Mersey Care NHS
NHS Trust

Annual Report 2014/15

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Welcome to our annual report for 2014 to 2015

Father and son Brian and Martin Murphy are more than willing to give their time and their talents – and as members of Mersey Care's army of volunteers

Our environment and the things around us have a profound effect on how we feel and our sense of wellbeing – and importantly for health services like ours – on recovery. So it is important for Mersey Care to ensure all our patient and staff environments are of the best quality now and into the future.

Our first significant step in delivering the expected quality of our buildings was the opening of our newest mental health facility, Clock View Hospital. We have championed Clock View locally and nationally as an exemplar site and spoken publicly about the human factors approach we took in involving service users, staff, carers and the local community in its design, right from the beginning, working with leading healthcare architects and landscape architects. We based our approach on learning and understanding how people interact with the environment in their workplace in a positive way and the way in which patients and staff benefit from an internal and external therapeutic setting, using landscaping, spaces and art.

Clock View showcases quality and safety. In fact safety has been an integral part of the building's design, thanks to the involvement of all its users in its design. Clock View also delivers parity for all our patients, with each having their own bedroom with en suite bathroom and we expect to deliver similar standards in all our buildings over the next four years.

Clock View is one of several big steps forward made by the organisation over the past year. Perhaps the boldest was our commitment to Perfect Care. Some people might say the notion of Perfect Care for a health provider, especially a mental health, learning disability and substance misuse service, is 'pie in the sky'. But if you turn the argument on its head and we do not aspire to provide Perfect Care, then what level of care should we try to achieve? Would you, your friends or your family be happy to accept a second or third rate service in any other area of life? We know we would not.

That's why our Centre for Perfect Care has been focusing on integrating research & development, audit, improvement and innovation across a wide range of areas in order to evaluate, understand and improve clinical care.

We continue to make wards safer with the empowering work of No Force First, initially implemented with five pilot wards, all of which reached their goal of achieving a 50 percent reduction in restraint by the end of the first year.

In May 2014 a conference was held so that other parts of the Trust could learn how No Force First can transform healthcare environments and enhance safety for both service users and staff. Eliminating physical and medication-led restraint with the introduction of a range of interventions that are less intrusive and more dignified – including listening, flexibility, compassion, patience and positive, recovery-focused communication, all fit well within our vision for Perfect Care.

One benefit of the No Force First pilots was a reduction in staff injury and illness. However, in the wider part of the Trust's staff still endure a high rate of physical violence from patients, relatives or the public, according to the 2014 NHS National Staff survey. This may partly be due to the particularly challenging environments of our secure mental health services. However, the survey did show an overall reduction in the percentage of staff feeling pressured to come into work when feeling unwell, with more receiving job relevant training, learning and development, plus an increase in the number of staff appraised. We encouraged more staff to report accidents, incidents and near misses, with learning from those events key to understanding causes and remedies. Mersey Care's staff survey rating climbed 26 places in a national league table, which is good news, but we are not complacent. We must continue to support more staff to complete health and safety training, enable more to contribute to improvements at work and agree how their role makes a difference to patients, if we are to achieve a continually better work environment.

It is encouraging that a number of service users from our Recovery College graduated from courses that enhance their confidence, self-esteem and knowledge, with some going on to volunteer or work as peer support workers within the Trust.

The year also saw Mersey Care use its expertise to provide several new services, including a personality disorder in-prison service; and the winning of Talk Liverpool, the contract to provide the city's Improving Access to Psychological Therapies (IAPT). It was important to us to reintegrate this aspect of care back into our Trust.

We met our statutory financial and legal obligations and again, due to good money management and practice, have managed to achieve cash surpluses which will be used to invest in future patient and working environments, helping provide quality and safe care with better outcomes.

Beatrice Fraenkel, Chairman

Joe Rafferty, Chief Executive

STRATEGY FOR SERVICE DEVELOPMENT

Service developments and progress towards the achievement of long-term business objectives

Mersey Care is striving to provide Perfect Care for the people it serves. At its core, this is an organisation that does not accept compromises in the quality of care or minimum targets set by others, but one which supports learning and improvement in its services: this is an organisation which strives to get the basics of care right every time, for every service user. Perfect Care means supporting staff to make small improvements that add up to big changes over time. This is a bold ambition in difficult times, but with engaged and motivated staff and supportive commissioner and partner organisations, Mersey Care believes improvement is possible and that the people it serves deserve nothing less.

2014 was a successful year for the Trust, with colleagues leading and participating in a number of change programmes which have led to real improvements in patient care and reduced overall cost. This has been achieved through a new organisational structure comprising three distinct divisions – local, secure and corporate – which went live in April 2014.

Through the piloting and roll-out of quality improvement techniques on inpatient wards in local and secure services, the Trust now has one of the lowest rates of use of restrictive and face-down restraint in our region.

The Trust's Zero Suicide philosophy and approach was endorsed by Deputy Prime Minister Nick Clegg, and attracted extensive national and local media coverage.

Mersey Care was commissioned to provide four mental health resilience schemes to enhance support for people with mental health problems over the winter period. These include care home liaison, enhanced A&E liaison, intermediate care and intensive home support for older adults.

Mersey Care was commissioned to provide a £14.4m Increasing Access to Psychological Therapies (IAPT) service for Liverpool. The service, which began in April 2015, is known as 'Talk Liverpool' and gives Mersey Care an opportunity to improve the provision of talking therapies across a range of pathways, from primary into specialist care.

Local services

March 2015 saw the opening of Clock View, a state-of-the-art, 80-bed acute inpatient unit, which has been co-designed in conjunction with service users and carers. Thanks to community engagement and local employment, this new facility has given the local economy a huge boost, creating hundreds of construction jobs and acting as a catalyst for growth in north Liverpool. The Trust has also begun to implement a new access and assessment service for Liverpool and Sefton; this was successfully piloted in Sefton. The development of the new access and assessment services at Clock View are planned to be fully operational from September 2015.

An enhanced role has been negotiated for Mersey Care within integrated care in Liverpool and Sefton. Additional funding has been secured for four new schemes that increase mental health liaison in care homes, A&E and older adults wards in acute hospitals, with mental health now part of the 'core' team in Liverpool neighbourhood working.

Chief Officers on Merseyside recently assessed that up to 20 per cent of all calls to the police are now related to mental health issues. In 2014/15 the Trust piloted a street triage service in partnership with the police, designed to increase specialist mental health support for people in crisis, and to reduce the use of Section 136.

The Trust has also been successful in growing its criminal justice liaison service, which now provides care for young people across a wider geographical area, and in winning back the IAPT service in Liverpool.

Health Education North West has named Mersey Care as a national 'demonstrator site' as part of its Integrated Care Workforce programme.

Secure services

Colleagues in secure services also had a busy 2014, with the development of a more integrated pathway and more consistent ways of working across high and medium secure services, as well as between high secure services and local prisons. This has meant the development of shared leadership and skill transfer across high and medium secure services, providing more support and stronger connections with the geographically isolated medium secure service at Scott Clinic. The Trust has consulted widely on a proposal to replace our medium secure service at Scott Clinic with a new building next to Ashworth Hospital in Maghull. A business case is now being developed, which will need the support of the NHS Trust Development Authority to proceed.

A capacity review for high secure services was completed in 2014/15; as a result the number of beds is to reduce from 228 to 204 by 2020/21. A ward in high secure services was closed in January 2015 to support the 2015/16 Secure Division Cost Improvement Plan (CIP). The flow and throughput into our services from prisons and on to medium secure services is being improved and, drawing on specialist expertise in delivering high quality mental health care in secure settings.

Mersey Care's Centre for Perfect Care and Wellbeing quality improvement programme

The Centre for Perfect Care and Wellbeing was established following Trust Board approval in January 2014. The Centre was designed to integrate a number of key functions, including quality improvement and governance, research & development and innovation. Its mission is to support staff as they strive to deliver Perfect Care, as well as supporting systematic learning each and every time care falls below the high standards expected. The Centre is raising standards to a new level of Perfect Care; in practice this means that every episode of care should be regarded by the patient, carers and staff as safe, timely, effective, equitable, efficient and positively experienced (STEEEP). The Centre, which is led by the Trust's Medical Director, has a core recurrent resource but non-recurrent resource has also been used to enable clinical staff from the two clinical divisions to work part time in the Centre. Nearly all of the key actions identified at the time the Centre opened have been completed or are nearing completion by April 2015, including:

- set up of three key programmes with stretching quality improvement goals: Zero Suicide, No Force First and 100 percent cardio-metabolic health screening for people with serious mental illness
- significant quality improvements, achieved in rapid cycles of improvement, in No Force First and 100 percent cardio-metabolic health programmes
- defined Perfect Care outcomes, pathways and key processes with clinicians in key areas (Payment by result (PBR) clusters and super-clusters)
- establishment of the Perfect Care and Wellbeing Advisory Panel, chaired by Mike Farrar
- national launch of the Zero Suicide programme, with adoption by the former Deputy Prime Minister and Norman Lamb, Minister of State for Care and Support at the Department of Health
- existing partnerships have been expanded over the last year, and additional collaborations forged, for example: The Walton Centre NHS Foundation Trust; North West Coast Academic Health Science Network; CLAHRC (Collaborations for Leadership in Applied Health Research and Care). The Trust is developing joint posts, exploring funding opportunities, exchanging knowledge and developing workforce skills through these relationships
- for Zero Suicide and No Force First programmes, organised stakeholder events with: commissioners, the North West Coast Academic Health Science Network, GPs, service users and carers, national suicide prevention programme, regional strategic clinical networks, voluntary organisations
- first design teams brought together to prototype and incubate first set of new products and services for treatment of depression/prevention of suicide
- attracted further external investment in quality improvement programmes from National Institute for Health Research (NIHR), Health Foundation, the North West Coast Academic Health Science Network and the Department for Work and Pensions
- successfully delivered the second year of a 3-year project *Innovate Dementia* in collaboration with John Moores University, funded through European Territorial Cooperation (INTERREG) IV B funding stream
- development of 109 open research studies, involving the participation of 1,063 patients and 252 Mersey Care colleagues.

As the table below shows, the Trust employs over 4,000 people. The majority of our staff work in the two clinical divisions. The Trust also hosts Informatics Merseyside, which provide IT services to a range of local NHS providers and clinical commissioning groups.

STAFF IN POST AS AT 31 MARCH 2015

Division	Division	Full Time Equivalent	Headcount
Local Services Division	Assessment Services	476.99	504
	Specialist Services	314.73	344
	Adult Mental Health Services	459.93	487
	Complex Care Services	284.72	310
Local Services Total		1,536.36	1,645
Secure Division	High Secure Services	882.27	914
	Low Secure	70.58	73
	Medium Secure	218.99	231
	Offender Health	53.07	56
Secure Division Total		1,224.91	1,274
Local & Secure	Trainee medics hosted by St Helens & Knowsley NHS Trust[1]	67.70	68
Corporate Services	Additional Staffing[2]	0.00	261
	Board	10.00	42
	Clinical Governance, Quality & Innovation	47.00	52
	Corporate Governance & Business Development	31.02	32
	Estates & Facilities	150.70	212
	Executive Nurse	29.43	36
	Finance, Contracts, Procurement & FT	51.84	53
	Informatics & Performance Improvement	40.87	43
	Medical Services	41.84	45
	Workforce	77.05	84
Corporate Services Total		479.76	860
Informatics Merseyside	Informatics Merseyside	195.07	205
Informatics Merseyside Total		195.07	205
Total		**3,503.80**	**4,052**
Recharges[3]	Resettle	6.60	7
	AQuA Recharge[4]	1.00	1
	Trainee Clinical Psychologists	48.80	49
Recharges Total		56.40	57
Total		**3,560.20**	**4,109**

1 Trainee medics are doctors who work in our two clinical divisions, but they are employed by St Helens and Knowsley NHS Trust.

2 The figures above include Bank Staff and Capital Staff who are part of the workforce.

3 Not included in the figures above are the Recharges out, which include Trainee Clinical Psychologist, CRACMS (Community Risk Assessment and Case Management Service), AQuA (Advancing Quality Alliance) hosted staff.

4. (With the exception of the one member of staff shown above, who is our employee but seconded to AQuA).

	Staff Sickness Rates
2008/09	6.61%
2009/10	6.17%
2010/11	6.17%
2011/12	6.23%
2012/13	5.88%
2013/14	5.63%
2014/15	5.64%

STAFF CHARTER

In 2013 we established Your Voice Your Change (YVYC), an engagement methodology. Through YVYC staff took part in a number of "Mega Conversations" led by our Chief Executive Joe Rafferty, these conversations were an opportunity for staff, service users and carers to discuss what is important to them and what enables or hinders the provision of the highest quality of care. One of the themes that emerged was our organisational culture which is demonstrated by the attitudes and behaviours of our staff. As a result a values work stream was set up and a series of "Mini Mega Conversations" took place which enabled staff to explore this theme further and propose potential ways of improving our culture. As a result staff said that we needed to renew our organisational values and produce a staff charter which would articulate what behaviours are expected of staff and what staff can expect from the Trust in return. From January to April 2014 a Values Road Show was then used to encourage as many staff, service users, staff side representatives and commissioners as possible to contribute to the co-production of a set of values and associated behaviours that are really unique and specific to Mersey Care and under pin the delivery of Perfect Care. The staff generated Values and Staff Charter was launched in June 2014 (see page 9 for further information).

INFORMATION AND CONSULTATION WITH EMPLOYEES

A number of staff consultations were undertaken during 2014/15. The process was in line with the Trust's Organisational Change Policy and involved consultation with staff-side representatives and affected staff.

These processes are identified below:

Local Services Division

- Service Re-configuration at band 8c level – (no reduction in posts). Process complete September 2014
- Nursing and Quality Lead organisational change – Band 8c reduction in one post. Process complete 2014
- Band 8b organisational change – reduction in one post. Process complete September 2014
- Relocation of Brain Injuries Unit from Mersey Care to Walton Centre which took effect in January 2015
- Relocation of Psychotherapy service from Mossley Hill site to Haigh Road in April 2015
- Relocation of Stoddart House and Psychiatric Intensive Care Unit (PICU) to Clock View which took effect on 28 February 2015
- Clinical Support Service (Performance) – Restructure of team to work across the division and centralised to Switch House. Reduction of 1 x band 7 in the new structure. Process complete 1st April 2015
- Psychology Lead organisational change. Reduction of Posts 3 to 1. Process complete January 2015
- Review of the Personal Assistants within the division – review of all roles to align to the senior management structure following the formation of the Local Services Division. Process complete July 2015
- Administrative and Clerical Review – Initial review commenced to understand the differing admin arrangements across the former Clinical Business Units (CBU's). A report was completed by Bernadine Lynam however this requires further work to align with the Division transformational programme. Two away days planned with the administrative and clerical staff to share themes of the review and further work that is required together to ensure the review is fit for purpose and fits with the wider change agenda
- TUPE – (Transfer of Undertakings Protection of Employment) - transfer of employment of Improving Access to Psychological Therapies (IAPT) services from South Staffordshire and Shropshire NHS Foundation Trust and Mental Health Matters organisation which was completed on 1st April 2015.

Secure Division

- Transfer of Undertakings Protection of Employment (TUPE) – due to a transfer of service 5 staff from Liverpool Community Health NHS Trust were transferred into Mersey Care NHS Trust. Completed January 2015
- Facilities – consultation on-going on changes to rotas for domestics, control room operators and catering staff at Medium Secure Unit and Low Secure Unit
- Transfer of Undertakings (TUPE) in process – five staff from Liverpool Community Health NHS Trust in January 2015.

Informatics Merseyside

- Systems and Service Development; Programme and Project Management; Training and Out of Hours service relocated to new bases as of September 2014
- TUPE (Transfer of Undertakings, Protection of Employment) of three staff from Informatics Merseyside to the Walton Centre in July 2014 as a result of the Walton Centre wanting to provide the service themselves
- Systems Development – disinvestment in this service by a partner organisation resulting in the removal of 2 posts (redundancy).

Corporate Services Division

- TUPE (Transfer of Undertakings Protection of Employment) – transfer of employment of facilities staff (domestics) from University Hospital Aintree to Mersey Care NHS Trust as a result of the proposed move of Stoddart House to Clock View. Completed September 2014
- Transport and Mailroom – informal consultation re move from local services to secure division. Completed January 2015
- Relocation of facilities staff from Stoddart House to Clock View. Completed March 2015
- Consultation with facilities staff, Psychiatric Intensive Care Unit (PICU) regarding the relocation to Clock View. Completed March 2015
- Transfer of management responsibility for facilities staff from local services to corporate division (Kevin White Unit, Brook Place, Olive Mount, Rathbone Hospital). Completed March 2015.

- Consultation with facilities staff – due to relocation of Brain Injuries Unit from Mossley Hill Site to Walton Centre. Completed January 2015
- Informal consultation with staff support team re move from Arundal House to Switch House. Completed December 2014
- Consultation with facilities site managers re change to job role. Completed October 2014
- TUPE (Transfer of Undertakings Protection of Employment) employment of facilities staff (domestics) from University Hospital Aintree to Mersey Care NHS Trust as a result of transfer of services undertaken in Ferndale Unit to Community Hub. Completed April 2015
- Relocation of facilities staff from Arundel House and Olive Mount to Community Hubs. Commenced March 2015 (ended June 2015).

PEOPLE PARTICIPATION

Mersey Care's Trust policy on involving service users and carers was widely acknowledged as best practice within mental health services when it was introduced in 2004. Since that time the policy and practice has evolved into a dynamic people participation programme based upon a commitment to co-production at all levels of our organisation. This programme encompasses a wide range of activities where decisions are made which affect the experience of and outcomes for service users and carers including:

- Co-facilitation and co-production activities (including recovery groups)
- Complaints and incident reviews
- Governance groups and networks
- Inspections (including PLACE and quality review visits)
- Leadership and management teams
- Policy development and review
- Recruitment and selection of staff
- Research
- Service development and design
- Training and induction of staff
- Trust Board and Board Sub Committees.

During the last two years the programme of participation has undergone considerable review and transformation and through a process of co-production, a new model of participation has been developed for the organisation based upon the principles of volunteerism, recovery and social inclusion. This was fully implemented in October 2014 and as part of that implementation Mersey Care developed a ground breaking approach to the reward and recognition of service user and carer participation in the organisation. In place of simple monetary reward people now have access to a range of opportunities aimed at supporting their own personal recovery and social inclusion goals.

The success of this approach was demonstrated during National Volunteers' Week in the early part of June 2015 when we celebrated the milestone of 500 volunteer participants contributing across the Trust. We are particularly proud that more than 60 per cent of those participating are service users and carers drawing upon their lived experience to change services, change culture and ultimately change lives. A point of particular pride is that this number includes an average of 1,250 hours of volunteer activity contributed by service users/ patients in our secure forensic services.

During our Volunteers' Week celebrations the first group of 18 volunteers, many of whom were service users, received accredited qualifications as a direct result of volunteering with the Trust. An additional 38 volunteers are currently undertaking accredited vocational courses and several of the first group of 18 embarked upon further vocational courses over the summer. It is a delight to see the new model of participation developing real recovery pathways to education and employment for those who give so much to our organisation.

Other groups of service user participants are now being supported in developing their own social enterprise, for example, a group of five younger service user participants have made their own film challenging the stigma that surrounds mental ill-health. They are working towards developing a social enterprise company engaging schools and colleges on the theme of mental health.

Clearly, the lived experience and insights of our service users and carers benefit the organisation and its services, but what is equally clear is that through this scheme their own recovery and social inclusion journey can really gain momentum.

EQUALITY, DIVERSITY AND HUMAN RIGHTS

Equality, Diversity and Human Rights continue to be fundamental to Mersey Care's work, both in terms of the people it serves and the staff it employs.

The concept of equality has been included in the standards by which the Trust judges quality and Perfect Care. This is now established within its strategic aims and is regularly reported to the Board.

An Equality Steering Group, chaired by a non executive board member has been established. The agenda for this Steering Group includes the setting up of a reference group; who invite members of the communities it serves to act as a critical friend to support its aims and objectives and to assist in its continued developments.

Mersey Care continues to be legally compliant in maintaining both its Equality and Human Rights Policy and the Policy for Supporting Disabled Staff.

In order to meet the Equality Act 2010's specific requirement to establish equality objectives, the Board agreed two new objectives:

- To set up systems that enable Mersey Care to address the proactive support needed for disabled staff. To reduce the inappropriate use of the attendance policy to identify and address issues that impact on disabled staff's work and wellbeing.
- To improve the Trust's analysis of the representation of the communities it serves within the workforce at all levels, and its involvement and participation initiatives, which include trust membership and taking positive action when needed.

These objectives replace the previous goal to establish 95 percent plus equality data for service users and staff. This objective has been met and continues to be monitored and maintained.

The Trust has also been working to bring the values it holds into practice through many activities. This includes aligning the work undertaken through the Equality and Human Rights agendas, two key pieces of activity which support the Trust's culture of dignity, respect, quality and innovation.

The Trust has maintained its commitment to Equality and Human Rights and has set out a clear set of actions to help establish and maintain equality for service users and staff alike. It is using the NHS Equality Delivery System and meeting the duties outlined within the Equality Act 2010. Together with its partners, the Trust is working to tackle health inequalities within its service provision to improve health and wellbeing.

THE TRUST'S STAFF CHARTER

Introduced in 2014, the staff charter was developed following consultation with staff, service users and carers. It seeks to show how the Trust's 'core' values are embedded into how we deliver services and support our staff in delivering perfect care.

The staff charter takes account of the rights and responsibilities described in the NHS Constitution. (www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx)

WHAT I CAN EXPECT FROM THE TRUST		WHAT THE TRUST CAN EXPECT FROM ME
Opportunities and support to continually improve the quality of mental health and learning disability services	CONTINUOUS IMPROVEMENT	**To contribute** to improving the quality of care services, to prioritise the recovery and wellbeing of our patients and service users through great teamwork and partnerships
The resources to enable me to deliver the best quality care services, and the support to maintain my wellbeing, excel at work, and challenge concerns	ACCOUNTABILITY	**To take ownership** for the delivery of the highest quality care and to challenge poor practice and inappropriate behaviour
A culture focused on person centred care, free from discrimination and harassment where my contribution is valued	RESPECT	**To value difference** and individuality, to show care, empathy and respect for my colleagues, patients, service users and carers
A rewarding job which makes a difference to the lives of our patients, service users, their families and our wider community	ENTHUSIASM	**To take pride** in my work and in our Trust, to genuinely care about my team and working together to make a difference to our patients, service users and their families every day

SUSTAINABILITY AND ENVIRONMENTAL MANAGEMENT

In response to the Sustainability Development Unit (SDU) objectives to embed sustainability into all areas of the NHS, the Trust has a Carbon Management Plan but has developed a sustainability framework and delivery plan that will be presented to the Trust Board in 2015/16 for approval. This will enable a more holistic view of the Trust's carbon footprint in order to extend carbon reductions beyond energy consumption and into areas such as procurement and travel, in order to meet national NHS carbon reduction targets. 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.

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. 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 elements of the sustainability framework.

The priority for the year ahead is to seek approval of the sustainability framework that will allow wider opportunities for reducing the carbon elements as well as focusing on good corporate citizenship.

Carbon Management

The Trust is continuing to work to the commitments set out in its 5-year Carbon Management Plan. This ambitious target is to reduce carbon emissions, attributable to electricity and gas, by 30 percent 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.

Carbon Emissions (electricity & gas) - CO_2e tonnes						
2009/10 (base year)	2010/11	2011/12	2012/13	2013/14	2014/15	Target by 2014/15
11,222	11,175	10,306	10,787	10,028	**9,748**	7,855

Carbon Emissions savings (electricity and gas)	2011/12	2012/13	2013/14	2014/15
Actual CO_2e tonnes	869	-481	759	**280**
Annual Target CO_2e tonnes	796	1,039	2,195	**3,367**
Percentage achievement of annual target	109%	-46%	35%	**8%**

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 (Megawatt hours)		Emissions (CO_2e tonnes)	
		2013/14	2014/15	2013/14	2014/15
Scope 1 (Direct) emissions - gas consumption		27,796	**25,997**	5,104	**4,798**
Scope 2 (Indirect) emissions - electricity consumption		9,572	**9,260**	5,178	**4,935**
		Distance Travelled (Miles)		Emissions (CO_2e tonnes)	
		2013/14	2014/15	2013/14	2014/15
Scope 3 - official business travel emissions	Air travel	34,302	**98,202**	9.21	**20.03**
	Road travel	2,821,422	**2,599,792**	871.42	**777.61**
	Rail travel	121,370	**208,531**	11.34	**16.47**

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	2013/14	2014/15
Cost of Scope 1 and Scope 2 consumption	£1,841,030	**£1,650,555**

Capital Projects successfully implemented in the current year have included the refurbishment of the Newman Ward at Ashworth Hospital with energy efficient measures (including LED lighting, replacement boilers, wall insulation, pipe insulation and double glazed windows) achieving a BREEAM* 'Good' standard. The ward refurbishment programme continues into 2015 with the upgrading of Owen Ward, along with a wholesale replacement of all existing windows with new double glazed windows.

The cost of the Trust's Carbon Reduction Committment (CRC) Energy Efficiency Scheme allowances for the 2014/15 year has been calculated to be **£159,867** based on carbon emissions of **9,748** tonnes CO_2e.

The Trust engaged external audit 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. All areas audited achieved a 100% compliance result with no recommendations for improvement being identified.

*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 monitoring across all Trust sites and night usage baselines established and wherever practical reduced or removed in order to eliminate unnecessary water usage. A number of new water meters have been installed at 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 20% fall on the previous year. However, costs have increased due to increased charges being levied by the water supplier.

Finite Resource Consumption Indicator	2012/13	2013/14	2014/15
Water consumption (m3)	149,004	141,379	**113,335**
Total expenditure – Water	£497,546	£506,336	**£509,333**

Waste Management

Currently the Trust has an integrated waste and recycling contract across all its sites, operated by independent waste contractors. Recyclable wastes are collected within the general waste containers and separated out into recyclable fractions 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 85-90% of general and clinical waste collected from sites is now sent for either recycling or energy recovery through incineration. As a result of this service the Trust has seen significant increases in the level of waste recycled year on year and proportionately less waste sent to landfill.

The production of clinical and hazardous waste by the Trust involves the commitment of significant financial resources to ensure statutory responsibilities are met. As a result we are working towards a concept of total waste management, with waste prevention and reduction at its heart, to reduce pollution and the Trust's carbon footprint and maximise cost savings that can be diverted to patient care.

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

Waste Minimisation and Management Indicators	2013/14		2014/15	
	Tonnes	%	Tonnes	%
Waste recycled/reused	575	69	**464**	**51**
Waste incinerated (clinical waste)/energy from waste	20	2	**335**	**38**
Waste to landfill	245	29	**100**	**11**
Total waste arising (tonnes)	**840**	**100**	**840**	**100**

Financial Indicators on Waste	2013/14	2014/15
Cost of waste incinerated (clinical waste)/energy from waste	£45,770	**£35,636**
Total expenditure on waste arising	£111,990	**£134,330**

Challenges remain in minimising the overall production of waste at source as well as reducing the amount of non-clinical waste being disposed of through clinical waste receptacles.

Clinical Waste Pre-acceptance Audits have been taking place across the Trust; this has enabled the Trust to ensure correct waste segregation is taking place and educate staff. Most of the audits have been completed, with only a handful remaining.

In the past two years, the Trust has introduced two new clinical waste streams, for hazardous and non-hazardous pharmaceutical waste. Whilst this has taken sometime for all Trust premises to implement, this has dramatically increased the volume of clinical waste that is incinerated.

The Trust has recently employed a new contractor for the recycling of non-contaminated mattresses, Teal Lifecare. Teal are better known for the supply of furniture within the NHS. Their most recent products are on show within the Trust's new facilitiy known as Clock View. Teal Lifecare also recycles furniture and waste electrical and electronic equipment (WEEE), which the Trust will be looking into in the near future.

Although the majority of the Trust's waste is currently recycled, including domestic waste, we are always looking at sustainable alternatives and improving our environmental performance.

EMERGENCY PLANNING

The Trust has continued to develop its arrangements for dealing with major incidents and other emergency situations. A full review of the Major Incident Plan was undertaken, and the plan amended to reflect internal changes, as well as changes which have taken place in the wider NHS. The plan was audited by commissioners and found to be compliant with national guidelines.

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

The plan is supported by a plethora of other contingency plans and guidance documents relating to events such as fuel shortage, pandemic influenza, winter-related events, heatwave and floods. Robust business continuity plans are in place at divisional level, all designed to ensure the continued provision of services in the event of a major incident, whether that incident is internal or external to the Trust.

Ownership for the development of the Trust's major incident and contingency plans lies with the Head of Quality and Risk who 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.

Emergency planning, however, is only successful if the Trust's own plans are linked in to those of the wider health economy. To ensure this is the case. The Trust is represented by its Head of Quality and Risk within a number of relevant groups and committees across Merseyside. These collective organisations ensure that plans are not written in isolation, but rather with the co-operation and involvement of key partners and stakeholders, which is 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 – an organisation that meets quarterly.

RISK MANAGEMENT

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

The Executive Committee and Audit Committee are the Trust's overarching bodies with responsibility 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:

- Quality Assurance Committee
- Performance & Investment Committee
- Remuneration and Terms of Service Committee
- 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 including the identification, management and monitoring of risks; and 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 of the three divisions has established governance arrangements in place; the local governance lead is responsible for implementing the corporate risk management processes on a local basis, as well as 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 multiple systems and processes and 2014/15 has seen:

- a fully revised Board Assurance and Escalation Framework
- the implementation and development of electronic risk management software across the organisation
- 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
- 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 Trust to systematically identify, record and action the key risks it faces in relation to the achievement of its overarching strategic objectives. An opinion on the assurance framework has been provided by Mersey Internal Audit Agency. The opinion (review) states that:

> *"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 and regularly reports 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 ensure that they answer all of the issues raised. 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. Any financial renumeration offered is monitored via the Trust's Audit Committee.

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 events, Quality Practice Alerts, Oxford Model Events and the Quality Surveillance process.

1. Complaints – Trustwide

The total number of complaints received in Mersey Care NHS Trust in 2014/15 was 480 with 100% of the closed complaints responded to within timescales agreed with the complainant*. 6 complaints remain open and are still within timescales agreed with the complainant. These complaints have been delayed due to the complexity of the cases, or due to other factors impacting on the complaints process such as safeguarding or disciplinary investigations.

These figures included 220 complaints in local services, of which 215 were responded to within agreed timescales and 5 complaints remain open. There were 259 complaints and high and medium secure services, of which 258 were responded to within agreed timescales and one complaint remains open. One complaint was responded to in respect of corporate services.

	Local Services Division		Secure Division		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 2014	55	55 (100%)	58	58 (100%)	113	113 (100%)
July – Sept 2014	49	49 (100%)	84	84 (100%)	133	133 (100%)
Oct – Dec 2014	61	57 (100%)	55	55 (100%)	116	112 (100%)
Jan – March 2015	55	51 (100%)	62	60 (100%)	117	111 (100%)
Total	220	212 (100%)	259	257 (100%)	480	469 (100%)

*See explanation regarding percentages above.

2. Health Service Ombudsman

Eight complaints were sent to the Health Service Ombudsman for consideration of Independent Review. Of these:

	Requests received	Outcome No Further Action	Outcome Further Action	Outcome Awaiting Outcome
Local Services Division	3	2	1	0
Secure Division	4	3	1	0
Total	7	5	2	0

Comparison with 2013/2014

- The number of complaints received by the Trust has increased from 374 during the period 1 April 2013 - 31 March 2014, to 480 during the last 12 month period
- The number of complaints referred to the Parliamentary and Health Service Ombudsman has reduced slightly from nine to seven during the last 12 month period.

An independent review is currently being undertaken to understand the reasons for the increase in complaints received across the Trust during this period.

Service Improvements

As a result of complaints, changes to service provision have been made which include:

- A service user who was being cared for on an inpatient ward was given leave of absence and when he returned, his bed was no longer available and did not have an appropriate bed to sleep in. The Trust has highlighted this type of incident as a 'Never Event' and in future, steps must be taken to prevent a similar incident occurring and Executive Directors kept informed of the on-going situation
- A patient raised concerns that documents containing his personal details were visible in the ward office. After the incident was highlighted, the Deputy Service Manager attended the ward to review the incident and the furniture in the ward office was rearranged to ensure that the desk was no longer positioned by the window, in view of others walking past the office. This was also highlighted in the hospital's 'Learning from Adverse Incidents' report which is sent to all secure division members of staff and discussed in reflective practice meetings across all wards
- A service user complained that a nursing report contained incorrect information. The investigation found that the report and risk assessment in the Care Programme Approach (CPA) pathway contained an incorrect statement about the service user. The clinical team providing care for the service user were made aware of how erroneous information contained in one report can potentially influence other documents and thereby impact on decisions made relating to care. Staff were advised that when such incidents occur, they must corroborate this type of information by locating multiple references, not singular references that may be erroneous. Where possible staff need to identify the source of the information and validate it as correct as the impact on the service user may be harmful if this process is not used. Where information cannot be validated, it should not be used in any reports or records relating to the service user
- A service user raised concerns about her appeal as the paperwork was lost whilst on the ward. The investigator ascertained that the appeal form was completed and should have been placed in the safe, however the form was misplaced. The Mental Health Administration Team were not aware that an appeal form had been completed and nursing staff thought the tribunal was being arranged. As a result of this complaint it was recommended that the forms are sent electronically to the Mental Health Administration Team administrators to prevent this from recurring in future
- A complaint was made by a service user's relatives about lack of communication regarding their son's care. As a result of this complaint, all qualified staff and the Multi Disciplinary Teams were reminded (via ward meetings) of the importance of involving families in the care and treatment of service users and communicating with them effectively. Issues such as communication are monitored by the Patient Experience Surveys. The Ward Manager reviewed the systems in place for completing Multi Disciplinary Team reviews and the implementation of the new Recovery Focused Model and the Introduction of Formulation meetings this problem will be resolved in the future). In addition, daily board meetings are now taking place which include formulation meetings

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

SERIOUS UNTOWARD INCIDENTS (2014/15)

Division	Type of incident	Total
Local Services Division	Allegation against staff	1
	Assault	1
	Breach of confidentiality	4
	Deterioration in health	1
	Falls	7
	Inpatient death	3
	Missing patient	4
	Possible homicide	2
	Possible suicide	32
	Self harm	4
	Service user accident	1
	Sexual incidents	3
	Under 18 admission	6
	Unexpected death	2
Secure Division	Allegation against staff	11
	Assault	20
	Breach of confidentiality	2
	Concerted indiscipline	1
	Deterioration in health	19
	Falls	10
	Hostage taking	1
	Inpatient death	2
	Loss/disruption of service	1
	Medication errors	1
	Missing patient	3
	Possible homicide	1
	Possible suicide	1
	Self harm	18
	Service user accident	4
	Sexual incidents	3
	Staff accident	6
Corporate Services Division	Breach of confidentiality	1
Total		**176**

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 Trust wide Patient Safety meeting and Quality Surveillance Group.

Clinical and managerial supervision, which has been identified as a deficit in a number of reviews, has been included in the monthly self-assessment audit carried out by each team; progress against the red, amber, green (RAG) ratings is monitored via divisional and corporate surveillance. Significant progress was made, with teams achieving the set targets over the last six months, with an increasing number of staff now receiving this important process on a regular basis.

Quality review visits are undertaken across the Trust on a weekly basis in order to audit all teams' compliance with the standards set by the Care Quality Commission (CQC). This includes the availability of risk assessments, quality of care plans and the overall standard of care provided to service users and their families.

The Trust has now set staffing levels within ward areas. These are monitored on a regular basis, with any shortfalls and associated risks also monitored and shared with divisional leads to ensure that remedial action can be undertaken. A review of the way in which the additional staffing service function has been undertaken, with the aim of enhancing the systems used to fill vacancies. The Trust Board has allocated a further £2.4 million to increase the level of staffing within inpatient wards, in order to enhance the quality and continuity of care provided, as highlighted in incident investigations.

Early Intervention Teams now work across both Mersey Care NHS Trust and the Child and Adolescents Mental Health Services provided by Alder Hey NHS Foundation Trust, as a means of enhancing communication between teams and reducing any gaps in service provision. It is possible that this new way of working has played a significant part in reducing the admission of service users under the age of eighteen to adult inpatient wards during the year.

The safeguarding team provides the three levels of safeguarding training for staff, as well as delivering Prevent training. The external training targets have been achieved across the Trust, which has enabled staff to adhere to best practice in safeguarding service users.

A further specialist practitioner in safeguarding has been appointed to the team, enhancing its ability to focus on further raising the profile of this specialism. A specific programme of training in, and a campaign to raise awareness of, child sexual exploitation has commenced. The training sessions delivered by *Safe Place Merseyside* have been very positively evaluated by staff and increased their confidence in dealing with this difficult issue. Training in domestic abuse and its identification and prevention has been commissioned from an external specialist, which has been very positively reviewed.

The role of safeguarding ambassadors within the organisation has been embedded further into the daily activities of staff. These ambassadors are clinical staff who have received enhanced training in safeguarding legislation and guidance so that they can provide support to their colleagues with regard to safeguarding concerns. These roles have been a key and successful part of the plan that has been implemented to increase the level of reporting appropriate incidents.

A pilot programme is in place in Liverpool to enhance the support and treatment provided to people who self harm. The Trust has also worked closely with Merseyside Police to establish a street triage approach to assessing people in the community who have been identified by the Police as requiring mental health assessment and intervention. This team works during the twilight hours and has reduced the usage of section 136 Mental Health Act 1983 (MHA) by 52 percent, a significant achievement which has greatly enhanced the experiences of service users and their families.

The Trust has a programme in place to reduce the harm caused when a patient falls in an inpatient area. This has included the establishment of clear guidelines of prevention techniques to help reduce the occurrence of falls and the actions to take to reduce further injury should a fall occur.

The quality practice alerts system (QPAs) continues to be used to disseminate information following incident reviews and compliance is monitored by the Trust-wide Patient Safety Group. These alerts have included:

- safer sharps usage
- ligature risks
- clinical responses to possible hip fractures.

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

- Policies in respect of information governance have been reviewed and amended as necessary.
- A number of bespoke training events were held during 2014/15 relating to the Data Protection Act, confidentiality and sharing information guidance.
- In order to meet the Information Governance Toolkit requirements, all staff are required to complete information governance training and the Trust is required to attain a minimum compliance level of 95 percent. At the end of March 2015, this target had been met.
- The Information Governance Toolkit was audited by Mersey Internal Audit during 2014/15 and the Trust was awarded *Significant Assurance* status.
- The Information Governance Toolkit was submitted at the end of March 2015 and the Trust declared a score of 83 percent (Satisfactory – Green), an increase from the 2013/14 submission of 78 percent (Satisfactory – Green).
- The Trust has implemented standardised letter templates for subject access requests, with all requests being recorded via the Datix system in a bespoke module to meet the requirements of Caldicott 2. Fees are no longer charged for the provision of subject access and assurance reports will be a standing item submitted to the Information Governance Sub Committee.

FINANCE DIRECTOR'S REPORT

Summary

Against the backdrop of a continuing challenging financial climate the Trust has delivered a strong financial performance and has delivered its four statutory financial duties (see below).

Supported by this platform of financial delivery, the Trust is developing detailed plans to transform existing services, which will support the delivery of perfect care. Over the next six years efficiencies of £38.9m will be delivered. These efficiencies will support delivery of an annual surplus that will provide cash to support improvements to our estate and IT services.

Strategic capital investment of £137m into the estate will ensure all our service users have single en suite accommodation and that this accommodation is of a suitable standard. This will move us from a position of 20 percent of our accommodation being single en suite to 100 percent, and the majority of our estate moving from being in need of repair and replacement to a minimum standard of good. This will be delivered by 2020.

Financial Duties

1. To achieve a balanced position on the income statement. The Trust made a surplus after impairment of £6.3m million for 2014/15.
2. To operate within the Capital Resource Limit (CRL). The Trust delivered a capital programme of £40.2m 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 £24.3m at the end of the year and achieved this.
4. To achieve a 3.5 percent return on the net assets owned by the Trust. This target was achieved with a 3.5 percent return on net assets.

Financial Overview

The Trust had an income budget of £206.9m in 2014/15. A cost improvement programme of £9.7m was delivered across the Trust which supported the delivery of the surplus of £6.3m. The surplus delivered each year provides funds to support capital investment for the benefit of service users and the local population.

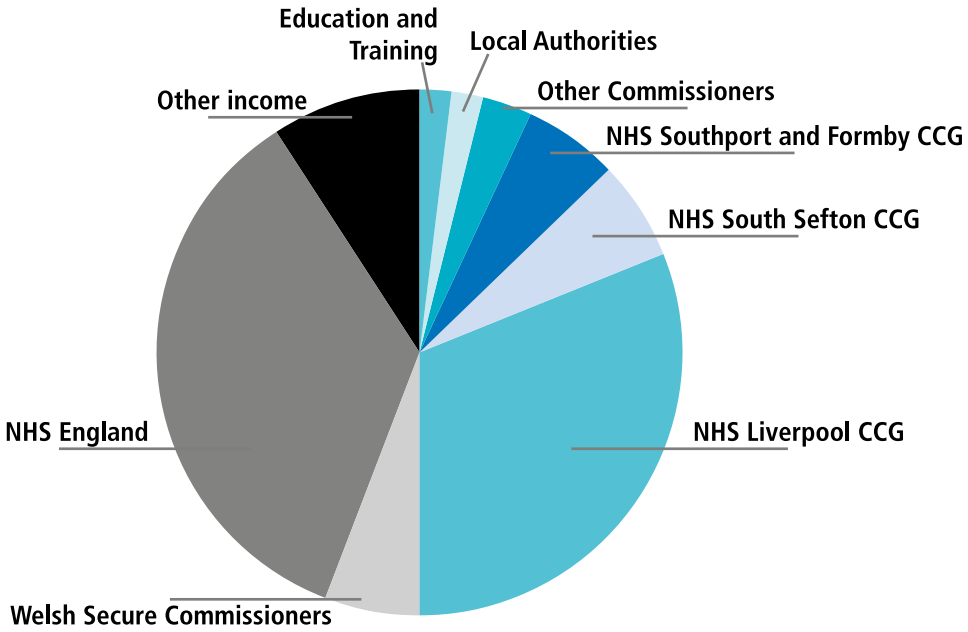
The Trust had capital funding of £40.2m available in 2014/15. Capital investment in 2014/15 includes:

- Completion of Clock View (new 80 bedded inpatient unit) £24.2m
- Brain Injury Rehabilitation Centre re-location £3.0m
- Refurbishment of Owen Ward in High Secure Services £2.9m
- Community Hubs and Spokes £1.8m
- Upgrade of windows in High Secure Services £1.3m
- Preparation of the Medium Secure Site £1.0m

Income and Expenditure

The Trust received income of £206.9m in 2014/15 which was generated from a number of sources as set out in Chart 1.

CHART 1
ANALYSIS OF INCOME



Clinical Commissioning Groups (CCG)

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.

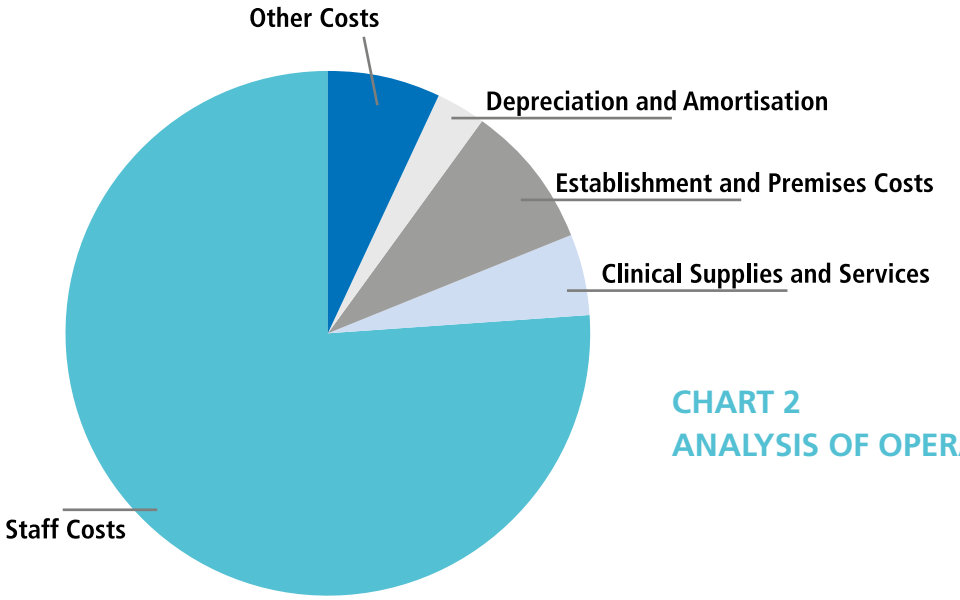


CHART 2
ANALYSIS OF OPERATING EXPENDITURE

Better Payments Practice Code

The Better Payments Practice Code (BPPC) requires the Trust to pay a minimum of 95 percent of all NHS and non-NHS invoices within 30 days of receipt of the goods or valid invoice. In 2014/15, the Trust achieved an average of 97 percent.

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.

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, which 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 2014/15 on the financial statements and opinion was £75,810 (2013/14, £85,810) detailed as follows:

Audit Services	£
Financial statements and value for money	75,810
Other services (including the Trust's Quality Accounts)	51,163
	126,973

Longer Term Outlook

In March 2015, the Trust Board approved a financial framework that will support the delivery of the Trust's strategy and ensures the Trust retains a sound financial position. The key elements of the framework are:

1. Maintain Sound Financial Performance

Ensuring that the Trust maintains sound financial performance provides a stable platform which will support the achievement of the Trust's strategic aims. Mersey Care aims to be the best mental health provider within the UK by providing the highest quality care for all service users and patients. 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.

Over the period 2015/16 to 2020/21, the financial framework will deliver the statutory financial duties of the Trust. The Trust will maintain annual surpluses totalling £35m, hold a minimum of £5m in cash and maintain a continuity of service rating of 3.

Key to maintaining sound financial performance will be the delivery of a cost improvement programme of £38.9m. 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/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. They have been presented to and discussed by the Clinical Senate, the Quality Assurance Committee and the Performance and Investment Committee and have been agreed by the Trust Board.

2. Service Transformation and Organisational Growth

Supported by a strong platform of financial delivery, the Trust is well placed to transform its services and deliver Perfect Care. Key enablers to this transformation are the delivery of the estates framework and new patient information IT system. The estates framework looks to improve all the Trust's estate to a minimum of condition B (good) by 2020. This will require strategic capital investment of £137m. New inpatient facilities will be provided within local and secure services. Therefore, by 2020 all staff will be working from new or refurbished upgraded premises. 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 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 in-patient and community 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 the cost of transactions, increase intelligence provision and become more customer focused.

The Trust has developed a growth strategy that will support service transformation and drive economies of scale.

3. Mental Health Payment System and Contracting

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 86 in 2013/14 (an RCI of 100 is the national average score). It is important that the organisation achieves an RCI below the national average of 100 to ensure income received will exceed costs, should we be required to operate within a national tariff payment system (NTPS).

The Trust is currently paid on a block contract basis. In future, a more sophisticated approach is required to ensure the Trust is paid for all the patients it treats. The 2015/16 contracting proposal for mental health is that care clusters will continue to be the currency for working age adults and older people. A move away from block to cost and volume arrangements will be encouraged, but alternative payment approaches will also be encouraged. These may include payment systems based on outcome measures, on the integration of physical and mental health and pathway-based payments. The Trust will use national developments in this area to test and refine service design but at this stage financial planning should not assume income growth from a new payment system.

Conclusion

The Trust continues to deliver a strong financial position during a challenging economic climate. All staff who have worked hard to deliver the planned surplus, and who have contributed to our investment in the estate and IT equipment deserve the Trust's thanks. We have opened new inpatient premises during 2014/15, Clock View in Walton, and the Sid Watkins Brain Injuries Unit on the Walton Foundation Trust Hospital site. We have opened a new community hub in Liverpool at the Liverpool Innovations Park. Next year will see the second Liverpool community hub open in Norris Green. Plans will be developed for investment in a medium secure campus, a new high secure dependency unit and two new inpatient units in Liverpool and Southport. This would not be possible without the commitment to delivery of the financial plans each year.

QUALITY ACCOUNT

In preparation for our Quality Account for 2014/15 the Trust has undertaken a process of involvement and engagement with key stakeholders to establish their views on delivery against the 2014/15 priorities and what the Trust's key priorities should be for 2015/16. Representatives from the following groups have been invited to provide feedback:

- Healthwatch for Liverpool, Sefton and Knowsley
- Local Overview and Scrutiny Committees
- NHS England (Merseyside) Local Area Team
- NHS Liverpool Clinical Commissioning Group
- NHS South Sefton Clinical Commissioning Group
- NHS Southport and Formby Clinical Commissioning Group
- NHS Knowsley Clinical Commissioning Group
- Mersey Care's Service User and Carer Assembly
- Local service user groups.

In addition to the above, the Mersey Care Perfect Care Steering Group has considered suggestions for 2015/16 quality improvement priorities and has agreed that there would be significant benefits in linking the Trust's priorities to the six key elements of quality, ie care that is:

- safe
- timely
- effective
- efficient
- equitable
- and provides a positive patient experience.

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

Part of the feedback received from stakeholders was that our quality priorities needed to include measurable outcomes. After consultation and discussion with The Trust Board the areas for quality improvement for 2015/16 will be:

- **Priority 1: No Force First**
  By March 2016 all wards will have introduced No Force First initiative that will result in a Trust wide reduction in the use physical and medication led restraint.
- **Priority 2: Zero Suicide**
  By September 2015 a Safe from Suicide Team will be established, the team will be led by a new Associate Medical Director. The Safe from Suicide team will monitor and report to the Board on the progress against the Board approved (May 2015) Zero Suicide strategy. We will work with academic partners and establish a definitive baseline measure for suicide.
- **Priority 3: Improvements in Physical Health**
  We will commence a staged implementation of a Smoke Free Policy in September 2015.

  We will monitor the impact of the policy on service user experience via our monthly patient experience survey.

  All inpatients will have metabolic screening completed in line with the National Audit of Schizophrenia standards by March 2016.
- **Priority 4: Falls**
  The Trust will approve a revised Fall Strategy by September 2015.

  The Trust will achieve a 20% reduction in the harm associated with falls by March 2016.
- **Priority 5: Self Harm**
  The Trust will approve by September 2015 a management of self harm strategy.

  The Trust will evaluate the pilot project in A&E to reduce people re-presenting with self harm at A&E by October 2015 and set with new ambitious targets approved by the Quality Assurance Committee based on the outcomes of the review of the pilot.

  The Trust will achieve a reduction of 20% in harm associated with the use of ligatures in inpatient settings.
- **Priority 6: Recovery Focussed Outcome Measures**
  There is no national consensus on outcome measures covering the breath of services provided by the trust. We will establish outcome measures for the following three initiatives:

  1) No Force First
  2) Zero Suicide
  3) Physical Health Care.

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

A copy of the Quality Account for 2014/15 is available upon request from the communications department.

Perfect Care

Perfect Care is all about people. It was the people employed by the Trust who managed the transition from big mental health hospitals in the 1980s to the community-based care which is provided today. It is the Trust's staff who strive on a daily basis to provide the best possible care for patients. It is these people who will use their knowledge to improve services, and who will innovate to create models of care in mental health and wellbeing for the future.

The Trust believes that delivering the best possible care to service users is its most important objective. The new Centre for Perfect Care and Wellbeing is designed to support staff commitment to patient care, enabling them to improve current services and to innovate in the services of tomorrow.

Perfect Care means:

- setting 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 the Trust provides because it is right for patients
- helping people to try improvements, to learn from their mistakes and apply what works more rapidly
- helping staff to innovate in ways that create better quality and outcomes for service users whilst reducing cost. The Trust is aware that people feel it has too many targets, resulting in pressure to comply with minimum standards that are not relevant to the care provided. The Trust is also aware that staff 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 to service users.

Name	Role	Trust Board	Member of these Board Committees				
			Audit	Performance & Investment	Quality Assurance	Remuneration	Foundation Trust Project Board
Beatrice Fraenkel	Chairman	V (Chair)	-	-	-	V	V (Chair)
Matt Birch	Non Executive Director	V	-	V (Chair)	-	V	V
Pearse Butler[1]	Non Executive Director	V	-	-	V	V	V
Gerry O'Keeffe	Non Executive Director	V	V	V	V	V	V
Brian Lawlor[2]	Non Executive Director	V	-	-	-	V	V
Brenda Roe	Non Executive Director	V	-	V	V (Chair)	V	V
Neil Willcox	Non Executive Director	V	V (Chair)	-	-	V	V
Nick Williams	Non Executive Director	V	V	-	V	V	V
Chris Dowrick	Board Advisory Member	NV	-	-	V	NV	V

Name	Role	Trust Board	Member of these Board Committees				
			Audit	Performance & Investment	Quality Assurance	Executive	Foundation Trust Project Board
Joe Rafferty	Chief Executive	V	-	-	-	V (Chair)	V
Neil Smith	Executive Director of Finance	V	-	V	-	V	V
David Fearnley	Executive Medical Director	V	-	V	V	V	V
Ray Walker	Executive Director of Nursing	V	-	V	V	V	V
Elaine Darbyshire	Executive Director of Communications & Corporate Governance	V	-	-	V	V	V
Amanda Oates[3]	Executive Director of Workforce	V	-	-	-	V	-

1 Pearse Butler was a Non Executive Director between 1 June 2014 and 19 September 2014 (when he resigned) 2. Brain Lawlor was a Non Executive Director until 30 May 2014 (when his term of office came to an end) 3. Amanda Oates was appointed an Executive Director from 1 Jan 2015 and became a voting member on the Board & Executive Committee from then.

Key:
ED = Executive Director
V = Voting Member
NV = Non Voting Member

REGISTER OF INTERESTS

Name	Job Title	Declaration 2014/15
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 • Member, Labour Party • Member, The Council of the University of the South Bank, London • Council Member, Edge Hill University
Neil Willcox	Non Executive Director	• Nil Return
Matt Birch	Non Executive Director	• Director, Sainsbury's Retail and Property Finance
Gerry O'Keeffe	Non Executive Director	• Nil Return
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
Nick Williams	Non Executive Director	• Nil Return
Chris 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 • Honorary Consultant in Primary Care, Liverpool Clinical Commissioning Group
Joe Rafferty	Chief Executive	• Director of Mersey Care Ltd
David Fearnley	Medical Director	• Nil Return
Neil Smith	Executive Director of Finance/Deputy Chief Executive	• Nil Return
Ray Walker	Executive Director of Nursing	• Nil Return
Elaine Darbyshire	Executive Director of Communications and Corporate Governance	• Nil Return
Amanda Oates	Executive Director of Workforce	• Nil Returrn

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 2015
- Sets out tables of information showing details of the salary and pension interests of all directors for the year ended 31 March 2015.

2. Role of the Remuneration and Terms of Service 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 executive directors are motivated to enhance the performance of the Trust.

3. Membership of the Remuneration and Terms of Service Committee

The membership of the committee is 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 roll except when his or her renumeration 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. Executive 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

Executive 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.

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

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 set by the Secretary of State for Health, notified by the Trust Development Authority and implemented locally by the Trust.

Note:

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

7. Salaries and allowances for the year ended 31 March 2015 (please see notes on page 29)

2014/15

Executive 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 £00s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000)
Joseph Rafferty - Chief Executive		170 - 175	–	–	–	54	17.5 - 20	195 - 200
Kim Crowe – Executive Director of Service Integration	1	N/A	–	–	–	N/A	N/A	N/A
David Fearnley – Medical Director	2	90 - 95	110 - 115	–	35 - 40	30	25 - 27.5	265 - 270
Neil Smith – Executive Director of Finance/Deputy Chief Executive	3	135 - 140	–	–	–	30	0.0	125 - 130
Ray Walker - Executive Director of Nursing		115 - 120	–	–	–	36	5 - 7.5	125 - 130
Elaine Darbyshire - Executive Director of Corporate Governance & Communications	4	115 - 120	–	–	–	49	15 - 17.5	140 - 145
Amanda Oates - Executive Director of Workforce	5	95 - 100	–	–	–	0	12.5 - 15	110 - 115
John Doyle - TIME Project Director	6	15 - 20	–	–	–	7	0.0	15 - 20
Christine Hughes - Director of Corporate Affairs/Communications	7	N/A	–	–	–	N/A	N/A	N/A
Band of Highest Paid Director's Total Remuneration (£'000)					235 - 240			
Median Total Remuneration of all staff					30,620			
Pay Multiple Ratio					7.8			

Salaries and allowances for the year ended 31 March 2014 (please see notes on page 29)

2013/14

Executive 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 £00s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000)
Joseph Rafferty - Chief Executive		170 - 175	–	–	–	52	92.5 - 95.0	270 - 275
Kim Crowe – Executive Director of Service Integration	1	50 - 55	–	–	–	44	0.0	55 - 60
David Fearnley – Medical Director	2	90 - 95	105 - 110	–	35 - 40	37	15.0 - 17.5	250 - 255
Neil Smith – Executive Director of Finance/Deputy Chief Executive	3	135 - 140	5 - 10	–	–	29	105.0 - 107.5	245 - 250
Ray Walker - Executive Director of Nursing		115 - 120	–	–	–	39	15.0 - 17.5	135 - 140
Elaine Darbyshire - Executive Director of Corporate Governance & Communications	4	100 - 105	–	–	–	0	25.0 - 27.5	125 - 130
Amanda Oates - Executive Director of Workforce	5	65 - 70	–	–	–	0	47.5 - 50.0	110 - 115
John Doyle - TIME Project Director	6	95 - 100	–	–	–	44	5.0 - 7.5	115 - 120
Christine Hughes - Director of Corporate Affairs/Communications	7	45 - 50	–	70 - 75	–	65	0.0 - 2.5	125 - 130
Band of Highest Paid Director's Total Remuneration (£'000)					235 - 240			
Median Total Remuneration of all staff					29,701			
Pay Multiple Ratio					8.0			

Benefits in kind are the taxable value attributed to 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 member of the 2008 section).

Salaries and allowances for the year ended 31 March 2015 (please see notes on page 29)

2014/15

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 £00s	All pension related benefits (bands of £2,500) £00s	Total (bands of £5,000) £000s
Beatrice Fraenkel - Chairman		20 – 25	_	_	11	_	20 – 25
Brian Lawlor	8	0 – 5	_	_	1	_	0 – 5
Marco Longhi	9	_	_	_	_	_	–
Matt Birch		5 – 10	_	_	10	_	5 – 10
Gerry O'Keefe		5 – 10	_	_	13	_	5 – 10
Christopher Dowrick		5 – 10	_	_	0	_	5 – 10
Neil Willcox		5 – 10	_	_	0	_	5 – 10
Brenda Roe	10	5 – 10	_	_	1	_	5 – 10
Nick Williams	11	0	_	_	0	_	0
Pearse Butler	12	0	_	_	0	_	0

Salaries and allowances for the year ended 31 March 2014

2013/14

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 £00s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s
Beatrice Fraenkel - Chairman		20 – 25	_	_	12	_	20 – 25
Brian Lawlor	8	5 – 10	_	_	1	_	5 – 10
Marco Longhi	9	0 – 5	_	_	31	_	0 – 5
Matt Birch		5 – 10	_	_	0	_	5 – 10
Gerry O'Keefe		5 – 10	_	_	21	_	5 – 10
Christopher Dowrick		5 – 10	_	_	0	_	5 – 10
Neil Willcox		5 – 10	_	_	0	_	5 – 10
Brenda Roe	10	5 – 10	_	_	1	_	5 – 10
Nick Williams	11	0	_	_	0	_	0
Pearse Butler	12	0	_	_	0	_	0

Notes:

1 Kim Crowe left the Trust on 11 September 2013.

2 The bonus payments relate to Clinical Excellence awards.

3 The other remuneration is pay arrears from 2012-13

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

5 Amanda Oates was appointed as Director of Workforce on 1 August 2013, and Executive Director of Workforce on 1 January 2015.

6 John Doyle went on secondment to Mid Staffordshire NHS Foundation Trust on 1 June 2014.

7 Christine Hughes left the Trust on 30 November 2013.

8 Brian Lawlor retired as a non executive director of 31 May 2014.

9 Marco Longhi left the Trust as a non executive director on 1 November 2013.

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

11 Nick 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.

12 Pearse Butler was appointed as a non executive director on 1 June 2014 and resigned on 19 September 2014. He received no remuneration from the Trust.

General – National Guidance requires that Trusts show comparator information on salaries and allowance for two years, which is why data is provided for both 2013/14 and 2014/15.

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 March 15 (bands of £5000) £000s	Total accrued lump sum at age 60 at 31 March 15 (bands of £5000) £000s	Cash Equivalent Transfer Value at 31 March 15 £000s	Cash Equivalent Transfer Value at 31 March 14 £000s	Real increase in Cash Equivalent Transfer Value £000s	Employers Contribution to Stakeholder Pension £000s
Joseph Rafferty – Chief Executive	0 - 2.5	5 - 7.5	50 - 55	155 - 160	992	904	63	0
David Fearnley – Medical Director	0 - 2.5	5 - 7.5	30 - 35	100 - 105	565	506	45	0
Neil Smith – Executive Director of Finance/ Deputy Chief Executive	0 - 2.5	0 - 2.5	50 - 55	150 - 155	931	875	33	0
Ray Walker – Executive Director of Nursing	0 - 2.5	2.5 - 5	15 - 20	55 - 60	381	341	30	0
Elaine Darbyshire - Executive Director of Corporate Governance and Communications	0 - 2.5	0	10 - 15	0	152	109	40	0
John Doyle – TIME Project Director	0 - 2.5	0 - 2.5	35 - 40	110 - 115	747	702	26	0
Amanda Oates – Executive Director of Workforce	0 - 2.5	2.5 - 5	15 - 20	45 - 50	250	219	25	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 2014/15 was £239,430 (2013/14, £236,525). This was 7.8 times (2013/14, 8.0) the median remuneration of the workforce, which was £30,620 (2013/14, £29,701).

In 2014/15, 0 (2013/14, 0) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £14,008 to £239,430 (2013/14 £14,311 to £236,525).

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 increased from 3,820 to 3,855. The pay multiple has decreased to 7.8 from 8.0. This reduction is due to the average salary increasing by 3% due to incremental drift and pay inflation, whereas the highest paid salary has increase by only 1%.

9. Reporting of other compensation schemes – exit packages

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

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	47	47 (£274,163)	0
£10,001 - £25,000	0	48	48 (£756,264)	0
£25,001 - £50,000	3 (£135,400)	36 (£1,326,136)	39 (£1,461,536)	0
£50,001 - £100,000	0	5	5 (£323,822)	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)	3 (£135,400)	136 (£2,680,385)	139 (£2,815,785)	0

Redundancy and other departure costs have been paid in accordance with the provisions of the MARS Scheme. Exit costs in this note are accounted for in full in the year of departure. 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.

Approved by:

Signed:  **Chief Executive**

Date: 27.05.15

Off-payroll engagements

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	11
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	4
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	4

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	0
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	0
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements.	6

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.

Signed:  **Chief Executive**

Date: 27.05.15

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

Date: 27.05.15  **Chief Executive**

Date: 27.05.15  **Finance Director**

ANNUAL GOVERNANCE STATEMENT 2014/15

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 NHS Trust, ensure the work of the Executive 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 & Escalation Framework and resource allocation relating to the 'significant risks' of the Trust. The recommendations of the Executive Committee, other Board Committees 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 2014/15 involved the following:
   a) the Medical Director had overall responsibility across the organisation for:
      - risk management
      - medicines management (including Accountable Officer for Controlled Drugs);
      - research and development;
      - undertaking the role of Caldicott Guardian and Responsible Officer for medical revalidation;

   b) As a result of changes in Executive Director portfolios in 2014/15, the following Executive Directors exchanged key accountabilities, which unless otherwise stated came into effect from 1 February 2015:
      - the Medical Director was accountable for Safeguarding Children and Adults, but this responsibility has now passed to the Executive Director of Nursing;
      - the Medical Director was accountable for the management of patient safety, complaints, claims and adverse incidents, but this responsibility has now passed to the Executive Director of Nursing;
      - the Executive Director of Nursing was the lead executive with responsibility for high secure psychiatric services, but this responsibility has now passed to the Medical Director

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

   d) the Executive Director of Finance (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);

   e) the Director of Patient Safety was the Nominated Individual with the Care Quality Commission (CQC), taking over this role from the Medical Director in October 2014. The Medical Director was accountable for CQC registration, but this responsibility has now passed to the Executive Director of Nursing in February 2015.

6. The development of effective and appropriate risk management processes within Mersey Care NHS Trust has been monitored by the Trust Board and through the various performance review processes of the NHS. The Board Assurance & Escalation Framework, the Strategic Risk Register, Clinical Division 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 2014/15, the Trust contracted with:
   a) NHS Liverpool Clinical Commissioning Group (with Liverpool City Council) and NHS Sefton Clinical Commissioning Group (and associates), for local mental health, learning disability and addiction services across the Liverpool, Sefton, Knowsley, Halton, St Helens and West Lancashire areas;
   b) Liverpool, Sefton, Knowsley, Halton, St Helens, Wirral and Lancashire Local Authorities for addiction services;
   c) NHS England (through its regional and various sub-regional teams) for:
      - low, medium and high secure services and colleagues from NHS Wales in respect of high secure services;
      - mental health and addictions services in HMP Liverpool and HMP Kennet;
      - personality disorder services at HMP Garth;
   d) Aintree University Hospitals NHS Foundation Trust for the Liverpool Community Alcohol Service and psychological support for Weight Management and Bariatric Services;
   e) Walton Centre NHS Foundation Trust for Neuropsychology and Neuropsychiatry services;
   f) Manchester Mental Health and Social Care Trust for psychiatry services to HMP Manchester;
   g) National Probation Service for community personality disorder services, Resettle and Psychologically Informed Planned Environment (PIPE) services.
8. Formal contract monitoring meetings and strategic commissioning meetings are 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 Mersey-side on behalf of the Local Health Resilience Partnership.
11. The Trust has a fully functioning Infection Control Committee which is co-chaired chaired by the Deputy Director of Nursing (as the Trust's Director for the Prevention and Control of Infection (DIPC)) and 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's Strategic Framework.
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. The terms of reference for all Board Committees were reviewed, updated and then approved at May 2014's Trust Board. A further annual review of terms of reference for all Board Committees has been undertaken, with revised terms of reference approved at March 2015's Trust Board. Both the Trust Board and its Board Committees have annual cycles of business.
16. The committee structure, to support achievement of the organisation's strategic objectives, is outlined in Table 1. Any Board Committee can ask for a risk to be considered for inclusion on the Trust's risk register.

Table 1: Mersey Care's Board Committee Structure

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 cycle of business • provides a form of independent check upon the executive arm of the Trust Board • provides independent verification to the Trust Board on internal financial controls based on reports from internal and external auditors • ensures effective organisational controls and risk management
Performance & Investment Committee	• provides assurance that the key performance and outcome measures for assessing delivery of the Trust's strategic framework and annual operating plan are appropriate and that performance is consistent with those measures • 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
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 meeting
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 to assess and control risk • commissions in-depth scrutiny of strategic risks, recommending actions and providing assurance to the Audit Committee and the Trust Board
Foundation Trust Project Board	• oversees the project being undertaken to ensure delivery of the Trust's ambition to be a 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 and contracts • ensures that appropriate performance management arrangements are in place for Executive Directors and work with the Chief Executive to relate performance judgements to pay • advises on the Trust's overarching reward and benefit strategy for all staff, the arrangements in the wider NHS and any relevant guidance from the Treasury and regulators

17. Significant changes to the Trust's governance arrangements in 2014/15 relate to its *advisory* Board Committee structure, namely:

    a) until December 2014 the Trust had a **Members' Council** which acted 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. The role of the Members' Council was to represent the Trust's membership and partner organisations. As a result of diminishing attendance/resignations (some of which would have required formal elections to replace members), in October 2014 the Trust Board agreed to disestablish the Members' Council. As a result of this a questionnaire was sent to all current and past members of the Council seeking their views and experience of the Council. The feedback from this questionnaire was compiled into a Lessons Learnt Report which was presented to the final meeting of the Members' Council in December 2014. A revised version of this Lessons Learnt Report, incorporating comments from the Members' Council, was then submitted to January 2015's Trust Board. In addition the remaining members of the Members' Council have agreed to act as a reference group for any documentation prepared for a Council of Governors (should the Trust achieve Foundation Trust status);

    b) in July 2014 the Trust established a **Perfect Care & Wellbeing Advisory Council** to provide the Trust Board, through the Chief Executive, with advice on the development of the Trust's Centre for Perfect Care and Wellbeing, part of the arrangements within the Trust to stimulate new thinking and innovation in the way it delivers services;

    c) in January 2014 the Trust established a Service Users and Carers Assembly as a mechanism for enhancing and developing two-way communication between the Trust and the people it services. To support the work of the Assembly a *Standing Committee* was established, elected by members of the Assembly, which meets monthly. In order to improve the links with the Trust Board terms of reference were agreed by the Trust Board in March 2015, following consultation with the Assembly, that means **Service User and Carer Assembly's Standing Committee** would, through the Chief Executive, advise the Trust Board on matters relating to service user and carer engagement and also be a critical friend to the Trust.

18. 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 Board Committee are also presented at public Board meetings (with the exception of the Remuneration & Terms of Service Committee which provides a highlight report to the Trust Board instead of minutes).

19. At the Audit Committee in April 2015, the Director of Internal Audit Opinion provided significant assurance for the period 2014/15 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 provided 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

20. The Trust Board met a total of seven times in public in 2014/15 (in May, July, September, November, December 2014 and January, March 2015). Attendance was monitored throughout the year and is detailed in the table attached at **Annex 1.**

21. The Trust Board achieved an average attendance level of 94% by its members in 2014/15, with the various Board Committees achieving average attendance levels of between 71% and 86% by their members in 2014/15.

Assessing Board Effectiveness

22. During March and April 2015 the Trust's governance arrangements are subject to a further two external reviews:

    a) a Well-led Governance Framework review pilot being undertaken by the NHS Trust Development Authority (the Trust is one of four NHS Trust selected by the Trust Development Authority to be subject to this review pilot); and

    b) a Quality Governance and Risk review which the Trust commissioned from the Good Governance Institute.

23. The results of both these reviews will inform a further internal assessment of the Trust's governance and risk management arrangements, as well as our preparations for Foundation Trust status.

24. In addition, the performance of individual board members has been assessed through annual appraisal processes

    a) the Trust's Chairman is subject to an independent appraisal process undertaken by the NHS Trust Development Authority;

    b) Non Executive Directors/Board Advisory Members are subject to an appraisal process undertaken by the Trust's Chairman against their agreed objectives;

    c) Executive Directors are subject to the organisation-wide Performance & Development Review process which was introduced in 2014/15, linking individual's objectives to the Trust's Strategic Framework objectives;

25. 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 regular reviews of its delegated arrangements through a review of its Scheme of Reservations and Delegations.

26. Mersey Care NHS Trust 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

27. In 2014/15 the Executive Committee and the Audit Committee where the Board's overarching committees responsible for scrutinising the arrangements in place for managing risk. These committees are supported by the following Board Committees and sub-committees/groups:
    - Performance and Investment Committee
    - Quality Assurance Committee
    - Remuneration and Terms of Reference Committee
    - Foundation Trust Project Board
    - Clinical Senate
    - Mental Health Act Managers Sub-committee
    - Health & Safety Sub-committee
    - Infection Control Sub-committee
    - Drugs & Therapeutics Sub-committee
    - Information Governance & Caldicott Sub-committee
    - Perfect Care and Wellbeing Sub-committee
    - Safeguarding Group

28. The Trust's Risk Management Strategy provides a framework for managing risk within the Trust and outlined the objectives of risk management; the structure in place to support the management of risk across the organisations; and the systems and processes to ensure identification, management and control of risk.

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

30. The Head of Quality & 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, Associate Medical 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.

31. 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 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.

32. Each Clinical Division 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.

33. 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 2014/15

34. 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 2014/15. In July 2014 the strategic risks facing the organisation were reviewed and initially nine strategic risks were identified and approved by the Trust Board. Throughout 2014/15 the number of strategic risks appearing on the Board Assurance and Escalation Framework varied between nine and ten, with nine appearing in the Framework reported to March 2015's Trust Board.

35. **Table 2** highlights the major risks facing the Trust in 2014/15 considered by the Trust Board following the review conducted in July 2014, with changes highlighted in the 'comments' column.

Table 2: Major Risks identified for 2014/15

Major Risk	Comments
There is a risk that the Trust will fail to deliver safe and effective care as a result of workforce efficiency savings	New from July 2014
There is a risk that the quality of care may suffer during a period of significant organisational change (both in the clinical divisions and the corporate division) over the next twelve months	New from July 2014
There is a risk that the estate will not improve and consequently have a negative impact on the quality of care including safety and parity of esteem	New from July 2014
There is a risk that the Trust will fail to deliver the right technology to support safe and effective care across all its services	New from July 2014
There is a risk of financial loss due to cross subsidy between local and secure commissioners being withdrawn	New from July 2014
There is a risk of failure to deliver the Secure Campus which may lead to an inability to improve the quality of care and deliver required income levels	New from July 2014
There is a risk that sickness absence levels will increase leading to an impact on the quality of care and increased cost	Carried over from May 2014, removed March 2015
There is a risk that there will be insufficient commissioner support for the development of services across the organisation	New from July 2014
There is a risk that due to the age profile and mental health officer status of some of our staff, the Trust will struggle to recruit adequately skilled and experienced staff which may lead to a failure to deliver high quality patient care	New from July 2014
There is a risk that due to the volume and organisation of the information received by the Trust from Capita that we could not provide documentary or electronic evidence if required during a future inspection or review	Added in November 2014, removed January 2015
There is a risk, following the high secure capacity review, that the planned reduction of 24 beds will impact financially resulting in insufficient income to maintain all HSS services	Added in March 2015

36. Two incidents have been reported to the Information Commissioner in respect of data loss/data breaches, further information on which can be found in paragraphs 59 – 62 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:
    a) overarching strategic aims for risk management;
    b) the Trust's Risk Management Strategy;
    c) organisational risk management objectives;
    d) the organisational process for risk identification and analysis;
    e) a definition of significant risk and acceptable risk within the organisation;
    f) organisational risk management structures;
    g) the development and application of risk registers within the organisation;
    h) incident reporting;
    i) the accountability and responsibility arrangements for risk management;
    j) the Board Assurance and Escalation Framework.
38. Embedding risk management as a core activity within the organisation is achieved through many systems and processes. 2014/15 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) the Quality Surveillance Group as a sub-committee of the Executive Committee;
    c) 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;
    d) continued development and scrutiny of Clinical Division risk registers;
    e) maintenance of compliance with the Care Quality Commission's Fundamental Standards, supported by Quality Review Visits and the introduction of Board Assurance Visits, to further support compliance;
    f) reviews of and improvements to the complaints, claims and adverse incident functions including detailed policy reviews in each area;
    g) the annual review and updating of the Trust's Anti Fraud, Corruption and Bribery Policy and Response Plan;
    h) continued development of organisational policies, including the introduction of a new policy template;
    i) 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 principle risks identified by the organisation".

QUALITY GOVERNANCE

40. In March 2015 the Trust Board approved the Trust's Framework for the Governance of Quality. This Framework outlined how established arrangements (such as the work of the weekly Quality Surveillance Group, Quality Review Visits, monitoring of complaints, patient experience, serious untoward incidents, the Quality Assurance Committee monitoring action plans resulting from independent reports in incidents, etc.) had been combined with new developments since January 2015 (such as clinical team self-assessments against Fundamental Standards, weekly Divisional Quality Surveillance Groups and weekly 'Stand-up Thursdays') to monitor and escalate concerns/emerging concerns and issues relating to the delivery of services and the CQC's Fundamental Standards using a wide range of information and intelligence sources. Through the Framework the Trust assesses if quality concerns are thematic (i.e., across more than one team) and the appropriate response to mitigate these concerns/emerging concerns by keeping the affected teams under special review.
41. The Trust has developed a Quality Account for 2014/15 that highlighted the quality improvements made across the Trust in 2014/15 and the priorities for quality improvement in 2015/16. The Quality Account has been shared with members of the Perfect Care and Wellbeing Sub-committee, trust Directors and the Trust Board to ensure all of the information contained within 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.
42. To determine the quality improvement priority areas for 2014/15 the Trust engaged in extensive consultation and this included the Perfect Care and Wellbeing Sub-committee, internal groups and committees, service users and carers, local Healthwatch and commissioners. The agreed priorities following the consultation were:
    - 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 on inpatient settings
    - Priority 6: Development of outcome measures for recovery.

43. The above priorities were all linked to the Trust's Strategic Framework and ensured that the key domains of quality (i.e. care that is safe, timely, effective, equitable, efficient and has a positive experience) remained at the top of our agenda.

44. Our progress against these priority areas will be captured in full for the Quality Account for 2014/15 which will be published in June 2015, but in summary we have:

    a) No Force First – the roll out of this initiative has continued across the Trust from the initial pilot wards and evidence from an independent review has indicated that this leads to a reduction of violence and aggressive incidents in the wards which utilise this initiative, as well as reductions in sickness levels amongst our staff. Two of our three pilot wards were successful in achieving the year 2 targets of a 75% reduction in medication led restraint and were very close to achieving the year 2 target of a 75% reduction in physical constraint. The third pilot ward had a more challenging year 2 and was unable to meet these targets. Sixteen of the inpatient wards are at various stages of rolling out this initiative and continuing to roll out Non Force First continues to be one of our quality priorities for 2015/16;

    b) Depression Pathway/Reduction in Suicides – following extensive engagement a depression pathway has been developed and agreed, which will be implemented by September 2015. The Mersey Care Suicide Review (2014) shows that suicide trends within the Trust mirror those seen in mental health services across England and Wales (2002 – 2012) and also across the north west (2014). A Zero Suicide Programme Board was established in January 2015 (the Trust has also appointed an Associate Medical Director for Suicide Prevention) which has overseen the development of a Zero Suicide Strategy which the Trust Board is being asked to approve in May 2015. The Trust is co-producing better safety planning with service users and is providing suicide prevention training to all clinical staff and a series of events *(Innovate Depression)* have taken place with staff and service users to identify and share innovation. A *Safe from Suicide* team will be established from September 2015 to oversee the implementation of the Strategy;

    c) Improvement in Physical Health – following discussion at a perfect care launch event in June 2014, it was agreed the physical health project would encompass all aspects of cardiovascular health in order to ensure the greatest impact on the health of our services users. The Trust is using the Royal College of Psychiatrists recommended 'Lester UK Adaption for Positive Cardiometabolic Health Resource' tool, with the aim to providing screening and resulting interventions to 100% of our patients in our care. Modified early Warning Scores (MEWS), which helps to recognise the deterioration of patients, has now been rolled out across the Secure Division and all but two of the wards in the Local Services Division. As a result in 2014/15 we have seen physical health screening levels for inpatients remain circa 98% and community service users on a Care Programme Approach (CPA) who have had an annual health check improve from 70% at the beginning of the year to 83% at the end. Improvement in the physical health of the Trust's service users continues to be a key quality and performance indicator for the Trust, which is why it remains as a quality indicator for 2015/16;

    d) Reduction in the Number of Falls – in 2014/15 the Trust focussed on those inpatient wards with the highest number of falls, namely older adults inpatient services and addiction inpatient services. A Trust-wide falls standards was also introduced. Within the services being focussed on for 2014/15, the number of falls reduced in addiction services (although the level of harm increased) and the number of falls increased in older adults services (although the level of harm decreased). Falls are reported weekly as part of the Trust's quality surveillance process and areas of concerns are responded to. Falls still remain as a quality priority for the Trust, which is why this continues to be a quality indicator for 2015/16;

    e) Reduction in Harm in Inpatient Settings – as **table 3** below shows, the Trust has achieved a reduction in the level of harm from violence on its inpatient wards

Table 3: Harm as a result of incidents (trust-wide data)

Impact of Incidents	2013/2014	2014/2015
Death	0.0%	0.0%
Severe Harm	0.0%	0.0%
Moderate Harm	1.3%	0.8%
Low Harm	11.4%	10.9%
No Harm	87.3%	88.3%

f) Outcome Measures for Recovery – there are no nationally agreed outcome measures used systematically and routinely across mental health trusts. A pilot to enhance the accuracy of data captured through the mental health cluster tool was started and the Local Services Division are piloting the use of the South Warwick and Edinburgh Mental Wellbeing Scale, together with changes to the patient experience questionnaire to allow better triangulation with other data collection tools. The Trust has been considering proposals for outcome measures developed internally, which services users and carers have been consulted, in May 2015. A plan has been agreed that, following a testing and piloting phase, will result in outcome measures for recovery being adopted by March 2016.

45. 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 2015/16 will be. These priorities should build on our achievements in 2014/15 and may include:

- Priority 1: No Force First – operationalise the initiative across the organisation
- Priority 2: Continued development of a depression pathway/towards zero suicides
- Priority 3: Improvement in physical health – and cardio-metabolic care and implementation of smoke free policy and monitoring the impact on service user experience
- Priority 4: Reduction in the number of falls and the implementation of revised falls protocols
- Priority 5: Reduction in self-harm on inpatient units and presenting at Accident and Emergency Department
- Priority 6: Development of a consistent approach to recovery focussed care planning which includes outcome measures.

46. The Trust is compliant with Care Quality Commission's fundamental standards and remained registered with the Care Quality Commission throughout 2014/15 without conditions.

NHS TRUST DEVELOPMENT AUTHORITY'S ACCOUNTABILITY FRAMEWORK

47. The Trust regularly monitors itself against the NHS Trust Development Authority's (TDA) Accountability Framework in the form of a self-assessment which is reported to the Trust Board and the TDA. The Overall Oversight and Escalation Score is agreed with the TDA through the regular Integrated Delivery Meetings the Trust has with the TDA. The trust's self-assessment of its performance against the TDA's Accountability Framework – which is reflected in the overall escalation score - has been informed by the technical guidance that accompanies the TDA's Accountability Framework.

48. As at the end of 2014/15 the Trust was assessed as having an overall escalation score as a Level 4 trust[1], with the scores for the different elements shown in **table 4** below.

Table 4: Overall Escalation Score as at March 2015

Element	Score
Quality Score	5
Finance RAG Assessment	Amber
Sustainability Score[2]	Not Available
Moderation Issues	None
Overall Score	**4**

49. The *amber score* recorded for the Finance RAG Assessment occurred as a result of the Trust changing its capital resource limit mid year. Although the TDA was informed of this change a mechanism does not exist to allow the submission of revised figures in-year. The Trust has achieved all of its statutory financial duties for 2014/15.

50. Mersey Care is not subject to the elective waiting time indicators as detailed in the TDA's Accountability Framework for 2014/15. In 2015/16 the Trust expects to be subject to Referral to Treatment (RTT) indicators in relation to its Improving Access to Psychological Therapies (IAPT) service and the Early Intervention in Psychosis indicators.

OTHER REGULATORY REQUIREMENTS

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

52. 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 in to 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.

53. 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. This year has seen a fall in carbon emissions from previous which 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 was allocated to install a Building Management System in high secure services during 2013/14 and a further six sites across the local division which will help measure and control our gas and electricity usage.

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

1 The top score is a Level 5 Trust, however such a score can only be considered if a NHS Trust has achieved 'good' or 'outstanding' rating following a CQC inspection.
2 The sustainability scoring mechanism has yet to be defined by the TDA.

55. As well as meetings with officers through the year, the Board has met with the Trust's three main clinical commissioning groups (CCGs) over the last year (i.e., Liverpool, South Sefton and Southport & Formby CCGs) as well as with representatives from the Trust's three main Local Healthwatch organisations (i.e., Knowsley, Liverpool and Sefton). The Trust participates in the Southport & Ormskirk Strategic Partnership Board and in February 2015 the Trust established the Mersey Care Strategic Partnership Board to strengthen mental health links with representatives from NHS providers, local authorities and CCGs across Knowsley, Liverpool and Sefton, as well as a representative from Merseyside Police.

REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

56. 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 & Escalation Framework and on the controls reviewed as part of Internal Audit's work. The overall opinion for 2014/15 is that there is 'significant assurance' (i.e., that there is a generally sound system of internal control designed to meet the organisation's objectives, and that 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 & 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.

57. My review is also informed by:

    a) external audit activities, including an audit of the Quality Account and the information governance arrangements

    b) Care Quality Commission inspections and compliance requirements

    c) Care Quality Commission's Intelligent Monitoring rating (which shows a Band 4 – lowest concern – rating);

    d) internal audit work including;

    e) financial systems assurance;

    f) assurance framework;

    g) safeguarding;

    h) risk management processes;

    i) clinical quality;

    j) information governance toolkit review;

    k) Local Health Resilience Partnership review of emergency planning arrangements;

    l) service performance.

58. The Trust 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

59. The Trust experienced the following issues in respect of two information governance breaches which occurred in 2014/15, both of which were self-reported by the Trust to the Information Commissioner:

    a) one related to personal identifiable data being sent out via secure Special Delivery, Royal Mail Delivery post to an NHS Trust headquarters address instead of the prison site managed by the Trust;

    b) the other related to two members of staff accessing a "hidden patient's" clinical record without having a legitimate reason to do so or being part of their care team – following disciplinary hearing these staff have been dismissed.

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

61. To mitigate the possibility of incidents reoccurring the Trust has:

    a) developed a Staff Code of Conduct relating to Confidentiality which will be published and circulated shortly;

    b) is seeking to procure additional technology to increase security in the event of staff accessing clinical records when they are not part of the patient's immediate care team;

    c) committed to ensuring that all staff complete Information Governance training upon Induction and thereafter on an annual basis.

62. The Trust did receive "significant assurance" in respect of the Information Governance Toolkit when it was audited by Mersey Internal Audit Agency (the Trust's internal auditors).

Accountable Officer: Dr Joe Rafferty Chief Executive

Organisation: Mersey Care NHS Trust (RW4)

Signature:

Date: 27.05.15

Annex 1 TABLES SHOWING ATTENDANCE AT BOARD AND BOARD COMMITTEES (April 2014 – March 2015)

Non Executives

Name	Role	Trust Board	Audit	Performance & Investment	Quality Assurance	Remuneration	Foundation Trust Project Board
Beatrice Fraenkel	Chair	**7/7 (100%)**	0/6	0/5	0/6	**2/3 (67%)**	**3/3 (100%)**
Matt Birch	Non Executive	**5/7 (71%)**	1/6	**4/5 (80%)** (Chair)	---	**2/3 (67%)**	**1/3 (33%)**
Gerry O'Keeffe	Non Executive	**7/7 (100%)**	**5/6 (83%)**	**4/5 (80%)**	2/5	**3/3 (100%)**	**3/3 (100%)**
Brenda Roe	Non Executive	**5/7 (71%)**	1/6	**3/5 (60%)**	**5/6 (100%)** (Chair)	**1/3 (33%)**	**2/3 (67%)**
Neil Willcox	Non Executive	**6/7 (86%)**	**5/6 (83%)** (Chair)	1/5	1/5	**3/3 (100%)**	**2/3 (67%)**
Nick Williams	Non Executive	**6/7 (86%)**	**3/6 (50%)**	---	**3/6 (50%)**	**3/3 (100%)**	**3/3 (100%)**
Brian Lawlor[3]	Non Executive	**1/1 (100%)**	0/2	0/1	0/1	**0/0**	**0/0**
Pearse Butler[4]	Non Executive	**1/1(100%)**	0/2	0/2	**0/2 (0%)**	**0/0**	**1/1 (100%)**
Chris Dowrick	Board Advisory Member	4/7	1/6	---	**3/6 (50%)**	1/3	0/3

3 Brian Lawlor left the trust on 31 May 2014 at the end of his term of office.
4 Pearse Butler was appointed as Non Executive Director on 1 June 2014, but resigned 19 September 2014.

Executives

Name	Role	Trust Board	Audit	Performance & Investment	Quality Assurance	Executive	Foundation Trust Project Board
Joe Rafferty	Chief Executive	**7/7 (100%)**	0/6	0/5	1/6	**10/12 (83%)** (Chair)	**2/3 (76%)**
Neil Smith	ED – Finance	**7/7 (100%)**	6/6	**5/5 (100%)**	**0/1 (0%)**	**10/12 (83%)**	**3/3 (100%)**
David Fearnley	Medical Director	**7/7 (100%)**	0/6	**3/5 (60%)**	**6/6 (100%)**	**9/12 (75%)**	**3/3 (100%)**
Ray Walker	ED – Nursing	**7/7 (100%)**	0/6	**2/4 (50%)**	**6/6 (100%)**	**11/12 (92%)**	**3/3 (100%)**
Elaine Darbyshire	ED – Comms & Corp. Governance	**7/7 (100%)**	0/6	1/5	**6/6 (100%)**	**9/12 (75%)**	**3/3 (100%)**
Amanda Oates[5]	ED - Workforce	**2/2 (100%)**	2/6	**1/1 (100%)**	4/6	**2/3 (67%)**	3/3

5 Amanda Oates was appointed as an Executive Director from 1 Jan 2015 and become a voting member the Board, Executive Committee and Performance and Investment Committee from then.

NOTE: Shaded cells indicate the person is a voting member of the Board/a particular Board Committee.

PERFORMANCE AND ACTIVITY

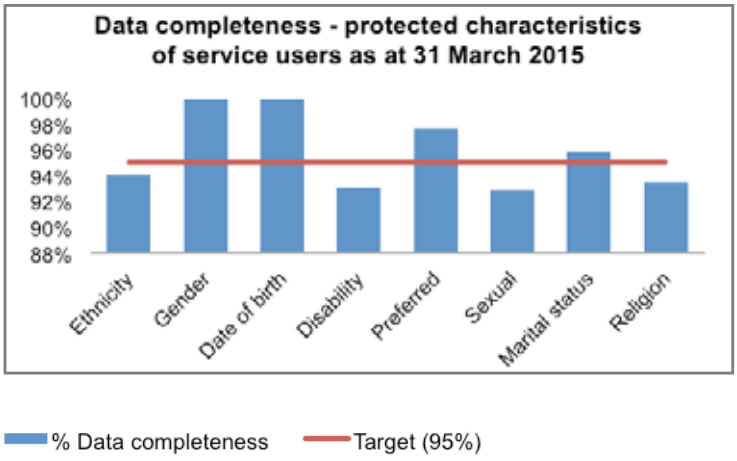
Fact File

Mersey Care:

- provided care, treatment and support to 38,729 service users in 2014/15 (37,813 in local services and 916 in secure services)
- is dispersed across over 32 sites both of its own and premises rented from others
- had 641 inpatient beds as at 31 March 2015
- had 482,184 outpatient attendances and contacts in 2014/15.

Mersey Care provides:

Adult and older people's mental health, learning disability, addiction, psychological, low secure, Cheshire and Mersey forensic psychiatry (medium secure) and high secure services.



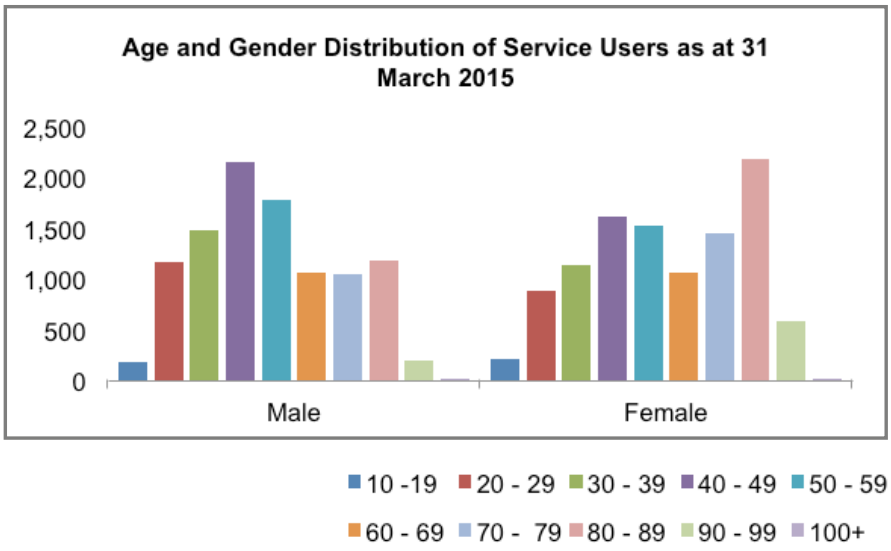
As at 31 March 2015, the Trust was achieving the equality objective targets of 95% data completeness for protected characteristics of service users across gender, date of birth, preferred language and marital status. Further work is required to achieve the standard for ethnicity, disability, sexual orientation and religion.

Source: ePEX and PACIS.

Ethnic breakdown of Service Users as at 31 March 2015

The graph shows that the greater majority of males on the caseload at 31 March 2015 were in the age group 40 - 49 (21%), 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 bracket. There are 2.1% more females on the caseload than males, despite HSS who have a male only service (190 resident at 31 March 2015).

Source: ePEX and PACIS.



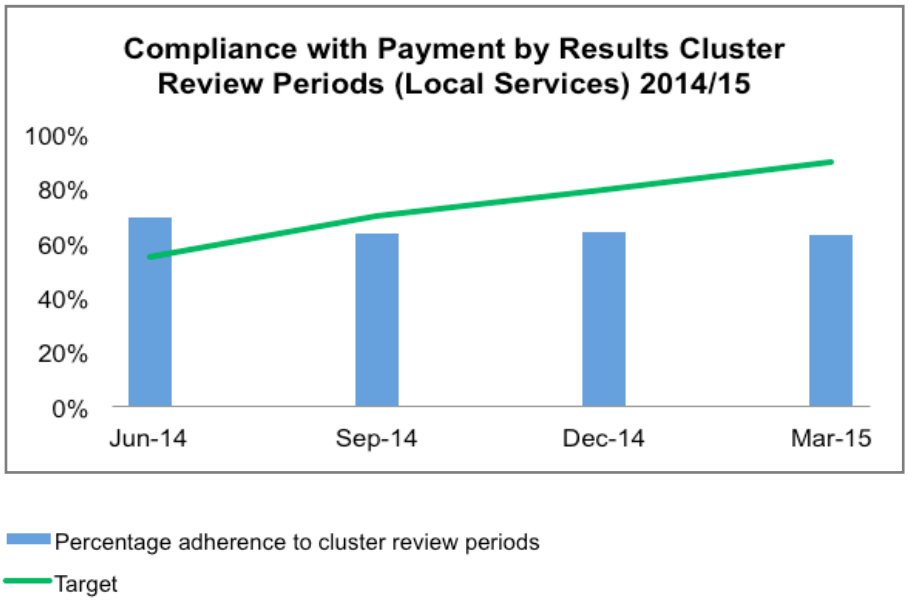
Ethnic Breakdown of Service Users as at 31 March 2015

Ethnicity	Number of Service Users	% of Total Service Users
African	81	0.4%
Arab	60	0.3%
Asian Other	84	0.4%
Bangladeshi	17	0.1%
Black British	214	1.1%
Black African	2	0.0%
Black Caribbean	36	0.2%
Black Other	55	0.3%
Caribbean	0	0.0%
Chinese	89	0.5%
Indian	33	0.2%
Mixed Other	83	0.4%
Other Ethnicity	100	0.5%
Pakistani	19	0.1%
Somali	35	0.2%
Turkish/Cypriot	8	0.0%
White British	17,872	92.3%
White European	155	0.8%
White Irish	167	0.9%
White Other	89	0.5%
White Welsh	8	0.0%
White/Asian	29	0.1%
White/Black/African	71	0.4%
White/Black/Caribbean	63	0.3%
Total Service Users with Known Ethnicity	**19,370**	

	Number of Service Users
Patient chose not to answer	490
Not known	1,122
Total Service Users with Unknown Ethnicity	**1,612**

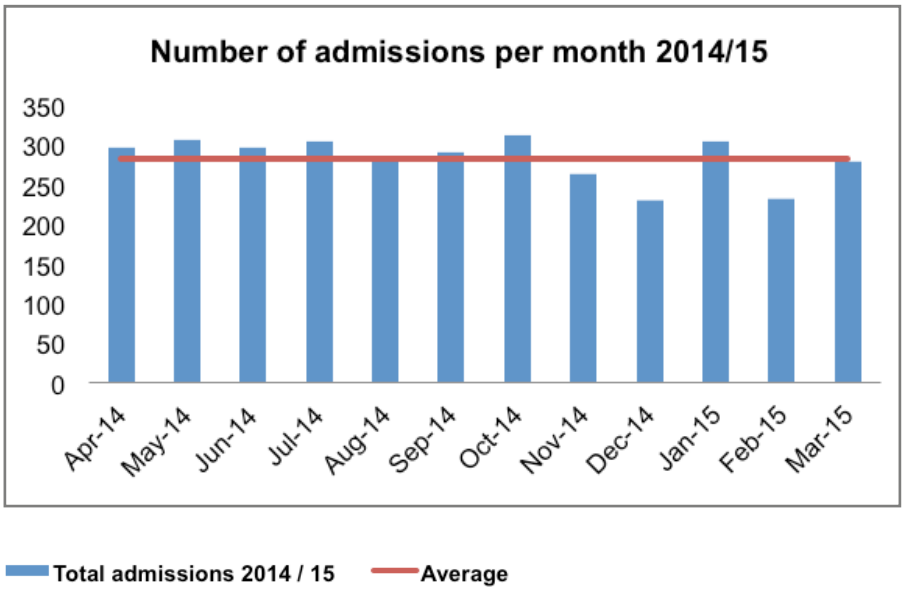
As at 31 March 2015, 20,982 patients were being provided with a service by Mersey Care NHS Trust, of which ethnicity was known for 19,370 (92.3%). 92% of service users with known ethnicity were White British. 96.3% of the population served by the Trust are White British.

Source: ePEX, PACIS and Membership Strategy.



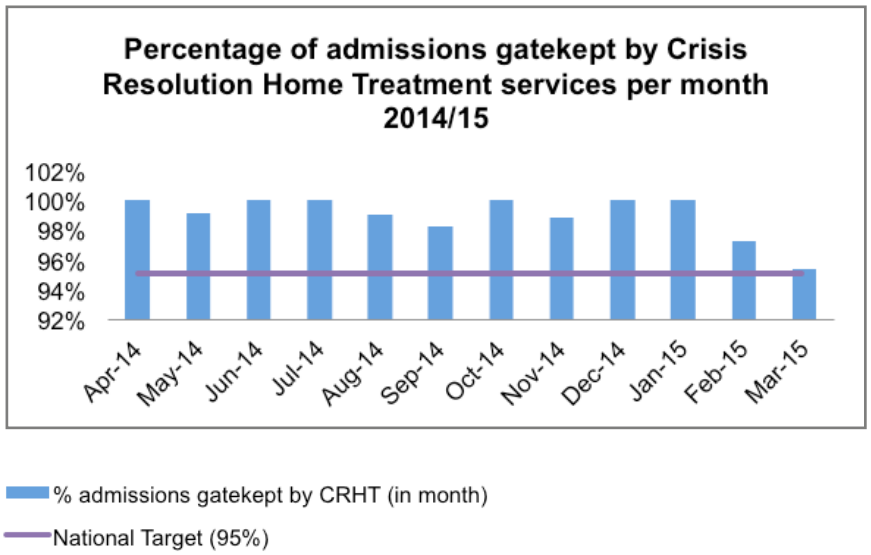
The Trust continues to work towards the achievement of the cluster view period adherence target. At 31 March 2015, the Trust was achieving a compliance rate of 62.78% against the target of 90%. Delivery of this standard is a key area for performance improvement in 2015/16.

Source: ePEX.



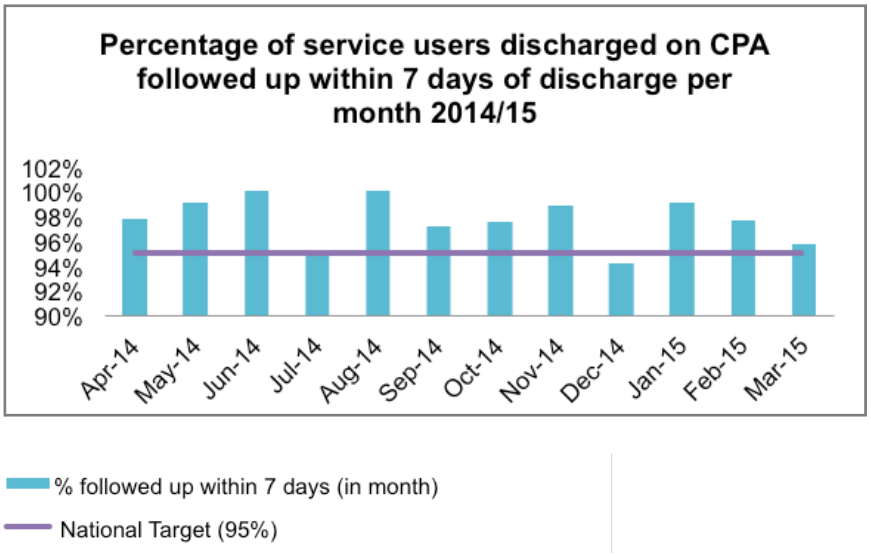
There has been a 9.6% decrease in admissions in 2014/15 with an average of 283 admissions across the Trust per month compared with 313 admissions per month in 2013/14.

Source: ePEX and PACIS.



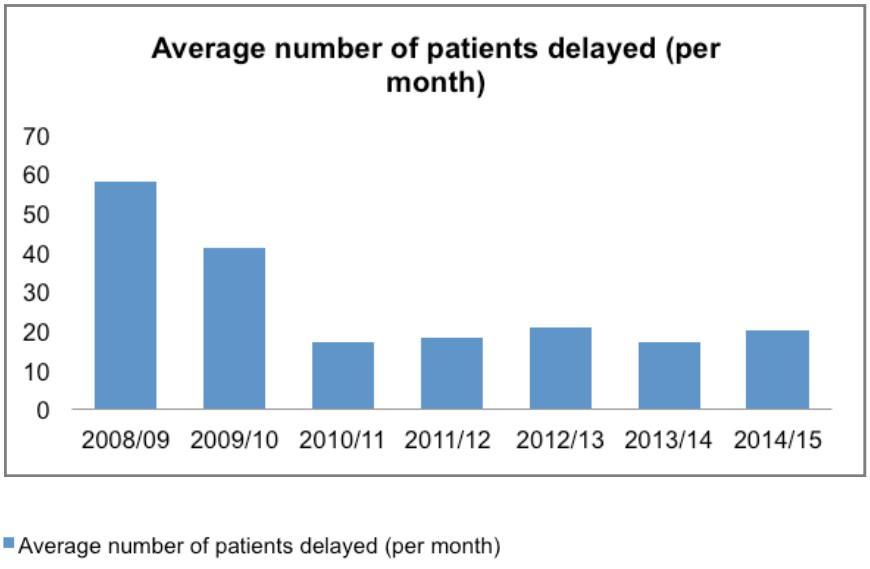
Mental Health Trusts are required to demonstrate that **service users are assessed (gatekept) prior to admission by Crisis Resolution Home Treatment (CRHT) teams to avoid unnecessary admissions to in-patient units.** During 2014/15, 99.1% of service users admitted to acute inpatient wards were gatekept by the Crisis Resolution Home Treatment (CRHT), compared to 99.7% in 2013/14. 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 Care Programme Approach (CPA) are followed up within 7 days of discharge.** 97.55% of service users discharged on a Care Programme Approach (CPA) in 2014/15 were followed up within 7 days, compared to 98.9% in 2013/14. The chart shows the percentage of service users followed up within 7 days of discharge against the national target each month.

Source: ePEX.



In 2014/15 an average of 20 **delayed discharges** were reported at the end of each month, compared with 17 during 2013/14. These figures include delays attributable to the NHS and social care. The majority of service users delayed (42%) were awaiting nursing home placement.

Source: ePEX.

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

Number of consultant outpatient contacts

Specialty	Adult Mental Health	Specialist Services	Assessment Services	Complex Services	Low Secure	Medium Secure	Offender Health	Total
Adult Mental Health – Acute	20,429		1,958	526	0	0	42	22,955
Adult Mental Health – Rehabilitation/Brain Injury/ Low Secure Unit	227	1,086	0	0	5	0	0	1,318
Older Peoples Mental Health	0	0	0	8,680	0	0	0	8,680
Learning Disabilities	0	1,285	0	0	0	0	0	1,285
Drug & Alcohol	0	1,560	0	0	0	0	1,653	3,213
Medium Secure	0	0	0	0	0	191	168	359
Psychotherapy	1,143	0	0	0	0	0	0	1,143
Total	**21,799**	**3,931**	**1,958**	**9,206**	**5**	**191**	**1,863**	**38,953**

There were 38,953 consultant outpatient attendances and face to face consultant community contacts in 2014/15, compared with 41,651 in 2013/14.

Source: ePEX.

Total number of patients provided with a service by local services in 2014/15	37,813
Total number of patients provided with a service by medium secure, low secure and offender health services in 2014/15	695

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

Specialty	Adult Mental Health	Specialist Services	Assessment Services	Complex Services	Low Secure	Medium Secure	Offender Health	Total
Adult Mental Health – Acute	143,362	3,270	30,490	7,430	0	747	2,312	187,611
Adult Mental Health – Rehabilitation/Brain Injury/ Low Secure Unit	3,656	2,838	0	0	4,103	0	0	10,597
Older Peoples Mental Health	2,855		2,941	86,132	0	0	0	91,928
Learning Disabilities	3,592	17,850	0	0	0	0	0	21,442
Drug & Alcohol	0	27,784	0	0	0	0	89,180	116,964
Medium Secure	0	0	0	0	65	8,569	2,040	10,674
Psychotherapy	3,040	0	0	0	0	0	0	3,040
Dietician	835	29				111	0	975
Total	**157,340**	**51,771**	**33,431**	**93,562**	**4,168**	**9,427**	**93,532**	**443,231**

There were 443,231 face to face community contacts not carried out by a Consultant in 2014/15, compared with 481,067 in 2013/14.

Source: ePEX.

Data Extracted from ePEX 8 April 2015.

High Secure Data 2014/15

Patient population by service as at 31 March 2014

Category	No. Patients	% of Population
Mental Health	126	66.3%
Personality Disorder	64	33.7%
Total	**190**	**100.0%**

The High Secure Service operates with wards of a maximum of 20 patients. The table indicates the patient population as at 31 March 2015 was 190, compared to 192 as at 31 March 2014. In addition to the 190 inpatient population, there were 15 patients on leave as at 31 March 2015 (compared to 15 patients on leave as at 31 March 2014).

Source: PACIS.

Source of patient admission

Admission Source	No. Patients	% of Admissions
Prison	23	65.7%
High Secure Hospital	0	0.0%
Medium Secure Unit	12	34.3%
Hospital	0	0.0%
Low Secure Unit	0	0.0%
Police Station	0	0.0%
Total	**35**	**100.0%**

This table shows the number of patients admitted to High Secure Services in 2014/15, and where they were admitted from. 35 patients (34% decrease) were admitted in 2014/15, compared with 53 in 2013/14.

Source: PACIS.

Outcome of referrals

Outcome	No. Patients	% of referrals
Rejected	13	20.3%
Accepted	36	56.3%
Open	0	0.0%
Withdrawn	12	18.8%
Inappropriate	3	4.7%
Referred	**64**	**100.0%**

During 2014/15 the service received 64 referrals, which is a 12% increase on 2013/14 when the service received 73. Of the 64 patients referred for admission to the service in 2014/15, 36 were accepted (56.25%). This is a decrease compared with the proportion accepted in 2013/14 (69.86%).

Source: PACIS.

Patients transferred/discharged by place

Destination	No. Patients	% of discharges
High Secure Hospital	0	0.0%
Medium Secure Unit	24	64.9%
Low Secure Unit	0	0.0%
Prison	10	27.0%
Court	0	0.0%
Hospital	0	0.0%
Repatriation	1	
Deceased	2	5.4%
Total	**37**	**100.0%**

During 2014/15, 37 patients were discharged from High Secure Services, which is a decrease of 35% on 2013/14 (when there were 57 patients discharged). The table shows where these patients were discharged/transferred to. The majority of High Secure patients discharged during 2014/15 went to a Medium Secure Unit (64.86%).

Source: PACIS.

Regional split of patients

Region	No. Patients	% of population
London	3	1.3%
Northern including North West	126	57.0%
Northern Ireland	1	0.5%
South East	1	0.5%
Wales	39	17.6%
West Midlands	51	23.1%
Total	**221**	**100.0%**

The table shows the number of patients accessing High Secure Services in 2014/15. From the information it can be seen that the majority of patients came from the North West, West Midlands and Wales. (95.93% of patients in total).

Source: PACIS.

Total number of patients provided with a service by high secure services in 2014/15	221

Data extracted from PACIS 9 April 2015.

Population served by Trust

	People	% White British	People White British
Liverpool	439,473	94.3%	414,423
Sefton	282,958	98.4%	278,431
Knowsley	150,459	98.4%	148,052
Total	**872,890**	**96.3%**	**840,905**

Membership Strategy IBP 2014.


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 2015 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
- 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 the 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 Auditing (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 misstatement, whether caused by fraud or error. This includes an 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 directors; 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 Introduction, the Finance Director's report and Performance and Activity Report 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 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 2015 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 NHS 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 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 in October 2014.

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 review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, 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 of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015. 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 2014, 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 2015.

Certificate

We certify that we have completed the audit of the accounts of Mersey Care NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission

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

28 May 2015

FOREWARD TO THE ACCOUNTS

These accounts for the year ended 31 March 2015 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 2015

	NOTE	2014/15 £000s	2013/14 £000s
Gross employee benefits	8	**(150,463)**	(154,190)
Other operating costs	6	**(45,706)**	(48,712)
Revenue from patient care activities	4	**186,942**	184,451
Other operating revenue	5	**19,961**	23,425
Operating surplus		**10,734**	**4,974**
Investment revenue	10	**118**	72
Other losses	11	(**123**)	(130)
Finance costs	12	**(1,380)**	(876)
Surplus for the financial year		**9,349**	4,040
Public dividend capital dividends payable		**(3,855)**	(3,618)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus for the year		**5,494**	**422**

Other Comprehensive Income

	2014/15 £000s	2013/14 £000s
Impairments and reversals taken to the revaluation reserve	**0**	(92)
Net gain on revaluation of property, plant & equipment	**10,012**	8,389
Total comprehensive income for the year*	**15,506**	8,719

Financial performance for the year

Retained surplus for the year	**5,494**	422
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)*	**335**	0
Impairments (excluding IFRIC 12 impairments)**	**506**	4,328
Adjustments in respect of donated gov't grant asset reserve elimination	**0**	0
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus	**6,335**	**4,750**

* 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 LIFT schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded whe measuring breakeven performance.

**An explanation of the impairment adjustments is provided in Note 15.

The notes on pages 60 to 93 form part of this account.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

	NOTE	31 March 2015 £000s	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	13.1	**190,362**	146,857
Intangible assets	14.1	**478**	93
Trade and other receivables	20.1	**64**	152
Total non-current assets		**190,904**	147,102
Current assets:			
Inventories	19	**382**	366
Trade and other receivables	20.1	**7,825**	7,506
Cash and cash equivalents	23	**24,306**	18,098
Sub-total current assets		**32,513**	25,970
Non-current assets held for sale		**0**	0
Total current assets		**32,513**	25,970
Total assets		**223,417**	173,072
Current liabilities			
Trade and other payables	24	**(16,662)**	(9,133)
Provisions	30	**(1,705)**	(1,764)
Borrowings	26	**(465)**	(121)
Total current liabilities		**(18,832)**	(11,018)
Net current assets/(liabilities)		**13,681**	14,952
Total assets less current liabilities		**204,585**	162,054
Non-current liabilities			
Provisions	30	**(21,830)**	(20,736)
Borrowings	26	**(30,834)**	(4,833)
Total non-current liabilities		**(52,664)**	(25,569)
Total assets employed:		**151,921**	136,485
FINANCED BY:			
Public Dividend Capital		**58,349**	58,099
Retained earnings		**(21,359)**	(28,433)
Revaluation reserve		**55,024**	46,912
Other reserves		**59,907**	59,907
Total Taxpayers' Equity:		**151,921**	136,485

The notes on pages 60 to 93 form part of this account.

The financial statements on pages 56 to 59 were approved by the Board on 27 May 2015 and signed on its behalf by

Chief Executive:  **Date** 27/05/2015

The Southport Focus Team walking group enjoy a trip to Liverpool

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDING 31 MARCH 2015

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2014	**58,099**	**(28,433)**	**46,912**	**59,907**	**136,485**
Changes in taxpayers' equity for 2014/15					
Retained surplus for the year	0	5,494	0	0	5,494
Net gain on revaluation of property, plant, equipment	0	0	10,012	0	10,012
Impairments and reversals	0	0	(320)	0	(320)
Transfers between reserves	0	1,580	(1,580)	0	0
Reclassification Adjustments					
New temporary and permanent PDC received - cash	250	0	0	0	250
Net recognised revenue for the year	**250**	**7,074**	**8,112**	**0**	**15,436**
Balance at 31 March 2015	**58,349**	**(21,359)**	**55,024**	**59,907**	**151,921**
Balance at 1 April 2013	**58,099**	**(32,235)**	**41,995**	**59,907**	**127,766**
Changes in taxpayers' equity for the year ended 31 March 2014					
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**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015

	2014/15 £000s	2013/14 £000s
Cash Flows from Operating Activities		
Operating surplus	**10,734**	4,974
Depreciation and amortisation	**5,495**	5,140
Impairments and reversals	**506**	4,328
Interest paid	**(1,446)**	(440)
Dividend paid	**(3,769)**	(3,454)
Increase in Inventories	**(16)**	88
Decrease in Trade and Other Receivables	**695**	(2,240)
Increase in Trade and Other Payables	**6,398**	2,773
Provisions utilised	**(1,572)**	(1,813)
Increase in movement in non cash provisions	**2,249**	2,521
Net Cash Inflow from Operating Activities	**19,274**	11,877
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**118**	72
Payments for Property, Plant and Equipment	**(12,571)**	(8,087)
Payments for Intangible Assets	**(561)**	(177)
Net Cash Outflow from Investing Activities	**(13,014)**	(8,192)
Net Cash Inflow before Financing	**6,260**	**3,685**
CASH FLOWS FROM FINANCING ACTIVITIES		
Gross Temporary and Permanent PDC Received	**250**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP LIFT	**(302)**	(103)
Net Cash Outflow from Financing Activities	**(52)**	(103)
NET INCREASE IN CASH AND CASH EQUIVALENTS	**6,208**	3,582
Cash and Cash Equivalents at Beginning of the Period	**18,098**	14,516
Cash and Cash Equivalents at year end	**24,306**	18,098

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 Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) 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 (FREM). Where the 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 2014/15.

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.

LIFT Assets

The Trust's Lift scheme is deemed under International Financial reporting Standards to be classed as on Statements of Financial Position on the basis that the asset is under the control of the Trust and all risks and rewards sit with the Trust. This is deemed to be a critical judgement that impacts on the financial statements.

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 adaption of IFRS as per the FREM and NHS manual for accounts. Details of impairments are included in Note 15.

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 30.

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 Trust 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.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- land and non-specialised buildings – market value for existing use
- specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses 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 Leases

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

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.

1.12 Local Improvement Finance Trust (LIFT) transactions

HM Treasury has determined that government bodies shall account for infrastructure LIFT schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the LIFT asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the LIFT asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

LIFT Asset

The LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

LIFT liability

A LIFT liability is recognised at the same time as the LIFT assets are recognised. It is measured initially at the same amount as the fair value of the LIFT assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.13 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.

1.14 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.

1.15 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 (1.5%), 6-10 years (1.05%) 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 (1.3% 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.

1.16 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 30.

1.17 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 NHS Litigation Authority 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.

1.19 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.

1.20 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 impairments 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.

1.21 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.

1.22 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.

1.23 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 given in Note 38 to the accounts.

1.24 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.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the 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 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.

1.26 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).

1.27 Subsidiaries

Material entities over which the Trust has the power to exercise control 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.

1.28 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

IFRS 9 Financial Instruments – subject to consultation

IFRS 13 Fair Value Measurement – subject to consultation

IFRS 15 Revenue from Contracts with Customers

2. Operating Segments

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

3. Income Generation Activities

For the financial years 2014/15 and 2013/14 the Trust has not undertaken any material income generation activities

4. Revenue from patient care activities

	2014/15 £000s	2013/14 £000s
NHS Trusts	**63**	6
NHS England	**73,039**	73,398
Clinical Commissioning Groups	**96,621**	93,310
Foundation Trusts	**1,420**	1,157
Non-NHS:		
Local Authorities	**3,570**	3,522
Other*	**12,229**	13,058
Total Revenue from patient care activities	**186,942**	**184,451**

* Includes patient's care income for High Secure Services from Welsh health bodies £11.6m (£12.7m in 2013/14).

5. Other operating revenue

	2014/15 £000s	2013/14 £000s
Education, training and research	3,973	3,658
Non-patient care services to other bodies*	10,639	12,239
Rental revenue from operating leases	3,028	3,038
Other revenue	2,321	4,490
Total Other Operating Revenue	19,961	23,425
Total operating revenue	**206,903**	207,876

* Includes income for Informatics Merseyside of £10.1m (£11.7m in 2013/14).

6. Operating expenses

	2014/15 £000s	2013/14 £000s
Purchase of healthcare from non-NHS bodies	**1,425**	1,099
Trust Chair and Non executive Directors	**53**	64
Supplies and services - clinical	**4,523**	4,925
Supplies and services - general	**3,927**	4,316
Consultancy services	**2,078**	1,990
Establishment	**7,546**	6,737
Transport	**388**	374
Service charges – On-SOFP LIFT contracts	**127**	0
Business rates paid to local authorities*	**731**	687
Premises	**13,468**	11,624
Hospitality	**122**	128
Insurance	**333**	319
Legal Fees	**266**	724
Impairments and Reversals of Receivables	**(17)**	51
Depreciation	**5,442**	5,095
Amortisation	**53**	45
Impairments and reversals of property, plant and equipment	**506**	4,328
Audit fees	**76**	74
Other auditor's remuneration**	**51**	8
Clinical negligence	**195**	207
Research and development (excluding staff costs)	**264**	251
Education and Training	**1,262**	1,136
Change in Discount Rate	**1,177**	1,228
Other***	**1,710**	3,302
Total Operating expenses (excluding employee benefits)	**45,706**	48,712

* Business rates have been restated for 2013/14, the costs have been moved from Premises (£0.5m) and Establishment (£0.2m)

Other auditor's remuneration includes £10k for review of the Trust's Quality Accounts, £5.3k for a review of Trust salary sacrifice schemes and £35k for the review of the Integrated Business Plan and Long Term Financial Model.

*** Other includes £0.9m for Early Retirements and Permanent Injury Benefits, £0.5m for Professional Fees.

Employee Benefits

Employee benefits excluding Board members	**149,486**	153,172
Board members	**977**	1,018
Total Employee Benefits	**150,463**	154,190
Total Operating Expenses	**196,169**	202,902

7. 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.

7.1 Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2014/15 Total £000s	2013/14 £000s
Payments recognised as an expense					
Minimum lease payments				698	455
Sub-lease payments				0	0
Total Payable:				**698**	455
No later than one year	0	672	60	**732**	578
Between one and five years	0	2,414	204	**2,618**	2,048
After five years	0	2,157	0	**2,157**	1,866
Total	**0**	**5,243**	**264**	**5,507**	4,492
Total future sublease payments expected to be received:				0	0

7.2 Trust as lessor

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

	2014/15 £000s	2013/14 £000s
Recognised as revenue		
Rental revenue		
	3,028	3,038
Total Receivable:	**3,028**	3,038
No later than one year	3,028	3,038
Between one and five years	3,911	6,962
Total	**6,939**	10,000

8. Employee benefits and staff numbers

8.1 Employee benefits

	2014/15 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**125,579**	115,111	10,468
Social security costs	**9,032**	8,756	276
Employer Contributions to NHS BSA - Pensions Division	**14,045**	13,616	429
Other pension costs	**1**	1	0
Termination benefits			
	2,816	2,816	0
Total employee benefits:	**151,473**	**140,300**	**11,173**
Employee costs capitalised	**1,010**	1,010	0
Gross Employee Benefits excluding capitalised costs	**150,463**	**139,290**	**11,173**

Employee Benefits – Gross Expenditure 2013-14*

	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	128,704	116,929	11,775
Social security costs	9,874	9,874	0
Employer Contributions to NHS BSA - Pensions Division	14,629	14,629	0
Other pension costs	1	1	0
Termination benefits	2,106	2,106	0
TOTAL - including capitalised costs	**155,314**	**143,539**	**11,775**
Employee costs capitalised	1,124	1,124	0
Gross Employee Benefits excluding capitalised costs	154,190	142,415	11,775

* The table has been restated to show the bank staff costs within the permanently employed figures. It has also been restated to show the seconded staff within other from permanently employed.

8.2 Staff numbers

	2014/15 Total Number	Permanently employed Number	Other Number	2013/14 Total Number
Average Staff Numbers				
Medical and dental	**156**	87	69	142
Administration and estates	**992**	943	49	1,017
Healthcare assistants and other support staff	**1,267**	1,249	18	1,310
Nursing, midwifery and health visiting staff	**1,076**	1,075	1	1,091
Scientific, therapeutic and technical staff	**303**	296	7	285
Social Care Staff	**23**	23	0	32
TOTAL	**3,817**	**3,673**	**144**	**3,876**
Of the above – staff engaged on capital projects	**32**	32	0	30

8.3 Staff sickness absence and ill health retirements

	2014/15 Number	2013/14 Number
Total Days Lost	**44,578**	44,368
Total Staff Years	**3,450**	3,483
Average working Days Lost	**12.92**	**12.74**

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

	2014/15 Number	2013/14 Number
Number of persons retired early on ill health grounds	**16**	17
	£000s	**£000s**
Total additional pensions liabilities accrued in the year	**1,333**	889

8.4 Exit packages agreed in 2013/14

	2014/15 *No. of compulsory redundancies	2014/15 *No. of other departures agreed	2014/15 Total No. of exit packages by cost band	2013/14 *No. of compulsory redundancies	2013/14 *No. of other departures agreed	2013/14 Total No. of exit packages by cost band
Less than £10,000	0	47	47	0	44	44
£10,000-£25,000	0	48	48	1	48	49
£25,001-£50,000	3	36	39	0	25	25
£50,001-£100,000	0	5	5	0	5	5
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	**3**	**136**	**139**	1	122	123
Total resource cost (£s)	**135,400**	**2,680,385**	**2,815,785**	18,805	2,254,723	2,273,528

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.

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.

8.5 Exit packages – other departures analysis

	2014/15 Agreements Number	2014/15 Total value of agreements £000s	2013/14 Agreements Number	2013/14 Total value of agreements £000s
Early retirements in the efficiency of the service contractual costs	114	2,567	98	2,088
Contractual payments in lieu of notice	22	113	24	167
Total	136	2,680	122	2,255
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	1	81

The Trust (MARS) scheme was agreed with HM Treasury. Of the 'other' departures all 114 staff (£2.6m) left as a result of the MARS scheme.

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 8.4 which will be the number of individuals.

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

8.6 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.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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.

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 year ending 31 March 2012.

The Scheme Regulations 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.

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.

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 statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

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.

9. Better payment practice code

9.1 Measure of compliance

	2014/15 Number	2014/15 £000s	2013/14 Number	2013/14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**34,734**	**48,054**	39,767	49,115
Total Non-NHS Trade Invoices Paid Within Target	**33,829**	**47,306**	38,820	48,369
Percentage of NHS Trade Invoices Paid Within Target	**97.39%**	**98.44%**	97.62%	98.48%

* Non NHS payables has been restated for 2013/14 to remove payments to HMRC and NHS Pensions Agency

NHS Payables				
Total NHS Trade Invoices Paid in the Year	**685**	**12,642**	696	11,997
Total NHS Trade Invoices Paid Within Target	**679**	**12,627**	687	11,876
Percentage of NHS Trade Invoices Paid Within Target	**99.12%**	**99.88%**	98.71%	98.99%

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

9.2 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 2014/15 and 2013/14.

10. Investment revenue

	2014/15 £000s	2013/14 £000s
Interest revenue	**118**	**72**

11. Other Gains and Losses

	2014/15 £000s	2013/14 £000s
Loss on disposal of assets other than by sale (intangibles)	**(123)**	(130)
Total	**(123)**	(130)

12. Finance Costs

	2014/15 £000s	2013/14 £000s
Interest		
Interest on obligations under finance leases	**473**	440
Interest on obligations under LIFT contracts:		
- main finance cost	**523**	0
- contingent rent	**26**	0
Total interest expense	**1,022**	440
Provisions – unwinding of discount	**358**	436
Total	**1,380**	876

13.1 Property, plant and equipment

2014/15	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 2014	**16,220**	**119,021**	**0**	**5,938**	**7,785**	**990**	**4,730**	**2,318**	**157,002**
Additions of Assets Under Construction	0	0	0	3,420	0	0	0	0	**3,420**
Additions Purchased	0	8,322	0	0	203	0	0	1,147	**9,672**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	26,671	0	0	0	0	0	0	**26,671**
Reclassifications	0	3,671	0	(3,671)	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(526)	(16)	(2)	(167)	**(711)**
Upward revaluation/positive indexation	55	9,957	0	0	0	0	0	0	**10,012**
Impairments/negative indexation	(30)	(290)	0	0	0	0	0	0	**(320)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**16,245**	**167,352**	**0**	**5,687**	**7,462**	**974**	**4,728**	**3,298**	**205,746**
Depreciation									
At 1 April 2014	**0**	**0**	**0**	**649**	**2,592**	**847**	**3,918**	**2,139**	**10,145**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(526)	(14)	(2)	(167)	**(709)**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	4,861	0	0	0	0	0	0	**4,861**
Reversal of Impairments	0	(4,355)	0	0	0	0	0	0	**(4,355)**
Charged During the Year	0	4,395	0	0	617	43	335	52	**5,442**
At 31 March 2015	**0**	**4,901**	**0**	**649**	**2,683**	**876**	**4,251**	**2,024**	**15,384**
Net Book Value at 31 March 2015	**16,245**	**162,451**	**0**	**5,038**	**4,779**	**98**	**477**	**1,274**	**190,362**
Asset financing:									
Owned - Purchased	16,245	128,981	0	5,038	4,779	98	477	1,274	**156,892**
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	5,715	0	0	0	0	0	0	**5,715**
On-SOFP PFI contracts	0	27,755	0	0	0	0	0	0	**27,755**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**16,245**	**162,451**	**0**	**5,038**	**4,779**	**98**	**477**	**1,274**	**190,362**

2014/15	Land	Buildings ex 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
At 1 April 2014	691	46,204	0	0	15	1	0	1	**46,912**
Movements*	25	8,091	0	0	(3)	(1)	0	0	**8,112**
At 31 March 2015	**716**	**54,295**	**0**	**0**	**12**	**0**	**0**	**1**	**55,024**

* The Trust has increased its revaluation reserve by £8.1m in 2014-15. The increase related to the an upward revaluation of the Trust estate by the District Valuer on 31 March 2015 (£9.7m). This was offset by £0.7m transferring to the Retained Earnings Reserve as assets were depreciated and £0.9m when assets were impaired.

Additions to Assets Under Construction in 2014-15

	£000s
Land	0
Buildings excl Dwellings	3,420
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**3420**

13.2 Property, plant and equipment – prior year

2013/14	Land £000s	Buildings £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**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	**0**
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 - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	**0**	0
Additions Leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	2,876	0	(3,701)	817	0	0	8	**0**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	(2,152)	0	0	(125)	0	(1,516)	(8)	**(3,801)**
Revaluation	299	8,090	0	0	0	0	0	0	**8,389**
Impairments/negative indexation charged to reserves	(51)	(41)	0	0	0	0	0	0	**(92)**
Reversal of Impairments charged to reserves	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**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	(2,152)	0	0	(125)	0	(1,516)	(8)	**(3,801)**
Revaluation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation charged to operating expenses	1,101	7,103	0	0	0	0	153	0	**8,357**
Reversal of Impairments charged to operating expenses	(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**
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**

13.3 Property, plant and equipment

The Trust's land and buildings were revalued on 31 March 2014 and updated on 31 March 2015 by the District Valuer.

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

The valuation of each property is on the basis of Market Value on the assumption that the property is sold as part of a continuing enterprise on 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 £7.2m fully depreciated assets still in use.

14.1 Intangible Non-Current Assets 2014/15

	IT in-house & 3rd Party software	Computer Licenses	Licenses & Trademarks	Patents	Development Expenditure -Internally Generated	Total
	£000s	£000s	£000s	£000s	£000s	£000s
At 1 April 2014	**0**	**1,058**	**0**	**0**	**0**	**1,058**
Additions Purchased	0	438	123	0	0	**561**
Additions Internally Generated	0	0	0	0	0	**0**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	(123)	0	0	**(123)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments charged to reserves	0	0	0	0	0	**0**
Reversal of impairments charged to reserves	0	0	0	0	0	**0**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	**0**	**0**
At 31 March 2015	**0**	**1,496**	**0**	**0**	**0**	**1,496**
Amortisation:						
At 1 April 2014	**0**	**965**	**0**	**0**	**0**	**965**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	53	0	0	0	**53**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2015	**0**	**1,018**	**0**	**0**	**0**	**1,018**
Net Book Value at 31 March 2015	**0**	**478**	**0**	**0**	**0**	**478**
Asset Financing						
Net book value at 31 March 2015 comprises:						
Purchased	0	478	0	0	0	**478**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	**0**	**0**
Finance Leased	**0**	**0**	**0**	**0**	**0**	**0**
On-balance Sheet PFIs	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2015	**0**	**478**	**0**	**0**	**0**	**478**
Revaluation reserve balance for intangible non-current assets:						
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

14.2 Intangible Non-Current Assets Prior Year 2013/14

	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 2013	**0**	**1,053**	**0**	0	0	**1,053**
Transfers under Modified Absorption Accounting – PCTs & SHAs	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting – Other Bodies	0	0	0	0	0	**0**
Additions – purchased	0	177	0	0	0	**177**
Additions – internally generated	0	0	0	0	0	**0**
Additions – donated	0	0	0	0	0	**0**
Additions – government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(172)	0	0	0	**(172)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2014	0	1,058	0	0	0	**1,058**
Amortisation:						
At 1 April 2013	**0**	**962**	**0**	**0**	**0**	**962**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(42)	0	0	0	**(42)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	45	0	0	0	45
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2014	**0**	**965**	**0**	**0**	**0**	**965**
Net book value at 31 March 2014	**0**	**93**	**0**	**0**	**0**	**93**
Net book value at 31 March 2014 comprises:						
Purchased	0	93	0	0	0	**93**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2014	**0**	**93**	**0**	**0**	**0**	**93**

14.3 Intangible non-current assets

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

14.4 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.

15. Analysis of Impairments and Reversals Recognised in 2014/15

	2014/15 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	(691)
Changes in market price	1,197
Total charged to Annually Managed Expenditure	**506**
Total Impairments of Property, Plant and Equipment changed to SoCI	**506**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Intangibles charged to SoCI	**0**
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Financial Assets charged to SoCI	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**

	2014/15 Total £000s
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**506**
Overall Total Impairments	**506**

There are no Donated and Government Granted Asset Impairments.

The Trust has total impairments of £0.5m in 2014/15.

£1.2m are impairments due to movements in market price less the net movement of £0.7m due to the reversal of previous economic impairments.

The net movement is made up of the following:

Economic impairments of £1.5m and £0.4m arose when Clock View and Brain Injuries Rehabilitation Centre were valued by the District Valuer when they were brought onto the asset register.

There was also an economic impairment of £1.1m when Owen Ward at Ashworth Hospital was valued by the District Valuer following major refurbishment.

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 2015 the value of the previously impaired buildings increased and the Trust has Reversal of Impairments of (£3.7m) within the total impairment.

The revaluations in 2014/15 increased the value of land and buildings by a further £9,692,372 which was credited to the Revaluation Reserve as this was due to movements in market value.

16. Analysis of Impairments and Reversals Recognised in 2014/15

	Total £000s	Property Plant & Equipment £000s	Intangible Assets £000s	Financial Assets £000s	Non-Current Assets Held for Sale £000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	0	0	0	0	0
Over-specification of assets	0	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0	0	0
Loss as a result of catastrophe	0	0	0	0	0
Other	(691)	(691)	0	0	0
Changes in market price	1,197	1,197	0	0	0
Total charged to Annually Managed Expenditure	**506**	**506**	**0**	0	0
Total Impairments of Property, Plant and Equipment changed to SoCI	**506**	**506**	**0**	**0**	**0**

Donated and Gov Granted Assets, included above
There are no Donated and Government Granted Asset Impairments

17. Capital commitments

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

	31 March 2015 £000s	31 March 2014 £000s
Property, plant and equipment	**3,277**	1,463
Intangible assets	**0**	0
Total	**3,277**	1,463

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	1,298	0	3,642	0
Balances with Local Authorities	224	0	172	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group*	2,349	0	622	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	3,454	64	12,191	30,834
At 31 March 2015	**7,325**	**64**	**16,627**	**30,834**
prior period:				
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	2,791	152	8,040	0
At 31 March 2014	**7,506**	**152**	**9,133**	**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 2014	**236**	**48**	**0**	**45**	**0**	**37**	**366**	0
Additions	2,434	1,686	0	65	0	62	**4,247**	0
Inventories recognised as an expense in the period	(2,404)	(1,676)	0	(78)	0	(73)	**(4,231)**	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 2015	**266**	**58**	**0**	**32**	**0**	**26**	**382**	**0**

20.1 Trade and other receivables

	Current		Non-Current	
	31 March 2014 £000s	31 March 2013 £000s	31 March2014 £000s	31 March 2013 £000s
NHS receivables - revenue	**2,844**	3,414	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**7**	0	**0**	0
Non-NHS receivables - revenue	**734**	630	**0**	0
Non-NHS receivables - capital	**0**	35	**0**	0
Non-NHS prepayments and accrued income	**3,319**	2,680	**64**	152
PDC Dividend prepaid to DH	**0**			
Provision for the impairment of receivables	**(117)**	(143)	**0**	0
VAT	**1,003**	868	**0**	0
Other receivables	**35**	22	**0**	0
Total	**7,825**	7,506	**64**	152
Total current and non current	**7,889**	7,658		
Included in NHS receivables are prepaid pension contributions:		1		

20.2 Receivables past their due date but not impaired

	31 March 2015 £000s	31 March 2014 £000s
By up to three months	**2,514**	3,252
By three to six months	**25**	55
By more than six months	**212**	25
Total	**2,751**	3,332

20.3 Provision for impairment of receivables

	2014/15 £000s	2013/14 £000s
Balance at 1 April 2014	**(143)**	(100)
Amount written off during the year	**9**	8
Amount recovered during the year	**544**	236
(Increase)/decrease in receivables impaired	**(527)**	(287)
Balance at 31 March 2015	**(117)**	(143)

21.1 Other financial assets - Current

The Trust had no other current financial assets in 2014/15 and 2013/14.

21.2 Other financial assets - Non Current

The Trust had no other non current financial assets in 2014/15 and 2013/14.

22. Other current assets

The Trust had no other non current capital financial assets in 2014/15 and 2013/14.

23. Cash and cash equivalents

	31 March 2015 £000s	31 March 2014 £000s
Opening balance	**18,098**	14,516
Net change in year	**6,208**	3,582
Closing balance	**24,306**	18,098
Made up of		
Cash with Government Banking Service	**5,273**	18,064
Commercial banks	**6**	8
Cash in hand	**27**	26
Liquid deposits with NLF	**19,000**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**24,306**	18,098
Bank overdraft – Government Banking Service	**0**	0
Bank overdraft – Commercial banks	**0**	
Cash and cash equivalents as in statement of cash flows	**24,306**	18,098
Patients' money held by the Trust, not included above	**972**	961

24. Trade and other payables

	Current		Non-Current	
	31 March 2015 £000s	31 March 2014 £000s	31 March 2015 £000s	31 March 2014 £000s
NHS payables - revenue	**860**	190	**0**	0
NHS payables - capital	**15**	0	**0**	0
NHS accruals and deferred income	**528**	5	**0**	0
Non-NHS payables - revenue	**3,440**	3,010	**0**	0
Non-NHS payables - capital	**957**	451	**0**	0
Non-NHS accruals and deferred income	**7,489**	4,551	**0**	0
Social security costs	**1,555**	378	**0**	0
Tax	**1,342**	238	**0**	0
Other	**476**	310	**0**	0
Total	**16,662**	9,133	**0**	0
Total payables (current and non-current)	**16,662**	9,133		
Included above:				
Outstanding Pension Contributions at the year end	**2**			

25. Other liabilities

The Trust had no other liabilities in 2014/15 and 2013/14.

26. Borrowings

	Current	Non-Current		
	31 March 2015 £000s	31 March 2014 £000s	31 March 2015 £000s	31 March 2014 £000s
LIFT liabilities:				
Main liability	**250**	0	**23,200**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**215**	121	**7,634**	4,833
Other (describe)	**0**	0	**0**	0
Total	**465**	**121**	**30,834**	**4,833**
Total other liabilities (current and non-current)	**31,299**	**4,954**		

The Trust has two Finance Leases one with Contour Housing for the Rathbone Rehabilitation Centre which is a 25 year lease running to 2032 and the other with The Walton Centre NHS Foundation Trust for the Brain Injury Rehabilitation which is a 25 year lease running to 2039.

27. Other financial liabilities

The Trust has no other liabilities in 2014/15 and 2013/14.

28. Deferred revenue

	Current		Non-Current	
	31 March 2015 £000s	31 March 2014 £000s	31 March 2015 £000s	31 March 2014 £000s
Opening balance at 1 April 2014	**145**	173	**0**	0
Deferred revenue addition	**144**	145	**0**	0
Transfer of deferred revenue	**(145)**	(173)	**0**	0
Current deferred Income at 31 March 2015	**144**	145	**0**	0
Total deferred income (current and non-current)	**144**	145		

29. Finance Lease Obligations as Lessee

The Trust has two Finance Leases.

One is with Contour Housing for the Rathbone Rehabilitation Centre which is a 25 year lease running to 2032. At the end of the lease in 2032 the property will revert to the Trust's ownership. The rental amount is based upon paying the loan Contour Housing took out to build the property, plus a management charge.

The other is with The Walton Centre NHS Foundation Trust for the Brain Injuries Rehabilitation Centre which is a 25 year lease running to 2039. At the end of this lease in 2039 the property will revert to the ownership of The Walton Centre NHS Foundation Trust.

Amounts payable under finance leases (Buildings)

	Minimum lease payments		Present value of minimum lease payments	
	31 March 2015 £000s	31 March 2014 £000s	31 March 2015 £000s	31 March 2014 £000s
Within one year	764	543	215	121
Between one and five years	3,200	2,172	1,070	667
After five years	12,818	7,602	6,564	4,166
Less future finance charges	(8,933)	(5,363)	0	0
Minimum Lease Payments/Present value of minimum lease payments	7,849	4,954	7,849	4,954
Included in:				
Current borrowings			**215**	121
Non-current borrowings			**7,634**	4,833
			7,849	4,954

30. Provisions

	Total £000s	Early Departure £000s	Legal Claims £000s	Other £000s
Balance at 1 April 2014	**22,500**	5,151	351	16,998
Arising during the year	**1,590**	263	228	1,099
Utilised during the year	**(1,572)**	(433)	(152)	(987)
Reversed unused	**(518)**	(97)	(187)	(234)
Unwinding of discount	**358**	83	0	275
Change in discount rate	**1,177**	153	0	1,024
Balance at 31 March 2015	**23,535**	**5,120**	**240**	**18,175**
Expected Timing of Cash Flows:				
No Later than One Year	**1,705**	435	240	1,030
Later than One Year and not later than Five Years	**5,441**	1,825	0	3,616
Later than Five Years	**16,389**	2,860	0	13,529

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

As at 31 March 2015	661
As at 31 March 2014	421

Pensions - the amounts are based on the current payments to former staff and estimated life expectancy of the former staff. The Trust uses 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 - £18.0m relates to Injury Benefits payable by the Trust under the NHS Pensions Injury Benefit Scheme. The amounts are based on the current payments and estimated life expectancy of those receiving payments. The Trust uses life tables from the National Office for Statistics to estimate the life expectancy. The remaining provision of £0.2m relates to the Carbon Reduction Commitment Energy Efficiency Scheme.

Pensions and Other - HM Treasury changed the discount rate to 1.30% (previously 1.8%) from 31 March 2015. The impact of this change is a charge to the Statement of Comprehensive Income of £1.2m as per HM Treasury guidance.

31. Contingencies

	31 March 2015 £000s	31 March 2014 £000s
Contingent liabilities		
NHS Litigation Authority legal claims*	**(71)**	(146)
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other	**0**	0
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**(71)**	(146)

*2013/14 contingent liability has been moved from other to NHS Litigation Authority legal claims, for competitive purposes.

The future contingent liabilities of £70,913 relate to potential legal claims (2013/14 £145,635). These figures have been provided by the NHS Litigation Authority.

Contingent assets		
Contingent assets [give details]	**0**	0
Net value of contingent assets	**0**	0

32. LIFT - additional information

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	2014/15 £000s	2013/14 £000s
Service element of on SOFP LIFT charged to operating expenses in year	**127**	0
Total	**127**	0

Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.	2014/15 £000s	2013/14 £000s
LIFT scheme expiry date:		
No Later than One Year	**464**	0
Later than One Year, No Later than Five Years	**2,054**	0
Later than Five Years	**23,557**	0
Total	**26,075**	0

The above tables discloses the total payments the Trust is committed to paying in respect of the service element of on SOFP LIFT on the basis of an RPI increase of 2.5% each year. At the current inflation rate the payments that the Trust would be committed to in respect of the service element until the end of the contract life would be £17,801k. The impact of future RPI is £8,274k.

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	2014/15 £000s	2013/14 £000s
No Later than One Year	**2,095**	0
Later than One Year, No Later than Five Years	**8,632**	0
Later than Five Years	**49,501**	0
Subtotal	**60,228**	0
Less: Interest Element	**(36,778)**	0
Total	**23,450**	0

IFRS 7 requires the Trust to disclose the fair value of financial liabilities. The PFI scheme is a non-current Financial Liability where the fair value is likely to differ from the carrying value. The Trust have reviewed the current interest rates available on the market and if these were used as the implicit interest rate for the scheme the fair value of the liability would range from £23,450k to £36,998k.

Present Value Imputed "finance lease" obligations for on SOFP LIFT contracts due Analysed by when LIFT payments are due	2014/15 £000s	2013/14 £000s
No Later than One Year	**250**	0
Later than One Year, No Later than Five Years	**1,537**	0
Later than Five Years	**21,663**	0
Total	**23,450**	0

Number of on SOFP LIFT Contracts	
Total Number of LIFT contracts	**1**
Number of LIFT contracts which individually have a total commitments value in excess of £500m	0

33. Impact of IFRS treatment - current year

	2014/15 £000s	2013/14 £000s
The information below is required by the Department of Heath for budget reconciliation purposes		
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. LIFT)		
Depreciation charges	**127**	0
Interest Expense	**549**	0
Impairment charge - AME	**0**	0
Impairment charge - DEL	**0**	0
Other Expenditure	**127**	0
Revenue Receivable from subleasing	**0**	0
Impact on PDC dividend payable	**188**	169
Total IFRS Expenditure (IFRIC12)	**991**	169
Revenue consequences of LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue)	**(656)**	(169)
Net IFRS change (IFRIC12)	**335**	0
Capital Consequences of IFRS : LIFT and other items under IFRIC12		
Capital expenditure 2014-15	**24,155**	285
UK GAAP capital expenditure 2014-15 (Reversionary Interest)	**117**	0

LIFT Additional Information

The LIFT scheme relates to Clock View, situated in Walton, Liverpool, will treat local people for a range of mental health issues including depression, anxiety and dementia, providing 80 individual bedrooms all with en-suite bathrooms. It will also provide the city's new psychiatric intensive care unit for those most in distress and in need of urgent inpatient care.

Clock View principally replaced an existing adult mental health inpatient unit at Aintree called Stoddart House, which was handed back to Aintree University Hospital as part of the agreement to purchase the Walton site.

The LIFT contract ends in December 2044. A monthly unitary payment will be made up to that point. The unitary payment is subject to annual increases in line with RPI. The arrangement requires the operator to deliver services to the Trust in accordance with the service delivery specification. Non delivery of quality or performance can lead to a reduction in the service charge being paid by the Trust. The Trust retains step in rights should the contractor fail to meet minimum standards as set out within the contract. Under IFRIC 12 the assets is treated as an asset of the Trust. The substance of the contract is that the Trust has a finance lease and payments comprise 2 elements - imputed finance lease charges and service charges.

34. Financial Instruments

34.1 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 Trust has with clinical commissioning groups/NHS England and the way those clinical commissioning groups/NHS England are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Currency risk

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

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust development agency. 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 Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 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 funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Fair value

IFRS 7 requires the Trust to disclose the fair value of financial liabilities. The PFI scheme is a non-current Financial Liability where the fair value is likely to differ from the carrying value. The Trust have reviewed the current interest rates available on the market and if these were used as the implicit interest rate for the scheme the fair value of the liability would range from £23,450k to £36,998k.

34.2 Financial Assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Receivables - NHS	0	2,408	0	**2,408**
Receivables - non-NHS	0	1,825	0	**1,825**
Cash at bank and in hand	0	24,306	0	**24,306**
Total at 31 March 2015	**0**	**28,539**	**0**	**28,539**
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
Total at 31 March 2014	0	23,611	0	23,611

34.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
NHS payables	0	1,041	1,041
Non-NHS payables	0	4,686	4,686
PFI & finance lease obligations	0	31,299	31,299
Total at 31 March 2015	0	**37,026**	**37,026**
NHS payables	0	211	211
Non-NHS payables	0	3,742	3,742
PFI & finance lease obligations	0	4,954	4,954
Total at 31 March 2014	0	8,907	8,907

35. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £	Receipts from Related Party £	Amounts owed Related Party £	Amounts due to Related Party £
Prof. Christopher Dowrick, Trust Board Advisor, Honorary Consultant in Primary Care - Liverpool Clinical Commissioning Group	0	69,263,864	0	432,500

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

Aintree University Hospital NHS Foundation Trust
Care Quality Commission
Calderstones Partnership NHS Foundation Trust
Cheshire and Merseyside Commissioning Support Unit
Health and Social Care Board
Health Education England
Lancashire Care NHS Trust
Liverpool Community Health NHS Trust
Liverpool Heart and Chest NHS Foundation Trust
Manchester Mental Health & Social Care Trust
NHS Business Services Authority
NHS England
NHS Knowsley CCG
NHS Liverpool CCG
NHS Pension Scheme
NHS St Helens CCG
NHS Southport and Formby CCG
NHS South Sefton CCG
NHS Supply Chain
NHS West Lancashire CCG
Northumbria Healthcare NHS Foundation Trust
Pennine Care NHS Trust
Royal Liverpool & Broadgreen University Hospitals NHS Trust
St Helens & Knowsley Teaching Hospitals NHS Trust
Salford Royal NHS Foundation Trust
Skills for Health
South Eastern Health & Social Care Trust
Southport and Ormskirk Hospital NHS Trust
The Walton Centre NHS Foundation Trust
Welsh Health Specialised Services Committee

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, Sefton Metropolitan Borough Council and Knowsley 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	450,964	1,284,013	16,000	137,456
Mrs Beatrice Fraenkel, Chairman, Council Member of Edge Hill University	34,649	0	440	0
Prof. Brenda Roe, None Executive Director, Professor of Health Research, Edge Hill University	34,649	0	440	0
Prof. Christopher Dowrick, Trust Board Advisor, Professor of Primary Medical Care University of Liverpool	484,212	228,159	0	11,336

36. Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases £s
Losses	8,134	12
Special payments	6,383	35
Total losses and special payments	14,517	47

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

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

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 £000s	2006/07 £000s	2007/08 £000s	2008/09 £000s	2009/10 £000s	2010/11 £000s	2011/12 £000s	2012/13 £000s	2013/14 £000s	2014/15
Turnover	183,724	194,010	189,824	195,288	196,919	200,293	196,181	208,526	207,876	**206,903**
Retained surplus/(deficit) for the year	12	99	500	500	(58,059)	7,359	(1,776)	(3,536)	422	**5,494**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 Agreements	0	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	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0	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	**0**
Adjustments for Impairments	0	0	0	0	61,059	0	7,018	7,536	4,328	**506**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	(242)	0	0	**0**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	0	0	0	0	0	**335**
Adsorption Accounting Adjustment	0	0	0	0	0	0	0	0	0	**0**
Other agreed adjustments	0	0	0	(200)	0	0	0	0	0	**0**
Break-even in-year position	**12**	**99**	**500**	**300**	**3,000**	**7,359**	**5,000**	**4,000**	**4,750**	**6,335**
Break-even cumulative position	**2,486**	**2,585**	**3,085**	**3,385**	**6,385**	**13,744**	**18,744**	**22,744**	**27,494**	**33,829**

*Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the 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 LIFT schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance.

	2005/06 %	2006/07 %	2007/08 %	2008/09 %	2009/10 %	2010/11 %	2011/12 %	2012/13 %	2013/14 %	2014/15 %
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	3.06
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	16.35

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.

	2014/15 £000s	2013/14 £000s
External financing limit (EFL)	**(3,196)**	(3,243)
Cash flow financing	**(6,260)**	(3,685)
Unwinding of Discount Adjustment	**0**	436
Finance leases taken out in the year	**3,040**	0
Other capital receipts	**0**	0
External financing requirement	**(3,220)**	(3,249)
Under spend against EFL	**24**	6

37.4 Capital resource limit

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

	2014/15 £000s	2013/14 £000s
Gross capital expenditure	**40,321**	7,422
Less: book value of assets disposed of	**(123)**	(130)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**0**	0
Charge against the capital resource limit	**40,198**	7,292
Capital resource limit	**40,291**	7,292
Underspend against the capital resource limit	**93**	0

38. Third party assets

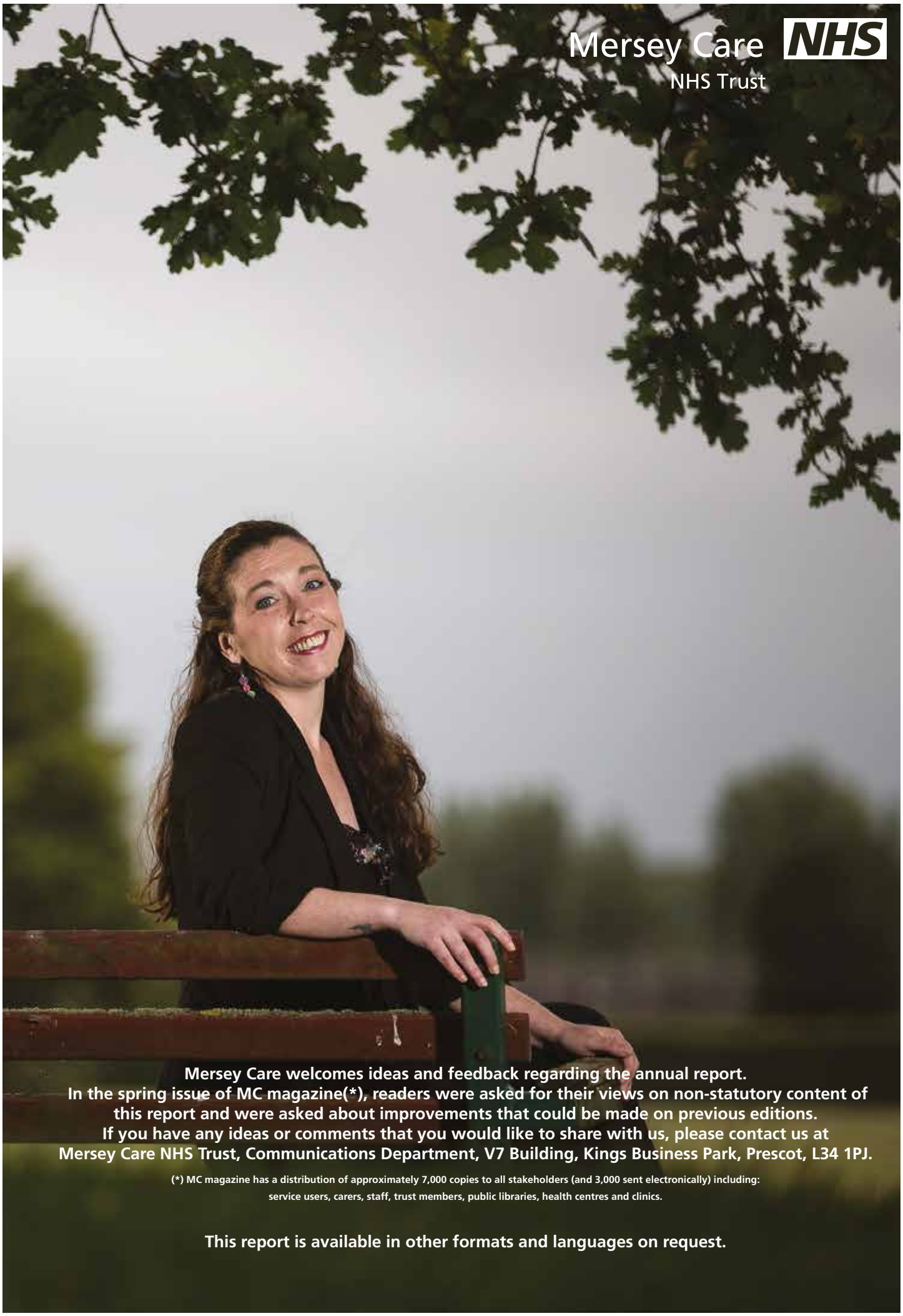
The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2015 £000s	31 March 2014 £000s
Third party assets held by the Trust.	**972**	**961**

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 2015	Trust £
	100



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.