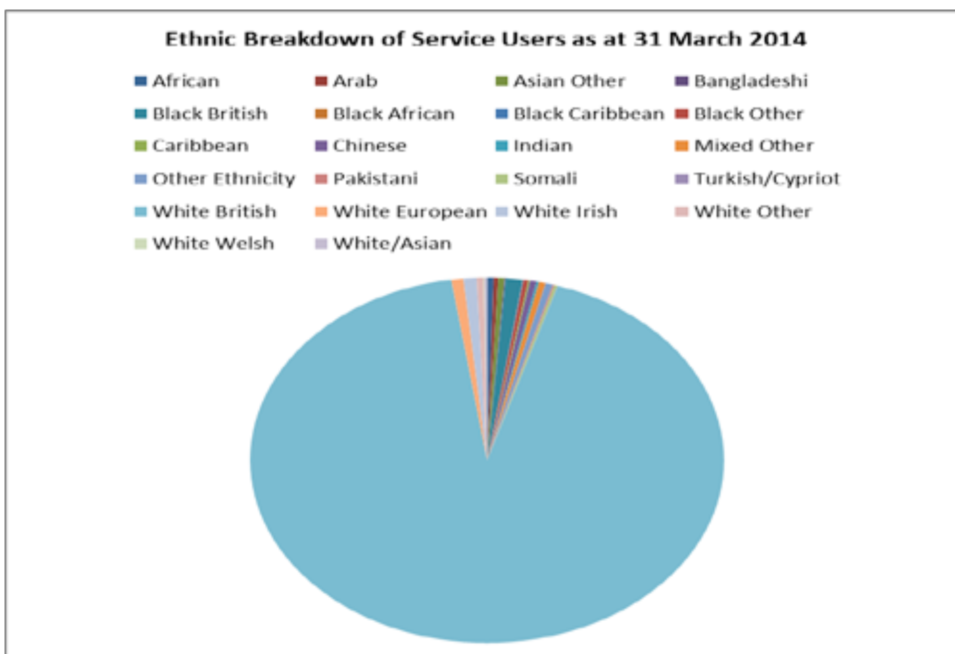
*Nick Williams - commenced 1 January 2014
**Marco Longhi - resigned September 2013
***Elaine Darbyshire - commenced June 2013
****Kim Crowe - resigned from 1 June 2013
*****Brenda Roe - commenced 16 May 2013
******Amanda Oates - commenced 1 August 2013

Attendance at Members Council

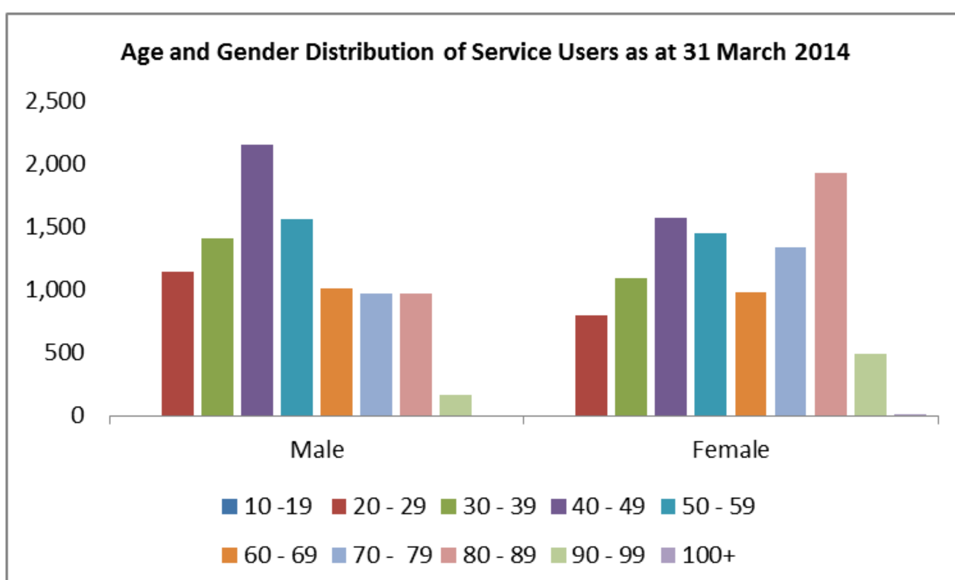
	Constituency	Members' Council
Beatrice Fraenkel	Chairman	3/4
Michael Riglesford	Service User/ Carer	3/4
Don Bryant	Service User/ Carer	1/4
Lee Bond	Service User/ Carer	0/4
Mofolusho Rosanwo	Service User/ carer	4/4
Les Carlile	Service User/ Carer	4/4
Stuart Sime	Service User/ Carer	3/4
Mary Brandt	Service User/ Carer	3/4
George Allen	Service User/ Carer	1/4
Monica Palfreyman	Public	3/4
Howard Winik	Public	4/4
John Mousley	Public	3/4
Ruth Smart	Public	0/3 [resigned]
Jessica Chittenden	Public	2/4
Dean Sullivan	Public	0/4
Russell Pringle	Staff	2/4
Rumbie Nyengerai	Staff	0/4
Emad Lilo	Staff	2/4
Julie Crompton	Staff	1/4
Gerard Carney	Staff	1/4
Joseph Forster	Staff	2/3 [resigned]
Clare Perkins	Appointed	2/3 [resigned]
Claire Glare	Appointed	1/1 [commenced March 2014]
Colin Vose	Appointed	0/3 [resigned]
Joseph Hemmington	Appointed	1/1 [resigned]
Clare Duggan	Appointed	0/4
Average Attendance		**49%**



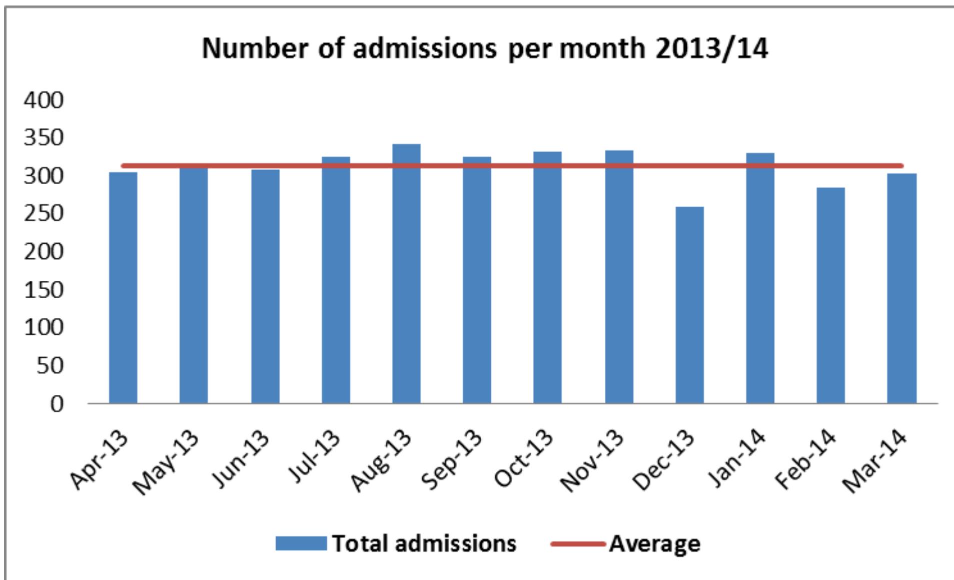
As at 31 March 2014, the trust was achieving the equality objective targets of 95% data completeness for protected characteristics of service users. Source: ePEX



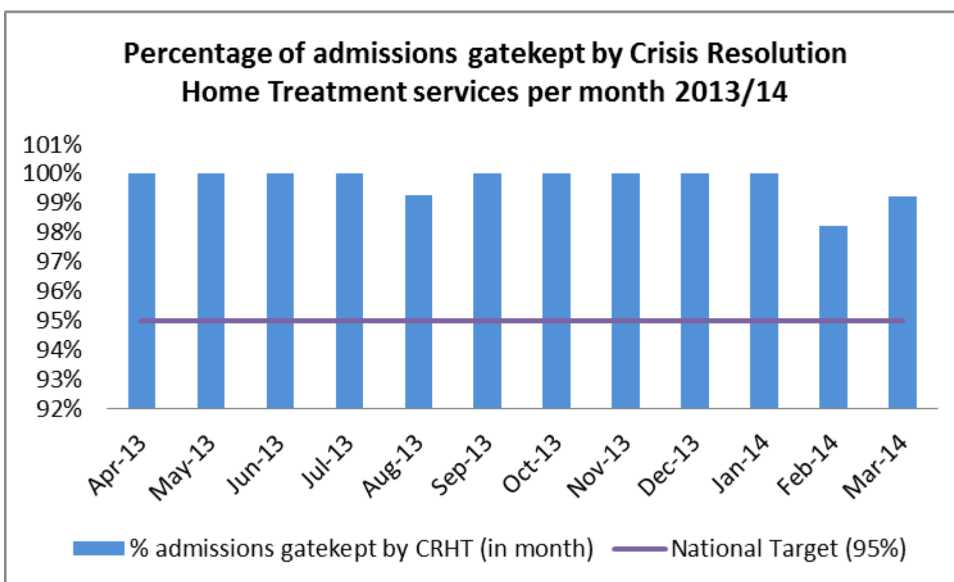
As at 31 March 2014, 19,372 patients were being provided with a service by Mersey Care, of which ethnicity was known for 18,327 (94.6%). 92% of service users with known ethnicity were White British, 87.15% of the population served by the trust are White British. Source: ePEX, PACIS and Membership Strategy



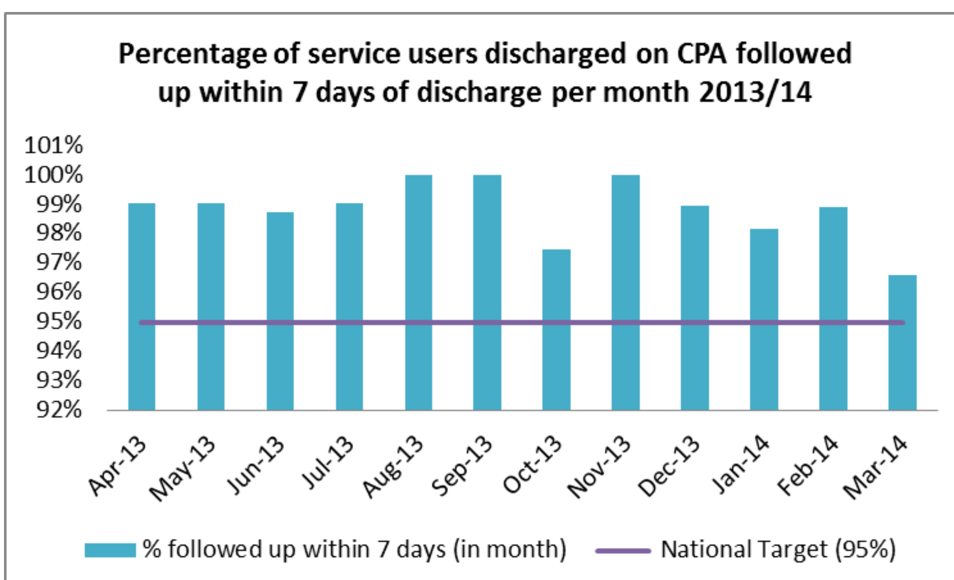
The graph shows that the greater majority of males on the caseload at 31 March 2014 were in the age group 40 - 49 (23%), where the larger majority of females were in the 80 - 89 (20%) age group. Although there is some activity for the younger age groups, most of these are in the 17 to 18 age range. There are 1.5% more females on the caseload than males, despite high secure services who have a male only service (192 resident at 31 March 2014). Source: ePEX and PACIS



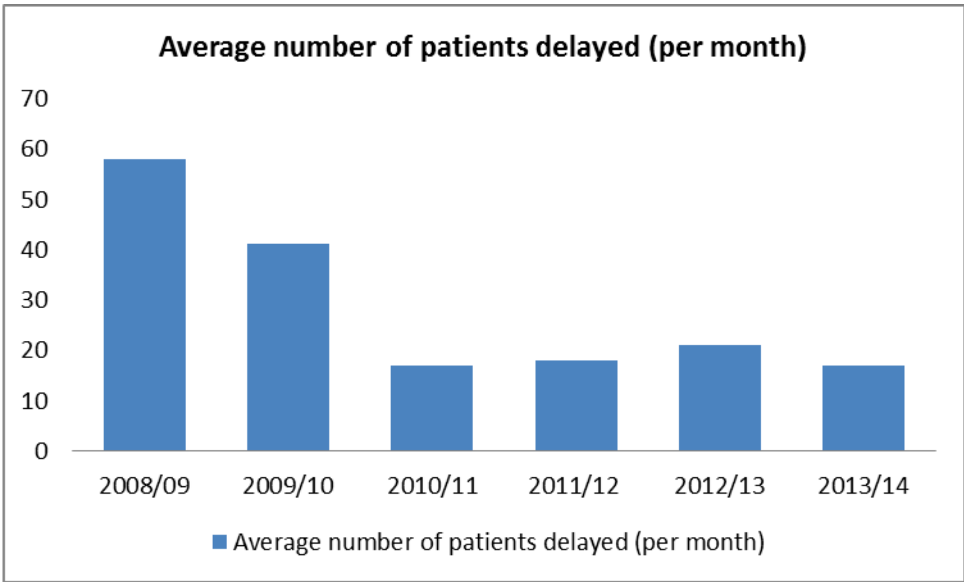
There has been a 2.6% increase in admissions in 2013/14 with an average of 313 admissions across the trust per month compared with 305 admissions per month in 2012/13. Source: ePEX and PACIS



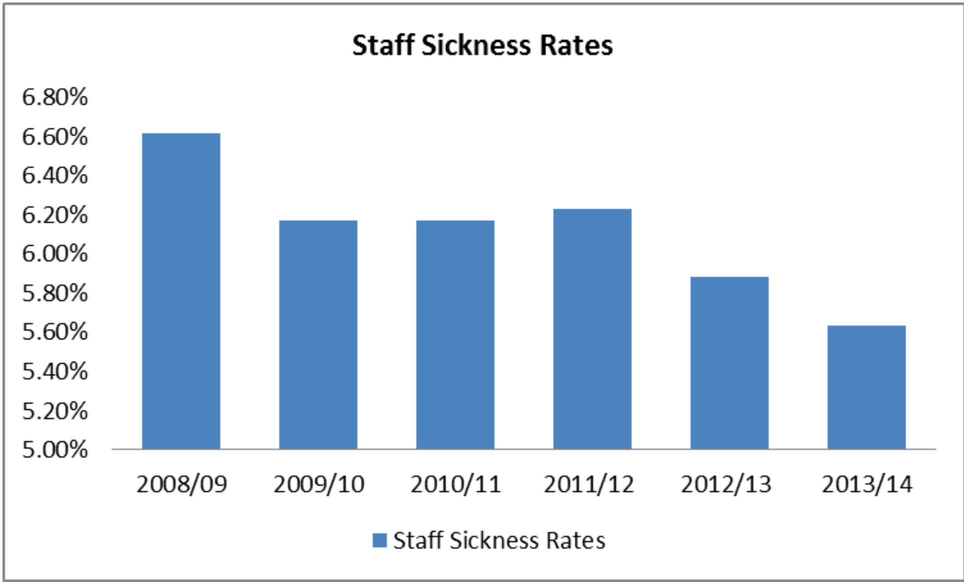
Mental health trusts are required to demonstrate that service users are assessed (gatekept) prior to admission by Crisis Resolution Home Treatment Teams to avoid unnecessary admissions to inpatient units. During 2013/14, 99.72% of service users admitted to acute inpatient wards were gatekept by CRHT, compared to 99.2% in 2012/13. The chart shows the percentage of admitted service users, gatekept against the national target each month. Source: ePEX



Mental health trusts are required to demonstrate that service users discharged on a CPA are followed up within 7 days of discharge. 98.86% of service users discharged on a CPA in 2013/14 were followed up within 7 days, compared to 96.7% in 2012/13. The chart shows the percentage of service users followed up within 7 days of discharge against the national target each month. Source: ePEX



In 2013/14 an average of 17 delayed discharges were reported at the end of each month, compared with 21 during 2012/13. The average proportion of beds occupied by delayed discharges was 5.47% in 2013/14 compared with 5.2% in 2012/13. These figures include delays attributable to the NHS and social care. The majority of service users delayed (44%) were awaiting nursing home placement. Source: ePEX



The cumulative staff sickness rate in 2013/14 was 5.63% compared with 5.9% in 2012/13. There has been a year on year improvement since 2011/12. Source: ESR

Local Services, Medium Secure, Low Secure and Offender Health Data

Number of consultant outpatient contacts

Specialty	Addiction Services	Liverpool	Positive Care Partnerships	Rebuild	SaFE Partnerships	Total
Adult mental health - acute		10,471	13,185		155	23,811
Adult mental health - rehab/BI/LSU				939	15	954
Older peoples mental health		3,562	6,657			10,219
Learning disabilities				1,304		1,304
Drug and alcohol	3,679					3,679
Medium secure					533	533
Psychotherapy		1,151				1,151
Total	**3,679**	**15,184**	**19,842**	**2,243**	**703**	**41,651**

There were 41,651 consultant outpatient attendances and face to face consultant community contacts in 2013/14, compared with 41,603 in 2012/13. Source: ePEX

Total number of patients provided with a service by local services in 2013/14	35,525
Total number of patients provided with a service by medium secure, low secure and offender health services in 2013/14	632

Number of face to face community contacts not carried out by a consultant

Specialty	Addiction Services	Liverpool	Positive Care Partnerships	Rebuild	SaFE Partnerships	Total
Adult mental health - acute		93,803	111,298	1,132	2,594	208,827
Adult mental health - rehab/BI/LSU				6,607	4,815	11,422
Older peoples mental health		51,051	32,958			84,009
Learning disabilities				26,621		26,621
Drug and alcohol	131,977					131,977
Medium secure					9,442	9,442
Psychotherapy		6,036			2,303	8,339
Dietician	9	172	184	35	30	430
Total	**131,986**	**151,062**	**144,440**	**34,395**	**19,184**	**481,067**

There were 481,067 face to face community contacts not carried out by a consultant in 2013/14, compared with 476,989 in 2012/13. Source: ePEX

Data extracted from ePEX 3 April 2014.

High Secure Services Data

Patient population by service as at 31 March 2014

Category	No. Patients	% of Population
Mental health	122	63.5%
Personality disorder	70	36.5%
Total	**192**	**100.00%**

The high secure service operates with wards of a maximum of 20 patients. The table indicates the patient population as at 31 March 2014 was 192, compared to 191 as at 31 March 2013. In addition to the 192 inpatient population, there were 15 patients on leave as at 31 March 2014 (compared to 20 patients on leave as at 31 March 2013). Source: PACIS

Source of patient admission

Admission Source	No. Patients	% of Admissions
Prison	29	54.7%
High Secure hospital	2	3.8%
Medium secure unit	21	39.6%
Hospital	0	0.0%
Low secure unit	0	0.0%
Police station	1	1.9%
Total	**53**	**98.11%**

This table shows the number of patients admitted to high secure services in 2013/14, and where they were admitted from. 53 patients (103.44% increase) were admitted in 2013/14, compared with 29 in 2012/13. Source: PACIS

Outcome of referrals

Outcome	No. Patients	% of referrals
Rejected	19	26.0%
Accepted	51	69.9%
Open	0	0.0%
Withdrawn	2	2.7%
Inappropriate	1	1.4%
Referred	**73**	**95.89%**

During 2013/14 the service received 73 referrals, which is a 24% increase on 2012/13. Of the 73 patients referred for admission to the service in 2013/14, 51 were accepted (69.86%). This is an increase in the proportion accepted from 54.2% in 2012/13. Source: PACIS

Patients transferred/discharged by place

Destination	No. Patients	% of discharges
High secure hospital	1	1.8%
Medium secure unit	36	63.2%
Low secure unit	1	1.8%
Prison	13	22.8%
Court	2	3.5%
Hospital	0	0.0%
Deceased	4	7.0%
Total	**57**	**92.98%**

During 2013/14, 57 patients were discharged from high secure services, which is an increase of 54% on 2012/13. The table shows where these patients were discharged/transferred to. The majority of high secure patients discharged during 2013/14 went to a medium secure unit (63.16%). Source: PACIS

Regional split of patients

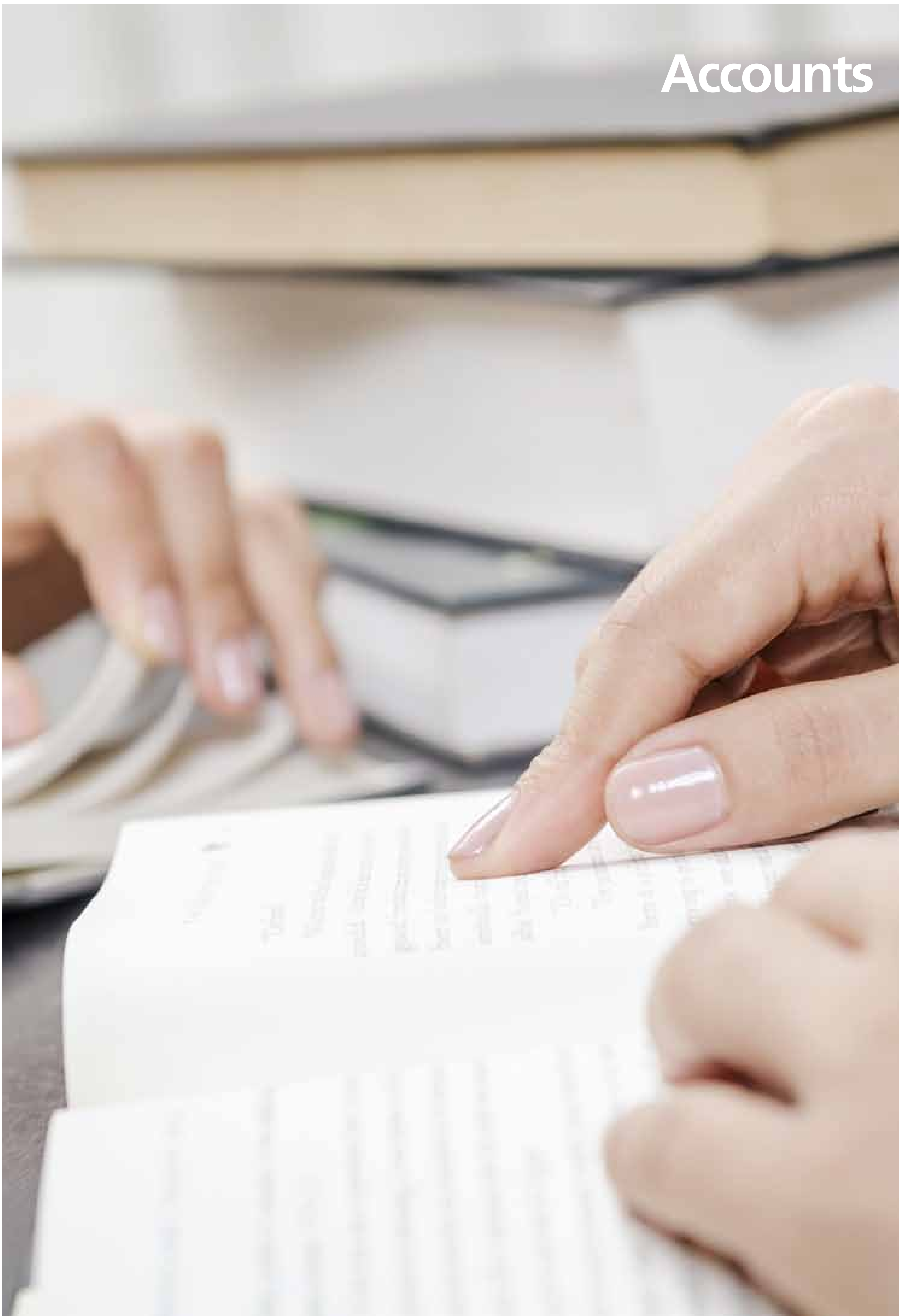
Region	No. Patients	% of population
London	3	1.2%
Northern excluding North West	6	2.5%
Northern Ireland	1	0.4%
North West	126	51.6%
South East	1	0.4%
Trent	0	0.0%
Wales	46	18.9%
West Midlands	60	24.6%
Not Available	1	0.4%
Total	**244**	**100.00%**

Total number of patients provided with a service by high secure services in 2013/14	244

Data extracted from PACIS 14 April 2014.

The table shows the number of patients accessing high secure services in 2013/14. From the information it can be seen that the majority of patients came from the North West, West Midlands and Wales. (95.08% of patients in total). Source: PACIS

Accounts



INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF MERSEY CARE NHS TRUST

We have audited the financial statements of Mersey Care NHS Trust for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes
- the table of pension benefits of senior managers and related narrative notes
- the table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of Mersey Care NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust's directors and the trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of Directors and auditors

As explained more fully in the Statement of Directors' Responsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Accounting (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit and the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. This includes and assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report which comprises the following:

Introduction, Strategy for Service Development, Equality, Diversity and Human Rights, Environment and Sustainability, Emergency Planning, Complaints including Service Improvements, Serious Untoward Incidents, Finance Director's Report.

We read these to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies and we consider the implications for our report.

Opinion on financial matters

In our opinion the financial statements:

- give a true and fair view of the financial position of Mersey Care NHS Trust as at 31 March 2014 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given 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 report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Trust Development Authority's Guidance
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the trust, or an officer of the trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Conclusion on the trust's arrangements for securing the economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the trust and auditors

The trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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.

Scope of the review or arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2013, as to whether the trust has proper arrangements for:

- securing financial resilience
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code if 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 2014.

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 form a view on whether, in all significant respects, the trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2013, we are satisfied that in all significant respects Mersey Care NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to provide assurance over the trust's annual quality account. We are satisfied that this work does not have a material effect on the financial statements or on our value for money conclusion.

Michael Thomas
for and on behalf of Grant Thornton UK LLP,
Appointed Auditor
Royal Liver Building
Liverpool
L3 1PS
30 May 2014

FOREWARD TO THE ACCOUNTS

These accounts for the year ended 31 March 2014 have been prepared by Mersey Care NHS Trust under Section 98(2) of the National Health Service Act 1977 (as amended by Section 24(2), Schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with approval of the Treasury, directed.

STATEMENT OF COMPREHENSIVE INCOME FOR YEAR ENDED 31 MARCH 2014

	NOTE	2013/14 £000s	2012/13 £000s
Gross employee benefits	9.1	**(154,190)**	(158,228)
Other operating costs	7	**(48,712)**	(48,737)
Revenue from patient care activities	4	**184,451**	189,322
Other Operating revenue	5	**23,425**	19,204
Operating surplus		**4,974**	**1,561**
Investment revenue	11	**72**	72
Other losses	12	**(130)**	(123)
Finance costs	13	**(876)**	(915)
Surplus for the financial year		**4,040**	**595**
Public dividend capital dividends payable		**(3,618)**	(4,131)
Transfers by absorption – gains		**0**	0
Transfers by absorption – (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	**0**
Retained surplus/(deficit) for the year		**422**	**(3,536)**

Other Comprehensive Income

Other Comprehensive Income	2013/14 £000s	2012/13 £000s
Impairments and reversals taken to the Revaluation Reserve	**(92)**	(5,034)
Net gain on revaluation of property, plant & equipment	**8,389**	82
Total Comprehensive Income for the year*	**8,719**	**(8,488)**

Financial performance for the year

	2013/14	2012/13
Retained surplus/(deficit) for the year	**422**	(3,536)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment	**0**	481
Impairments*	**4,328**	7,055
Adjusted retained surplus	**4,750**	**4,000**

* An explanation of the adjustments is provided in Note 16 Impairments

The notes on pages 66 to 101 form part of this account.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	14	**146,857**	140,738
Intangible assets	15	**93**	91
Trade and other receivables	20.1	**152**	578
Total non-current assets		**147,102**	**141,407**
Current assets:			
Inventories	19	**366**	454
Trade and other receivables	20.1	**7,506**	4,961
Cash and cash equivalents	23	**18,098**	14,516
Total current assets		**25,970**	**19,931**
Non-current assets held for sale		**0**	**0**
Total current assets		**25,970**	**19,931**
Total assets		**173,072**	**161,338**
Current liabilities			
Trade and other payables	25	**(9,133)**	(7,160)
Other liabilities	26	**0**	0
Provisions	31	**(1,764)**	(1,805)
Borrowings	27	**(121)**	(103)
Other financial liabilities	26	**0**	0
Working capital loan from Department		**0**	0
Capital loan from Department		**0**	0
Total current liabilities		**(11,018)**	**(9,068)**
Net current assets		**14,952**	**10,863**
Non-current assets plus net current assets		**162,054**	**152,270**
Non-current liabilities			
Trade and other payables	25	**0**	0
Other liabilities	26	**0**	0
Provisions	31	**(20,736)**	(19,551)
Borrowings	27	**(4,833)**	(4,953)
Other financial liabilities	26	**0**	0
Working capital loan from Department		**0**	0
Capital loan from Department		**0**	0
Total non-current liabilities		**(25,569)**	**(24,504)**
Total Assets Employed:		**136,485**	**127,766**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**58,099**	58,099
Retained earnings		**(28,433)**	(32,235)
Revaluation reserve		**46,912**	41,995
Other reserves		**59,907**	59,907
Total Taxpayers' Equity:		**136,485**	**127,766**

The financial statements on pages 62 to 65 were approved by the Board on 28 May 2014 and signed on its behalf by

The notes on pages 66 to 101 form part of this account.

Signed: Chief Executive

Date: 28.05.14

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2014

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2013	**58,099**	**(32,235)**	**41,995**	**59,907**	**127,766**
Changes in taxpayers' equity for 2013/14					
Retained surplus for the year	0	422	0	0	422
Net gain on revaluation of property, plant, equipment	0	0	8,389	0	8,389
Impairments and reversals	0	0	(92)	0	(92)
Transfers between reserves	0	3,380	(3,380)	0	0
Reclassification Adjustments					
Net recognised revenue for the year	**0**	**3,802**	**4,917**	**0**	**8,719**
Balance at 31 March 2014	**58,099**	**(28,433)**	**46,912**	**59,907**	**136,485**
Balance at 1 April 2012	**58,099**	**(31,019)**	**49,267**	**59,907**	**136,254**
Changes in taxpayers' equity for the year ended 31 March 2013					
Retained deficit for the year	0	(3,536)	0	0	(3,536)
Net gain on revaluation of property, plant, equipment	0	0	82	0	82
Impairments and reversals	0	0	(5,034)	0	(5,034)
Transfers between reserves	0	2,320	(2,320)	0	0
Reclassification Adjustments					
Net recognised revenue for the year	**0**	**(1,216)**	**(7,272)**	**0**	**(8,488)**
Balance at 31 March 2013	**58,099**	**(32,235)**	**41,995**	**59,907**	**127,766**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2014

	2013/14 £000s	2012/13 £000s
Cash Flows from Operating Activities		
Operating Surplus	**4,974**	1,561
Depreciation and Amortisation	**5,140**	5,831
Impairments and Reversals	**4,328**	7,536
Interest Paid	**(440)**	(444)
Dividend Paid	**(3,454)**	(4,314)
Decrease in Inventories	**88**	13
Increase in Trade and Other Receivables	**(2,240)**	(181)
Increase/(Decrease) in Trade and Other Payables	**2,773**	(2,036)
Provisions Utilised	**(1,813)**	(1,756)
Increase in Provisions	**2,521**	3,537
Net Cash Inflow from Operating Activities	**11,877**	9,747
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**72**	72
(Payments) for Property, Plant and Equipment	**(8,087)**	(8,606)
(Payments) for Intangible Assets	**(177)**	(123)
Net Cash Outflow from Investing Activities	**(8,192)**	(8,657)
NET CASH INFLOW BEFORE FINANCING	**3,685**	1,090
CASH FLOWS FROM FINANCING ACTIVITIES		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(103)**	(84)
Net Cash Outflow from Financing Activities	**(103)**	(84)
NET INCREASE IN CASH AND CASH EQUIVALENTS	**3,582**	1,006
Cash and Cash Equivalents at Beginning of the Period	**14,516**	13,510
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents at year end	**18,098**	14,516

NOTES TO THE ACCOUNTS

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013/14 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

The trust has not had any transfer of assets in 2013/14.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities 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.

1.4.1 Critical judgements in applying accounting policies

The following are the critical 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.

Valuation of non current assets, their useful lives and the depreciation policy

The trust uses appropriately qualified valuers to determine the value of assets and their useful lives. The Depreciation Policy follows HM Treasury and Department of Health guidance.

1.4.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing 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 adaptation of IFRS as per the FREM and the NHS manual for accounts. Details of impairments are included in Note 16.

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 31.

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.

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

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 e.g. by an insurer. The trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the trust commits itself to the retirement, regardless of the method of payment.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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 fair value.

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment, subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the trust expects to obtain economic benefits or service potential from the asset. This is specific to the trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.11 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.13 Non-current assets held for sale

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

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.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

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 so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the 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 on a straight-line basis over the lease term.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the trust's cash management.

1.17 Provisions

Provisions are recognised when the trust has a present legal or constructive obligation as a result of a past event, it is probable that the trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate for either short, medium or long term provisions. The rates applied are 0-5 years (1.9%), 6-10 years (0.65%) and over 10 years 2.2%. The majority of the trust's provisions are long term and therefore the discount rate is 2.2% in real terms (1.8% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 31.

1.19 Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHSLA 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 as and when they become due.

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable. Where the time value of money is material, contingencies are disclosed at their present value.

1.21 Financial assets

Financial assets are recognised when the trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.22 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the trust's surplus. The trust has reviewed all contracts to identify any embedded derivatives that are not closely related to the host contracts. Following this review the trust has deemed its embedded derivatives to be immaterial and as such no adjustment has been made to the accounts.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.23 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.24 Foreign currencies

The trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.25 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. Details of third party assets are provided in Note 38 to the accounts.

1.26 Other reserves

Other reserves represent the increase of the net assets of the trust as a result of the integration of Ashworth Hospital into the trust on 1 April 2002. The reserve will remain in perpetuity until such time as the trust is dissolved.

1.27 Public dividend capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS Trust. 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. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets, net assets transferred from NHS bodies dissolved on 1 April 2013 and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.28 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).

1.29 Subsidiaries

Material entities over which the trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines.

1.30 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Income (SOCNE)/ Statement of Comprehensive Income (SOCI) on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.31 Accounting standards that have been issued but have not yet been adopted

The Treasury Finance Reporting Manual (FReM) does not require the following Standards and Interpretations to be applied in 2013/14. The application of the Standards as revised would not have a material impact on the accounts for 2013/14, were they applied in that year:

IAS 27 Separate Financial Statements – subject to consultation

IAS 28 Investments in Associates and Joint Ventures – subject to consultation

IFRS 9 Financial Instruments – subject to consultation

IFRS 10 Consolidated Financial Statements – subject to consultation

IFRS 11 Joint Arrangements – subject to consultation

IFRS 12 Disclosure of Interests in Other Entities – subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

The Treasury FReM does not require the following Standard and Interpretations to be applied in 2013/14. The application of the Standard as revised would have a material impact on the accounts for 2013/14, were it applied in that year:

IPSAS 32 - Service Concession Arrangement - subject to consultation

In February 2013, the trust entered into a Land Retained Agreement under the NHS Local Improvement Finance Trust (LIFT) initiative for the construction, finance and operation of an 82-bed local services Mental Health unit in Walton, Liverpool. As at 31 March 2014, the certified construction value of the building was £13.5m. Once the building is completed, the liability associated with the concession, over the full 30 year life of the contract is estimated to be approximately £25.6m.

2. Operating segments

The trust has only one operating segment, that of healthcare.

3. Income generation activities

For the financial years 2013/14 and 2012/13 the trust has not undertaken any material income generation activities.

4. Revenue from patient care activities

	2013/14 £000s	2012/13 £000s
NHS Trusts	**6**	16
NHS England	**73,398**	0
Clinical Commissioning Groups	**93,310**	0
Primary Care Trusts	**0**	172,305
Strategic Health Authorities	**0**	0
NHS Foundation Trusts	**1,157**	635
Department of Health	**0**	4
NHS Other (including Public Health England and Prop Co)	**0**	0
Non-NHS:		
Local Authorities	**3,522**	2,813
Private patients	**0**	0
Overseas patients (non-reciprocal)	**0**	0
Injury costs recovery	**0**	3
Other*	**13,058**	13,546
Total Revenue from patient care activities	**184,451**	**189,322**

* Includes patient care income for High Secure Services from Welsh health bodies (£12.7m 2013/14, £13.5m 2012/13).

5. Other operating revenue

	2013/14 £000s	2012/13 £000s
Recoveries in respect of employee benefits	**0**	0
Patient transport services	**0**	0
Education, training and research	**3,658**	3,636
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**0**	0
Receipt of donations for capital acquisitions - NHS Charity	**0**	0
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies*	**12,239**	10,881
Income generation	**0**	0
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**3,038**	2,873
Other revenue**	**4,490**	1,814
Total Other Operating Revenue	**23,425**	**19,204**
Total operating revenue	**207,876**	**208,526**

*Includes income for Informatics Merseyside of £11.7m (£10.2m in 2012/13).

** Includes £1.7m relates to the Dallas Assisted Living scheme that was hosted for part of the year.

6. Revenue

	2013/14 £000s	2012/13 £000s
From rendering of services	**207,876**	208,526
From sale of goods	**0**	0

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

7. Operating expenses

	2013/14 £000s	2012/13 £000s
Purchase of healthcare from non-NHS bodies	**1,099**	495
Trust Chair and Non-executive Directors	**64**	60
Supplies and services - clinical	**4,925**	4,820
Supplies and services - general	**4,316**	4,262
Consultancy services	**1,990**	961
Establishment	**6,903**	6,196
Transport	**374**	362
Premises	**12,145**	13,043
Hospitality	**128**	0
Insurance	**319**	0
Legal Fees	**724**	0
Impairments and Reversals of Receivables	**51**	(3)
Inventories write down	**0**	0
Depreciation	**5,095**	5,734
Amortisation	**45**	97
Impairments and reversals of property, plant and equipment	**4,328**	7,536
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Impairments and reversals of investment properties	**0**	0
Audit fees	**74**	79
Other auditor's remuneration	**8**	0
Clinical negligence	**207**	221
Research and development (excluding staff costs)	**251**	206
Education and Training	**1,136**	1,535
Change in Discount Rate	**1,228**	919
Other*	**3,302**	2,214
Total Operating expenses (excluding employee benefits)	**48,712**	**48,737**

*Other includes £2.2m for Professional Fees, £0.9m for Early Retirements and Permanent Injury Benefits

Employee Benefits		
Employee benefits excluding Board members	**153,172**	157,165
Board members	**1,018**	1,063
Total Employee Benefits	**154,190**	**158,228**
Total Operating Expenses	**202,902**	**206,965**

8. Operating leases

The trust has operating leases in respect of: Photocopiers, Buildings and Lease Cars. None of these leases are significant.
The trust entered into an operating lease for the new Trust Offices in December 2012.

	Land £000s	Buildings £000s	Other £000s	2013/14 Total £000s	2012/13 £000s
8.1 Trust as lessee					
Payments recognised as an expense					
Minimum lease payments				**455**	505
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**455**	**505**
Payable:					
No later than one year	0	501	77	**578**	479
Between one and five years	0	1,763	285	**2,048**	1,901
After five years	0	1,866	0	**1,866**	1,898
Total	**0**	**4,130**	**362**	**4,492**	**4,278**
Total future sublease payments expected to be received:				**0**	**0**

8.2 Trust as lessor

The trust is leasing 8.5 hectares of land. No buildings form part of the lease.

	2013/14 £000s	2012/13 £000s
Recognised as revenue		
Rental revenue	**3,038**	2,873
Contingent rents	**0**	0
Total	**3,038**	**2,873**
Receivable:		
No later than one year	**3,038**	3,038
Between one and five years	**6,962**	10,000
After five years	**0**	0
Total	**10,000**	**13,038**

9. Employee benefits and staff numbers

9.1 Employee benefits

	2013/14 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**128,704**	113,808	14,896
Social security costs	**9,874**	9,284	590
Employer Contributions to NHS BSA* - Pensions Division	**14,629**	13,754	875
Other pension costs	**1**	1	0
Termination benefits	**2,106**	2,106	0
Total employee benefits	**155,314**	**138,953**	**16,361**
Employee costs capitalised	**1,124**	**1,124**	**0**
Gross Employee Benefits excluding capitalised costs	**154,190**	**137,829**	**16,361**

* Business Service Authority

Employee Benefits - Gross Expenditure 2012/13

	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	**132,852**	117,813	15,039
Social security costs	**10,030**	9,406	624
Employer Contributions to NHS BSA - Pensions Division	**14,681**	13,767	914
Other pension costs	**1**	**1**	**0**
Termination benefits	**1,694**	1,694	0
TOTAL - including capitalised costs	**159,258**	**142,681**	**16,577**
Employee costs capitalised	**1,030**	1,030	0
Gross Employee Benefits excluding capitalised costs	**158,228**	**141,651**	**16,577**

In 2012/13 there were rows for ‘other post-employment benefits’ and ‘other employment benefits’. These are now included within the ‘Salaries and wages’ row.

9.2 Staff numbers

	2013/14 Total Number	Permanently employed Number	Other Number	2012/13 Total Number
Average Staff Numbers				
Medical and dental	**142**	132	10	141
Ambulance staff	**0**	0	0	0
Administration and estates	**1,017**	931	86	943
Healthcare assistants and other support staff	**1,310**	1,121	189	1,459
Nursing, midwifery and health visiting staff	**1,091**	1,025	66	1,101
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**285**	281	4	329
Social Care Staff	**32**	20	12	41
Other	**0**	0	0	0
TOTAL	**3,876**	**3,510**	**366**	**4,014**
Of the above - staff engaged on capital projects	**30**	30	0	29

9.3 Staff sickness absence and ill health retirements

	2013/14 Number	2012/13 Number
Total Days Lost	**44,368**	48,208
Total Staff Years	**3,483**	3,616
Average working Days Lost	**12.74**	**13.33**

* The staff sickness figures are based on a calendar year (Jan - Dec) not the financial year.

	2013/14 Number	2012/13 Number
Number of persons retired early on ill health grounds	**17**	9

	£000s	£000s
Total additional pensions liabilities accrued in the year	**889**	542

9.4 Exit packages agreed in 2013/14

	2013/14			2012/13		
	*No. of compulsory redundancies	*No. of other departures agreed	Total No. of exit packages by cost band	*No. of compulsory redundancies	*No. of other departures agreed	Total No. of exit packages by cost band
Less than £10,000	**0**	**44**	**44**	1	29	30
£10,000-£25,000	**1**	**48**	**49**	2	29	31
£25,001-£50,000	**0**	**25**	**25**	3	10	13
£50,001-£100,000	**0**	**5**	**5**	1	4	5
£100,001 - £150,000	**0**	**0**	**0**	1	0	1
£150,001 - £200,000	**0**	**0**	**0**	1	0	1
>£200,000	**0**	**0**	**0**	0	0	0
Total number of exit packages by type (total cost)	**1**	**122**	**123**	**9**	**72**	**81**
Total resource cost	**18,805**	**2,254,723**	**2,273,528**	**548,250**	**1,218,265**	**1,767,515**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme/Trust's Mutually Agreed Redundancy Scheme (MARS). Where the trust has agreed early retirements, the additional costs are met by the trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

The Trust (MARS) scheme was agreed with HM Treasury. Of the 'other' departures all 98 staff (£2,087,532) left as a result of the MARS scheme.

This disclosure reports the number and value of exit packages taken by staff agreed in the year.

9.5 Exit packages - other departures analysis

	2013/14		2012/13	
	Agreements Number	Total value of agreements £000s	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	98	2,088	56	1,145
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	24	167	16	72
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT* approval	0	0	0	0
Total	**122**	**2,255**	**72**	**1,218**

* Her Majesty's Treasury

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

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 9.4 which will be the number of individuals.

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

9.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that
employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

The trust has one employee who is a member of the Teachers pension scheme.

10. Better payment practice code

10.1 Measure of compliance

	2013/14 Number	2013/14 £000s	2012/13 Number	2012/13 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**39,776**	**70,853**	40,158	98,009
Total Non-NHS Trade Invoices Paid Within Target	**38,829**	**70,107**	39,202	97,255
Percentage of NHS Trade Invoices Paid Within Target	**97.62%**	**98.95%**	97.62%	99.23%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**696**	**11,997**	879	23,455
Total NHS Trade Invoices Paid Within Target	**687**	**11,876**	866	23,453
Percentage of NHS Trade Invoices Paid Within Target	**98.71%**	**98.99%**	98.52%	99.99%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

The trust made no payments under the Late Payment of Commercial Debts (Interest) Act 1998 for the years 2013/14 and 2012/13.

11. Investment revenue

	2013/14 £000s	2012/13 £000s
Rental revenue	**0**	**0**
Interest revenue		
Bank Interest	72	72
Subtotal	**72**	**72**
Total investment revenue	**72**	**72**

12. Other gains and losses

	2013/14 £000s	2012/13 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	0
Loss on disposal of assets other than by sale (intangibles)	**(130)**	(123)
Total	**(130)**	**(123)**

13. Finance costs

	2013/14 £000s	2012/13 £000s
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**440**	444
Total interest expense	**440**	444
Other finance costs	**0**	0
Provisions - unwinding of discount	**436**	471
Total	**876**	**915**

14.1 Property, plant and equipment

2013/14	Land £000s	Buildings ex excluding dwellings £000s	Dwellings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & Fittings £000s	Total £000s
Cost or valuation:									
At 1 April 2013	**16,420**	**118,428**	**0**	**9,040**	**6,238**	**990**	**6,125**	**2,175**	**159,416**
Additions of Assets Under Construction	0	0	0	599	0	0	0	0	599
Additions Purchased	0	5,527	0	0	855	0	121	143	6,646
Additions Donated	0	0	0	0	0	0	0	0	0
Reclassifications	0	2,876	0	(3,701)	817	0	0	8	0
Disposals other than for sale	0	(2,152)	0	0	(125)	0	(1,516)	(8)	(3,801)
Upward revaluation/positive indexation	299	8,090	0	0	0	0	0	0	8,389
Impairments/negative indexation	(51)	(41)	0	0	0	0	0	0	(92)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Cumulative dep'n adjustment following revaluation	(448)	(13,707)	0	0	0	0	0	0	(14,155)
At 31 March 2014	**16,220**	**119,021**	**0**	**5,938**	**7,785**	**990**	**4,730**	**2,318**	**157,002**
Depreciation									
At 1 April 2013	**0**	**8,106**	**0**	**649**	**2,200**	**781**	**4,859**	**2,083**	**18,678**
Disposals other than for sale	0	(2,152)	0	0	(125)	0	(1,516)	(8)	(3,801)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	1,101	7,103	0	0	0	0	153	0	8,357
Reversal of Impairments	(653)	(3,376)	0	0	0	0	0	0	(4,029)
Charged During the Year	0	4,026	0	0	517	66	422	64	5,095
Cumulative dep'n adjustment following revaluation	(448)	(13,707)	0	0	0	0	0	0	(14,155)
At 31 March 2014	**0**	**0**	**0**	**649**	**2,592**	**847**	**3,918**	**2,139**	**10,145**
Net Book Value at 31 March 2014	**16,220**	**119,021**	**0**	**5,289**	**5,193**	**143**	**812**	**179**	**146,857**
Purchased	16,220	119,021	0	5,289	5,193	143	812	179	146,857
Donated									0
Government Granted									0
Total at 31 March 2014	**16,220**	**119,021**	**0**	**5,289**	**5,193**	**143**	**812**	**179**	**146,857**

Asset financing:									
Owned - Purchased	16,220	116,439	0	5,289	5,193	143	812	179	144,275
Owned - Donated	0	0	0	0	0	0	0	0	0
Owned - Government Granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	2,582	0	0	0	0	0	0	2,582
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2014	**16,220**	**119,021**	**0**	**5,289**	**5,193**	**143**	**812**	**179**	**146,857**

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & Fittings	Total
2013/14	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Revaluation Reserve Balance for Property, Plant & Equipment									
At 1 April 2013	568	41,398	0	0	24	3	0	2	41,995
Movements (specify)	123	4,806	0	0	(9)	(2)	0	(1)	4,917
At 31 March 2014	**691**	**46,204**	**0**	**0**	**15**	**1**	**0**	**1**	**46,912**

Additions to Assets Under Construction in 2013/14	£000s
Land	0
Buildings excl Dwellings	599
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**599**

14.2 Property, plant and equipment –prior year

2012/13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2012	17,243	122,084	0	5,501	4,804	1,051	5,853	2,188	158,724
Additions - Assets Under Construction	0	0	0	4,707	0	0	0	0	4,707
Additions - purchased	0	3,427	0		962	0	275	0	4,664
Reclassifications	0	696	0	(1,168)	472	0	0	0	0
Disposals other than by sale	(823)	(2,827)	0	0	0	(61)	(3)	(13)	(3,727)
Revaluation & indexation gains	0	82	0	0	0	0	0	0	82
Impairments	0	(5,034)	0	0	0	0	0	0	(5,034)
At 31 March 2013	**16,420**	**118,428**	**0**	**9,040**	**6,238**	**990**	**6,125**	**2,175**	**159,416**
Depreciation									
At 1 April 2012	0	0	0	0	1,452	773	4,120	1,967	8,312
Disposals other than for sale	0	(2,827)	0	0	0	(61)	(3)	(13)	(2,904)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	6,590	0	649	291	0	1	31	7,562
Reversal of Impairments	0	(26)	0	0	0	0	0	0	(26)
Charged During the Year	0	4,369	0	0	457	69	741	98	5,734
At 31 March 2013	**0**	**8,106**	**0**	**649**	**2,200**	**781**	**4,859**	**2,083**	**18,678**
Net book value at 31 March 2013	**16,420**	**110,322**	**0**	**8,391**	**4,038**	**209**	**1,266**	**92**	**140,738**
Purchased	16,420	110,322	0	8,391	4,038	209	1,266	92	140,738
Donated									0
Government Granted									0
Total at 31 March 2013	**16,420**	**110,322**	**0**	**8,391**	**4,038**	**209**	**1,266**	**92**	**140,738**
Asset financing:									
Owned - Purchased	16,420	107,938	0	8,391	4,038	209	1,266	92	138,354
Held on finance lease	0	2,384	0	0	0	0	0	0	2,384
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	**16,420**	**110,322**	**0**	**8,391**	**4,038**	**209**	**1,266**	**92**	**140,738**

14.3 (cont). Property, plant and equipment

The trust's land and buildings were revalued on 31 March 2014 by the District Valuer.

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

The valuation of each property is on the basis of Market Value on the assumption that the property is sold as part of a continuing enterprise in occupation.

The estimated useful lives of the trust's assets are as follows:

Buildings (excluding dwellings) between 3 and 90 years

Plant and Machinery between 10 and 15 years

Transport equipment 7 years

Information technology between 5 and 8 years

Furniture and fittings 5 years

The trust believes that there is not a material difference between its current asset values and market value.

The trust has £5,848,788 fully depreciated assets still in use.

During 2014/15, the trust's new development at Clock View Walton will become operational. This scheme, which has a construction value of approximately £25m, has been procured under the NHS LIFT Initiative and is subject to a Land Retained Agreement. As such, it will be treated as a Service Concession under IFRIC 12, by which the fair value of the building will come onto the Balance Sheet as a fixed asset with a corresponding liability for the future payments to the LIFT Company, net of operating costs, due under the concession.

15.1 Intangible non-current assets 2013/14

	IT in-house & 3rd Party software £000s	Computer Licenses £000s	Licenses & Trademarks £000s	Patents £000s	Development Expenditure -Internally Generated £000s	Total £000s
At 1 April 2013	**0**	**1,053**	**0**	**0**	**0**	**1,053**
Additions - purchased	0	177	0	0	0	177
Disposals other than by sale	0	(172)	0	0	0	(172)
At 31 March 2014	**0**	**1,058**	**0**	**0**	**0**	**1,058**
Amortisation						
At 1 April 2013	**0**	**962**	**0**	**0**	**0**	**962**
Disposals other than by sale	0	(42)	0	0	0	(42)
Charged during the year	0	45	0	0	0	45
At 31 March 2014	0	965	0	0	0	965
Net Book Value at 31 March 2014	**0**	**93**	**0**	**0**	**0**	**93**
Asset Financing: Net book value at 31 March 2014 comprises:						
Purchased	0	93	0	0	0	93
Total at 31 March 2014	**0**	**93**	**0**	**0**	**0**	**93**
Revaluation reserve balance for intangible non-current assets						
At 1 April 2013	0	0	0	0	0	0
Movements	0	0	0	0	0	0
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**

15.2 Intangible non-current assets prior year 2012/13

	IT in-house & 3rd Party software	Computer Licenses	Licenses & Trademarks	Patents	Development Expenditure -Internally Generated	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:						
At 1 April 2012	**0**	**1,053**	**0**	**0**	**0**	**1,053**
Additions - purchased	0	0	123	0	0	123
Disposals other than by sale	0	0	(123)	0	0	(123)
At 31 March 2013	**0**	**1,053**	**0**	**0**	**0**	**1,053**
Amortisation						
At 1 April 2012	**0**	**865**	**0**	**0**	**0**	**865**
Charged during the year	0	97	0	0	0	97
At 31 March 2013	**0**	**962**	**0**	**0**	**0**	**962**
Net book value at 31 March 2013	**0**	**91**	**0**	**0**	**0**	**91**
Net book value at 31 March 2013 comprises:						
Purchased						0
Donated						0
Government Granted						0
Total at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

15.3 Intangible non-current assets

All the trust's intangible assets relate to computer software and have a useful life of between 3-5 years.

15.4 Revaluation reserve balance for intangible assets

The trust has no revaluation reserve for intangible assets. The trust still uses the MAPS Health Roster software that was purchased in 2007-08 at a cost of £792,087 and is now fully amortised.

16. Analysis of impairments and reversals recognised in 2013/14

	2013/14 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Other	4,294
Changes in market price	34
Total charged to Annually Managed Expenditure	**4,328**
Total Impairments of Property, Plant and Equipment changed to SoCI	**4,328**
Total Impairments charged to SoCI - Departmental Expenditure Limits	**0**
Total Impairments charged to SoCI - Annually Managed Expenditure	**4,328**
Overall Total Impairments	**4,328**

Donated and Government Granted Assets, included opposite.

There are no Donated and Government Granted Asset Impairments.

The trust has total impairments of £4,328,334 in 2013/14.

£4,293,687 are economic impairments and £34,647 are impairments due to movements in market price.

Economic impairments of £2,017,944, £1,997,219, £1,342,503 and £94,015 respectively arose when Ruskin Ward, Shelley Ward, the Secure Entrance at Ashworth Hospital and Waterloo Day Hospital were valued by the District Valuer on completion of major refurbishment work.

There were also economic impairments of £152,833 and £15,252 following the scrapping of obsolete IT equipment and the replacement of the lift at the Hesketh Centre.

In 2009/10 the trust revalued its Estate on a Modern Equivalent basis and as a result had an impairment of £61m. Following the revaluation of the trust estate by the District Valuer on 31 March 2014 the value of the previously impaired buildings increased and the trust has Reversal of Impairments of £1,291,421 within the total impairment.

The revaluations in 2013/14 increased the value of land and buildings by a further £8,296,602 which was credited to the Revaluation Reserve as this was due to movements in market value.

16.1 Analysis of impairments and reversals recognised in 2013/14

	Total £000s	Property Plant & Equipment £000s	Intangible Assets £000s	Financial Assets £000s	Non-Current Assets Held for Sale £000s
Unforeseen obsolescence	**0**	0	0	0	0
Loss as a result of catastrophe	**0**	0	0	0	0
Other	**4,294**	4,294	0	0	0
Changes in market price	**34**	34	0	0	0
Total charged to Annually Managed Expenditure	**4,328**	**4,328**	**0**	**0**	**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**4,328**	**4,328**	**0**	**0**	**0**

Donated and Government Granted Assets, included above

There are no Donated and Government Granted Asset Impairments

17. Commitments

17.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2014 £000s	31 March 2013 £000s
Property, plant and equipment	**1,463**	3,082
Intangible assets	**0**	0
Total	**1,463**	**3,082**

18. Intra-Government and other balances

	Current receivables £000s	Non-Current receivables £000s	Current payables £000s	Non-Current payables £000s
Balances with other Central Government Bodies	3,925	0	824	0
Balances with Local Authorities	335	0	96	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	455	0	173	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,792	152	8,041	0
At 31 March 2014	**7,507**	**152**	**9,134**	**0**
prior period:				
Balances with other Central Government Bodies	1,294	0	286	0
Balances with Local Authorities	95	0	117	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	242	0	146	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,330	578	6,611	0
At 31 March 2013	**4,961**	**578**	**7,160**	**0**

19. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**290**	**44**	**0**	**57**	**0**	**63**	**454**	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0		0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0		0
Additions	2,585	1,530	0	76	0	121	**4,312**	0
Inventories recognised as an expense in the period	(2,639)	(1,526)	0	(88)	0	(147)	**(4,400)**	0
Write-down of inventories (including losses)	0	0	0	0	0	0	**0**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Transfers (to) Foundation Trusts	0	0	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**	0
Balance at 31 March 2014	**236**	**48**	**0**	**45**	**0**	**37**	**366**	**0**

20.1 Trade and other receivables

	Current		Non-Current	
	31 March 2014	31 March 2013	31 March2014	31 March 2013
	£000s	£000s	£000s	£000s
NHS receivables - revenue	**3,414**	251	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	121	**0**	0
Non-NHS receivables - revenue	**630**	315	**0**	0
Non-NHS receivables - capital	**35**	0	**0**	0
Non-NHS prepayments and accrued income	**2,680**	3,141	**152**	578
Provision for the impairment of receivables	**(143)**	(100)	**0**	0
VAT	**868**	1,015	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**22**	218	**0**	0
Total	**7,506**	**4,961**	**152**	**578**
Total current and non current	**7,658**	**5,539**		
Included in NHS receivables are prepaid pension contributions:	**1**			

20.2 Receivables past their due date but not impaired

	31 March 2014 £000s	31 March 2013 £000s
By up to three months	**3,252**	252
By three to six months	**55**	0
By more than six months	**25**	0
Total	**3,332**	**252**

20.3 Provision for impairment of receivables

	2013/14 £000s	2012/13 £000s
Balance at 1 April 2013	**(100)**	**(110)**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0
Amount written off during the year	8	7
Amount recovered during the year	**236**	177
(Increase) in receivables impaired	**(287)**	(174)
Transfer to NHS Foundation Trust	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2014	**(143)**	**(100)**

The trust has a specific receivables provision of £121,195 (2012/13: £88,561) relating to all receivables over 60 days. The remaining £21,679 is a general receivables provision (2012/13 : £11,332).

21.1 Other financial assets - Current

The trust had no other current financial assets in 2013/14 and 2012/13.

21.2 Other financial assets - Non Current

The trust had no other non current financial assets in 2013/14 and 2012/13.

22. Other current assets

The trust had no other non current capital financial assets in 2013/14 and 2012/13.

23. Cash and cash equivalents

	31 March 2014 £000s	31 March 2013 £000s
Opening balance	**14,516**	13,510
Net change in year	**3,582**	1,006
Closing balance	**18,098**	**14,516**
Made up of		
Cash with Government Banking Service	**18,064**	14,484
Commercial banks	**8**	7
Cash in hand	**26**	25
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**18,098**	**14,516**
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**18,098**	**14,516**
Patients' money held by the trust, not included above	**961**	**975**

24. Non-current assets held for sale

The trust had no non-current assets held for sale in 2013/14 and 2012/13.

25. Trade and other payables

	Current		Non-Current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
NHS payables - revenue	**190**	95	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**5**	51	**0**	0
Non-NHS payables - revenue	**3,010**	898	**0**	0
Non-NHS payables - capital	**451**	1,258	**0**	0
Non-NHS accruals and deferred income	**4,551**	4,470	**0**	0
Social security costs	**378**	68	**0**	0
VAT	**0**	0	**0**	0
Tax	**238**	5	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**310**	315	**0**	0
Total	**9,133**	**7,160**	**0**	**0**
Total payables (current and non-current)	**9,133**	**7,160**		

26. Other liabilities

The trust had no other liabilities in 2013/14 and 2012/13.

27. Borrowings

	Current 31 March 2014 £000s	31 March 2013 £000s	Non-Current 31 March 2014 £000s	31 March 2013 £000s
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
Loans from Department of Health	**0**	0	**0**	0
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**121**	103	**4,833**	4,953
Other (describe)	**0**	0	**0**	0
Total	**121**	**103**	**4,833**	**4,953**
Total other liabilities (current and non-current)	**4,954**	**5,056**		

The trust has a Finance Lease with Contour Housing for the Rathbone Rehabilitation Centre. The 25 year lease runs to 2032.

28. Other financial liabilities

The trust had no other liabilities in 2013/14 and 2012/13.

29. Deferred revenue

	Current 31 March 2014 £000s	31 March 2013 £000s	Non-Current 31 March 2014 £000s	31 March 2013 £000s
Opening balance at 1 April 2013	**173**	663	**0**	0
Deferred revenue addition	**145**	173	**0**	0
Transfer of deferred revenue	**(173)**	(663)	**0**	0
Current deferred Revenue at 31 March 2014	**145**	**173**	**0**	**0**
Total deferred revenue (current and non-current)	**145**	**173**		

30. Finance lease obligations as lessee

The trust has one Finance lease, this relates to the Rathbone Rehabilitation Centre with Contour Housing.
At the end of the lease in 2032 the property will revert to the trusts ownership.
The rental amount is based upon paying the loan Contour Housing took out to build the property, plus a management charge.

Amounts payable under finance leases (Buildings)

	Minimum lease payments		Present value of minimum lease payments	
	31 March 2014	31 March 2013	31 March 2014	31 March 2013
	£000s	£000s	£000s	£000s
Within one year	**543**	528	**121**	103
Between one and five years	**2,172**	2,112	**667**	594
After five years	**7,602**	7,919	**4,166**	4,359
Less future finance charges	**(5,363)**	(5,503)		
Minimum Lease Payments / Present value of minimum lease payments	**4,954**	**5,056**	**4,954**	**5,056**
Included in:				
Current borrowings			**121**	103
Non-current borrowings			**4,833**	4,953
			4,954	**5,056**

The trust does not expect to receive any future sublease payments.

The trust has had a change in practice on the calculation of present value of minimum payments, therefore 2012/13 has been restated.

31. Provisions

	Total	Comprising: Early Departure Costs	Legal	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change)	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**21,356**	**5,113**	**415**	**0**	**0**	**0**	**15,828**	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0	0	0	0	0	0	0
Arising During the Year	**1,806**	238	392	0	0	0	1,176	0
Utilised During the Year	**(1,813)**	(429)	(351)	0	0	0	(1,033)	0
Reversed Unused	**(513)**	(55)	(105)	0	0	0	(353)	0
Unwinding of Discount	**436**	109	0	0	0	0	327	0
Change in Discount Rate	**1,228**	175	0	0	0	0	1,053	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	**0**	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2014	**22,500**	**5,151**	**351**	**0**	**0**	**0**	**16,998**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**1,764**	437	351	0	0	0	976	0
Later than One Year and not later than Five Years	**5,407**	1,843	0	0	0	0	3,564	0
Later than Five Years	**15,329**	2,871	0	0	0	0	12,458	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2014	421
As at 31 March 2013	505

Pensions - The amounts are based on the current payments to former staff and estimated life expectancy of the former staff. The trust use life tables from the National Office for Statistics to estimate the life expectancy.

Legal Claims - These figures are provided by the NHS Litigation Authority and the Trust Solicitors.

Other - £16.9m relates to Injury Benefits payable by the trust under the NHS Pensions Injury Benefit scheme. The amounts are based on the current payments and estimated life expectancy of those receiving payments. The trust use life tables from the National Office for Statistics to estimate the life expectancy. The remaining provision of £0.1m relates to the Carbon Reduction Commitment Energy Efficiency Scheme.

Pensions and Other - HM Treasury changed the discount rate to 1.80% (previously 2.35%) from 31 March 2013. The impact of this change is a charge to the Statement of Comprehensive Income of £0.9m as per HM Treasury guidance.

32. Contingencies

	31 March 2014 £000s	31 March 2013 £000s
Contingent liabilities		
Equal Pay	**0**	0
Other [give details]	**(146)**	(132)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(146)**	**(132)**
Contingent Assets		
Contingent Assets [give details]	**0**	0
Net Value of Contingent Assets	**0**	**0**

The future contingent liabilities of £145,635 relate to potential legal claims (2012/13 £131,999). These figures have been provided by the NHS Litigation Authority.

33. Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with clinical commissioning groups/ NHS England and the way those clinical commissioning groups/ NHS England are financed, the NHS 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 NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the trust's internal auditors.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by the trust development authority. 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

Because the majority of the Mersey Care'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 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with clinical commissioning groups and NHS England, which are financed from resources voted annually by Parliament. The trust is not, therefore, exposed to significant liquidity risks.

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The trust therefore has low exposure to currency rate fluctuations.

33.2 Financial assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0	0	0	**0**
Receivables – NHS	0	3,431	0	**3,431**
Receivables – non-NHS	0	2,082	0	**2,082**
Cash at bank and in hand	0	18,098	0	**18,098**
Other financial assets	0	0	0	**0**
Total at 31 March 2014	**0**	**23,611**	**0**	**23,611**
Embedded derivatives	0	0	0	**0**
Receivables – NHS	0	252	0	**252**
Receivables – non-NHS	0	1,937	0	**1,937**
Cash at bank and in hand	0	14,516	0	**14,516**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**16,705**	**0**	**16,705**

33.3 Financial liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0	0	**0**
NHS payables	0	211	**211**
Non-NHS payables	0	3,742	**3,742**
Other borrowings	0	0	**0**
PFI and finance lease obligations	0	4,954	**4,954**
Other financial liabilities	0	0	**0**
Total at 31 March 2014	**0**	**8,907**	**8,907**
Embedded derivatives	0	0	**0**
NHS payables	0	130	**130**
Non-NHS payables	0	2,731	**2,731**
Other borrowings	0	0	**0**
PFI and finance lease obligations	0	5,056	**5,056**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**7,917**	**7,917**

34. Events after the end of the reporting period

The accounts were signed on behalf of the Trust Board by the Chief Executive on 28 May 2014.

35. Related party transactions

Details of related party transactions with organisations, with which senior trust officers are associated:

	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
Prof. Christopher Dowrick, Trust Board Advisor, Honorary Consultant in Primary Care - Liverpool Clinical Commissioning Group	1,710	67,580,395	0	20,147

The Department of Health is regarded as a related party. During the year Mersey Care NHS 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. These entities are:

Aintree University Hospital NHS Foundation Trust
Care Quality Commission
Central Lancashire Primary Care Trust
Cheshire, Warrington and Wirral Area Team
Greater Manchester West Mental Health NHS Foundation Trust
NHS Halton CCG
Health Education England
NHS Knowsley CCG
Lancashire Area Team
NHS Liverpool CCG
Liverpool Community Health NHS Trust
Liverpool Heart and Chest NHS Foundation Trust
Liverpool Womens Hospital NHS Foundation Trust
Manchester Mental Health and Social Care Trust
Merseyside Area Team
NHS Business Services Authority
NHS Cheshire and Merseyside CSU
NHS Commissioning Board
NHS England
NHS Pension Scheme
NHS Property Services
NHS Supply Chain
Northumbria Healthcare NHS Foundation Trust
Penine Acute Hospitals NHS Trust
Royal Liverpool & Broadgreen University Hospitals NHS Trust
Salford Royal NHS Foundation Trust
NHS Southport and Formby CCG
NHS South Sefton CCG
South Yorkshire and Bassetlaw Area Team
Southport and Ormskirk Hospital NHS Trust
NHS St Helens CCG
St Helens & Knowsley Teaching Hospitals NHS Trust
The Walton Centre NHS Foundation Trust
NHS West Lancashire CCG

In addition, the trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Liverpool City Council and Sefton Metropolitan Borough Council.

	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
Mrs Beatrice Fraenkel, Chairman, Liverpool City Councillor	454,540	1,181,046	0	154,628
Mrs Beatrice Fraenkel, Chairman, Council Member of Edge Hill University	69,553	930	0	0
Mr Brian Lawlor, Non Executive Director, Morecrofts LLP Solicitors	300	0	0	0
Prof. Brenda Roe, Non Executive Director, Professor of Health Research, Edge Hill University	69,553	930	0	0
Prof. Christopher Dowrick, Non Executive Director, Professor of Primary Medical Care University of Liverpool	117,025	214,598	0	17,783
Prof. Christopher Dowrick, Trust Board Advisor, Honorary President Compass Counselling Services	220	0	0	0

36. Losses and special payments

The total number of losses cases in 2013/14 and their total value was as follows:

	Total Value of Cases £000s	Total Number of Cases £000s
Losses	8,470	9
Special payments	4,868	48
Total losses and special payments	**13,338**	**57**

The total number of losses cases in 2012/13 and their total value was as follows:

	Total Value of Cases £000s	Total Number of Cases £000s
Losses	6,835	9
Special payments	5906	38
Total losses and special payments	**12,741**	**47**

37. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

37.1 Breakeven performance

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Turnover	183,724	194,010	189,824	195,288	196,919	200,293	196,181	208,526	**207,876**
Retained surplus/(deficit) for the year	12	99	500	500	(58,059)	7,359	(1,776)	(3,536)	**422**
Adjustment for:									
Timing/non-cash impacting distortions:									
Pre FDL(97)24 Agreements	0	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	**0**
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	**0**
Adjustments for Impairments	0	0	0	0	61,059	0	7,018	7,536	**4,328**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	(242)	0	**0**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	0	0	0	0	**0**
Adsorption Accounting Adjustment	0	0	0	0	0	0	0	0	**0**
Other agreed adjustments	0	0	0	(200)	0	0	0	0	**0**
Break-even in-year position	**12**	**99**	**500**	**300**	**3,000**	**7,359**	**5,000**	**4,000**	**4,750**
Break-even cumulative position	**2,486**	**2,585**	**3,085**	**3,385**	**6,385**	**13,744**	**18,744**	**22,744**	**27,494**

*Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	%	%	%	%	%	%	%	%	%
Materiality test (I.e. is it equal to or less than 0.5%):									
Break-even in-year position as a percentage of turnover	0.01	0.05	0.26	0.15	1.52	3.67	2.55	1.92	2.29
Break-even cumulative position as a percentage of turnover	1.35	1.33	1.63	1.73	3.24	6.86	9.55	10.91	13.23

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

37.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

37.3 External financing

The trust is given an external financing limit which it is permitted to undershoot.

	2013/14 £000s	2012/13 £000s
External financing limit (EFL)	**(3,243)**	2,052
Cash flow financing	**(3,685)**	(1,090)
Unwinding of Discount Adjustment	**436**	0
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**(3,249)**	(1,090)
Under Spend against EFL	**6**	**3,142**

37.4 Capital resource limit

The trust is given a capital resource limit which it is not permitted to exceed.

	2013/14 £000s	2012/13 £000s
Gross capital expenditure	**7,422**	9,494
Less: book value of assets disposed of	**(130)**	(123)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**0**	0
Charge against the capital resource limit	**7,292**	9,371
Capital resource limit	**7,292**	9,704
Underspend against the capital resource limit	**0**	**333**

38. Third party assets

The trust held cash and cash equivalents which relate to monies held by the NHS 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 2014 £000s	31 March 2013 £000s
Third party assets held by the trust	**961**	**975**

39. Investment in subsidiary

Mersey Care NHS Trust has established a subsidiary company, Mersey Care Limited to allow for growth and expansion of service provision. The company was established in May 2012. The company has no transactions and is still in development. Mersey Care NHS Trust owns 100% of Mersey Care Limited.

Shares at 31 March 2014	Trust £
	100

NOTES

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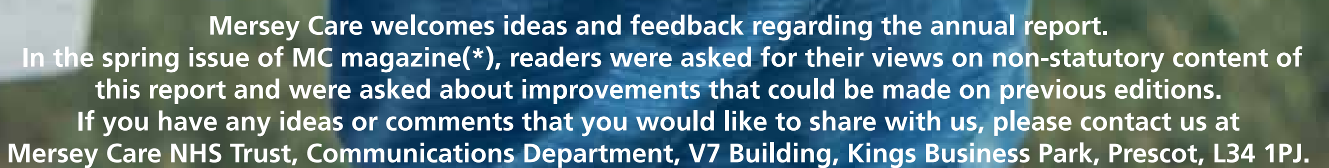
Mersey Care NHS Trust



Mersey Care welcomes ideas and feedback regarding the annual report.
In the spring issue of MC magazine(*), readers were asked for their views on non-statutory content of this report and were asked about improvements that could be made on previous editions.
If you have any ideas or comments that you would like to share with us, please contact us at Mersey Care NHS Trust, Communications Department, V7 Building, Kings Business Park, Prescot, L34 1PJ.

(*) MC magazine has a distribution of approximately 7,000 copies to all stakeholders (and 3,000 sent electronically) including: service users, carers, staff, trust members, public libraries, health centres and clinics.

This report is available in other formats and languages on request.