Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Annual Report and Accounts

For the period 1st December 2009 to 31st March 2010

Liverpool Heart and Chest Hospital
NHS Foundation Trust

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

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Contents

This Annual Report provides information on the Liverpool Heart and Chest Hospital NHS Foundation Trust. The Trust was authorised as an NHS Foundation Trust on 1st December 2009.

As part of this change there are two Annual Reports for the accounting year 2009-2010. This report relates to the four month period as Liverpool Heart and Chest Hospital NHS Foundation Trust from 1st December 2009 to 31st March 2010. Whilst information has been provided that gives the reader an overview of the entire 2009-2010 year, this Annual Report should be read in conjunction with the Liverpool Heart and Chest Hospital NHS Trust Annual Report which contains information on the period 1st April 2009 to 30th November 2009.

Copies of this Annual Report and Account, together with other information on Liverpool Heart and Chest Hospital NHS Foundation Trust can be found on our website www.lhch.nhs.uk

This report is based on guidelines issued by the Independent Regulator of NHS Foundation Trusts and was approved by the Board of Directors on 3rd June 2010.

1. Welcome from Neil Large, Chairman

Tuesday, 1st December, 2009 is a date that will be forever etched in our memories because it is the date that we formally announced that Liverpool Heart and Chest Hospital had been authorised as an NHS Foundation Trust.

Across the Trust the elation was clear to see and it would be remiss of me not to start our first Annual Report and Accounts as an NHS Foundation Trust by thanking, first and foremost, our staff. Their hard work was incomparable, their loyalty continuous and their sheer determination to ensure that we achieved Foundation Trust status undeterred.

Since April 1991, when our hospital first became an NHS Trust, every member of staff, including our volunteer workforce, has helped establish us as one of the leading specialist cardiothoracic hospitals in the country. Throughout the years staff wanted our hospital's success to continue and for us to remain a specialist hospital. I am delighted to report that our hospital's future is now assured and I am confident that, working together as an NHS Foundation Trust, our stakeholders will benefit from this achievement.

Throughout our application process we have worked closely with, and I am very grateful for, the passionate support received from our Council Members. I look forward to developing an even greater engagement with them over the years and to developing the links with our members and the communities we serve across the North West of England.

Membership of our Foundation Trust continues to grow thanks to the many thousands of people who value our services and readily enlist to become members so that they can be involved and help to share our vision and shape our services in the future.

The popular 'Medicine for Members' health promotion events continue to attract large audiences in our constituency areas, particularly in North Wales, which has added to the success of these Consultant led events. Next year in addition to heart related health topics we will also be focusing on raising awareness of lung cancer and respiratory diseases.

Our ongoing commitment and determination to delivering the highest quality of patient care across all our services is reflected in the results for the National Inpatient Survey carried out by the Care Quality Commission (CQC). For the third year in succession our patients have rated Liverpool Heart and Chest Hospital as one of the best hospitals in the country for overall patient care. This is an excellent achievement and one that we are all keen to retain.

I do hope that, through this annual report, you will gain some insight into the incredible work that is undertaken by the dedicated members of staff at Liverpool Heart and Chest Hospital. Quality, safety and clinical excellence are at the forefront of everything we do and I would like to close my report by paying tribute once again to all of our staff, our volunteers, Council Members and Board of Directors. The very highest levels of quality are inherent and the successes of the past year have been a team effort and I thank everyone for their commitment.

Neil Large

2. Our Hospital at a Glance

Liverpool Heart and Chest Hospital NHS Foundation Trust (formerly known as The Cardiothoracic Centre Liverpool NHS Trust) is a specialist hospital based in the Liverpool suburb of Broadgreen.

The Trust provides a wide range of specialist services such as cardiothoracic (heart and lung) surgery, cardiology, respiratory medicine and diagnostic imaging.

Since its formation in April 1991 the hospital has grown into one of the largest specialist hospitals in the U.K. gaining an excellent reputation for it specialist services and patient care.

The Trust is referred to as a tertiary referral centre which means that, unlike district general hospitals with accident and emergency departments, patients are referred to Liverpool Heart and Chest Hospital directly by other hospitals and General Practitioners. This is because the range of services we provide are highly specialised.

Patient Choice now offers NHS patients the opportunity to have more choice and control of their care and more freedom to choose about how, when and where they would like to be treated. Further information on Patient Choice can be found on the following website www.nhs.uk/choiceintheNHS

Patients, staff and visitors to the hospital have benefited greatly from the investment into new facilities and the continual upgrading of state of the art equipment. This reflects the Trust's commitment to providing high quality healthcare to the 2.8 million people who reside within our catchment area of Merseyside, Cheshire, parts of Lancashire, North Wales and the Isle of Man.

Our principal activities are to provide adult cardiothoracic (heart and lung) services which include:

- Cardiac surgery – such as bypass grafts, valve repair and aneurysm surgery
- Thoracic surgery – such as lobectomy, pneumonectomy and cancer surgery
- Upper Gastro Intestinal surgery – inclusive of gastrectomy
- Cardiology – access to the very latest diagnostic facilities in electrophysiology, angioplasty and pacemaker services
- Respiratory medicine – specialist centre for the diagnosis and treatment of Pulmonary vascular diseases, adult cystic fibrosis and sleep apnoea
- Radiology and Diagnostic Imaging
- Oncology

Why choose Liverpool Heart and Chest Hospital?

- It is the largest single sited specialist cardiothoracic hospital in the UK
- Staff are highly skilled professionals in the treatment of heart and chest disease
- One of the best performing hospitals in the country for overall patient care for the 3rd year in succession. (Care Quality Commission National Inpatient Survey)
- Patient Safety remains a top priority and our infection prevention record is one of the best in the country. Since February 2008 one case of MRSA bacteraemia has been recorded
- Excellent ratings for cleanliness are maintained through the Patient Environment Action Team (PEAT) inspections.
- Excellent results from an unannounced inspection by the Care Quality Commission (CQC) held in December 2009. There were no concerns and no recommendations for improvement
- £46 million site development project completed in 2006
- £19 million capital investment programme is planned for the next 5 years
- One of the largest critical care units in Europe with 40 beds
- 8 Operating theatres including 1 hybrid aneurysm theatre
- 6 Cardiac Catheter Laboratories
- 1 Pacing Theatre
- 210 beds
- 1st hospital in the world to implant the Altrua Pacemaker device
- 1st hospital in the U.K. to install the CARTO 3 imaging system in the catheter laboratories tailored for patients with cardiac arrhythmias
- Offers patients' relatives hotel style accommodation on site
- A two-deck car park on site with 350 spaces.
- A courtesy minibus service is available for patients and visitors across the hospital site.

3. Directors' Report

3.1 An introduction from Raj Jain, Chief Executive

Liverpool Heart and Chest Hospital NHS Foundation Trust was founded on 1st December 2009, following its official authorisation from Monitor, the regulatory body for NHS Foundation Trusts.

Within this annual report and accounts a more comprehensive and detailed assessment of the Trust's overall performance during the past twelve months can be gained by the reader. 2009-2010 has resulted in another year of considerable achievement for the Trust and I hope the following overview will provide a flavour of our achievements which include:

- Authorisation of the Hospital as a NHS Foundation Trust. This provides the management freedom to shape the services of the Trust to meet the needs of the patients we serve

- Implementation of the new 24/7 primary percutaneous coronary intervention (PPCI) service which provides the most effective emergency medical treatment for patients suffering a heart attack. Due to the success of the service it has been agreed to extend the service from June 2010 to cover the additional areas of North Cheshire, Chester, Southport and Wirral

- Receiving a 'clean bill of health' in December 2009, following an unannounced inspection of the Trust by the independent health regulator, the Care Quality Commission. The Care Quality Commission had no concerns on inspection and there were no recommendations for improvement

- Receiving registration with the Care Quality Commission without conditions. That is no concerns expressed or remedial action needed

- Achievement of the rating of 'Good' for quality of services and 'Good' for use of resources in the Annual Health Check of all NHS providers in England

- Recognition of innovative work in the fields of privacy & dignity and financial management in two national NHS award competitions

- For the fourth year running scoring in the top 5% of hospitals for 'overall patient care' as assessed by our patients in the National Inpatients Survey conducted by the Care Quality Commission

- Recognition of our Hospital as an exemplar site for patient safety by the National Patient Safety First Campaign

- Extremely low rates of infection shown by only one case of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia since February 2008. Cases of Clostridium difficile (C-diff) are also well below target

- Recognition that the Trust is at the "cutting edge" of quality measurement as reported in Lord Darzi's Report "High Quality Care for All: Our Journey so Far"

- Consultation with Council Members, patients, staff and Foundation Trust Members of our Patient Experience Delivery Plan – a 3 year vision to improve the patient experience at Liverpool Heart and Chest Hospital NHS Foundation Trust and be recognised by our patients as the **"best hospital in the country"**

- Low waiting times for treatment. 19 of every 20 patients receiving their procedure within 18 weeks of referral by their General Practitioner

- Installation and upgrade of "Wayfinding" Kiosks across the Trust to assist patients with signage

- A three fold increase in research funding, ensuring we bring cutting edge treatments and new models of care to our patients as soon as possible

- All minimum standards of care met or exceeded as defined by the Department of Health

Our overall performance during the financial year 2009-2010 has been exceptional. Our ambition to continuously strive for improvement is undeterred with quality and patient safety paramount in our daily activities.

Staff awareness and consultation on our Cost Improvement Programme has been ongoing since June 2009 with many inspirational ideas received to reduce costs without affecting patient care and safety.

Now, as an NHS Foundation Trust, working together with patients, staff and our Council Members the future for Liverpool Heart and Chest Hospital is guaranteed. I am exceptionally proud to be part of a team that values good ethics for our patients and in closing this introduction I would like to acknowledge and pay thanks to our staff, volunteers, Council Members and last, but not least, my colleagues on the Board for their loyal and unswerving contribution to this Trust.

Raj Jain,
Chief Executive

3.2 Board of Directors

During the period 1st December 2009 to 31st March 2010 the following were members of the Board of Directors of Liverpool Heart and Chest Hospital NHS Foundation Trust.

Name	Title
Non Executive Directors	
Neil Large	Chair
Patricia Firby	Deputy Chair and Senior Independent Director
Dr. Robert Toomey	Non Executive Director
Bridget Leek	Non Executive Director
Geoffrey Appleton	Non Executive Director
Dr. David Bricknell	Non Executive Director
Michael Hewitt	Non Executive Director

Name	Title
Executive Directors	
Raj Jain	Chief Executive
Dr. Glenn Russell	Medical Director
Hazel Holmes	Director of Nursing
Aaron Cummins	Director of Finance

Further details of the Board of Directors, including biographies, are given in Section 6 of this Annual Report.

3.3 Principal Activities of the Trust during the year

During the period 1st December 2009 to 31st March 2010 the Trust's principal activity was the provision and delivery of health services as required to be provided by our Terms of Authorisation as an NHS Foundation Trust.

3.4 Financial Summary for 2009 – 2010

Liverpool Heart and Chest Hospital NHS Foundation Trust was authorised as an NHS Foundation Trust on 1st December 2009.

As an NHS Foundation Trust it is vitally important that the organisation's finances are secure and that it develops robust long-term financial plans that are achievable and support its future development. A key consideration during the Foundation Trust assessment process was the likely financial viability and sustainability of the organisation.

The following are the main financial headlines for the period:

- For the four month period to 31st March 2010, the Trust achieved a normalised surplus of £0.6m (£2.1m for the full 12 month period). This represents 2.5% of Turnover, which compares to a normalised deficit of (£800k) in 2008-2009.
- The Trust's normalised surplus excludes £8.9m of Impairments realised during 2009-2010 (of which £527k relates to the four month period) which have been written down through the Statement of Comprehensive Income as a result of downward revaluations of the Trust's Estate, following a series of three revaluations. This is attributable to changes in the valuation methodology used combined with the continuing downturn in property values.
- The normalised surplus also excludes £0.4m of NHS Bank Funding received during 2009-2010 (£0.1m relates to the four month period). This represents funding received phased over a number of years to support the Hospital's redevelopment
- The Trust's Surplus has contributed towards a Cash increase of £3.9m in the four months, generating a closing cash balance of £13.7m. This will be invested in future Capital Schemes as part of the Estates Strategy, which will support delivery of the Trust's Annual Plan for 2010-2011 and beyond, including the delivery of the Patient Experience Delivery Plan.

The Trust's Risk Rating based on the Financial Performance to 31st March 2010 is 4, reflecting strong financial performance throughout 2009-2010. The highest risk rating achievable is 5, but there is an overriding rule for NHS Foundation Trusts that have been authorised for less than 12 months, restricting the maximum rating to a 4.

Copies of the full Annual Accounts of the Trust are available on the following websites:

www.lhch.nhs.uk
www.monitor.nhsft.gov.uk

Copies are also available on request from the PR & Communications department on 0151 600 1409.

3.5 Meeting Infection Prevention Control Targets

Over the past five years the Trust has made significant progress in the field of infection prevention and control, reducing the number of healthcare infections for both Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (C-diff) cases.

The Trust had one case of MRSA bacteraemia in the financial year 2009-2010 (October 2009) meeting its nationally set target of 7 cases of MRSA bacteraemia.

The nationally set target of 25 cases of Clostridium difficile (C.diff) was also met. The number of C-diff cases at the Trust has continued to fall over the last year with 15 cases reported.

Staff training continues to play an important role in the reduction of infections and as at the end of March 2010, 82% of staff have undertaken a training session on infection prevention within the last 12 months.

Care bundles, which are a small set of evidence based practices, were introduced into the Trust in June 2007. This practice continues to standardise care and contributes greatly to reducing infections and improving patient outcomes. The Trust's analysis is fed back to ward staff on a monthly basis so that staff are able to identify the areas in which they need to make changes or improvements.

All wards complete hand hygiene observational audits and audits of facilities and standards on a weekly basis. Audits have shown that the compliance levels have increased, as well as the number of observations performed. The Trust has set a target to have greater than 1120 observations performed per month. The compliance level for each staff group is 95%. Electronic reporting has now replaced the paper system for hand hygiene audits.

The Infection Prevention Committee will monitor the Trust's forward plan for 2010-2011 throughout the year.

3.6 Our Performance 2009-2010

	Existing Commitments	2008/09 performance	2009-2010 performance
1	Access to GUM Clinics (Offer of Appt within 48hrs)	N/A	N/A
2	Cancelled Operations and those not admitted within 28 days	Achieved	Achieved
3	Data Quality on Ethnic Group	Achieved	Achieved
4	Delayed Transfers of Care	Under achieved	Achieved*
5	Number of Inpatients waiting longer than standard (26wks)	Achieved	Achieved
6	Number of Outpatients waiting longer than standard (13wks)	Achieved	Achieved
7	Patients waiting no longer than 3 months for revascularisation	Achieved	Achieved
8	Time to reperfusion for patients following a heart attack	N/A	N/A
9	Total Time in A&E: 4 hours or less	N/A	N/A
10	Waiting Times for Rapid Access Chest Pain services	Achieved	Achieved
	National Priorities	**2008/09 performance**	**2009-2010 performance**
1	18 Week Referral to Treatment Times: Audiology, Admitted & Non-Admitted Pathways.	Achieved	Achieved*
2	All Cancers: One Month Diagnosis to Treatment (including new cancer strategy commitment)	Achieved	Achieved*
3	All Cancers: Two Month GP Urgent Referral to Treatment (including new cancer strategy commitment)	Achieved	Achieved*
4	All Cancers: Two Week Wait	Achieved	Achieved*
5	Engagement in Clinical Audits	Achieved	Achieved
6	Experience of Patients	Satisfactory	Unavailable
7	Incidence of Clostridium Difficile	Achieved	Achieved*
8	Incidence of MRSA	Achieved	Achieved*
9	Infant Health & Inequalities: smoking during pregnancy and initiation of breastfeeding	N/A	N/A
10	Maternity Hospital Episode Statistics: Data Quality Indicator	N/A	N/A
11	NHS Staff Satisfaction	Failed	Unavailable
12	Participation in Heart Disease Audits	Achieved	Achieved*

Note: The assessment on 2009-2010 position is based on the Trust's self assessment using the thresholds & guidance provided by the CQC.

* The thresholds for these indicators has not been finalised however based on current guidance this is the Trust's self assesment.

3.7 Factors likely to affect the future development and performance of the Trust

The Trust manages risk through a well developed Risk Management Strategy and through closely aligning this to the annual planning process. The Trust's Assurance Framework provides the Board with the assurance that such risks are being well managed and identified.

Whilst operational risks will change over time the Trust bases its strategic thinking on those risks that are driven by external factors where the Trust has less direct control. The risks facing the Trust in the final quarter of 2009-2010 and into the new financial year are set out below:

- Impact of economic downturn on public spending
- Commissioners reaction to economic downturn
- Political focus on services being patient centred, preventative and performance related
- Changes in the competitive landscape
- Regulatory focus on Quality and Patient Experience
- Opportunities and threats driven by developments in technology
- Managing workforce change and in particular a potential shortage of technical staff.
- Fully engaging the Trust membership

Systems and controls have been established to manage the risks, which are monitored by the Board of Directors on a regular basis.

3.8 Forward Look – The Year Ahead

Looking ahead to 2010-2011 the Trust will be building on the good results achieved during 2009-2010. This includes sustaining strong financial performance and investing in front line services to ensure the delivery of continued improvements both in clinical quality and patient and staff experience. In addition, the Trust will further develop the Council of Members and grow public membership.

In support of the objective, the Trust has a plan to deliver a £482k surplus for the 2010-2011 financial year with capital investment of £7.6m, which will provide a more efficient facility from which to continue providing high quality healthcare.

The plan for 2010-2011 includes a Cost Improvement Plan of £4.1m, principally delivered through a Lean/Workforce review and Procurement Savings and Investment in technology to support efficiencies.

The Trust is planning to deliver similar levels of clinical activity to those delivered over the last 12 months. An important development is the successful application for the delivery of a 3 year Community Cardiovascular Disease contract with Knowsley NHS.
The financial challenges certain to be faced by NHS organisations in 2010-2011 are well publicised as the government looks to address the funding deficit through reduced public spending. PCT's faced with reductions in real term allocations are focussed on reducing activity. This has been supported by several key levers within the Operating Framework 2010-2011, including the new tariff, zero price inflation, marginal pricing for activity over performance and increases in quality related payments.

Commissioners are becoming increasingly reluctant to agree activity growth. The Trust is proactively managing this, for example by trialling and investing in new services such as the Transcatheter Aortic Valve Implantation (TAVI) service, a new therapy which can be used as an alternative to standard Surgical Aortic Valve replacement where the risk of open heart surgery is too high. The Trust is considering applying to be one of two Approved Centres within the Northwest, the first step being to take part in a three year randomised trial. The Trust has undertaken 40 procedures during 2009-2010 absorbing the costs internally from its own resources, with no funding from Commissioners in order to ensure it builds the clinical expertise to provide this service.

3.9 Serious untoward incidents involving data loss

During the year 2009-2010 there were no serious untoward incidents involving data loss.

3.10 Trust Employees

As at 31st March, 2010 the Trust employed 1,320 staff (Whole Time Equivalent (WTE) 1,193.60).

The Trust recognises the commitment shown by its staff in their efforts to deliver high quality, safe and effective care. Throughout 2009 the Trust continued to engage with staff to continually improve our services. From listening to staff feedback the Trust developed it's 'More than a Workplace' programme aimed at improving staff satisfaction and motivation at work.

- **Staff Satisfaction**

Effective leadership is a key driver to improve staff satisfaction. Our staff told us that they wanted to be well led and managed. As a result, one of our key actions in 2009 was the design and delivery of our Excellence in Management and Leadership Development Programme. Over 40 managers have attended a two day assessment and development programme resulting in individually tailored development plans.

Actions taken since during 2009-2010 to support "More than a Workplace" included:

- √ Design and delivery of Excellence in Management and Leadership Programme
- √ Staff Summer Celebration to recognise achievement in National Inpatient Survey and performance against MRSA targets
- √ Provision of on-site services for alternative therapy, chiropody and Citizens Advice Bureau, Stress Awareness Event & refurbishment of staff gym facility
- √ Redesign of appraisal process to improve quality of discussion
- √ Sign up of 80+ staff for the Apprenticeship training supported by NHS North West
- √ Improved communications through team brief, weekly e-bulletin, patient safety walkabouts and departmental annual plan briefings

A revised Directorate structure, implemented in September 2009, has supported greater engagement with clinical teams resulting in increased ownership at the 'front line' and greater involvement in decisions.

- **2009 National Staff Survey**

For the second year running the Trust surveyed all staff. The responses have been analysed at ward and department level allowing each area to develop local action plans to address areas of concern.

The 2009 results demonstrate a continued and significant improvement in staff satisfaction when compared with the 2008 survey. The Trust has improved in 22 out of 36 key findings (an additional 4 indicators have been introduced for which comparative data is not available). There was no deterioration in scores. The table below show the top and bottom ranked scores for 2009 and the changes in comparison to 2008 benchmarked against acute specialist Trusts.

a) Staff Survey Comparison

	2008/09		2009-2010		Trust improvement / deterioration
Response rate	**Trust**	**National average**	**Trust**	**National average**	
	63%	52%	64%	54%	1% increase
Top 4 ranking scores					
KF32: % of staff agreeing that they understand their role and where it fits in	54%	52%	67%	55%	13% increase
KF9: % of staff working extra hours**	66%	68%	59%	67%	7% improvement
KF 15: % of staff appraised with personal development plans in last 12 months	49%	57%	74%	65%	25% increase
KF 26: % of staff experiencing harassment, bullying or abuse from patients / relatives in last 12 months**	13%	15%	9%	14%	4 % improvement
Bottom 4 ranking scores					
KF 30: % of staff feeling pressure in last 3 months to attend work when feeling unwell	-	-	32%	23%	Question not asked in 2008.
KF 33: % of staff able to contribute towards improvements at work	55%	65%	59%	66%	4% increase

KF 12: % of staff receiving job-relevant training, learning or development in last 12 months	71%	80%	73%	77%	2% increase
KF 4: % of staff agreeing that they have an interesting job	69%	81%	77%	81%	8% increase

** the lower the score the better

b) Staff experience has most improved in:

- Quality of job design (clear job content, feedback and staff involvement)
- Staff intention to leave jobs
- Staff job satisfaction
- Staff feeling valued by their work colleagues

This is a positive local result but the latter three scores remain below average when compared with other acute specialist Trusts.

The Trust will build on the successes of 2009 and continue to engage with staff. The further development of service line management and reporting will support greater autonomy and accountability within Directorate teams.

The Board of Directors has approved the Vision for Patient Experience. Work has commenced in sharing the vision with staff. A set of values and associated behaviours have been developed which will be shared with staff during Quarter One of 2010-2011. These values and behaviours will be used in the recruitment of new staff and in the appraisal of existing staff.

◆ **Sickness Absence**

Further evidence of improved satisfaction is demonstrated in the Trust's performance against the Human Resources Key Performance Indicators. Of particular note is the reduction in sickness absence rates which stood at 5.59% for 2008-2009.
The Trust was one of the top performing Trusts across the North West region in its management of sickness absence, continually having one of the lowest absence rates month on month.

No. of Staff	Sickness Absence (year to date)	Appraisal Coverage	Mandatory Training	Turnover
1,320 WTE 1193.60	3.97%	62%	82%	9.62%
Target	4.4%	85%	85%	10%

- **Learning and Development**

Effective leadership is a key driver of organisational performance and staff motivation. The Trust has designed and implemented the Excellence in Management and Leadership programme. Over 40 managers have commenced the programme which provides managers with an individually tailored development programme based on outputs of a two day assessment and development process. The programme is designed to provide flexibility to meet the needs of our managers at different stages of their career.

The Learning and Development team and managers from the Trust worked with local and national trade union representatives to develop and implement a streamlined Appraisal and Personal Development Plan process based on the core elements of the Knowledge and Skills Framework. The revised system is aimed at continuing to improve the quality of appraisals so that our staff can fully understand how they can contribute to team, department and Trust objectives. Early feedback has been positive. A full evaluation will be completed in the first quarter of 2010-2011. During 2009-2010 the Trust performed well against its internal target of 85% coverage of appraisals. This dropped during February and March with the year to date figure standing at 62%. Plans are in place to return to 85% coverage by June 2010.

The Trust has strengthened its monitoring and reporting arrangements related to mandatory training requirements. Regular reports sent to managers ensure that staff can receive the appropriate training to meet statutory and regulatory requirements and, as a result, work in a safer way minimising risks to patients and staff.

A range of internally facilitated clinical and non-clinical training opportunities are continually offered to staff. In addition support is offered to staff to pursue further qualifications through local education institutions as well as accessing regional and national training programmes.

The Trust made a successful bid to NHS North West for support of staff to undertake apprentice pathway training. By February 2010, over 80 staff across a range of professional groups had signed up to a formal training programme agreed with their manager. This training is targeted at staff in Bands 1-4 who traditionally have had limited opportunities for development compared to other healthcare professionals. Given the workforce challenges facing the NHS over the coming years this will provide staff with an opportunity to develop their skills allowing them to work more flexibly and across professional boundaries.

- **Human Resources Systems and Processes**

Following work which commenced in August 2009, the Human Resources (HR) function has worked with managers to review the operational support provided by the department. This has included more extensive use of NHS Jobs and Electronic Staff Record to improve recruitment processes and the provision of more timely and robust information and interventions to support the management of sickness absence.

In November 2009, the Trust was ranked number one nationally for data quality on its Electronic Staff Records system.

3.11 Equality and Diversity

During 2009-2010 the Trust reviewed and strengthened the membership of the Equality, Diversity and Human Rights Steering Group. The group meets monthly and during the past 12 months has reviewed and updated the Single Equality Scheme and self assessed the Trust against the NHS North West Equality Performance Improvement Toolkit.

Progress is monitored by the Workforce Committee which is a standing committee of the Board. The committee receives regular workforce profile reports, including recruitment information to ensure that staff are not disadvantaged on the basis of age, disability, race, gender, sexual orientation, religion or belief.

Recruitment and selection processes ensure that staff are recruited based on their skills and experience. Training is available for managers with responsibility for recruitment and Equality and Diversity training is available to all staff.

Staff who develop a disability during their employment are supported to continue working through rehabilitation and redeployment where necessary. Reasonable adjustments are made where possible and the Trust ensures that it meets all of its obligations in accordance with the Disability Discrimination Act.

Demographic Workforce Profile

	Staff 2008/09	**%**	**Staff 2009-2010**	**%**		**Public Membership 2009-2010**	**%**
Age					**Age**		
16-20	9	0.71%	11	0.83%	0-16	2	0.02%
21-25	93	7.34%	100	7.58%			
26-30	123	9.71%	125	9.47%	17-21	85	0.93%
31-35	207	16.34%	207	15.68%			
36-40	204	16.10%	199	15.08%	22+	8439	92%
41-45	213	16.81%	208	15.76%			
46-50	187	14.76%	220	16.67%	Unknown	634	7%
51-55	118	9.31%	123	9.32%			
56-60	67	5.29%	71	5.38%			
61-65	36	2.84%	44	3.33%			
66-70	8	0.63%	10	0.76%			
71 & above	2	0.16%	2	0.15%			
Ethnicity					**Ethnicity**		
White	1082	85.0%	1154	87.42%	White	8375	91.4%
Mixed	9	0.71%	7	0.53%	Mixed	35	0.38%
Asian or Asian British	132	10.42%	117	8.86%	Asian or Asian British	147	1.6%
Black or Black British	9	0.71%	13	0.98%	Black or Black British	81	0.88%
Other	35	2.76%	29	2.20%	Other	36	0.39%
					Unknown	486	5.3%
Gender					**Gender**		
Male	333	26.28%	349	26.44%	Male	4775	52%
Female	934	73.72%	970	73.48%	Female	4194	45.6%
Transgender	0	0.00%	0	0.00%	Transgender	0	0
					Unknown	191	2.09%
Recorded Disability	8	0.63%	7	0.53%	**Recorded Disability**	N/A	N/A
Total	1,267		1,320		-	9,160	-

During 2010 the Trust will review and consult on the Single Equality Scheme to reflect the changes in the Equality Bill and promote best practice. As at 31st March, 2010 the Trust employed 1,320 staff (Whole Time Equivalent (WTE) 1,193.60).

The Trust recognises the commitment shown by its staff in their efforts to deliver high quality, safe and effective care. Engaging with our staff to continue to motivate them for the benefit of our patients will ensure that we remain one of the most highly rated Trusts in the Country via the National Inpatient Survey conducted by the Care Quality Commission.

3.12 Environment, Corporate and Social Responsibility

Stakeholder Relations

The Trust manages relations with many key stakeholders in its day to day business – these are essential to ensure that the services provided meet the needs of the local commissioners and ultimately the patients of Merseyside, Cheshire, North Wales and the Isle of Man.

The Trust works closely with the **North West Specialist Commissioners (NWSC)** to ensure the Trust develops the necessary capacity to deliver NHS Plan and waiting time targets on behalf of PCTs and facilitates financial and clinical risk sharing between Trust and constituent PCTs, and in particular the Trust's host, **Liverpool PCT.**

The Trust also works in partnership with **Health Commission Wales (HCW)** who commission activity on behalf of Welsh patients in line with Welsh Assembly targets – though this arrangement will change in 2010-11 as the Welsh commissioners develop a new organisational structure.

The **Cheshire and Merseyside Cardiac Network** brings together cardiologists from DGHs as well as LHCH and acts as a forum to develop joint clinical protocols. It is also a vehicle for making recommendations to Commissioners for the development of cardiology services. Work recently completed with the Cardiac Network has protected the Trust's position in being the sole provider of PCI in Cheshire and Merseyside, and they have been instrumental in developing the Primary PCI service

The **Cancer Network** is part of a coordinated approach to the management of cancer services across Cheshire & Merseyside. The Network's objective is to ensure that minimum access times are achieved and that there is an effective network of multi-disciplinary teams supporting rapid referral, diagnosis and treatment.

The Trust is part of the **Cheshire and Merseyside Critical Care Network** which aims to harmonise best practice in Critical Care through the development and implementation of care bundles and capacity and demand tools, together with sharing best practice.

The Trust shares the **Royal Liverpool and Broadgreen University Hospitals NHS Trust's** Broadgreen site and the recent major site development includes a number of shared services. A joint Management Team ensures collaborative management and development of the Broadgreen site. This group meets quarterly with a set agenda to improve working relations and maximise opportunities related to the sharing of the site.

A major development in 2009-10 is the agreement for the Trust with **Knowsley PCT** for the delivery of a Community CVD Service. This three year contract, starting 1 April 2010, will see the Trust delivering CVD Clinics in the community for the people of Knowsley, as well as taking over the management of both Cardiac and Stroke rehabilitation services. This delivers on the agenda of care closer to home and also helps the Trust play a more defining role in the management of patient pathways for those people suffering CVD.

Environment, Corporate and Social Responsibility

Liverpool Heart & Chest Hospital sees itself as an important part of the local community. As good corporate citizens, active within the local community and engaged in local planning decisions through processes such as Local Strategic Partnerships, the Trust can help to improve the health of local people, promote social cohesion, regeneration and tackle health inequalities. It can also help the wider environmental issues by managing its carbon footprint.

The Board of Directors has identified specific benefits that can be delivered if it is successful in managing these issues:

- Financial savings through better energy and water management
- Improved staff morale from recruitment of local people and the promotion of employee health
- Faster patient recovery from the provision of pleasant natural surroundings and nutritious locally sourced food
- Improved reputation from external communications about what the Trust is doing to be more socially and environmentally responsible
- Good governance for the identification and management of longer term social and environmental changes and the engagement with local communities and stakeholders
- Contributing to the health of the population beyond the delivery of healthcare from supporting healthier and more sustainable lifestyles and the investment of resources in ways that benefit the local economy
- Investing in the long term viability of the NHS arising from the freeing up of resources that result from improved efficiency, direct savings and a healthier population

A dual strategic approach

To deliver against these benefits the Trust has developed a dual strategy that focuses resources on delivering improvements in line with corporate social responsibility (CSR) and the NHS Carbon Reduction Strategy (CRS).

Corporate Social Responsibility

Following an assessment of the trust's current position against the 'good corporate citizenship assessment model', the Board of Directors agreed to prioritise the Trust's activity to improve the outcome of its assessment. Rather than try to improve on all elements of the model the Board agreed to focus its energy in those areas where the most impact can be made. The Trust is working with staff, members and other stakeholders to help determine these priority areas.

Carbon Reduction strategy

The Board has confirmed its commitment to participate in the Carbon Trust Management Programme 2010-11 as part of the Liverpool Carbon Collective which is led by Liverpool PCT.

The aim of the Collective is to:

- Incorporate and embed carbon reduction and sustainable development practices, within the Liverpool NHS organisational culture and its corporate activities.
- Co-ordinate the 'collective' participation in a Carbon Trust endorsed approach to carbon reduction.
- Share ideas, services, information and possibly resources to reduce the carbon impact of all NHS and PCT Trust activities within Liverpool.

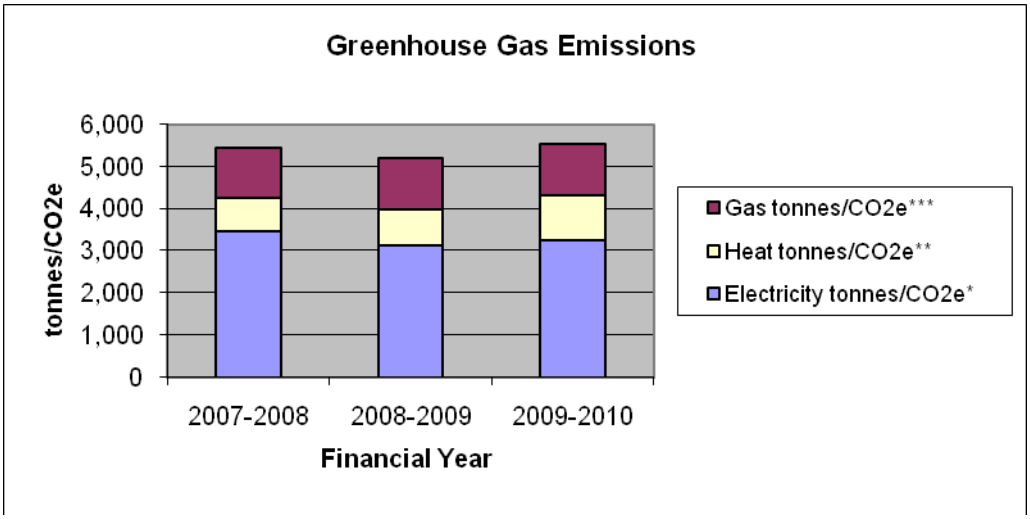
The use of energy efficiency savings to fund the programme in the long term from both reduced energy consumption and a reduction in the carbon tax bill prevents the need for mainstream funding to be constantly sought in order to implement improvements.

The Trust has already undertaken some measures to reduce its Carbon Footprint:

- Heat and Power obtained from a Combined Heating and Power Unit (CHP).
- Variable speed drives on all Pumps and Air Handling Units (AHU).
- Energy efficient lighting including sensor control throughout the new buildings.
- Installation of variable speed drives on Catheter Labs 1 & 2; Theatres E & F and Pacing Theatre's Air Handling Units.
- Energy efficient lighting installed in AL1, Wards A, E & G, Patient Services, Clinical Skills Lab and along the Surgical Corridor.

The Board of Directors receives regular information on the progress of this approach through its assurance framework, and will formally review progress at Board in 2011.

The profile of the Trust's greenhouse gas emissions for the past three years is illustrated below, and reflects the growth of the Trust as opposed to a lack of carbon management.

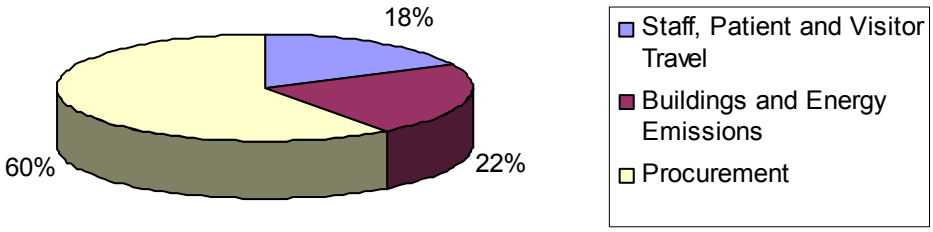


	2007-2008	2008-2009	2009-2010
	Kw/hr		
Annual Electrical Consumption	6,403,073	5,757,448	6,004,987
Electricity tonnes/CO2e*	3,483	3,132	3,267
Annual Heat Consumption	3,311,667	3,695,278	4,605,614
Heat tonnes/CO2e**	768	857	1,069
Annual Gas Consumption	5,865,842	5,963,769	5,980,917
Gas tonnes/CO2e***	1,195	1,215	1,219

	2008-2009	2009-2010
	£'000	
Water	87,063	90,056
Electricity	464,645	289,651
Gas	217,226	209,283
Other (Heat)	243,745	218,925

	2008-2009	2009-2010
Absolute values for total amount of waste produced by the trust	102,186	219,443
Methods of disposal (optional).		
	£'000	
Expenditure on Waste Disposal £'000	205,817	230,768

For 2008-2009 the source of these gases has been identified as illustrated below:



3.13 Statement on Compliance with the NHS Foundation Trust Code of Governance

The Board of Directors and the Council of Members are committed to the principles of good corporate governance. As a newly established NHS Foundation Trust, the Board of Directors has established processes to comply with the majority of provisions of the NHS Foundation Trust Code of Governance.

Throughout 2009-2010 in preparing for Foundation Trust status, the Trust has tested the balance of its Board of Directors and developed the role of its Non Executive Directors. New governance structures have been established to enable the Council of Members to operate effectively and to develop communication processes with the membership.

Governance policies have been reviewed or established including:

- Governance Manual including the Committee structures, schemes of reservation and delegation and Standing Financial Instructions
- The Constitution of the Liverpool Heart and Chest Hospital NHS Foundation Trust incorporating Standing Orders for the Board of Directors and Standing Orders for the Council of Members
- Appointment of a Senior Independent Director
- Improved induction programme for Non Executive Directors
- Induction and Development for Council Members
- Nomination of Senior Council Member
- Separate Nominations and Remuneration Committees for Executive and Non Executive Directors
- Monthly meetings between the Chair and Non Executive Directors
- Quarterly meetings between the Chair and Council Members
- Council Members' work programme
- Membership Strategy
- Registers of Interests for Board Directors and Council Members

Each provision of the Code has been reviewed by the Board of Directors (January 2010) and action has been taken to ensure compliance except in the case of provision C2.1 which recommends that Executive Directors are appointed on time-limited contracts of employment at intervals of not more than 5 years. At the present time all Executive Directors have permanent contracts of employment. The Medical Director holds a permanent contract as a consultant medical practitioner but a time limited contract for his role as Medical Director. The Board of Directors does not intend to change these arrangements in the foreseeable future but existing

contractual performance review and management arrangements are subject to regular and rigorous review.

The Remuneration and Succession Committee will review this position as vacancies arise but will seek to ensure that the Trust is well placed to attract high calibre individuals when recruiting to an Executive Director position.

4. Operational and Financial Review 2009-2010

4.1 Healthcare Associated Infection Targets:

The Trust has successfully delivered all of the infection and activity performance targets set by the Department of Health in 2009-2010.

	Target Number	Actual Number
To remain within trajectory MRSA bacteraemia	7	1
To remain within trajectory Clostridium Difficile	25	15

4.2 Patient Care

4.2.1 The Trust has implemented a three year patient experience delivery plan which compliments our vision for 2013 to continually improve the patient's journey at Liverpool Heart and Chest Hospital.

The following are some of the initiatives that has continued to improve the patient experience during the past twelve months.

- **The implementation of the Productive Ward** focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency. During the past year the Trust has seen very positive results and there has been a marked increase in the amount of time the nurses are spending on direct patient care.

- **Review of pre operative procedures** streamlines the patient's journey through pre-op ensuring that all necessary tests are undertaken with minimal delay.

- **Revised fasting guidelines for pacing patients -** improvements in theatre scheduling has enabled the Trust to significantly reduce the time a patient must fast prior to a pacing procedure.

- **Our primary angioplasty service** (which began in January 2009) has been hugely successful. Over 400 patients have received a primary angioplasty in the first year, with full roll out to Cheshire and Merseyside in June 2010. The Trust continues to work with partnership organisations to ensure the best and quickest treatment for heart attack patients.

- **Improvements to diagnostic testing** has increased the Trust's capacity and reduced waiting times for patients for a full range of diagnostic tests, including X-ray, ECG and Echo tests.

- Patient and Public Involvement and Engagement continues to improve

the patient's journey. Listening and responding to patients' experiences acts as a mechanism to help improve the way services are developed and delivered.

The following are some examples of how the Trust responds proactively to the patient and public involvement and engagement:

- ✓ Publicising patient stories at Board level and through internal communications
- ✓ Matron's ward rounds
- ✓ Action plans drawn from complaints and concerns raised
- ✓ Inpatient and relative satisfaction surveys
- ✓ Outpatient satisfaction questionnaire
- ✓ Executive and Non Executive "walkabouts"
- ✓ "Listening & Learning" Comments Cards which are available across the Trust
- ✓ Developing action plan following National Inpatient survey results

4.2.2 Complaints handling - The Trust's Customer Care Service offers an impartial and confidential service for patients, their families, carers and staff. They provide information on NHS services, listen and act upon suggestions and concerns and help resolve problems quickly on behalf of patients and their families.

During the financial year 2009-2010 the Trust received 101 complaints and 773 customer contacts through the Trust's Customer Care office. Out of the 101 complaints all were acknowledged and responded to within the negotiated time frame. No complaints to date have been referred to the second stage of the Department of Health's Complaints Process (Ombudsman). As at 31st March 2010 95 complaints have been resolved satisfactorily and 6 cases remain open.

Customer Care acts independently when handling concerns and liaises with other organisations to negotiate immediate or prompt solutions. They offer advice and support patients through the complaints process and co-ordinate investigations.

4.2.3 Patient Information - a wide range of information on the procedures and services we provide at Liverpool Heart and Chest Hospital is available for patients in hard copy or electronically. This information is also available in other formats and languages on request. Brousealoud is available on the Trust's website www.lhch.nhs.uk

A full review of the information patients receive has been undertaken and patients have been consulted to understand what they see as being beneficial.

The Trust is indebted to our volunteer lay-readers group who review patient information prior to publication. The majority of this group are ex-patients and their input is instrumental in helping us to improve the patient experience.

4.3 Stakeholder Relations

The Trust manages relations with many key stakeholders in its day to day business. These are essential to ensure that the services provided meet the needs of the local commissioners and ultimately the patients of Merseyside, Cheshire, North Wales and the Isle of Man.

The Trust works closely with the **North West Specialist Commissioners (NWSC)** to ensure the Trust develops the necessary capacity to deliver NHS Plan and waiting time targets on behalf of Primary Care Trusts (PCTs) and facilitates financial and clinical risk sharing between Trust and constituent PCTs and in particular the Trust's host, **Liverpool PCT.**

The Trust also works in partnership with **Health Commission Wales (HCW)** who commission activity on behalf of Welsh patients in line with Welsh Assembly targets, though this arrangement will change in 2010-2011 as the Welsh Commissioners develop a new organisational structure.

The **Cheshire and Merseyside Cardiac Network** brings together cardiologists from District General Hospitals, as well as Liverpool Heart and Chest Hospital, and acts as a forum to develop joint clinical protocols. It is also a vehicle for making recommendations to Commissioners for the development of cardiology services. Work recently completed with the Cardiac Network has protected the Trust's position in being the sole provider of Percutaneous Intervention (PCI) in Cheshire and Merseyside and they have been instrumental in developing the Primary PCI service.

The **Cancer Network** is part of a co-ordinated approach to the management of cancer services across Cheshire and Merseyside. The Network's objective is to ensure that minimum access times are achieved and that there is an effective network of multi-disciplinary teams supporting rapid referral, diagnosis and treatment.

The Trust is part of the **Cheshire and Merseyside Critical Care Network** which aims to harmonise best practice in Critical Care through the development and implementation of care bundles and capacity and demand tools, together with sharing best practice.

The Trust shares the **Royal Liverpool and Broadgreen University Hospitals NHS Trust's** Broadgreen site and following the recent major site development, includes a number of shared services. A joint Management Team ensures collaborative management and development of the Broadgreen site. This group meets quarterly with a set agenda to improve working relations and maximise opportunities related to the sharing of the site.

A major development in 2009-2010 is the agreement for the Trust with **Knowsley PCT** for the delivery of a Community Cardiovascular Disease (CVD) Service. This three year contract, starting 1st April 2010, will see the Trust delivering CVD Clinics in the community for the people of Knowsley, as well as taking over the management of both Cardiac and Stroke rehabilitation services. This delivers on the agenda of care closer to home and also helps the Trust play a more defining role in the management of patient pathways for those people suffering from cardiovascular disease.

4.4 Financial Summary

4.4.1 Introduction

The purpose of this section of the Annual Report is to provide a narrative on the financial performance of the Trust, highlighting key points of interest within the Annual Accounts and the Trust's performance against its financial targets.

The Annual Accounts have been prepared under a direction issued by Monitor (Independent Regulator of NHS Foundation Trusts) and are appended to this report. The Annual Accounts reflect the results over the four months since authorisation as a Foundation Trust on December 1st 2009.

For comparison purposes, the financial tables below reflect the full 12 month period ending 31st March 2009, which includes eight months from April 2009 to November 2009 (operating as an NHS Trust) and the four months from December 2009 to March 2010 (operating as an NHS Foundation Trust).

As this is the first period as an NHS Foundation Trust, the Annual Accounts do not have prior year figures however we have detailed below some of the key comparisons.

The Annual Accounts for the earlier period from April 1st 2009 to November 30th 2009 have been audited and approved by the Board of Directors and will be presented to a public meeting and made available to the public.

4.4.2 Terminology

The table below provides definitions of key terminology contained within this section of the report as an aid to readers.

Terminology	Definition
Annual Accounts	Statutory Financial Statements, includes four Primary Statements, comprising a Statement of Comprehensive Income, a Statement of Financial Position, a Statement of Changes in Taxpayers Equity and a Statement of Cashflow and supporting notes as required by International Financial Reporting Standards and HM Treasury.
Capital Investment	Funds invested to purchase Fixed Assets, such as land, machinery and buildings rather than used to cover the business' day to day operating expenses.
Cost Improvement Programme (CIP's)	The Department of Health and Monitor imposes a fixed percentage of recurrent savings for all NHS Trusts and Foundation Trusts to deliver each year as a proportion of operating expenditure. For 2009/10 this percentage is 3%.
Depreciation	A non-cash expense that reduces the value of an asset over time through for example wear and tear and obsolescence.
EBITDA	Earnings before Interest, Tax, Depreciation and Amortisation, deducts these items from the Net Surplus to reflect the Trading Surplus, which eliminates the effects of financing and accounting decisions for greater comparability against other Organisations.
Full Time Equivalents	Reflects the number of staff employed in terms of weekly Contracted Hours, for example a full time person working 37.5 hours is classed as 1 FTE.
Impairment	When an assets carrying value exceeds its recoverable amount, the fall in value is treated as an impairment.
Liquidity	This reflects the liquid resources available to the Organisation. How quickly Current Assets can be converted into cash to meet Liabilities as they fall due.
MFF	Using an index called the Market Forces Factor, geographical variations in the costs of providing health services are factored into the complex calculations which inform the allocation of the Health Service budget to NHS Bodies.
NHS Foundation Trust	NHS Foundation Trust's (FT's) are not for profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital and mental health services. NHS FT's are a result of the Government's drive to devolve decision making from central to local organisations and communities. They provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay.
Normalised Surplus/(Deficit)	This is the Net Surplus/(Deficit) ajdusted for exceptional/one off items such as impairments.
PCT's	Primary Care Trust - an NHS Organisation that provides some Primary and Community services and commission Secondary Care from other Providers.
PDC Dividend	Public Dividend Capital (PDC) Dividends are payments made by NHS Trusts and Foundation Trust's back to the Department of Health as a return on the capital funding provided. The Dividend payments are calculated as 3.5% on the Net Relevant Assets of the Trust.
Private Patient Income	Income from activties in relation to treating or providing other services to private patients (i.e. those patients who are not being treated under the National Health Service.
Prudential Borrowing Code	Section 12 of the Health and Social Care (Community Health and Standards) Act 2003 required the Independent Regulator of NHS Foundation Trusts (Monitor) to devise a code to determine a limit on the total amount of borrowing by NHS Foundation Trust's.
Prudential Borrowing Limit	The limit of Borrowing set by Monitor for NHS Foundation Trusts. This covers long term Borrowing for Capital Investment and short term borrowing (Working Capital Facility) for day to day operational cashflows. This limit is set annually based on the NHS FT's Annual Plan.
Financial Risk Rating	To ensure Foundation Trusts remain financially viable after authorisation, Monitor's risk based framework assigns a financial risk rating to each NHS Foundation Trust on the basis of Trust's Annual Plans and in-year performance. These ratings are used by monitor to guide the intensity of its monitoring. A number of indicators are used to assess the level of financial risk at an NHS Foundation Trust including Delivery of Plan, Operating Margin, Return on Assets and Liquidity.
Statement of Comprehensive Income	One of the four Primary Statement in the Annual Accounts showing all Income and Expenditure for the reporting period.
Terms of Authorisation	Monitor (the Independent Regulator of NHS Trusts) authorises NHS Foundation Trusts under Section 35 of the National Health Service Act 2006. This authorisation is subject to certain conditions in repsect of The Trust's Governance, Finance, Membership and Services provided.
Turnover	The amount of Income received by the Organisation.
Working Capital Facility	All NHS Foundation Trust's must have a Working Capital Facility (WCF) agreed with a Bank, representing a sum of money reserved by the relevant bank for potential use for the Foundation Trust, similar to an overdraft facility. The amount of WCF must cover one month's expenditure and is in place to smooth large cashflow fluctuations on a short term basis.

4.4.3 Performance compared to the Planned Monitor Risk Ratings

When assessing financial risk, Monitor will assign a risk rating using a scorecard which compares key financial metrics on a consistent basis across all NHS Foundation Trusts. The Risk Rating is intended to reflect the likelihood of a breach of the Terms of Authorisation.

The financial indicators used to derive the financial risk rating include:

- Achievement of Plan
- Underlying Performance
- Financial Efficiency
- Liquidity

Each financial criterion is rated 1 (high risk) to 5 (low risk). The Trust's current risk rating is 4, a risk rating below 3 would require increased frequency and intensity of reporting to monitor (from quarterly to monthly) and may result in intervention from Monitor.

1. Financial Performance Summary

Financial Performance Summary	Plan Target		Actual Performance to 31st March 2010	
	Achievement	Risk Rating	Achievement	Risk Rating
EBITDA Margin	8.9%	3	8.7%	3
EBITDA Percentage Achieved	101.6%	5	104.8%	5
Return on Assets	6.5%	5	7.9%	5
I&E Surplus Margin	2.6%	4	2.5%	4
Liquidity Ratio	44.6	4	59	4
Overall Weighted Average		**4**		**4**

The Trust's financial performance to 31st March 2010 has generated a score of 4 against the Monitor Risk Assessment – as detailed above the maximum rating is 5, but this would be restricted to a 4 for Liverpool Heart & Chest Hospital under the overriding rules of being authorised for less than 12 months.

4.4.4 Income and Expenditure Position

The following table summarises the Income and Expenditure performance for the 12 month period, split between pre-authorisation (eight months from 1st April 2009 to 30th November 2009), which generated a normalised surplus of £1.6m and post-authorisation (four months from 1st December 2009 to 31st March 2010), which delivered a further normalised surplus of £0.6m. This equates to an annual normalised surplus of £2.1m.

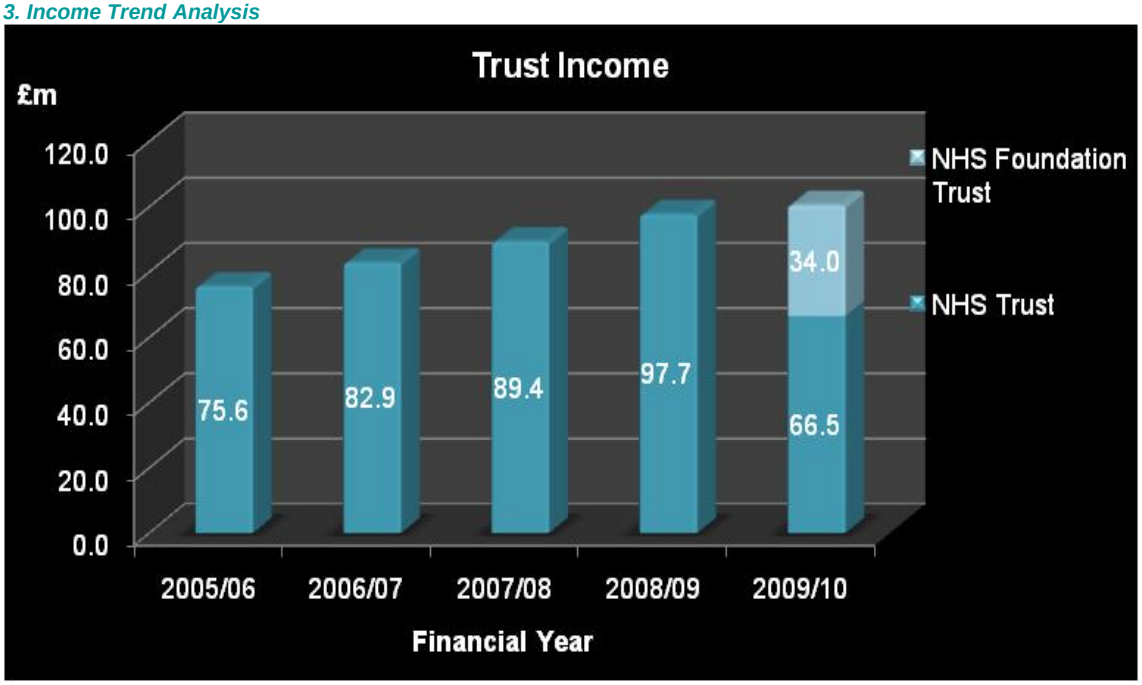
2. Financial Summary

Trust Financial Summary	Pre Authorisation	Post Authorisation	Annual Total
	Actual 8 Months to 31st March 2010 £000's	Actual 4 Months to 31st March 2010 £000's	Total Actual for 12 Months
Income	66,524	34,012	100,536
Expenditure	-60,390	-31,344	-91,734
EBITDA	**6,134**	**2,668**	**8,802**
Depreciation	-2,784	-1,338	-4,122
Interest Receivable/(Payable)	-36	6	-30
PDC Dividends	-1,453	-638	-2,091
Non Recurring Income	-285	-142	-427
Normalised Surplus/(Deficit)	**1,576**	**556**	**2,132**
Impairments	-8,367	-527	-8,894
Non Recurring Income	285	142	
Net Surplus/(Deficit)	**-6,506**	**171**	**-6,762**

4.4.5 Trust Income

The total Income of the Trust in the twelve month period was £100.5m (for the four month period to 31st March 2010 the Trust has received £34.0m), which is an increase on the previous year of £2.8m or 2.9%. This compares to income of £97.7m during 2008-2009 (including £4.5m brokerage returned to Trust and £0.6m NHS Bank Funding all relating to the Site Development).

3. Income Trend Analysis



PCTs continue to provide the majority of income, principally through the North West Specialised Commissioning Team which commission services on behalf of PCTs in the North West. This income has increased from £65.4m in 2008-2009 to £72.7m in 2009-2010 (of which £24.2m relates to the four month period as a Foundation Trust) an overall increase of 11.1%.

This increase has been as a result of the roll out of Primary Percutaneous Coronary Intervention (PCI) services across two PCTs within the Northwest. This provides the most effective treatment for patients suffering a heart attack. This service will be expanded across North Cheshire, Chester, Southport and Wirral in 2010-2011, increasing the number of cases from 400 to 650.

Health Commission Wales also provide a significant level of Income and Activity for patients in North Wales. This has increased by £2.6m or 20.3% in 2009-2010 from £12.8m to £15.5m (of which £5.4m relates to the four month period as a Foundation Trust). This increase is partly attributable to an Arrhythmia Service that the Trust successfully bid for, following a designation of service exercise that was undertaken by Welsh Commissioners. This activity was previously undertaken by Central Manchester NHS Trust.

Income from the Department of Health (DH) has fallen considerably due to Market Forces Factor (MFF) payments being made under contract arrangements with Commissioners rather than being funded directly from the DH.

Private Patient Income at £2.5m (of which £0.9m has been included within the four month period) and has increased by £44k or 1.8% compared to 2008-2009. This is equates to 2.7% of total Clinical Income and therefore well within the Cap of 5.2%.

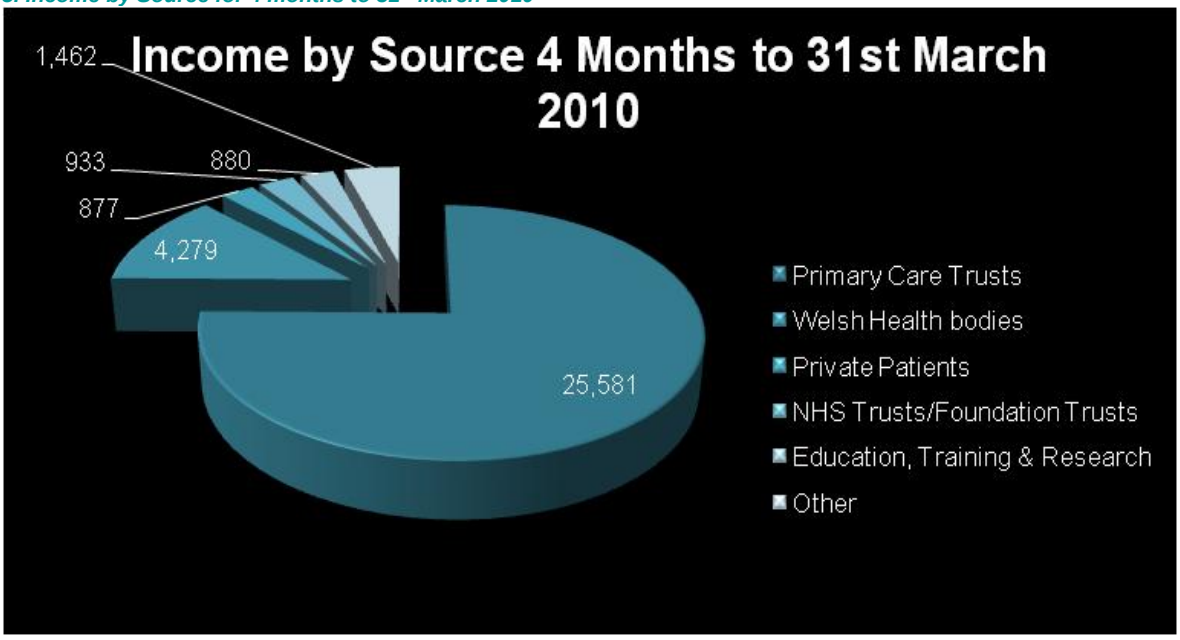
The Trust has continued to play a key role on the Department of Health Expert Working Groups for the formulation of Cystic Fibrosis, Devices, Respiratory and Critical Care tariffs for the future.

4. Income by Source

Analysis of Income	Pre Authorisation	Post Authorisation	Total	Prior Year	Change
	Actual 8 Months to 31st March 2010 £000's	Actual 4 Months to 31st March 2010 £000's	2009/10 12 Months to 31st March £000's	2008/09 12 Months to 31st March £000's	
Primary Care Trusts	51,363	25,581	76,944	73,878	**3,066**
Welsh Health bodies	10,098	4,279	14,377	12,403	**1,974**
Private Patients	1,669	877	2,546	2,496	**50**
NHS Trusts/Foundation Trusts	1,366	933	2,299	1,840	**459**
Education, Training & Research	1,772	880	2,652	2,794	**-142**
Other	256	1,462	1,718	831	**887**
Total	**66,524**	**34,012**	**100,536**	**94,242**	**6,294**

The chart below graphically represents the breakdown of Income by source for the four months to 31st March 2010.

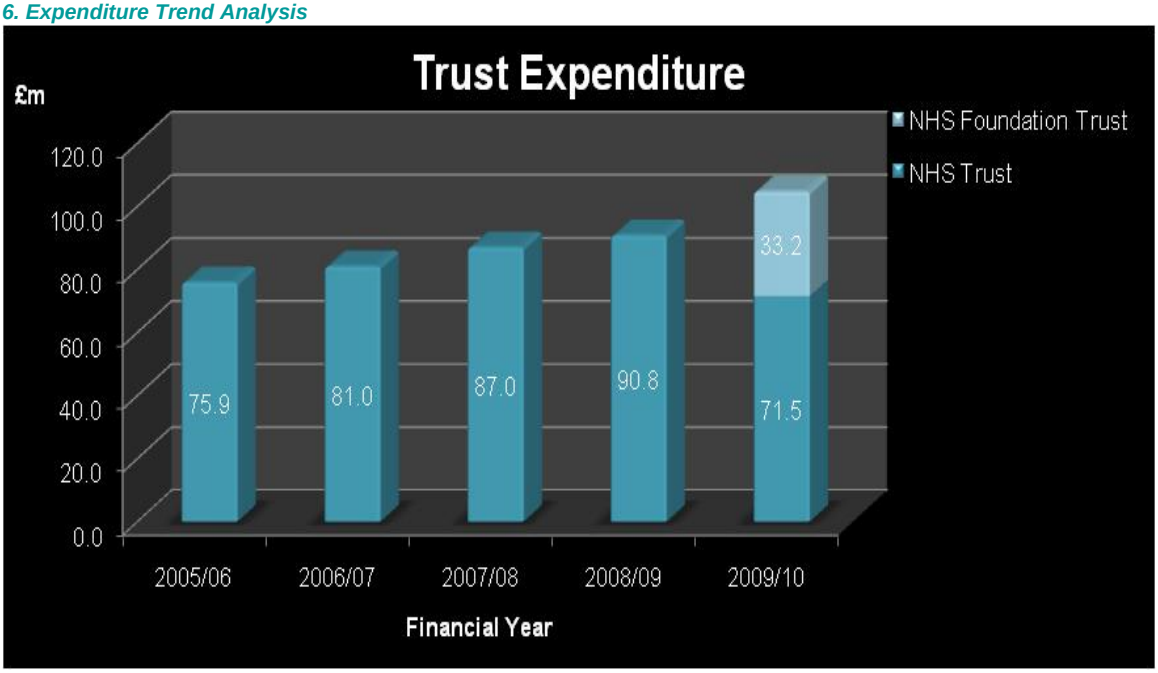
5. Income by Source for 4 months to 31st March 2010



4.4.6 Trust Revenue Expenditure

Total expenditure incurred in the twelve month period for 2009-2010 is £104.8m, of which £33.2m relates to the four months from December 2009. This compares to expenditure of £90.8m in 2008-2009.

6. Expenditure Trend Analysis



The Chart above shows the pattern of expenditure over the last 5 years, which has increased as a result of Activity. Inflation has been partly offset by the efficiency savings from the Trust's Annual Cost Improvement Programme.

7. Expenditure by Source

Analysis of Expenditure	Pre Authorisation Actual 8 Months to 31st March 2010 £000's	Post Authorisation Actual 4 Months to 31st March 2010 £000's	Total 2009/10 12 Months to 31st March £000's	2008/09 2008/09 12 Months to 31st March £000's	Change
Services from Other NHS Trust's/Foundation	2,775	1,391	4,166	3,984	182
Services from Other NHS Bodies	39	35	74	48	26
Staff Costs	34,216	17,478	51,694	48,845	2,849
Clinical Supplies & Services	19,790	10,273	30,063	26,888	3,175
Non Clinical Supplies & Services	3,604	2,167	5,771	5,562	209
Depreciation & Impairments	11,117	1,865	12,982	5,498	7,484
Total	**71,541**	**33,209**	**104,750**	**90,825**	**13,925**

The largest category of expenditure within the Trust relates to Pay Costs, which for the four months are £51.7m (of which £17.5m relates to the four month period) or 49.3% of Operating Expenses.

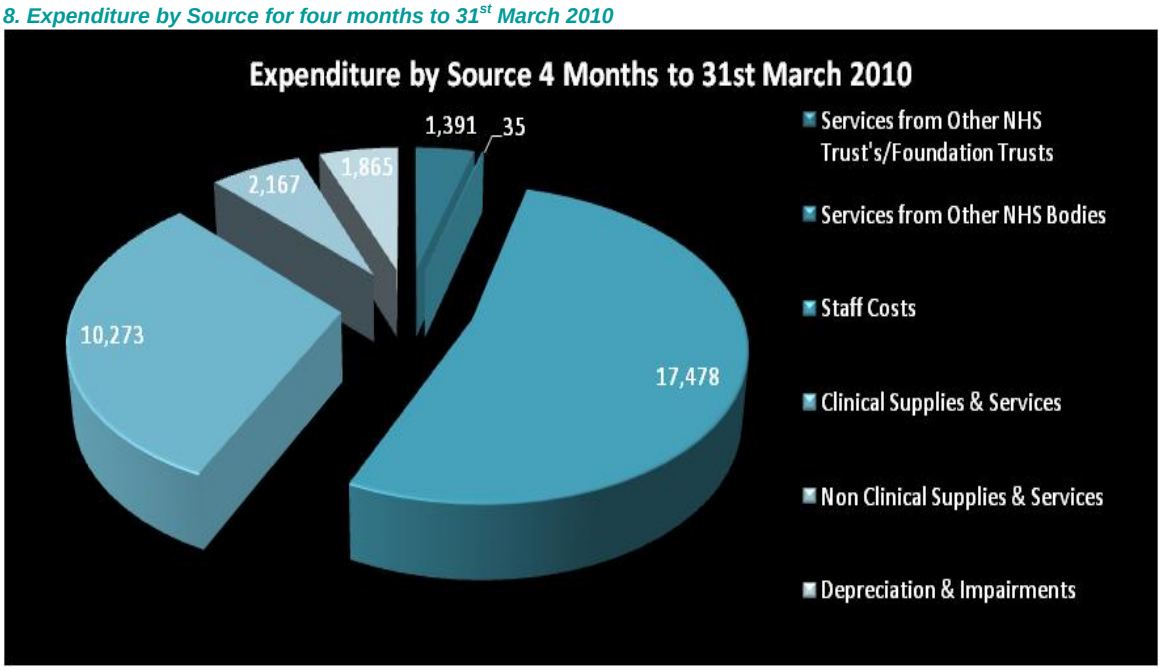
Overall Pay Costs have increased by £2.9m from 2008-2009 as a result of inflation, incremental progression and growth across the following staff groups:

- Medical Staff of 5 Full Time Equivalents (FTE's);
- Nursing Staff 29 FTE's; Scientific,
- Therapeutic & Technical Staff 6 FTE's; and
- Non Clinical Staff 12 FTE's.

This growth in the workforce is largely to support growth in activity, in particular the Primary PCI Developments and Arrhythmia Service awarded by Health Commission Wales. Part of the growth also relates to recruitment during the year to vacant posts at 31st March 2009.

Overall Non Pay Costs have increased by £11.1m from 2008-2009. A large proportion of this increase relates to writing down the value of fixed assets through expenditure (£8.9m); this is discussed further below under the Accounting Policies section. The impairment cost is offset in part by reductions in depreciation charges £1.4m also in respect of the reduction in asset values. The remaining increase in costs is largely driven by increases in clinical supplies necessary to support the increased levels of activity realised during 2009-2010.

8. Expenditure by Source for four months to 31st March 2010



4.4.7 Cost Improvement Programme

The Trust recognises its responsibility to manage its finances efficiently.

This has been driven by the Trust's Annual Cost Improvement Programme, with nominated Executive Leads for each scheme. A process of risk assessment has been undertaken on the CIP Schemes to ensure no adverse impact on Patient Safety or Clinical Quality.

A Cost Improvement Programme of £3.9m has been delivered during 2009-2010. These savings have been delivered from a number of sources. The key enabling strategies implemented to deliver the efficiencies have been:

- A workforce review
- A review of procurement arrangements and
- Investment in technology to support efficiency and lean methods of working

4.4.8 Capital Investment

During the year, the Trust has funded £2.6m of capital investment which has improved services for both patients and staff.

A summary of the capital investment undertaken this year is shown in the table below. The table represents the capital programme for the full financial year to 31st March 2010 at £2.6m. For the four month period from December, the Trust invested £1.3m in Capital schemes.

9. Capital Investment for 2009-2010

Capital Investment	Pre Authorisation Actual 8 Months to 31st March 2010 £000's	Post Authorisation Actual 4 Months to 31st March 2010 £000's	Total 2009/10 12 Months to 31st March £000's
Estate Repairs & Developments	784	289	1,073
New Equipment/Replacements	321	320	641
IT Schemes	121	594	715
Other Capital Schemes	13	83	96
Schemes brought forward from 2008/09	48	4	52
Total	**1,287**	**1,290**	**2,577**

4.4.9 Prudential Borrowing limit and compliance with the Prudential Borrowing Code

As an NHS Foundation Trust, the Trust now is able to borrow money to finance Capital Investment. The limits on the amount the Trust can borrow and the conditions that it must meet to demonstrate that the levels of borrowing are affordable are set out in the Trust's Prudential Borrowing Limit (PBL) issued by Monitor. The Prudential Borrowing Limit set for Liverpool Heart and Chest Hospital for 2009-2010 is £25.3m of which £17.7 relates to Long Term Borrowing and £7.6m relates to Short Term Borrowing (Working Capital Facility).

Currently, against this limit the only source of external borrowing during 2009-2010 has been a small number of Finance Leases, with an obligation of £0.7m at 31st March 2010. The following table shows the Trust's Prudential Borrowing Code ratios, against the limits set by Monitor. These ratios demonstrate the level of borrowings that the Trust would be able to meet in terms of the repayment obligations. As shown in the table, the Trust is well within the set limits.

10. Prudential Borrowing Limit performance vs thresholds

Prudential Borrowing Code Ratios	Actual Ratio at 31st March 2010	Limits 2009/10	Status
Minimum Dividend Cover (times)	4	>1	Achieved
Minimum Interest Cover (times)	127	>3	Achieved
Minimum Debt to Service Cover (times)	18	>2	Achieved
Maximum Debt to Service	0.4%	<2.5%	Achieved

In addition, the Trust has a Working Capital Facility of £7.6m, which was approved prior to authorisation as a Foundation Trust on 1st December 2009. Through effective cash management the Trust has not required to draw down any part of this facility during the four months to 31st March 2010.

4.4.10 Liquidity & Short Term Investments

The Trust's cash balance remains strong at £13.7m at 31st March 2010, with interest receivable at £27k, which reflects current interest rates at an historic low.

The cash balance has been accumulated from previous year's surpluses as well as from internally generated resources (depreciation, etc). This cash will be used by the Trust to make further investments in capital infrastructure in future years to support the Estates Strategy and Patient Experience Delivery Plan.

The Trust has an Investment Committee which has been set up with the following functions:

- Approving the Trust's investment and borrowing strategy and policies
- Approve performance against benchmarks
- Review performance against the benchmarks
- Ensuring proper safeguards are in place for the security of Trust's funds.
- The Committee reviews all short, medium and long term investments of funds, and evaluates and selects the most appropriate sources of financing the investments.

4.4.11 Accounting Policies

The Trust has produced the Annual Accounts for the four months to 31st March 2010 in accordance with the requirements of International Financial Reporting Standards and Monitor's NHS Foundation Trust Annual Reporting Manual.

The policies are approved by the Audit Committee for use in preparing the Annual Accounts and are amended annually to reflect the changing circumstances and accounting regulation and guidance.

Following a cross Government review of the valuation of specialised assets, the Trust has implemented a change in valuation methodology from Depreciated Replacement Cost to a Modern Equivalent Asset Valuation. This method of valuation compares the structure of the asset to a similar structure having the equivalent productive capacity, which could be built using modern materials, techniques and design.

The Trust carried out three valuations in the twelve month period, of which one was at 31st March 2010.

The table below shows the value of assets brought forward from the NHS Trust at 30th November 2009, and subsequent movement in values to 31st March 2010.

11. Movements on Tangible Fixed Assets during four months to 31st March 2010

Equipment for the Period 1st December - 31st March 2010	Total £000's
Cost or Valuation at 1st December 2009	**58,567**
Revaluation 31st March 2010	**-1,947**
Additions Purchased	**1,289**
Additions Donated	**44**
Depreciation charged during period	**-1,334**
Subtotal	**-1,948**
Cost or Valuation at 31st March 2010	**56,619**

4.4.12 Disclosure to auditors

The Board of Directors would confirm that at the date of the approval of this report that:

So far as the Directors are aware there is no relevant audit information of which the auditors are unaware and further that each Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

4.4.13 Other Disclosures

The Trust maintains a Register of Interest (detailing company directorships and other significant interests held by Directors or Governors which may conflict with their management responsibilities. The register is publicly available and can be obtained by contacting the Trust Secretary on 0151 600 1249 or email lucy.lavan@lhch.nhs.uk

4.4.14 Going Concern

As set out in the notes to the Annual Accounts below the Annual Accounts have been prepared on a going concern basis. This decision has been made by the Directors of the Trust on the basis that after making enquiries the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the Annual Accounts.

4.4.15 Private Patient Cap

In order to protect the provision of goods and services for purposes related to the provision of National Health Care, Monitor sets a limit on the value of Private Patient Activity that a Foundation Trust can undertake.

This limit is set out within the terms of Authorisation of the Trust at 5.2%, and is calculated by taking the value of Private Patient Income as reported in the 2002-2003 Annual Accounts as a proportion of total Clinical Income for the same year.

During the four months to 31st March 2010, the Trust has generated £0.9m Private Patient Income which equates to 2.7% of the Trust's total Clinical Income for the year. This is well below the limit set by Monitor and highlights the potential for further increases in this area of income in the future.

From April 1st 2010 the calculation of Private Patient Income is changing to include all income received (both directly and indirectly) from Private Patient activity.

This change follows a consultation by Monitor and a High Court Judgement of December 2009 which determined that the interpretation of the income that should be included as Private Patient Income (PPI) for the purposes of the PPI Cap was not valid and, in particular, required revision to bring the PPI Cap requirements in line with the relevant PPI Cap legislation.

The changes to the definition of Private Patient Income will not have a material impact to the Trust's limit.

5. Quality Report

Statement on Quality from the Chief Executive Officer

It is my pleasure to introduce to you the first formal quality account to be published by the Liverpool Heart & Chest Hospital NHS Foundation Trust following our voluntarily produced quality report published last year.

The Board of Directors has a very strong commitment to quality which is reflected in the values it holds:

Value	Excellent	Compassionate	Safe
Patients say …	Give me professional care	Treat me as an individual	Do me no harm (Keep me safe)
Which means we deliver …	- Make me well - Honest communication - Be efficient	- Warm welcome for all - Respect & Dignity - Two way communication	- Clean hospital - Safe environment - No mistakes

We have upheld these values throughout 2009-2010 which has resulted in another year of considerable achievement

The Board has very recently adopted a new mission statement for the Trust which embodies our values:

"Excellent, Compassionate, Safe care for every patient every day"

From this flows our goal to be recognised by our patients as the **best Hospital in the country** and as such we are aligning all we do to improve the experience of our patients.

We have led an extensive consultation exercise with our own staff together with the hospital's commissioning bodies, patients, carers and other services with whom we work to ensure we focus on those aspects of quality improvement which will bring the biggest benefit to the people we serve. This report provides detail of those aspects of clinical care we have selected over the coming twelve months, together with reviewing our performance over the year just passed.

I confirm that the information in this document is an accurate reflection of the quality of our services.

Raj Jain
Chief Executive Officer

5.1 Quality Account Summary

This Quality Account takes a look at the past year and reflects upon the commitments we made to improve quality in addition to spelling out what our priorities are for the coming year.

We have successfully met three of the five primary challenges we set ourselves last year, namely reducing surgical site infections and non-clinical cancellations and improving the patient experience. We dramatically improved many of the key processes of cardiac care and have an impact on reducing mortality, but we did not reach the high standards we set for ourselves.

We have added three new priorities to improve this year (risk assessments for blood clots, discharge and communication and pathway compliance for patients with acute heart problems) in addition to one achieved (patient experience) and two underachieved but improved (key processes of cardiac care and mortality) priorities which will continue from last year. These priorities much better reflect the needs of our partner organisations, Foundation Trust members and our patients & carers.

This Quality Account also provides an excellent level of assurance regarding work that is a key enabler of quality, including clinical audit, research, data quality, workforce management and leadership. It draws upon the outcomes from our survey work with patients and other quality improvement initiatives supporting different services and functions of the Trust. It has also been the subject of extensive external consultation with our Primary Care Trust, local involvement networks and relevant Local Authority Overview and Scrutiny Committees.

5.2 Introduction to Liverpool Heart and Chest Hospital NHS Foundation Trust

Liverpool Heart and Chest Hospital NHS Foundation Trust is a single site specialist hospital serving the population of 2.8 million people resident in Cheshire, Merseyside, North Wales and the Isle of Man. It provides the full range of heart and chest services with the exception of organ transplantation. Throughout 2009-2010 this included:

1. Coronary angiography and intervention (procedures used to visualise the coronary arteries and treat narrowings using balloons and stents)

2. Arrhythmia management (pacemakers and other devices & treatments used to control and restore the normal rhythm of the heart)

3. Cardiac surgery (procedures to bypass narrowings, replace the valves of the heart or deal with other problems of the major vessels in the chest)

4. Thoracic surgery (procedures to treat all major diseases of the chest including lung removal and surgery to the oesophagus (food pipe)

5. Respiratory medicine (medical management of asthma, chronic obstructive pulmonary disease and cystic fibrosis).

5.3 Priorities for Improvement and Statements of Assurance from the Board of Directors

Review of last years priorities:

Last year the Trust published an informal Quality Report in which we committed to improve a total of 5 safety, effectiveness and patient experience priorities. What follows is a review of our progress in 2009-2010 against these priorities.

5.3.1 Priority One: Reduce the number of deaths in-hospital

Category: Safety

What: Reduce the percentage mortality in patients admitted to hospital

Why: Mortality after treatment is a measure of the safety and effectiveness of systems and processes used in caring for patients

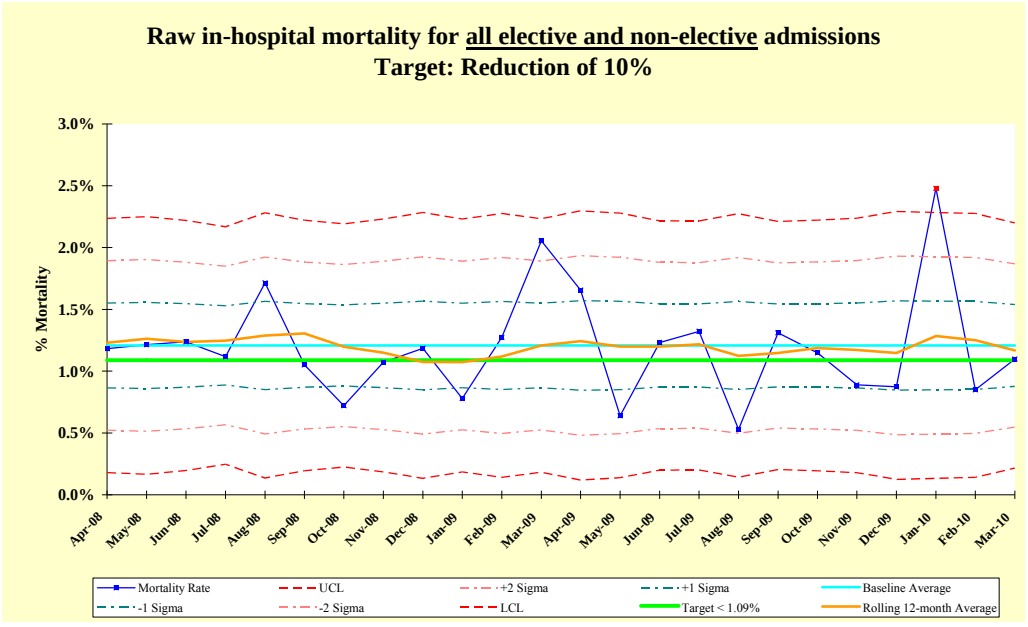
By how much: 10%

By when: March 2010

Who collects these data and how?
The Trust's clinical coders record on the Trust Patient Administration System the outcome of every patient at the time of discharge

Result and meaning: Underachieved but improved.
Average mortality in the 12 months up to April 2009 was 1.21%.
The average mortality for the 12 months after was 1.17%.
Reduction is 3%.

Current status:



Patients receiving primary percutaneous coronary intervention (PPCI) have been excluded from the above graph as this was a new service developed at the beginning of last year with potential to increase mortality. Leaving these patients in the calculations would have meant that we were not making like comparisons with previous years. Our PPCI service does however perform well compared to national performance (3% mortality vs. 4.1% nationally).

The orange line in the above graph is a 12 month rolling average and shows that up to December 2009 the Trust was making good progress towards achieving this target. However, an unprecedented number of deaths in January 2010 eroded all the improvements made over the preceding 10 months. Results from February and March have, however, returned to previously low (and below target) levels.

Keep as future priority?

Yes.

However, in keeping with the Trust being at the forefront of specialist treatments, new services are continuously being introduced and sicker patients are being treated all the time. This makes it very difficult to measure mortality without:

1. Restricting it to a few key high volume procedures

2. Risk adjusting the results to take account of the complexity of the patients treated.

As such for 2010-2011, we will focus on delivering a *continuous improvement* in mortality following bypass graft surgery and percutaneous coronary interventions (PCI; excluding primary PCI for heart attack) as these procedures have well studied methods of risk adjustment in place (see new priorities for 2010-2011).

Improvements achieved:

- Improved the consistency (reliability) of all elements of the sepsis care bundle
- Introduced a regular multidisciplinary team (MDT) discussion for cardiac patients where it was not certain which treatment method was the best for the patient concerned
- Improved the escalation of the Modified Early Warning Score (MEWS) for patients who were showing signs of clinical deterioration
- Introduced the multidisciplinary review of all deaths with dissemination of learning across entire organisation

Further improvements identified:

- Achieve 60% perfect care score for sepsis bundle
- Embed cross organisational learning from mortality reviews
- Reduce rates of post-operative bleeding

5.3.2 Priority Two: Improve the outcomes of care in heart attack, heart failure and bypass grafting patients (Advancing Quality)

Category:

Effectiveness

What:

Ensure all appropriate patients receive all elements of the relevant care bundles (perfect care)

Why:

Getting the processes of care right leads to improved outcomes for patients

By how much?

> 98%

By when?

March 2010

Who collects this data and how?

Clinical Quality staff review the case notes of every patient discharged with the diagnosis of heart attack, heart failure or who received bypass grafting and record whether the care prescribed in the care bundle has been delivered. Patients must receive all elements of the bundle to be considered as receiving "perfect care".

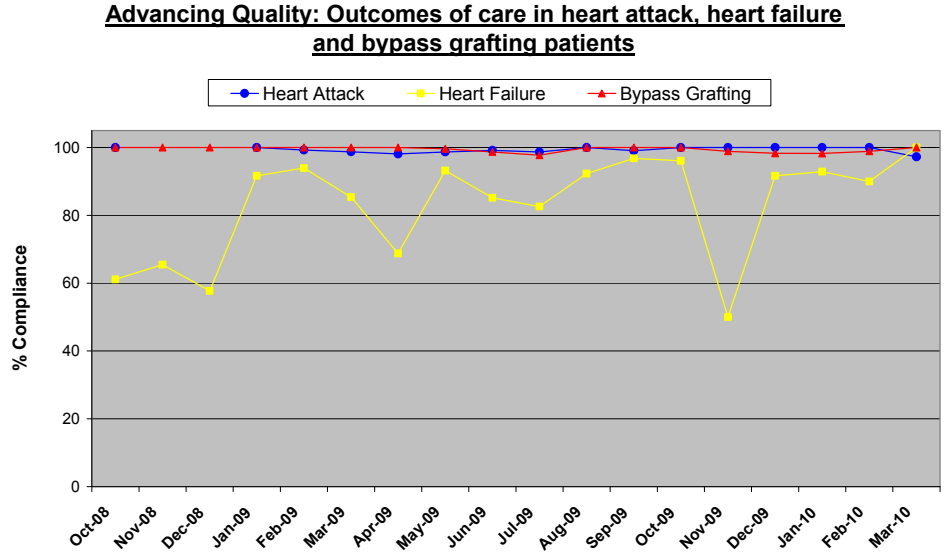
Result and meaning:

Underachieved but improved. Average compliance for patients discharged with a diagnosis of heart attack, heart failure or who received bypass grafting in the 6 months up to April 2009 was 100%, 100% and 76% respectively. The average compliance for the 12 months after was 99%, 99% and 87%. Results for heart failure are 11% short of our target.

Keep as future priority?

Yes – see new priorities for 2010-2011

Current status:



Improvements achieved:

- Improved the provision of smoking cessation advice
- Ensured all patients with heart failure received the necessary self care and lifestyle advice and received an evaluation of their heart function
- Ensured all patients who have suffered a heart attack received the appropriate medication

Further improvements identified:

- Reliable identification of all in-patients with heart failure
- Improve the recording of the delivery of discharge instructions (activity, arrangements for follow up, diet, medication, weight and symptom management) in our care pathways

5.3.3 Priority Three: Reduce the number of surgical site infections

Category:

Safety

What:

Reduce the percentage of wound infections following coronary artery bypass grafting

Why:

Infection is a big concern for patients when admitted to hospital. It also prolongs hospital stay, and increases costs.

How much:

20%

By when:

March 2010

Who collects this data and how?

The infection control team reviews the wounds of all patients following coronary artery bypass immediately before discharge or sooner if there is a problem.

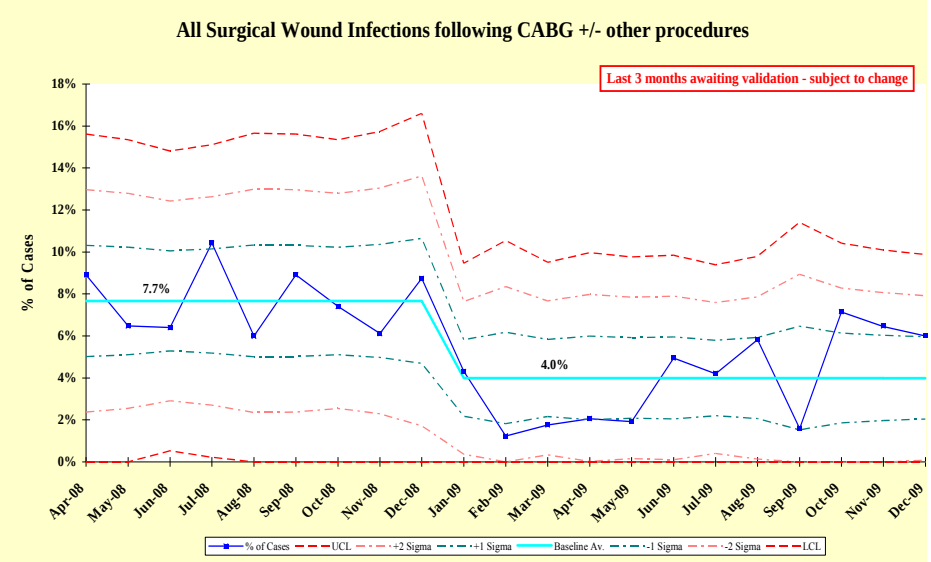
Result and meaning:

Achieved. The average rate of infection in the 12 months up to April 2009 was 6.4%. The average rate of infection for the 12 months after was 4.5%. We have successfully reduced wound infections by 30% overall.

Keep as future priority?

No. However, keeping surgical site infection under control remains a key priority of our infection prevention and control plans and as such, we will continue to monitor this important outcome and take action if it increases.

Current status:



The above graph demonstrates the dramatic reduction in surgical site infections which occurred when the new measures were introduced in January 2009. Rates have been variable over the last few months but the overall position is much improved.

Improvements achieved:

- Implemented the surgical site infection care bundle. Compliance measurement and improvement ongoing
- Improved the discipline of staff working in the theatre areas in order to minimise unnecessary movement in and out of the theatre, and ensured strict adherence to the theatre clothing policy
- Achieved excellence in hand hygiene practice

Further improvements identified:

- Introduce a new pre-operative skin preparation proven to reduce infections (2% chlorhexidine)
- Improve the use of the non-touch technique for wound dressing and cleaning
- Introduce a competency and audit framework into the theatre environment in relation to scrubbing and gowning
- Improving compliance with antibiotic therapy given before the operation

5.3.4. Priority Four: Reduce the number of non-clinical cancellations for elective procedures

Category:

Patient Experience

What:

Reduce the number of cancellations for non-clinical reasons

Why:

Having your operation cancelled after admission to hospital is upsetting and distressing for patients and their carers.

How much:

30%

By when:

March 2010

Who collects this data and how?

Directorate Managers, who run our operating theatre environment, record if admitted patients are cancelled either the day before or on the day of their intended procedure.

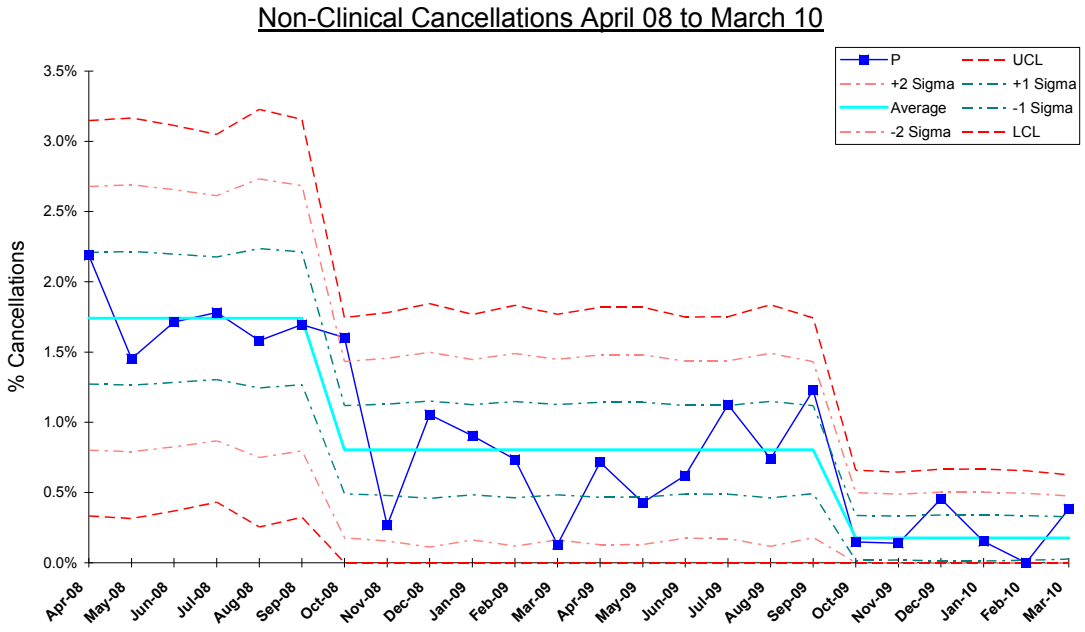
Result and meaning:

Achieved. The average non-clinical cancellation rate in the 12 months up to April 2009 was 1.3%. The average non-clinical cancellation rate for the 12 months after was 0.5%. We have successfully reduced non-clinical cancellations by 62% overall.

Keep as future priority?

No. However, this measure is a national target and as such will remain closely monitored, with action taken if it increases.

Current status:



The graph demonstrates increasing yearly improvement.

Improvements achieved:

- Improved the planning and scheduling of pacemaker and bypass grafting procedures
- Ensured efficiency of practices on the day of the procedure
- Improved the delivery of care from procedure through to discharge

Further improvements identified:

- Further improvements to planning and scheduling of pacing services, including implementation of a weekly bed meeting, a new scheduling tool and listing criteria
- Modernisation of the systems & process supporting the medical secretaries
- Regular feedback on performance via visual management displays for Thoracic and Aortic Surgery

5.3.5 Priority Five: Improve the experience of care for our patients

Category:

Patient Experience

What:

Develop and begin the implementation of a comprehensive patient experience strategy

Why:

Patients want to be treated with dignity and respect, have their views listened to and acted upon, not be harmed as a consequence of the healthcare delivery and receive care in a comfortable, clean and friendly environment in addition to many other things. Collectively, these issues (and many more) make up the experience of the patient.

How much:

Develop and start to implement

Who collects this data and how?

We track ongoing satisfaction with our services from the monthly distribution of questionnaires to inpatients and outpatients by our customer care team. Results are summarised by clinical quality staff. Additionally, the clinical quality department manage the Trust's participation in the National Inpatient and Out-patient surveys, the results of which are analysed by the Care Quality Commission.

By when:

March 2010

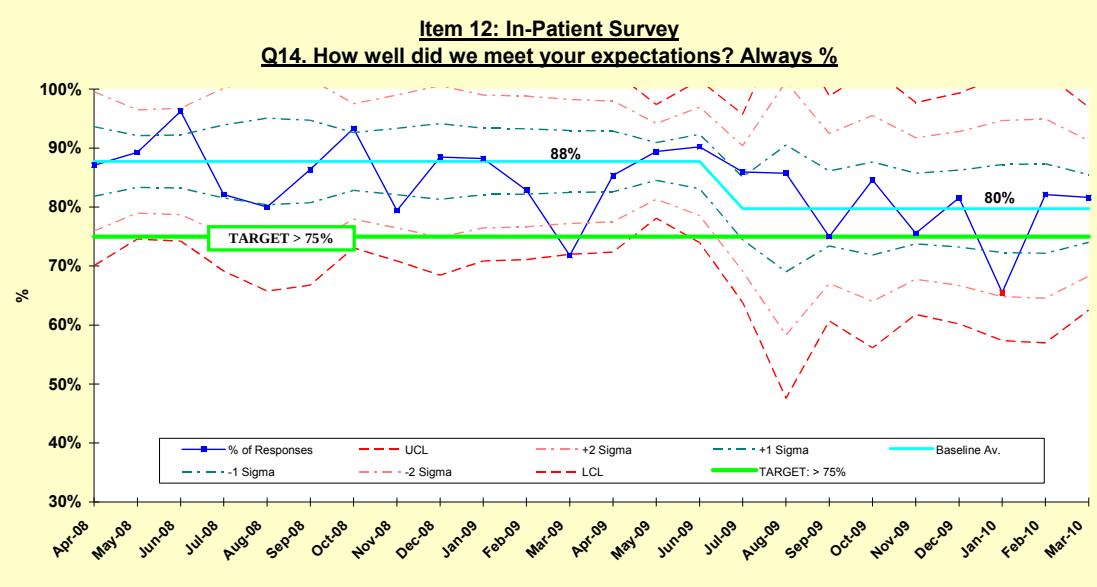
Result and meaning:

Achieved. We now have a comprehensive plan which focuses on what we can do at all levels of the organisation to improve the experiences of our patients.

Keep as future priority?

Yes. Even though we have achieved this priority, improving the patient experience remains the Trust's top ambition for the future. We have developed a comprehensive delivery plan for the future, and wish to see this implemented across the next year and beyond (see new priorities for 2010-2011).

Current status:



Even though the percentage of patients in whom we meet their expectations all of the time has reduced slightly, it still remains above target.

Improvements achieved:

- Presented the patient experience development plan and implementation plan to the Board of Directors
- Explored and developed a number of different methods of capturing feedback from the users of our services and acted on the results
- Implemented the Nursing Assessment and Accreditation system which assesses clinical standards that include the delivery of person centred care
- Implemented a number of changes to the environment to reduce concerns raised regarding mixed sex accommodation
- Participated in the 2009 National Inpatient and Outpatient surveys and action planned the results

Further improvements identified:

- Fully implement the delivery plan arising from the first year of implementation of the patient experience development plan. This will include the development of a patient contract, the deployment of case managers, comprehensive training and development of staff and the development of new methods of obtaining service user feedback.

5.3.6. New priorities for 2010-2011

From the review of performance in 2009-2010, the Trust has committed to continue the following work:

5.3.7 Priority One: Reduce the number of deaths in hospital.

However, our experience in 2009-2010, and the recent experience of the NHS (e.g. failings at the Mid-Staffordshire Trust) have led us to believe that quantifying a specific mortality improvement is unwise. This is because the population of patients we treat are presenting as more ill and with more complex disease with every

passing year and it is not possible to accurately tease apart true performance improvement from the "masking" created by the increased risks these patients face, despite our use of risk adjustment tools[1]. What we can agree to deliver, however, is a *continuous improvement* in mortality in our two highest volume procedures, coronary artery bypass grafting and percutaneous coronary intervention (PCI; excluding primary PCI), corrected as best we can for patient complexity. We believe patients can still draw significant assurance from this as mortality rates in the setting of an increasingly complicated patient population would surely rise if we did not have a programme of continuous mortality improvement in place.

During 2010-2011 we also plan to develop a method of identifying harm (which will include mortality) which is not expected as a consequence of the natural progression of the patient's disease state in preparation for introducing its improvement as a quality account commitment in 2011-2012.

5.3.8. Priority Two: Improve the outcomes of care in heart attack, heart failure and bypass grafting patients (Advancing Quality)

We will achieve greater than 98% compliance in all care bundles by March 2011.

Priority Three: Improve the experience of care for our patients

We will fully implement the delivery plan arising from the first year of implementation of the patient experience delivery plan.

What follows are the new **additional** priorities for improvement in 2010-2011.

Priority Four: Improve discharge planning and communication

Category:

Patient Experience

What is the priority?

Improve the quality of discharge planning and communication with patients, carers, district general hospitals and general practitioners

Why is it important?

Discharge planning prepares the patient for leaving the hospital. Most patients return to the care of a loved one and it is important that both patient and carer feel supported. Other health care professionals who may be called upon in the early weeks after discharge must have a good understanding of the patients' treatment and the plan for recuperation if they are to provide effective support.

How much will we improve?

We aim to improve the percentage of patients satisfied with discharge from 72% to at least 78%.

By when?

July 2011

[1] Lilford R & Pronovost P. Using hospital mortality rates to judge hospital performance: A bad idea that just won't go away. BMJ 2010;340:c2016

Who will collect these data and how?

Each year, the Trust participates in the National Inpatients Survey. We have averaged the results from 4 key questions related to the discharge process from the 2009 survey to provide a baseline measure. The survey will be run again in the autumn of 2010 when the same questions will be asked. We have also included these same 4 questions in our local monthly survey to ensure we are making the expected progress.

Current status:

	LHCH 2009-2010	LHCH 2008-2009	Most Recent National
Average scores of discharge indicators not ranked in top 20% of performance from national in-patients survey	72%	73%	78%

Improvements identified:

- Review the function and performance of discharge planning service and redesign as appropriate
- Improve the timeliness and usefulness of discharge letters to other healthcare professions
- Improve information for patients and carers about how to look after themselves once discharged.
- Increase opportunities for our Nurses to lead the discharge process
- Universally employ predicted date of discharge so patients know when discharge is likely to occur
- Deliver electronic discharge summaries within 24 hours of discharge

5.3.11 Priority Five: Improve the assessment of risk of venous thromboembolism

Category:

Safety

What is the priority?

Improve the assessment of risk for venous thromboembolism (blood clots) on admission

Why is it important?

Venous thromboembolism is responsible for a great many deaths in the NHS each year. Many of these deaths are preventable if the correct therapy is delivered. A comprehensive assessment of risk allows patients to be identified who would benefit from this therapy.

How much will we improve?

Our target is to ensure more than 90% of our patients are risk assessed

By when?

March 2011

Who will collect these data and how?

Whether a risk assessment is performed on admission or not data will be collected for each patient and entered onto the Patient Administration System. Each month, results for all admitted patients will be summarised and a performance score derived.

Current status:

Patients are at high risk of venous thromboembolism if they are elderly, have a history of cardiovascular or respiratory disease and are having operations that last over 90 minutes. As such, the vast majority of our patients are high risk and we have historically had a policy of treating them as such, without necessarily performing the risk assessment. However, the requirement to risk assess is a national initiative which we will commence in April 2010.

Improvements identified:

- Improve patient information to raise awareness amongst patients about the risks of venous thromboembolism
- Introduce a structured risk assessment tool to the admission process
- Educate doctors and nurses how to perform the risk assessment and deliver the appropriate therapy

5.3.12 Priority Six: Improve care for patients with acute coronary syndromes

Category:

Effectiveness

What is the priority?

To ensure there is a consistent approach to delivering care to patients transferred to our Hospital who are suffering from an acute coronary syndrome

Why is it important?

The delivery of effective care to all who have the capacity to benefit is an important part of the Trust's commitment to clinical excellence. However, not every patient is a suitable candidate for treatment.

How much will we improve?

Our target is to ensure all appropriate patients referred are accepted for transfer.

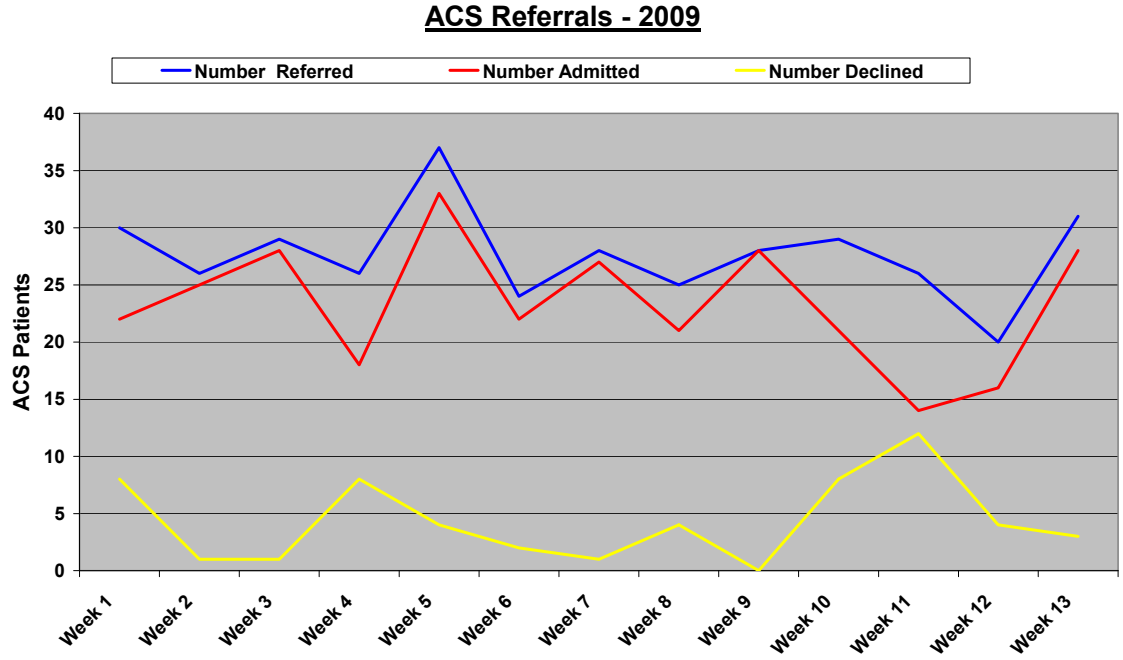
By when?

March 2011

Who will collect these data and how?

When being referred patients with an acute coronary syndrome, Doctors gather information about the patient's clinical status, background and responses to therapy initiated in the referring hospital. Using an evidence-based guideline, they assess the patient's ability to benefit and arrange transfer to our hospital if appropriate. We will examine how the difference between the number referred and accepted for transfer varies to ensure any gap is explainable by inability to benefit alone.

Current status:



The data presented above are less than perfect as they do not specifically address the patient's capacity to benefit. We will ensure this key issue is included in our future data collection.

Improvements identified:

- Re-circulate pathway to all Doctors and ensure responsibilities are understood
- Improve ability for referring Doctors to discuss with Doctors at our Hospital potential referrals and the capacity to benefit
- Peer review of patients not accepted for transfer to identify any inconsistencies in the application of the evidence-based guideline
- Reduce delays in transfer to Liverpool Heart and Chest Hospital NHS Foundation Trust

5.3.13 How our priorities were selected

In the pursuit of our goal to become the best hospital in the country, throughout 2009-2010 we led a continuous and comprehensive consultation exercise focussed on the identification of those priorities for improvement which would bring the biggest benefits to the people we serve. By people, this naturally includes our patients, but importantly also the carers, our Foundation Trust Members and other health and social care professionals with whom we interact daily.

We have held a number of internal and external consultation events which have successively refined our decision making over which priories to select. Our final selection has emerged from a synthesis of priorities contributed from:

1. Staff delivering front line services who know where improvements need to be made
2. The Executive team who have considered the wider agenda in terms of national targets and quality incentive schemes

3. Our newly formed quality, safety and patient experience Council of Members sub-group, who are continuously identifying priorities from the Trust's 9,000 plus members.
4. Issues raised by our patients arising from both national and local surveys.
5. Our key stakeholders (the doctors, nurses and managers from referring hospitals, our commissioners, patient self help groups, higher education institutions) who from a dedicated workshop identified a range of improvements they would like to see implemented which would improve relationships with the Trust.

Priorities were shortlisted by the Executive team based upon the gap in performance between Liverpool Heart and Chest Hospital and the best performance, together with number of people likely to benefit. We call this the scope for improvement. The shortlist was presented to the Trust's Clinical Quality Committee who recommended the final shortlist of priorities to the Board of Directors. The Board of Directors reviewed and agreed the priorities in April 2010.

5.3.14 Statements of Assurance from the Board:

The Board of Directors is wholly committed to achieving the very best standards of quality for the patients it serves. Indeed, many of the financial plans (a traditional area of scrutiny by the Board of Directors) are dependent upon achieving excellence in quality of care. The Trust's new mission statement, together with its values (see Part 1: Statement on Quality from the Chief Executive Officer) demonstrates the attention paid to clinical excellence, compassion and safety – all key elements of quality.

In support of this, our regulators require us to make a number of statements which are intended to assure the reader of the Trust's commitment to quality.

5.3.15 Assurance regarding review of services:

During 2009-2010 Liverpool Heart and Chest Hospital NHS Foundation Trust provided and/or sub-contracted 10 (ten) NHS services.

Liverpool Heart and Chest Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in 10 (ten) of these NHS services.

The income generated by the NHS services reviewed in 2009-2010 represents 100 per cent of the total clinical income generated from the provision of NHS services by Liverpool Heart & Chest Hospital NHS Foundation Trust for 2009-2010.

In order to further improve our capacity and capability to collect data and review performance of our services, we intend to:

- Begin the implementation of a strategy for making all patient records available in an electronic format, which means important data will always be available for review and analysis
- Further embed our commitment to dashboards which are an easy to understand summary of complex information for use by key users in the Trust
- Develop our benchmarking capability which will allow us to identify "what is possible" as opportunities for improvement by comparing our performance to those of our peers

- Further improve our capacity and capability from the implementation of an improvement training programme tailored to the needs of our staff and our expectations of them

5.3.16 Assurance regarding participation in clinical audits

During 2009-2010, 8 national clinical audits and 3 national confidential enquiries covered NHS services that Liverpool Heart and Chest Hospital NHS Foundation Trust provides.

During that period Liverpool Heart and Chest Hospital NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital NHS Foundation Trust was eligible to and participated in during 2009-2010 as stated by the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and those listed for inclusion by the Department of Health are as follows:

5.3.17 Heart

- Adult cardiac surgery
- Cardiac interventions percutaneous coronary intervention (BCIS) procedures
- Congenital heart disease
- Heart failure
- Heart rhythm management (pacing and implantable cardiac defibrillators)
- The Myocardial Ischaemia National Audit Project (MINAP; myocardial infarction)

5.3.17 Cancer

- National Lung Cancer Audit
- Oesophago-gastric (stomach) cancer

5.3.18 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

- Parental nutrition
- Elective & emergency surgery in the elderly
- Peri-operative Care

5.3.19 Centre for Maternal and Child Enquiries (CMACE) and National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI / NCISH).

National studies proposed during 2009-2010 have been presented at the Clinical Audit and Effectiveness Group throughout the year for potential action, however, none have been relevant to NHS services Liverpool Heart and Chest Hospital NHS Foundation Trust provide.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2009-2010 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Heart

Adult cardiac surgery data submissions are undertaken every 12 weeks as required by the Central Cardiac Audit Database (CCAD). For data period April 2009 to March 2010 1,846 cases have been submitted (100%) to CCAD.

Percutaneous coronary intervention (PCI) procedures are captured onto the TOMCAT internal database system. A total of 2563 cases for 2009 (100%) have been submitted to CCAD.

Congenital heart disease procedures are captured onto the Cardiac Surgery and TOMCAT internal database systems. A total of 138 cases for period April 2009– March 2010 have been submitted to CCAD.

Heart failure – Liverpool Heart and Chest Hospital have participated since 1st August 2009. Cases submitted are for patients admitted with a primary diagnosis of heart failure. Cases are submitted directly onto CCAD on a regular ongoing basis. A total of 81 cases have been submitted for reporting period August 2009 – December 2009 (100%).

Heart rhythm management (pacing and implantable cardiac defibrillators) data is captured using TOMCAT and cases are submitted to CCAD on a regular ongoing basis. A total of 1,584 (pacing and implantable cardiac defibrillators cases) and 1042 (EPS cases) have been submitted for the reporting period January 2009 – December 2009 (100%). Data submission is due 31st May 2010 for calendar year 2009 data to CCAD.

The Myocardial Ischaemia National Audit Project (MINAP; myocardial infarction) cases are captured onto the TOMCAT internal database system and submitted monthly to CCAD on a regular ongoing basis. A total of 375 cases (100%) have been submitted for reporting period April 2009 – February 2010. Data submission is due 31st May 2010 for remaining 2009-2010 data to CCAD.

Cancer

National Lung Cancer Audit – data submission for patients first seen in 2009 is 30th June 2010. A total of 252 cases have been submitted for the reporting period January 2009 – December 2009 (100%). Final data submission is due 30th June 2010 for calendar year 2009.

Oesophago-gastric (stomach) cancer - 201 cases (100%) were identified matching the entry criteria of date and diagnosis between 1st October 2007 to 30th June 2009. These cases were either entered directly onto the Augis database or in some cases uploaded as a text file. As a tertiary centre we reported on surgery and pathology for operations done by 5 upper GI and thoracic surgeons.

National Confidential Enquiry into Patient Outcome and Death (CEPOD)

Parental Nutrition – 14 cases were identified by LHCH and reported to NCEPOD. NCEPOD selected 8/14 cases that matched enquiry criteria. 3/8 (38%) questionnaires and 1/8 casenotes (13%) were returned to NCEPOD.

Elective & Emergency surgery in the elderly: - 3 Cases were identified using CCAD national database that met the study criteria. 2/3 (67%) surgeon questionnaires and 1/3 (33%) anaesthetic questionnaires were returned to NCEPOD. (2/3 anaesthetists had left the Trust and NCEPOD were informed).

Peri-operative Care (pilot study) – 20 cases were submitted as required by the criteria for this pilot study.

Peri-operative Care (main study) – Study commenced 1st March for a 1 week period. 31 Data collection forms were completed by anaesthetists for procedures undertaken during the study period that met study criteria. Analysis and submission of data for this study is currently underway.

5.3.21 Other National Clinical Audits

The Department of Health has published a list of national clinical audits for inclusion in quality accounts (table below). In addition to those described above, a total of 25 other national audits and registries were listed, of which 24 are not NHS services that Liverpool Heart & Chest Hospital NHS Foundation Trust provides. During 2009-2010 Liverpool Heart & Chest Hospital NHS Foundation Trust participated in 1 national clinical audit in addition to those listed.

National Clinical Audits for Inclusion in Quality Accounts

Other National Audits /Registries	Relevant / Comments	Participation Yes / No
Paediatric Intensive Care Audit Network	Not relevant	No
The Vascular Society of Great Britain and Ireland	Not relevant - The Society focuses on non cardiac vascular disease, including diseases of peripheral arteries, veins & lymphatic	No
National Neonatal Audit Programme	Not relevant	No
National Diabetes Audit	Not relevant – Focuses on PCTs, GPs, Secondary care and specialist paediatric units	No
Intensive Care National Audit and Research Centre (Case Mix Programme (CMP) is an audit of patient outcomes from adult, general critical care units).	Other specialist units (neurosciences, multiple injury and cardiac) also participate. However Due to small numbers of participating units, it is not possible at this time to compare cardiothoracic units.	Future participation planned
Patient Outcomes in Surgery Audit	Procedures covered by the Audit are: total hip and knee replacements inguinal hernia repair removal of varicose veins Not relevant to LHCH	No
National Joint Registry (NJR)	Not relevant	No
UK Renal Registry (collects and analyses information on all patients receiving Renal Replacement Therapy)	Data collection for Renal units Not relevant	No
National Bowel Cancer Audit	Not relevant	No
National head and neck cancer audit	Not relevant	No
National Audit of Pulmonary Hypertension	Rare at LHCH. Patients are referred to a regional unit in Sheffield. Not relevant	No
National Hip Fracture Database	Not relevant	No
National Audit of Psychological Therapies for Anxiety and Depression	Not relevant	No
Trauma Audit and Research Network	Not relevant	No
NHS Blood & Transplant – intrathoracic; liver and renal transplants	Not relevant	No
NHS Blood & Transplant - Potential donor audit	Not relevant- From 01/04/06, Cardiothoracic Intensive Care Units have no longer been included.	No
National kidney care audit	Not relevant	No
National Sentinel Stroke Audit	Not relevant	No
National audit of dementia	Not relevant	No
National falls and bone health audit	Not relevant	No
Prescribing topics in mental health services	Not relevant	No
National comparative audit of Blood Transfusion- changing topics	Relevant	Yes
British Thoracic Society - Community Acquired Pneumonia in Adults NIV – Adults	Not relevant	No
College of emergency medicine: pain in children, fractured neck of femur, severe and moderate asthma	Not relevant	No
National mastectomy and breast reconstruction	Not relevant	No
National Audit of Continence Care	Not relevant	No

During 2009-2010 Liverpool Heart and Chest Hospital NHS Foundation Trust participated in 4 other national clinical audits not listed for inclusion (Table 2) relevant to NHS services that Liverpool Heart and Chest Hospital NHS Foundation Trust provides.

Other National Audits /Registries

Other National Audit	Relevant / Comments	Participation Yes / No
National Audit of Cardiac Rehabilitation	Relevant	Yes
National Health Promotion in Hospital Audit	Relevant	Yes
Royal College of Anaesthetists major complications of airways management in the UK	Relevant	Yes
UK Cystic Fibrosis Registry	Relevant	Yes

5.3.22 Other National Audits /Registries

The reports of 9 national clinical audits were reviewed by Liverpool Heart and Chest Hospital NHS Foundation Trust 2009-2010 and we intend to take the following actions to improve the quality of healthcare provided:

National Cardiac Surgery Audit – implement new national dataset and commence three monthly reporting.

National Percutaneous Coronary Intervention Audit – participate in national work to develop a mortality only prediction model and exploit links with the Myocardial Ischaemia National Audit Project.

Myocardial Ischaemia National Audit – roll out primary percutaneous coronary intervention to the rest of the Hospital's catchment area and continue to deliver excellent call and door to balloon times.

National Upper GI Cancer Audit and National Lung Cancer Audit - improve recording and tracking of clinical data by implementing a dedicated tracking data base.

National Heart Failure Audit - development and implementation of a heart failure pathway across primary, secondary and tertiary care.

National Congenital Audit - development of data validation process and procedures for congenital data working closely with CCAD

NCEPOD report adding insult to injury - "Acute Kidney Injury"

– introduce measures to ensure reagent strip urinalysis is performed on all emergency admissions

- develop risk assessment procedure for development of Acute Kidney Injury for all emergency patients

NCEPOD report Caring to the End - “Death in acute Hospitals”

-improve systems of communication between doctors and other health care professionals

- undertake and complete a trustwide documentation review

National Outpatients Survey – improve waiting times together with the quality and amount of information provided around the time of outpatient consultation.

The Trust has a clinical audit and effectiveness strategy which helps prioritise the use of resources between the national and local agenda. Our local clinical audit programme includes the work we do as part of major internal improvement initiatives such as Productive Ward, Patient Flow, Patient Safety First Campaign, Advancing Quality and the Care Bundles programme. In addition we support audits of the effectiveness of key policies such as consent and documentation and changes in practice as a result of isolated failures in care that have been the subject of root cause analyses.

The reports of 102 local clinical audits were reviewed by the provider in 2009-2010 and Liverpool Heart & Chest Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- Develop smoking cessation services incorporating NICE guidelines & DH Service & Monitoring Guidance 2009-2010
- Develop an education strategy for Trust staff in line with End of Life Care Strategy recommendations and Merseyside Cancer Network Palliative Education Framework
- Roll out Primary PCI service and continue the ongoing monitoring of “call” and “door” to balloon times
- Further training of professional groups regarding obtaining consent
- Improve reliability of risk assessments being performed to prevent injury from slips, trips and manual handling
- Improving the clarity of a number of Trust policies
- Review Trust documentation to reduce duplication and aid ease of use, whilst maintaining accurate records of the highest quality.
- Further embed use of the World Health Organisation surgical safety checklist
- Reorganisation of surgical wards and scheduled ward rounds to optimise senior led review of patients
- Improve compliance with key care bundles to reduce the risk of infection

Assurance regarding research

The number of patients receiving NHS services provided or sub-contracted by Liverpool Heart & Chest Hospital NHS Foundation Trust in 2009-2010 that were recruited during that period to participate in research approved by a research ethics committee was 805.

Compared to 2008/9, we have more than tripled our participation in studies supported by the National Institute of Health Research. This increasing level of participation in clinical research demonstrates Liverpool Heart & Chest Hospital NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Liverpool Heart & Chest Hospital NHS Foundation Trust was involved in conducting 35 clinical research studies. Liverpool Heart & Chest Hospital NHS Foundation Trust completed 14% of these studies as designed within the agreed time and to the agreed recruitment target. Liverpool Heart & Chest Hospital NHS Foundation Trust used national systems to manage the studies in proportion to risk. Of the 35 studies given permission to start, 75% were given permission by an authorised person less than 30 days from receipt of a valid complete application. Fourteen of the studies were established and managed under national model agreements and 17% of the 35 eligible research involved used a Research Passport. In 2009-2010 the National Institute for Health Research (NIHR) supported 14 of these studies through its research networks.

In the last three years, 14 publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

Research is an essential component of the Trusts activities. It provides the opportunity to contribute to the generation of new knowledge about whether new treatments or models of care truly deliver the improvements in quality anticipated.

Ongoing example projects include:

- Transcatheter Aortic Valve Implantation (TAVI) which seeks to offer patients thought too high risk for traditional surgery an alternative intervention which can alleviate symptoms and improve quality of life
- Whether antibiotic resistance can be avoided yet effectiveness maintained by reducing antibiotic course to two days rather than seven.

Those projects that do offer benefit can be implemented quickly for future patients, subject to the service the project evaluated being funded as part of routine NHS care.

Innovation – doing things differently or doing different things to achieve a step change in performance - is another important commitment the Trust makes to improving patient care. In 2010/11 the Trust will be providing an innovative community cardiovascular disease service for the residents of Knowsley. A suite of quality measures will be used to track the provision of high quality care in the delivery of a streamlined diagnostic and treatment pathway which includes lifestyle advice and rehabilitation.

The adoption of innovative practice is governed by the Trusts Clinical Audit & Effectiveness Committee who ensures new technologies are safe and effective before they are used to treat our patents. An example of an approved technology includes a new method for continuously measuring the blood glucose concentration of patients in our critical care area so that levels may be proactively managed, better outcomes achieved and costs of care reduced.

Assurances regarding goals agreed with commissioners

A proportion of Liverpool Heart & Chest Hospital NHS Foundation Trust income in 2009-2010 was conditional on achieving quality improvement and innovation goals agreed between Liverpool Heart & Chest Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The CQUIN indicators for Liverpool Heart & Chest Hospital NHS Foundation Trust in 2009-2010 were to:

1. Achieve our infection control targets (<=7 MRSA, <=25 Clostridium Difficile)
2. Improve the delivery of discharge summaries to General Practitioners within 48 hours of discharge
3. Reduce the percentage of patients readmitted as an emergency within 28 days of discharge to <=8%
4. Undertake patient experience surveys in all areas of the Trust
5. Improve the patients perception of mixed sex facilities
6. Develop a system to measure smoking prevalence, the provision of advice to stop smoking, and initiation of smoking cessation referral

£350,175 was conditional upon achieving the above quality improvement and innovation goals; Liverpool Heart & Chest Hospital achieved all goals (with the exception of slight (0.2%) underachievement of the readmissions target) and received full payment.

The CQUIN indicators for Liverpool Heart & Chest Hospital NHS Foundation Trust in 2010/11 are to:

1. Improve the responsiveness to the personal needs of patients
2. Improve the assessment of risk of venous thromboembolism
3. Improve the outcomes of care in heart attack, heart failure and bypass grafting patients (Advancing Quality)
4. Participate in relevant Quality, Innovation, Productivity & Prevention work streams within the City of Liverpool
5. Deliver all relevant High Impact Actions for Nursing & Midwifery
6. Reduce the percentage of patients readmitted as an emergency within 28 days of discharge
7. Improve discharge planning and communication
8. Achieve targets to record smoking prevalence, deliver smoking cessation advice and referral
9. Improve care for patients with acute coronary syndromes
10. Complete a comprehensive quality report for review by our specialised commissioners.

Further details of the agreed goals for 2009-2010 and for the following 12 month period are available on request from Dr Mark Jackson, Associate Director – Quality Improvement (email Mark.Jackson@lhch.nhs.uk or telephone 0151 600 1332).

Assurances regarding what others say about the provider

Liverpool Heart & Chest Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

Liverpool Heart & Chest Hospital NHS Foundation Trust has received no conditions on registration.

The Care Quality Commission has not taken enforcement action against Liverpool Heart & Chest Hospital NHS Foundation Trust during 2009-2010.

Liverpool Heart & Chest Hospital NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission and the last review was on 8th December 2009. The CQC's assessment of the Liverpool Heart & Chest Hospital NHS Foundation following that review was that there was no evidence that the trust has breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare-associated infection.

Liverpool Heart & Chest Hospital NHS Foundation Trust has not been invited to participate in special reviews or investigations by the Care Quality Commission during 2009-2010.

Assurances regarding data quality

NHS Number and General Medical Practice Code Validity

Liverpool Heart & Chest Hospital NHS Foundation submitted records during 2009-2010 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.8% for admitted patient care;
- 98.6% for out patient care;

.

Which included the patient's valid General Medical Practice Code was:

- 98.9% for admitted patient care;
- 99.8% for out patient care;

Note: Liverpool Heart & Chest Hospital NHS Foundation Trust does not have an accident and emergency department, so A&E indicators do not apply.

Information Governance Toolkit attainment levels

Liverpool Heart & Chest Hospital NHS Foundation Trust score for March 2010 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 82%.

Clinical Coding Error Rate

Liverpool Heart & Chest Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary diagnoses incorrect – 2.5%
- Secondary diagnoses incorrect – 1.1%
- Primary procedures incorrect – 0.5%
- Secondary procedures incorrect – 0.6%

It is important to note that results should not be extrapolated beyond the actual sample audited; the 2009-2010 audit included cases from Cardiology, Thoracic procedures & disorders, and Percutaneous Coronary intervention (0-2 stents).

5.4 Review of Quality Performance

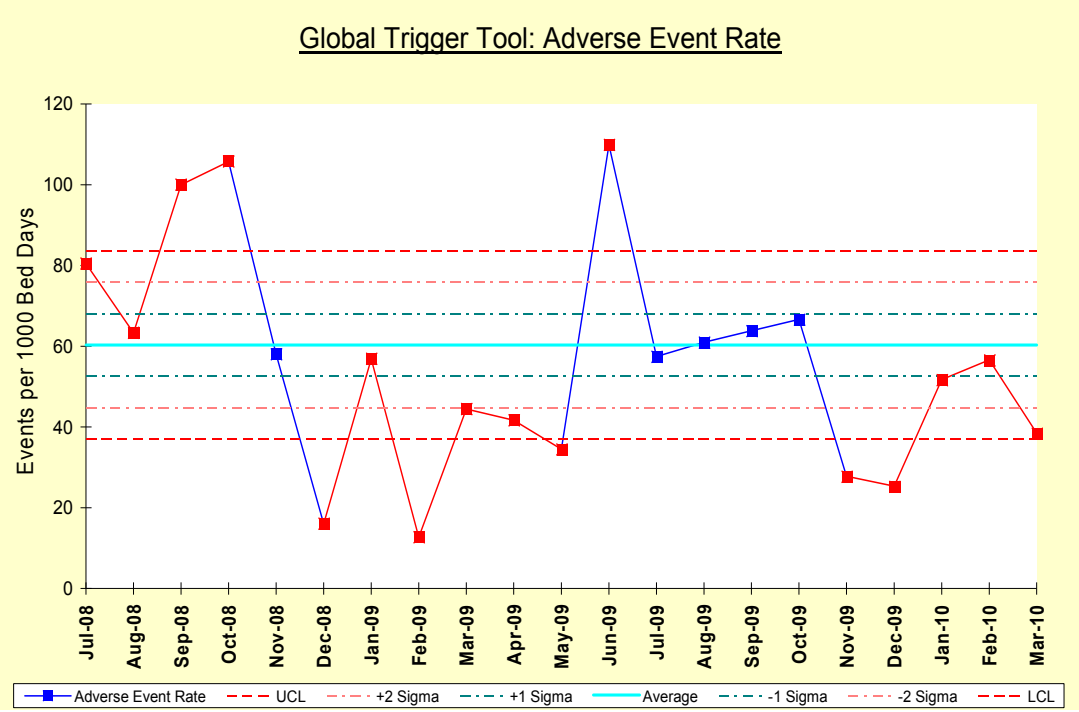
This section of the quality account presents an overview of performance in areas not selected as priorities for 2010/11.

Presented are:

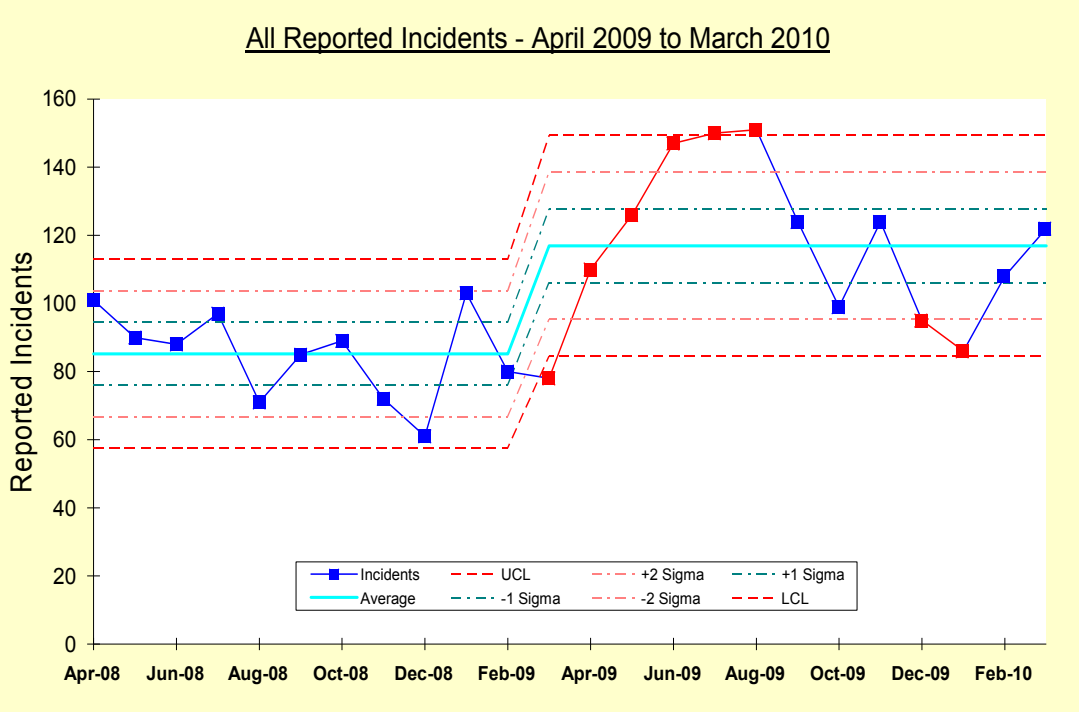
- Quantitative metrics, that is aspects of safety, effectiveness and patient experience which we measure routinely to assure ourselves of the quality of care provided, and
- Qualitative findings, that is themes emerging from comments provided by patients who have used our services

Quantitative Metrics

Safety			
Metric	Adverse events (rate per 1000 bed days)	**Organisation Wide or Service Specific**	Corporate
Derived From	Trust	**Why metric chosen**	Harm occurring during hospitalisation
How is data collected	Casenote review using standardised global trigger tool methodology but no standard national definitions of hard (guidelines only)	**Improvements planned**	Reduction in complications following treatment
LHCH 2009-2010	55.5	**LHCH 2008/09**	58.2

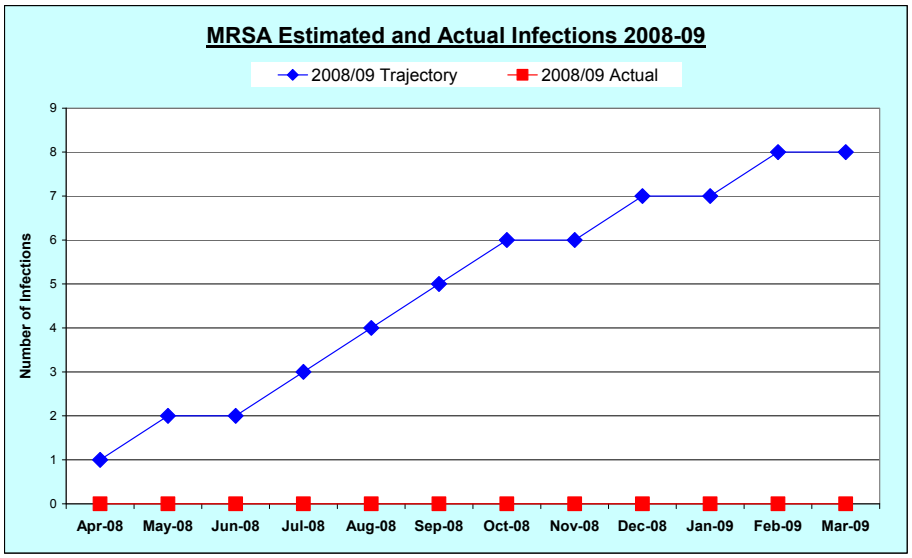


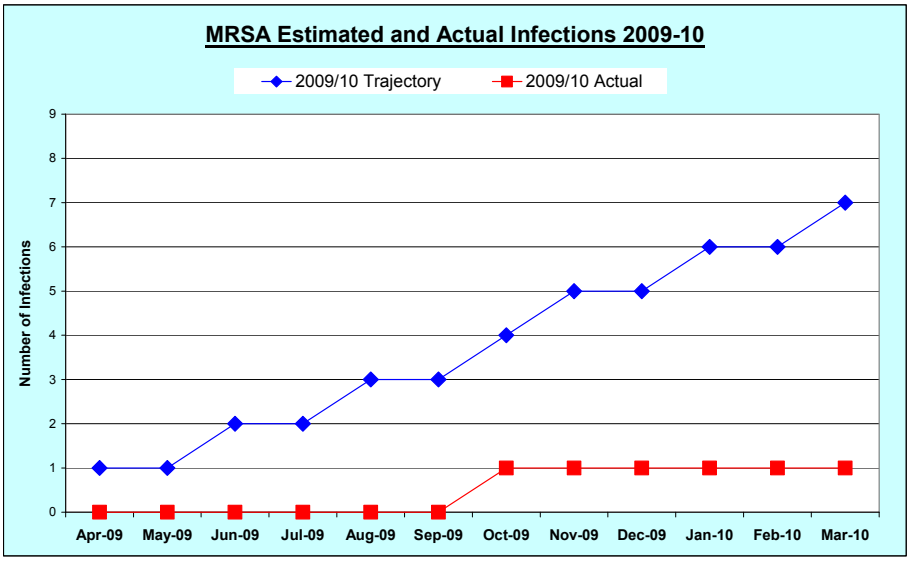
Safety			
Metric	No. Incidents reported[2]	**Organisation Wide or Service Specific**	Corporate
Derived From	Trust	**Why metric chosen**	Harm occurring during hospitalisation
How is data collected	Trust incident reporting system. Results submitted to National Patient Safety Agency. National standard definitions used for most incidents.	**Improvements planned**	Reinforce reporting culture
LHCH 2009-2010	1183	**LHCH 2008/09**	811



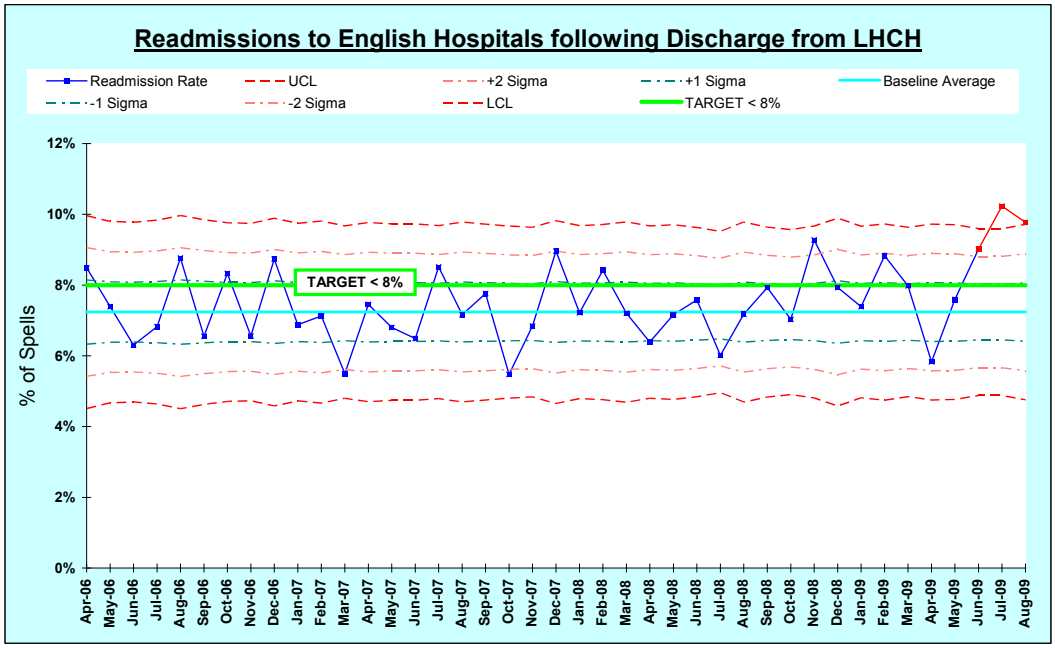
[2] A higher number of reported incidents reflects a healthy reporting culture and is a sign of a open and learning organisation

Safety			
Metric	No MRSA bacteraemias	**Organisation Wide or Service Specific**	Corporate
Derived From	Trust	**Why metric chosen**	Concern of patients; Department of Health priority
How is data collected	Monthly surveillance reported to Health Protection Agency. National definitions of bacteraemia applied.	**Improvements planned**	Learn from each occurrence
LHCH 2009-2010	1	**LHCH 2008/09**	0

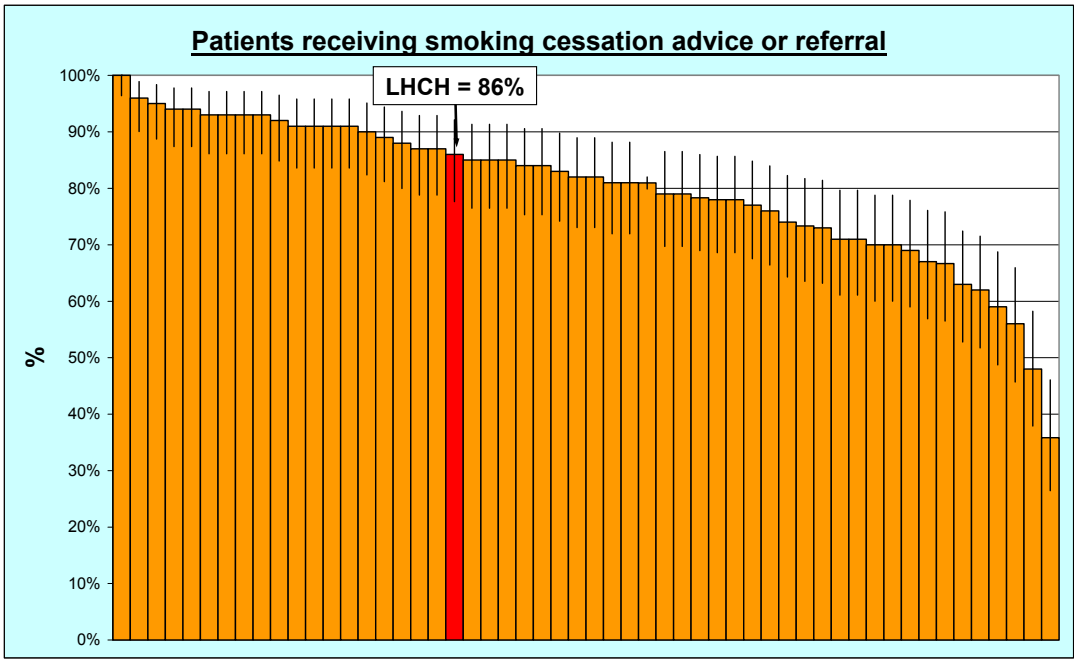




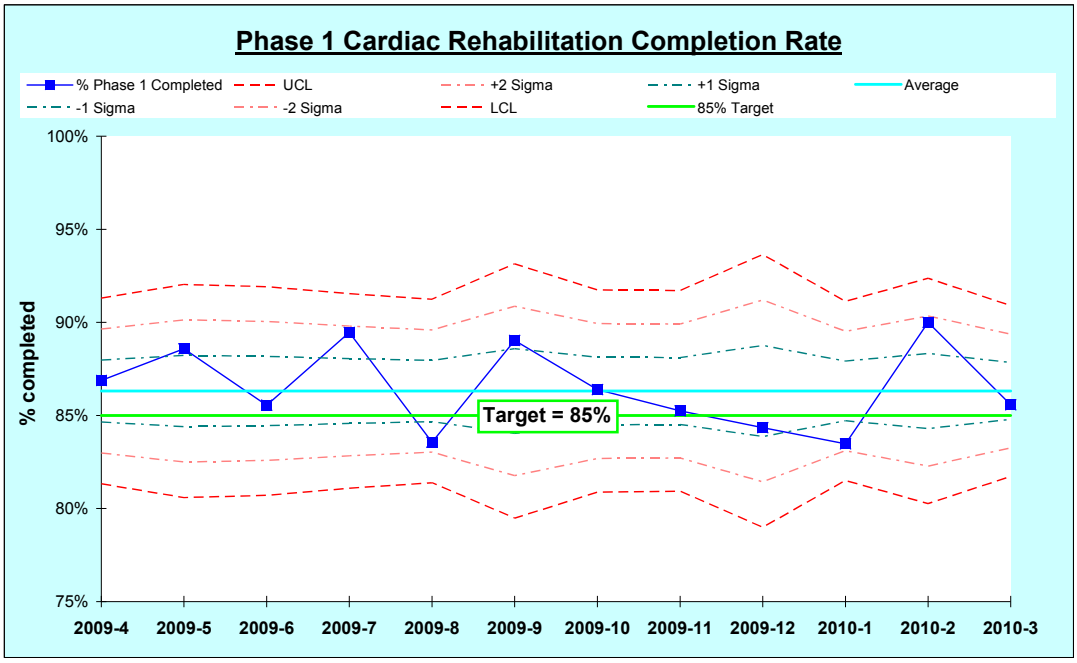
Effectiveness			
Metric	Readmission rate (%)	**Organisation Wide or Service Specific**	Corporate
Derived From	Trust	**Why metric chosen**	Reduces patient experience
How is data collected	Dr Foster benchmarking system. National definition of readmission applied, but only includes readmission to English hospitals.	**Improvements planned**	Care right first time and risk reduction strategies
LHCH 2009-2010	8.4% (Apr-Sep10)	**LHCH 2008/09**	7.5%



Effectiveness			
Metric	% patients receiving smoking cessation advice or referral	**Organisation Wide or Service Specific**	Corporate
Derived From	Patient	**Why metric chosen**	Promotes recovery
How is data collected	LHCH contribution to National Health Promotion in Hospitals Audit. Data loaded onto bespoke webtool. National definitions applied drawn from audit.	**Improvements planned**	Brief intervention training, improved referral to cessation services
LHCH 2009-2010	86% of eligible patients offered smoking health promotion	**LHCH 2008/09**	Not available

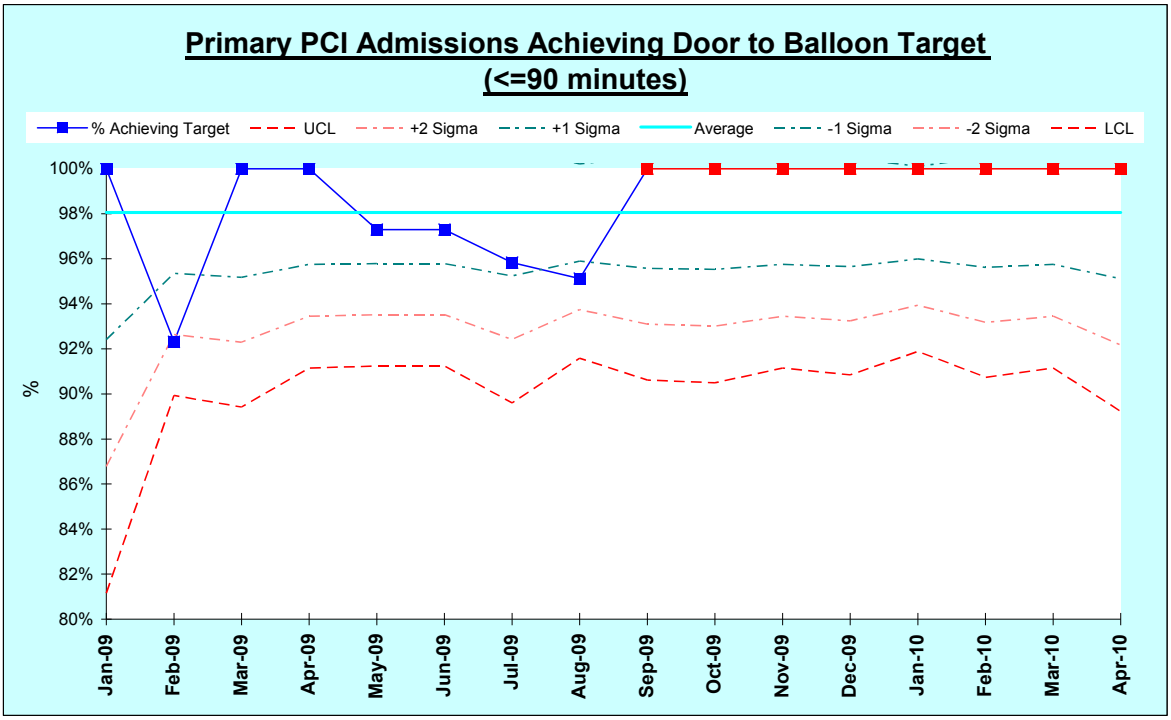


Effectiveness			
Metric	% patients receiving Phase one Cardiac rehabilitation	**Organisation Wide or Service Specific**	Corporate
Derived From	Patient	**Why metric chosen**	Promotes lifestyle change
How is data collected	LHCH contribution to national audit of cardiac rehabilitation collected into in house electronic database. National definition of definition of phase one rehabilitation applied.	**Improvements planned**	Improve capacity of service
LHCH 2009-2010	87%	**LHCH 2008/09**	62%



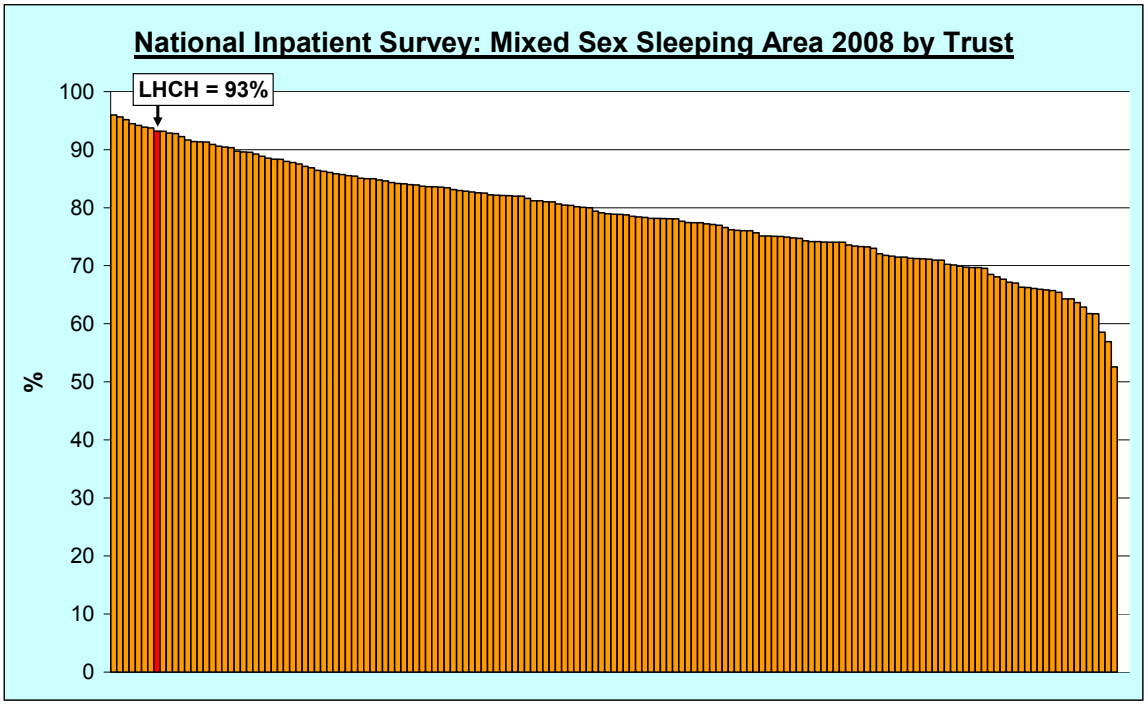
Effectiveness			
Metric	% patients with heart attack receiving treatment within 90 minutes of arrival (door to balloon time)	**Organisation Wide or Service Specific**	Service
Derived From	Trust	**Why metric chosen**	New service measure
How is data collected	LHCH contribution to myocardial infarct national audit project (MINAP) collected into in house electronic database. National definition of	**Improvements planned**	Learn from each breach

	performance measures used from MINAP.			
LHCH 2009-2010	99%	**LHCH 2008/09**	96%	



Patient Experience			
Metric	% patients who did not have to share a sleeping area with patients of the opposite sex.	**Organisation Wide or Service Specific**	Corporate
Derived From	Commissioner	**Why metric chosen**	National priority
How is data collected	LHCH contribution to national patient survey. National definitions applied from National In-Patient Survey.	**Improvements planned**	Improved estate
LHCH 2009-	89.5% **(Unadjusted**	**LHCH 2008/09**	93.2%

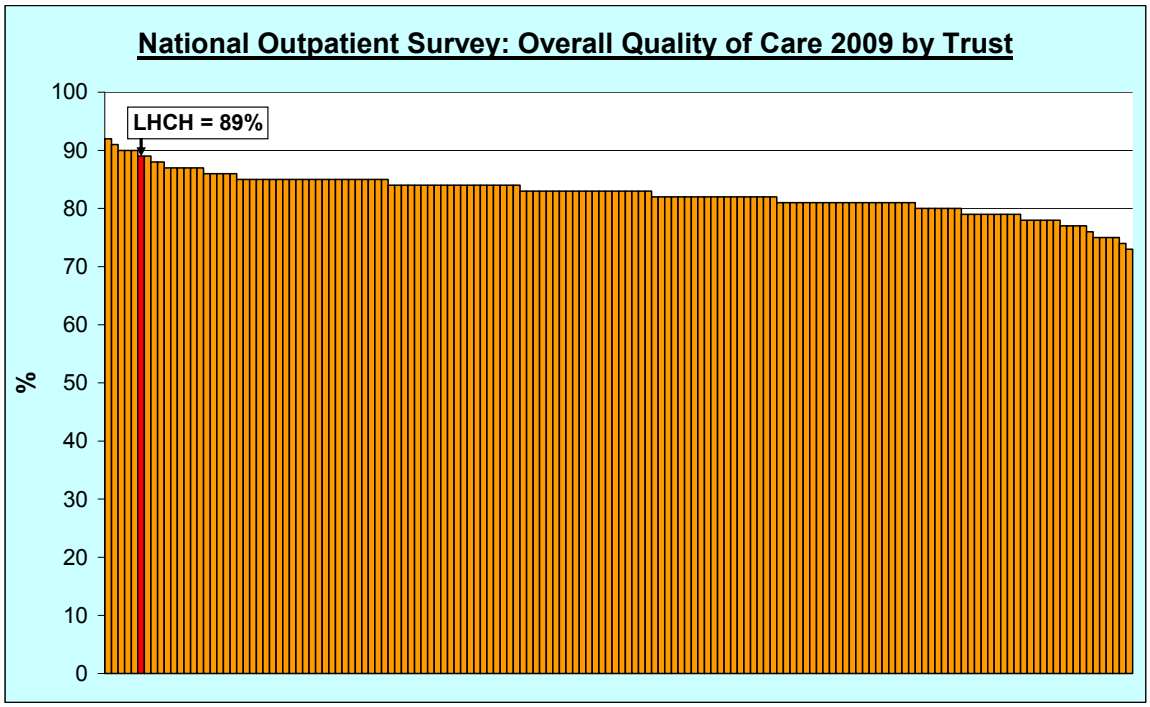
2010	**figure, awaiting external refinement by Picker UK)**			



Note: Performance differs from that reported in the Trusts 2008/09 quality report in order to align with Department of Health national priority.

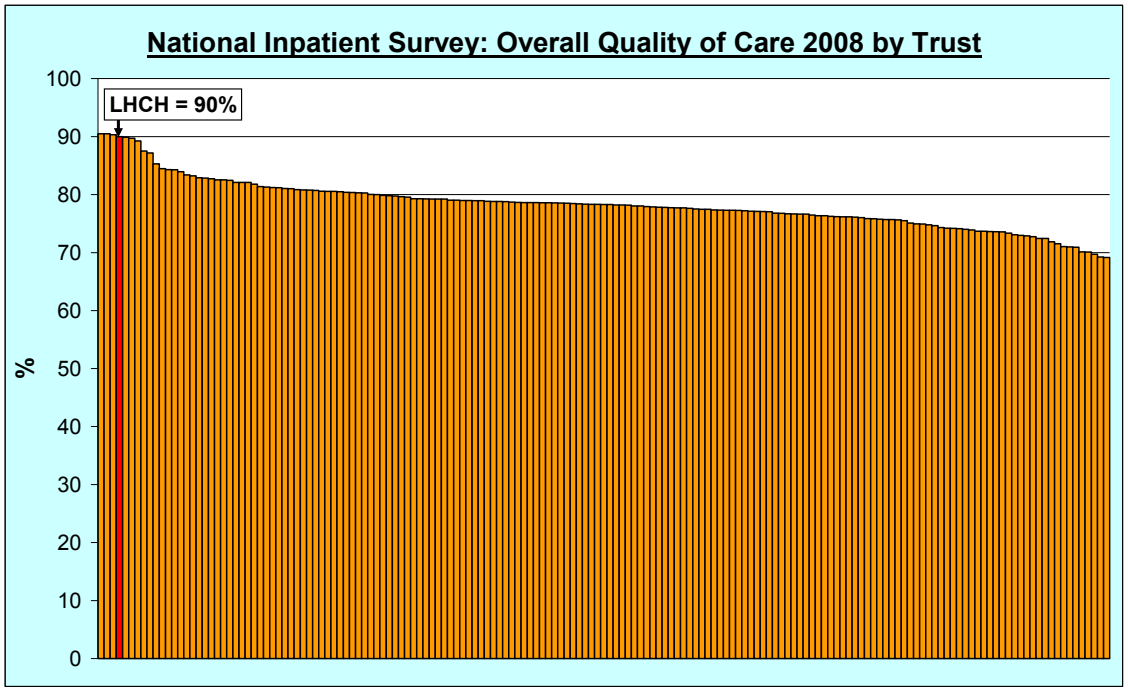
Patient Experience			
Metric	% patients reporting good or excellent overall quality of care – Outpatients	**Organisation Wide or Service Specific**	Corporate
Derived From	Trust	**Why metric chosen**	Composite indicator
How is data collected	LHCH contribution to national patient survey. National definitions applied from National Out-	**Improvements planned**	Patient experience delivery plan

	Patient Survey.			
LHCH 2009-2010	89%	**LHCH 2008/09**	88% (2005)	



Patient Experience				
Metric	% patients reporting good or excellent overall quality of care– Inpatients	**Organisation Wide or Service Specific**	Corporate	
Derived From	Trust	**Why metric chosen**	Composite indicator	
How is data collected	LHCH contribution to national patient	**Improvements planned**	Patient experience delivery plan	

	survey. National definitions applied from National In-Patient Survey.			
LHCH 2009-2010	96% **(Unadjusted figure, awaiting external refinement by Picker UK)**	**LHCH 2008/09**	90%	



Qualitative Findings

The themes below have been derived from feedback received from patients who have participated in the 2009 in-patient and out-patient national surveys. The top three good aspects of our services our services that have led to a positive patient experience are presented together with the top three aspects of our services that need improvement. Each theme is supported by a direct quote from a patient.

Aspects of our service that provided a positive patient experience

In-Patient Survey		Out-Patient Survey	
Theme	**Quote**	**Theme**	**Quote**
Excellent care	"The care and response given to me was excellent. I can only thank all the staff for caring for me"	Excellent care	"All aspects of clinical care administered in OPD is excellent considering the number of patients throughout and especially the amount of personal care & help needed by patients attending. It has excellent standards of care"
Excellent staff	"I would like to take this opportunity to thank all doctors, nurses & staff at the LHCH for all their excellent care & support during & after my stay in hospital. They were all totally fantastic and always put me at ease in such a stressful time"	Excellent staff	"As most people I normally hate hospitals but every time I have been to the OPD the doctors and staff are just the best and make you feel just great"
Life saving	"LHCH saved my life - thank you very much"	Helpful	"I have always found the staff very helpful and pleasant. When attending the LHCH clinic the staff make you feel that they have you best interests at heart"

Aspects of our service that require improvement

In-Patient Survey		Out-Patient Survey	
Theme	**Quote**	**Theme**	**Quote**
Food	"The food left a lot to be desired"	Site geography	"I found the walk to the department from the entrance too far to walk for patients with heart or breathing difficulties"
Discharge	"Medications that was put on was confusing, nurses had to speak to doctors to find out, this took hours, to sort. I was taken to the discharge reception and left waiting for a discharge interview over an hour. It did not happen"	Waiting times	"My past 2 appointments have had lengthy waiting times - approx 1.5-2 hours which is frustrating when I travel from North Wales. It makes it a very long day so some information about waiting times would be better rather than sitting and waiting wondering what is going on!"
Communication	"When I had returned home I had cause to contact the hospital because my condition had worsened. I did not feel my fears and concerns were dealt with in a helpful way. I eventually ended up in the RLUH"	Administration	"The letter for this appointment just stated it was for pre-op tests which I had undergone 2 months before and so I thought it was just another round of tests (bloods, lung capability, ECG, etc) so I told my wife to stay at home. As it turned out, the appointment was more to do with the operation and if I had know this beforehand I would have liked my wife to have attended with me"

Improvements planned

- Food – We will be placing a new catering contract early in 2010/11. This will include the delivery of food in new and innovative ways.
- Discharge & Communication – These issues have been specified as priorities for 2010/11 (see above).
- Site geography - Improved signage to Out Patients Department is being addressed by signage group. The Trust is currently exploring the possibility of opening additional entrance located adjacent to the Out Patients Department.
- Waiting times – Our Corporate Matron now undertakes regular review of waiting time data and meets with individual clinicians to discuss any issues.
- Administration - Letters have been re-worded to clarify the purpose of our clinic appointments.

Metrics against Department of Health national priorities and performance against Healthcare Commission national core standards

National Targets and Regulatory Requirements	2009-2010	2008/09	Target
Healthcare Commission core standards and national targets met	24/24	24/24	24/24
Clostridium Difficile – year on year reduction (to fit the trajectory for the year as agreed with PCT – assumed a 15% reduction if no level agreed in a contract)	15	18	<=25
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level (assumed target is 50% of 2003/04 if no level agreed in a contract)	1	0	<=7
Screening all elective in-patients for MRSA	138%	76% (Sep08 – Mar09)	100%
Maximum waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspected cancer referrals	99%	100%	93%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	98%	100%	96%
Maximum waiting time of 31 days for subsequent treatments for all cancers	100%	N/A	94%
Maximum two month wait from referral to treatment for all cancers	89%	92%	85%
For admitted patients, maximum time of 18 weeks from point of referral to treatment	94%	91%	90%
For non-admitted patients, maximum time of 18 weeks from point of referral to treatment	97%	95%	95%

Statements of Local Involvement Networks (LINkS), Overview & Scrutiny Committees and Primary Care Trusts

a) Statement from the Commissioning Primary Care Trust

As Director for Service Improvement and Executive Nurse in Liverpool Primary Care Trust I can confirm that to the best of my knowledge this is a true and accurate reflection of the 2009-2010 progress Liverpool Heart & Chest has made against the identified quality standards. The Trust has complied with all contractual obligations and has made good progress over the last year with evidence of significant improvements in key quality measures.

Liverpool PCT is supportive of the process that Liverpool Heart and Chest Hospital Trust has taken to engage with patients, staff and stakeholders in developing a set of quality priorities and measures for 2010/11, and applaud the continued commitment to improvement.

We find the submitted quality account to represent an appropriate level of effort and areas of focus for service improvement.

Trish Bennett
Director for Service Improvement & Executive Nurse

b) Statement from the Health Services Consultative Committee (Isle of Man)

I have read the above Account forwarded to HSCC by Dr Jackson. I have also been apprised, by the Isle of Man Department of Health, of a favourable and complimentary response by our senior medical personnel to the Account.

Therefore, I, as Chairman and on behalf of HSCC, am content that your service, as experienced by patients referred to Liverpool Heart & Chest Hospital NHS Foundation Trust from Noble¹s Hospital, Isle of Man, is both managed and delivered to commendable standards.

We thank you for the provision of specialised and advanced procedures which cannot be done on the Island. We look forward to receiving future Accounts and trust that the priorities you have set your teams will be realised and subsequently detailed for us to read.

Dr Linda M Cottier
Chairman HSCC

c) Statements from Local Involvement Networks (LINks)

Liverpool:

Due to time constraints this year, the Liverpool LINk Core group has been unable to consult with the wider LINk membership when compiling a statement for this Quality Account. The statement below is therefore made by elected Core Group members based on the available evidence. Liverpool LINk aims to provide a more representative statement in future years led by our designated Health and Social Care Ambassador to Liverpool Heart and Chest Hospital NHS Foundation Trust.

Liverpool LINk supports the decision to continue to focus on the existing priorities – where they remain – and the choice of new priorities as identified. Liverpool LINk is particularly interested in planned improvements to discharge instructions as this is in line with our interest in 'joined up' health and social care pathways within a Healthy City approach to health and wellbeing.

Liverpool LINk is also supportive of the way in which staff and patients have been involved in setting quality priorities – including improving the patient experience – and would like to see even more emphasis on letting patients know how their input has changed things.

On the basis of the draft Quality Account as presented, Liverpool LINk has not seen any evidence which leads it to doubt the Trust's ongoing commitment to providing quality services and to improvement and positive innovation wherever possible. Liverpool LINk welcomes its developing relationship with Liverpool Heart and Chest Hospital NHS Foundation Trust, looks forward to following its progress against its chosen quality priorities and hopes to continue to have a positive and productive working relationship with the Trust in the future.

Sefton:

Sefton LINk found it difficult to judge whether this account was representative as we felt it was poorly structured and quite confusing. We felt the account supports Sefton LINk's focus on existing priorities. The discharge planning process has improved and corresponds with Sefton LINk work plan and we are pleased with the involvement of patients. However, we did find the structure of the accounts difficult to follow.

In general, we felt that improvements in services were identified but additional details and explanation of how those improvements were achieved and how they will continue to be monitored were not clear. We could find no mention of specialist liaison or British Heart Foundation nursing services. Increased opportunities for nurses were highlighted but it remains unclear whether this suggests nurses will be given increased discharge authority.

With regard to Priority 3 in the report "reduce the level of surgical site infections" we are concerned that this appears to refer only to patients recovering from coronary artery bypass procedures and we wonder why other patient group data is not included.

Sefton LINk were pleased to note that the Quality Accounts share our focus on changing priorities and there are positive points to be made on discharge planning. We did think improvement could be made in the presentation of the accounts and

clarification of successes should be made clearer – for example, how success was achieved and how it will continue to be monitored.

d) Statement from the Trusts Council of Members Sub-Group for Quality, Safety & Patient Experience

The Quality & Safety sub-group was created in September 2009 by the Council of Members with a specific term of reference to represent the Foundation Trust membership in the identification of priority areas related to quality and safety for inclusion in the Trust Quality Account. In April 2010 we formally merged with the Patient Experience Council of Members sub-group due to a commonality of issues.

Since our inception, we have held a total of three meetings, and engaged in a comprehensive survey of the Foundation Trust membership to identify issues of importance to them. These issues were reviewed at the April 2010 meeting and we heard how many have influenced the priorities selected for inclusion in this quality account. We agree with the overall selection of priorities and the development of the account generally.

We are sure that the organisation is fully committed to the needs of patients and is a quality hospital. Our involvement with the public has developed over time and we feel that we (as a sub-group with a specific remit) are beginning to be known in the community.

Enabling Quality Management Systems

The delivery of high quality care depends as much on the workforce, leadership and information technology as it does upon the systems and processes that lead to the delivery of direct patent care. What follows is a short summary of our position with respect to some of these key "enabling" systems:

Planning & developing the workforce

- The Trust has almost completed the development of a comprehensive education strategy which will ensure the training, development & learning required to deliver our planned service and care improvements is identified and is deliverable.
- The Trust has demonstrated a large increase in the percentage of staff receiving an appraisal (Q8a 2008 – 52% vs 2009 75%; national average 68%) and a small increase in the percentage of staff reporting receipt of an effective appraisal (Q8b 2008 – 57% vs 2009 61%; national average 56%).
- Medical staff responsible for assessing the performance of peers have undertaken appraisal training. In 2010/11 the Trust will be using the self assessment tool AQMAR (Assessing the Quality of Medical Appraisal for Revalidation) with a view to producing a development plan.
- The Trust has workforce plans in place to manage gaps between the future demand & supply of our workforce, and includes how services could be delivered differently (for example we are introducing assistant practitioners to support nursing staff and reskilling existing staff using the modern apprentice scheme). The plans however do not include cross organisational working along patient pathways, but this will become a feature of future plans as the Trust expands its services into traditional primary and secondary care settings. These plans are subject to bi-

annual review by the Workforce Committee, an assurance committee of the Board of Directors.

- The Trust has improved its performance in terms of key workforce statistics:

Workforce Statistic	Performance 2008/09	Performance 2009-2010
Sickness-Absence (%)	5.6%	3.9%
Turnover of Staff (%)	11.4%	9.6%
Spend on Temporary Staffing (£)	£1,445,323	£1,359,012

These statistics compare very favourably with other hospitals in the North West (we have the second lowest rate of sickness-absence for example). This is all good news for patient care. Having our staff present more of the time rather than having to bring in temporary staffing results in more consistent and safer care as staff are familiar with our systems and procedures. There is also a impact on staff satisfaction and morale in that the pressure felt by staff in covering for absent colleagues is also reduced.

- The Trust provides training opportunities for many student nurses and other professionals allied to medicine. Robust systems are in place to gather feedback from students during their time in the Trust, with any deficiencies reported being corrected quickly. This feedback is shared with the appropriate local Higher Education Institution (HEI). Improving these systems and ensuring future workforce plans are used to design new training courses has been raised as an improvement opportunity by our HEI's and work will be done in 2010/11 to identify the number of students who have:
    - Failed during placement at our Hospital
    - Progressed to fitness to practice panels at the HEI

  During the academic year September 2008 to September 2009, 8 students did not complete their course (4 discontinued; 4 suspended).

Staff Experience

- Each year, the Trust participates in the National Staff Survey which asks of staff key questions about their job and the systems around them to perform well. The table below sets out a few of these key indicators relevant to the staff experience:

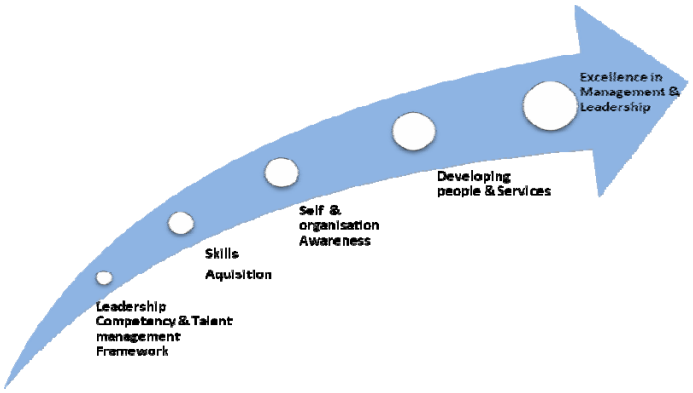
Staff Survey Statistic	Performance 2008/09	Performance 2009-2010
Staff agreeing we are meeting physical and mental health needs (%)	Question not asked in 2008	44%
Staff agreeing we are meeting health	Question not asked in 2008	50%

& wellbeing needs (%)		
Staff agreeing we are meeting safety needs (%)	77%	82%

- The Trust has in place a public health strategy which includes some aspects of supporting the health & well-being of staff. As a consequence of the publication of the Boorman review of staff health and wellbeing however, a dedicated health & wellbeing strategy is being developed which will be much stronger on how Liverpool Heart & Chest Hospital NHS Foundation Trust can become an exemplary health and wellbeing employer and realise the benefits this brings to quality of care and productivity.

Leadership

Good leadership provides the will and resources necessary to improve patient care and the patient experience, and as such, good leaders must exist at every level of the organisation. Recognising this, Liverpool Heart & Chest Hospital NHS Foundation Trust launched in 2009 the Excellence in Management and Leadership Programme. This aims to build and strengthen management & leadership skills for all new and existing managers across the Trust by providing a tailored approach to support career development, talent management, and succession planning for the future. It comprises a three tiered, structured programme of learning for strategic, operational, first line & new leaders with a range of learner led interventions will be linked to individual development needs defined against the leadership competency and talent management frameworks.



Staff Engagement

- We have engaged with staff throughout in the development of this quality account. This has been achieved via the Directorate senior leadership teams who have in turn involved front line staff using a variety of meetings and events.
- Front line staff are leading many of our improvement initiatives. For example:
  - Our pre-assessment nurses and discharge team are designing systems of prioritising patients at high risk of readmission so effective measures can be taken in hospital and in the community to prevent occurrence.

- o A theatre nurse introduced a fasting guideline prior to pacemaker surgery which is now going to be rolled out into the cardiac catheterisation laboratories.
- o A critical care nurse introduced a very visible early discharge planning board in our post operative critical care unit, which helps prioritise those patients who are ready for early discharge and reduces unnecessary stay.
- o A ward nurse identified that we could improve the quality of our dressing packs by switching supplier which was not only cheaper but better quality. All staff nurses prefer the new pack.

Our staff rate the quality of care they deliver on behalf of Liverpool Heart & Chest Hospital NHS Foundation Trust highly, as judged by the following indicators drawn from the annual staff survey:

Staff Survey Statistic	Performance 2008/09	Performance 2009-2010
Staff agreeing they feel satisfied with quality of work and patient care they are able to deliver (%)	72%	84%
Staff agreeing they are satisfied with their job (maximum score=5)	3.33	3.54
Staff agreeing they are able to contribute to improvements at work (%)	55%	59%

- Moreover, these scores are improving.

Link between Quality & Resources

Information resources

In order to improve, you have to know how you are doing. This requires robust data and appropriate analysis. The Trust is fortunate in being especially strong in this area.

The Trust employs a number of information systems which are constantly used for quality improvement purposes. These include:

1. The Patient Administration System (PAS)
2. The data warehouse, which integrates a number of clinical information systems with the PAS
3. Service line reporting, which brings together administrative, clinical and financial information so that productivity as well as quality can be assessed.

4. Clinical databases, populated by the clinicians at the point of delivery of clinical care which capture detailed data about a patients disease and treatment

Each system has a number of internal and external audit & verification processes in place to ensure the data from the systems that is used to supporting decision making is accurate. The Trust plans to improve these systems further in 2010/11 and make the quality of the data much more transparent.

The Trust uses a number of dashboards - easy to understand graphical summaries of complex information - which are updated regularly, at least monthly for use by key users in the Trust. A dashboard exists for the Board, Clinical Quality Committee, the Directorates and the Wards.

The Trust uses a number of readily available benchmarks, but suffers from the specialist nature of its work and the consequent lack of comparability with many. In order to improve the effectiveness of benchmarking, the Trust:

- Uses national clinical audit reports from the specialist services it provides
- Is a member of the National Cardiothoracic Benchmarking Collaborative where information collected is highly relevant and benchmarks produced much more useful.

In 2010/11, the Trust plans to improve its capacity and capability in benchmarking through purchase of an appropriate system together with freeing up the personnel to invest time in benchmarking work.

Quality of the Environment

Quite rightly, patients worry about the quality and cleanliness of the hospital environment to which they are admitted. At our Trust, this is currently measured annually by the Patient Environment Action Team, which comprises staff from nursing, support services, estates and customer services together with patient representation that randomly inspect key areas of the Trust to ensure high standards are being maintained. The Trust score for 2010 was:

Environment – Excellent
Food – Excellent
Privacy & Dignity – Good

Additionally, the Trust also conducts mini PEAT assessments quarterly and Matrons rounds monthly. Results are discussed at the Patient Experience Committee, an assurance committee of the Board and action taken as appropriate.

Aligning Quality with Wider Business Strategy

The delivery of safe, effective, high quality care with an excellent patient experience is fundamental to the business strategy of the Trust. Indeed, its financial viability (reflected in cost improvement programmes and income recovery from CQUIN for example) in future years is dependent upon it. But our influence and desire to do more will extend much further in 2010/11 through the Trust:

- Delivering community cardiac services for Knowsley Primary Care Trust. Income from this contract is dependent upon the delivery of a suite of quality indicators.

- Assuming lead responsibility for the implementation of all cardiac related pathways in Liverpool. This provides an excellent opportunity to redesign current pathways to be efficient, cost effective and most importantly high quality.

We remain forward looking as a Trust and annually revise our business plans and strategies taking account of new opportunities to become unassailable in the delivery of an excellent patient experience. This includes regular dialogue with our partners in the health and social care sectors so that Liverpool Heart & Chest Hospital NHS Foundation Trust can play its part as a key member of the local health economy.

Acknowledgements

The Board of Directors of the Liverpool Heart & Chest Hospital NHS Foundation Trust acknowledges the following who have directly contributed to the content of this quality account:

- Clinical and managerial staff of the Liverpool Heart & Chest Hospital NHS Foundation Trust
- Leigh Thompson - Head of Clinical Quality Improvement, Liverpool Primary Care Trust
- Trish Bennett - Director of Service Improvement & Executive Nurse, Liverpool Primary Care Trust
- The Council of Members Quality, Safety & Patient Experience Subgroup:
    - Carol Birch
    - David Hicks
    - Debbie Mawson
    - Pat Firby
    - Judy Wright
    - Ken Blasbery
    - Mandy Jones
    - Bashir Matata
    - Menna Wyn-Harland
    - Roy Stott
    - Stephanie Greenway
    - Vera Hornby

- Stakeholders who participated in the prioritisation event:
    - Dr Alison Rylands - Director of Public Health, North West Specialist Commissioning
    - Dr Rob Barnett General Practitioner and Secretary - Liverpool Liverpool Medical Committee
    - Karen Keating - Directorate General Manager - Medicine Wrexham Maelor Hospital
    - Stephen Saltissi - Clinical Director, Royal Liverpool & Broadgreen University Hospitals
    - Linda Phippard - Service Manager, Royal Liverpool & Broadgreen University Hospitals
    - Roy Dixon - Manager for Cardiology, Aintree Hospital
    - Lynda Carey - Head of Quality Primary Care (Nursing), Liverpool Primary Care Trust

- Sarah Marshall - Clinical Governance Co-ordinator, Liverpool Primary Care Trust
- Tony Novotny - Quality Project Manager, Liverpool Primary Care Trust
- Sue Williams - Head of Clinical Quality, Sefton Primary Care Trust
- Sylvia Carney - Director of Nursing & Therapies, Liverpool Primary Care Trust
- Dot McCarthy – Chair, Broadgreen Heart Support Group
- Mrs Carol Law, Cystic Fibrosis Advocate
- Linda Meredith - Associate Dean, University of Chester
- Menna Wyn Harland - Head of Practice Learning Support, John Moores University

- Liverpool Local Involvement Network (LINk) Core Group Members:
  - Dr Eric Toke (Liverpool LINk Health and Social Care Ambassador to Liverpool Heart and Chest Hospital NHS Foundation Trust)
  - Mike Marsh (Chair, Liverpool LINk)
- Our patients and carers who have participated in our programme of surveys

How to Provide Feedback on the Quality Account

Liverpool Heart & Chest Hospital NHS Foundation Trust would be pleased to either answer questions or receive feedback on how the content and layout of this quality account can be improved. Additionally, should you wish to make any suggestions on the content of future reports or priorities for improvement we may wish to consider then please contact Dr Mark Jackson, Associate Director – Quality Improvement (email Mark.Jackson@lhch.nhs.uk or telephone 0151 600 1332).

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

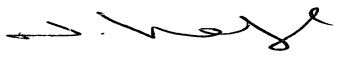
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the quality report presents a balanced picture of the foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

NB: sign and date in any colour ink except black



...24th May 2010 ..Date.....Chairman

...24th May 2010 Date.....Chief Executive

6. Our Board of Directors

6.1 The key functions of the role of the Board of Directors are:

- Compliance - ensuring compliance with the Terms of Authorisation, Care Quality Commission (CQC) regulations and Monitor's compliance framework

- People and the Organisation – developing Board performance, ensuring appropriate quality of leadership and plans for succession, effective membership engagement and monitoring capacity and capability to execute strategy

- Strategic Development – setting the Trust's strategy and annual plans, ensuring effective stakeholder management including understanding and influencing of commissioner plans

- Operations and Performance Management – systematic evaluation of integrated governance, risk management and internal controls to ensure robust mechanisms for Board Assurance in respect of performance against regulatory standards; developing and monitoring financial and quality plans; and evaluating how well the Trust meets customer requirements; ensuring proactive development of improvement strategies that deliver customer expectations and mitigate the impact of competitor offerings.

The Chair and Chief Executive have complementary roles in board leadership.

- The Chair leads the Board of Directors and ensures the effectiveness of the Board. The Chair also leads the Council of Members and ensures effective engagement and working relationships between the Council and the Board

- The Chief Executive leads the Executives and the organisation.

The Trust's constitution requires the Foundation Trust to have a Board of Directors comprising a Non Executive Chairman, not less than four but not more than six, Non Executive Directors and not less than four, but not more than six, Executive Directors. The team of Executive Directors must include a Chief Executive (the Accounting Officer), a Finance Director who is a qualified accountant, a registered medical practitioner and a registered nurse.

The Board is supported by four (non voting) Associate Directors, one of whom is the Trust Secretary.

The Board has determined that its members must have the necessary skills and qualities to perform its functions effectively and that the skill mix of the Non Executive Director team must be balanced to reflect a range of expertise to include finance and commercial skills. The Council of Members has endorsed a policy on the composition of Non Executive Directors to this effect.

The Board has evaluated its requirements in terms of the skills and experience required and believes that the balance and completeness of skills and experience is

appropriate. This evaluation will continue to be tested, at least on an annual basis, and whenever a vacancy arises.

An external assessment of the Board's performance was commissioned in 2009 and a Board Development Plan is in place. The process for ongoing annual evaluation of the Board and individual Directors is in progress and will be agreed with the Council of Members in early 2010-2011.

The initial Chairman and Non Executive Directors of the Foundation Trust were appointed in accordance with Paragraph 21 of the Constitution for the unexpired periods of their office on 1st December 2009.

	Name	Expiry of current term of office
Chairman	Neil Large	13th October 2013
Non Executive Director/ Deputy Chair	Patricia Firby	28th February 2013
Non Executive Directors :	Michael Hewitt	28 February 2011 (Resigned 28 February 2010)
	Dr. Robert Toomey	30 April 2013
	Bridget Leek	31 May 2013

Since this time, two new Non Executive Directors have been appointed by the Council of Members, following a selection process undertaken on behalf of the Council of Members by its Nominations and Remuneration Committee.

The Council of Members has agreed that the standard term of office for these posts and any further Non Executive appointments will be for a period of 3 years.

The Chairman and Non Executive Directors can also be removed by the Council of Members through a process which is described in paragraph 20 (and Annex 6) of the Constitution.

The Council of Members has approved the appointment of Patricia Firby as Senior Independent Director in accordance with Paragraph 23 of the Constitution.

Neil Large, Chairman *

Neil is an accountant by profession with a diverse NHS career spanning 40 years in the North West of England, including both board level Executive and Non Executive Director appointments over the last 20 years. After retiring from his last position as Finance Director of the former Cheshire & Merseyside Strategic Health Authority Neil joined the Board of Liverpool Heart and Chest Hospital NHS Trust as an Associate Non Executive Director. He was then appointed Non Executive Director in October 2007, Acting Chair in August 2009 and Chair in October 2009.

Patricia Firby, Deputy Chair and Senior Independent Director *□

Pat was re-appointed as Non Executive Director in February 2009. Formerly Pat was Director for the School of Nursing and Primary Care Practice at Liverpool John Moores University. With 25 years experience in nurse education Pat is the author of several

academic publications and curriculum documents and a lay member for stem cell research committees for the Universities of Liverpool and Manchester. Pat's qualifications include an MSc in Social Research methods, certificate in Counselling, Diplomas in Education and Nursing and she is a Registered Nurse.

Dr. Robert Toomey, Non Executive Director *□

Rob is Chair of the Audit Committee. His qualifications include a BA (Oxon) in History and Economics, a PhD (Wales) in Economic History and he is a qualified CIMA Accountant. Rob has many years of experience in a range of roles at Director level. His most recent experiences include being a Non Executive Director at Edward Billington and Son Ltd (formerly Finance Director) - a food and agricultural products business; Chairman for the Investment Panel of Merseyside Special Investment Fund and Director/Trustee of Emmaus Liverpool, a charity for the homeless.

Bridget Leek, Non Executive Director *□

Bridget has 10 years senior level experience in the Financial Services Industry and is currently a Governor at Parkgate Primary School. Bridget has also worked previously as a Commercial Manager for Resolution and a Director/Company Secretary for SL Embroidery. Her qualifications include a BSc (Hons) in Mathematics and a Fellow of the Institute of Actuaries.

Geoffrey Appleton, Non Executive Director *□

Geoffrey was the national lead for the re-organisation of the Magistrate's Courts Service into the creation of Her Majesty's Court Service (HMCS) with an annual budget of £500m and currently heads the service for HMCS in Cheshire and Merseyside, chairing the Area Management Board and is responsible for a budget of £37.5m. Geoffrey has extensive experience in legal and HR roles and has an LLB (Hons) and an MA in Criminology. He is also a Chartered Member of the Institute of Personnel and Development and is a member of the Institute of Management. Geoffrey is currently Managing Trustee of the Liverpool Cathedral Centenary Fund, is a Trustee and Hon Treasurer High Sheriff and Chief Constable's Charitable Trust and was previously a Non-Executive Director at St. Helens PCT.

Dr. David Bricknell, Non Executive Director *□

David was a Group Legal & Personnel Director and Company Secretary for Heckett Multiserve plc and held the position of Group Legal Advisor and Company Secretary at Pilkington plc. David holds a Directorship at The World of Glass (St Helens) and has spoken at external conferences on legal and glass industry matters. David is a Master in Research and PHD in strategic decision making and is also a Solicitor. David was also the base camp manager at the British Everest expedition in 1985.

Member of Audit Committee is denoted by □
Member of Remuneration and Succession Committee is denoted by*

Independence of Non Executive Directors

The Board considers all of its current Non Executive Directors (including the Chairman) to be independent. It was a requirement that the two new appointments made by the

Council of Members met the independence criteria set out in Monitor's 'NHS Foundation Trust Code of Governance'.

Raj Jain, Chief Executive

Raj's qualifications include BA (Hons) in Management Accounting and Economics, a Diploma in Management Studies and CBA Management. His former and most recent roles include the Executive Director responsible for Workforce and Service Improvement and Foundation Trust Project Director - both at Salford Royal NHS Foundation Trust.

Dr. Glenn Russell, Medical Director and Deputy Chief Executive

Dr. Russell is a Consultant Anaesthetist at the Trust. He is an Honorary Lecturer at the University of Liverpool and has formerly been a Clinical/Research Fellow in Cardiac Anaesthesia at the University of Ottawa Heart Institute, Canada. Dr. Russell is a member of Liverpool Society of Anaesthetists, British Medical Association (BMA), Association of Cardiothoracic Anaesthetists of Great Britain, European Association of Cardiothoracic Anasthesiologists (EACTA), Society of Cardiovascular Anaesthesiologists (USA) and International Anaesthetic Research Society.

Hazel Holmes, Director of Nursing

Hazel holds a wide range of qualifications in nursing and health care including a Diploma of Higher Education in Renal Nursing, BSc (Hons) in Professional Health Studies, ENB N17 Therapeutic Aspects of Nursing, a MA (Distinction) in Health Services Management. Hazel is also a Registered General Nurse and her former roles include Deputy Director of Nursing & Governance at Salford Royal NHS Foundation Trust, Acting Director of Nursing, Divisional Nurse Director and a Directorate Manager at the Royal Liverpool & Broadgreen University Hospital NHS Trust.

Aaron Cummins, Director of Finance

Aaron holds a BA (Hons) in Law and Business Studies and is a member of the Chartered Institute of Public Finance and Accountancy (CIPFA). Aaron has a wealth of experience as a senior manager in the NHS prior to joining this Trust he had held the role of Deputy Director of Finance at the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust.

A register of interests of each member of the Board of Directors is held by the Trust Secretary and is accessible to the public through the office of the Trust Secretary at Liverpool Heart and Chest Hospital NHS Foundation Trust, Thomas Drive, Liverpool L14 3PE.

The Board met on three occasions during the 4 month period of this report, 1.12.09 – 31.3.10. The individual attendance by Directors was as follows:

Director	Board of Directors – meeting dates			Summary : Proportion of meetings attended
	15th December 2009	26th January 2010	26th March 2010	
Neil Large	✓	✓	✓	3/3
Patricia Firby	✓	✓	✓	3/3
Michael Hewitt *1	X	X		0/2
Robert Toomey	✓	✓	✓	3/3
Bridget Leek	✓	✓	✓	3/3
Geoffrey Appleton 2			✓	1/1
David Bricknell *2			✓	1/1
Raj Jain	✓	✓	✓	3/3
Glenn Russell	✓	✓	✓	3/3
Hazel Holmes	✓	✓	✓	3/3
Aaron Cummins	✓	✓	✓	3/3

*1 – left 28.02.2010
*2 – started 02.03.2010

6.2 Audit Committee

The Audit Committee is a Committee of the Non Executive Directors and is chaired by Dr Robert Toomey. Other nominated members are Patricia Firby and Bridget Leek although all Non Executive Directors have the right to attend the Audit Committee. The Audit Committee is authorised by the Board.

The Audit Committee met on two occasions during the 4 month period of this report, 1.12.09 – 31.3.10. The individual attendance by members was as follows:

Member	Audit Committee – meeting dates		Summary : Proportion of meetings attended
	20th January 2010	23rd March 2010	
Robert Toomey	✓	✓	2/2
Patricia Firby	✓	✓	2/2
Bridget Leek	✓	✓	2/2
Geoffrey		✓	1/1

Appleton *			
David Bricknell *		✓	1/1

* started 02.03.2010

The key objective of the Audit Committee is to assure the Board of Directors that there are effective systems of internal control (clinical, organisational and financial) across the organisation so as to ensure that the objectives of the Trust will be met.
The work of the Audit Committee during 2009-2010 has been to review the effectiveness of the organisation in the following areas:

- Governance, Risk Management and Internal Control
- Internal Audit
- External Audit
- Management Assurance
- Financial Assurance

In discharging its duties the Audit Committee ensures that its responsibilities are met through self assessment and review, requesting assurances from Trust officers and Chairs of Assurance Committees, and directing and receiving reports from auditors and fraud specialists.
The Audit Committee agrees and monitors an annual work programme which includes an annual evaluation of the Audit Committee and an annual review of each off the Board's Standing Committees. The Audit Committee meets at least once per year with the auditors and in the absence of any Trust officer.

The Council of Members requested a report from the Audit Committee to inform its decision to appoint the incumbent auditor (District Auditor of the Audit Commission) until the end of 2010-2011.

6.3 Nominations Committees

The Trust has established separate Nominations Committees to oversee the appointment of Executive and Non Executive Directors.

The Council of Members' Nominations and Remuneration Committee is responsible for the appointment of Non Executive Directors. It is chaired by Neil Large; other members are Patricia Firby (Deputy Chair), David Hicks (Senior Council Member – Public) and Carol Law (Appointed Council Member – Cystic Fibrosis Trust). Two further elected public Council Members, Paula Pattullo and Michael Brereton are attendees. During the period of this report the Committee met on two occasions and made recommendations on the appointments of Geoffrey Appleton and Dr. David Bricknell as Non Executive Directors. There was full attendance by members at both meetings. The Appointments Commission was engaged by the Trust as an independent recruitment advisor and ensured that the process undertaken was open, fair and transparent and that candidates were assessed on the basis of merit and in line with best practice for public appointments.

The Committee also considered the level remuneration of the Chair and Non Executive Directors taking account of market research, benchmarking data and a report by the Appointments Commission.

The Board of Directors' Nominations, Remuneration and Succession Committee is responsible for the appointment of Executive Directors. It is chaired by Neil Large and all other Non Executive Directors are members. The Committee has not made any appointments during the period of this report but has met to consider Executive Director remuneration.

7. Our Council of Members

The Council of Members was formally established on 1st December 2009. As the initial elections took place in October 2008, Council Members had a 12 month period in which to build relationships with the Board of Directors and undertake induction and orientation into the hospital – this has proven valuable in preparation for Foundation Trust status. Since 1st December 2009, the Council of Members has met on two occasions and has commenced its statutory work, including in this time, the appointment of two new Non Executive Directors, the setting of remuneration of the Chair and Non Executive Directors and the appointment of the auditor.

The specific statutory powers and duties of the Council of Members are to:

- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, remove the other non executive directors
- Decide the remuneration and allowances, and other terms and conditions of office, of the Chair and other NEDs
- Approve the appointment of the Chief Executive
- Appoint and, if appropriate, remove the NHS foundation trust's auditor
- Receive the NHS Trust's annual accounts, any report of the auditor on them and the annual report

In addition:

- in preparing the NHS Foundation Trust's 'forward plan' the Board of Directors must have regard to the views of the Council of Members

- The Council of Members should hold the Board of Directors collectively to account for the performance of the NHS Foundation Trust, ensuring that the Board acts so that the Trust does not breach its terms of authorisation

- Council Members are responsible for regularly feeding back information about the NHS Foundation Trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected them or appointed them

In addition to the above statutory duties, the Council of Members has determined with the Board of Directors, terms of reference for key work streams led by Council Members with executive support that will enable:

- development, review and delivery of the membership strategy, ensuring representation and engagement levels are maintained and increased as appropriate
- identification and prioritisation of indicators that will continuously improve quality, safety and patient experience
- support for initiatives such as 'More than a Workplace' and corporate social responsibility

The Council of Members comprises 27 Council Members, under the leadership of Trust Chairman, Neil Large. David Hicks is Senior Council Member.

The Council Members elected in the first election have tenures of either 2 or 3 years (in order to secure continuity). Subsequent tenures will be for 3 years. Nominated Council Members will hold office for as long as they are employed in their current role, subject to periodic review.

The composition of the Council of Members is set out below:

PUBLIC CONSTITUENCY – 14 elected seats	
Merseyside (6 seats) :	**Cheshire (4 seats) :**
Edward Barnes (deceased February 2010)	Kenneth Blasbery *3
Kenneth Halligan *3	Michael Brereton *3
Vera Hornby *3	David Hicks *3
Mandy Jones *2	Judith Wright *2
Debbie Mawson (filled vacant seat March 2010 – next highest polling candidate)	
Paula Pattullo *2	**North Wales (3 seats) :**
Roy Stott *2	Stephanie Greenway *3
	Catrin Hanks *2
Rest of England (1 seat):	Malcolm McAdam (resigned 15.2.10)
Tony Roberts *3	

*2 – 2 year tenure
*3 – 3 year tenure

STAFF CONSTITUENCY – 6 elected seats	
Qualified Nurses and Unqualified Nurses (2 seats)	**Non Clinical (2 seats)**
Peter Hannaford *3	Carol Birch (resigned 28.1.10)
Neville Rumsby *2	Anthony Grimes *2
Allied Healthcare Professionals, Technical and scientific (1 seat)	**Registered Medical Practitioners (1 seat)**
Bashir Matata *3	Dr. Johan Waktare *3

*2 – 2 year tenure
*3 – 3 year tenure

NOMINATED COUNCIL MEMBERS - 7 appointed seats	
Liverpool Primary Care Trust: Trish Bennett	**Liverpool City Council:** Cllr Roger Johnston
North West Specialised Commissioning: Jon Develing	**Cystic Fibrosis Trust:** Carol Law
Friends of Robert Owen House: Glenda Corkish	**Health Commissioning North Wales:** Wyn Thomas
Liverpool John Moores University:	

Menna Harland	

A register of interests of each member of the Council of Members is held by the Trust Secretary and is accessible to the public through the office of the Trust Secretary, Liverpool Heart and Chest Hospital NHS Trust, Thomas Drive, Liverpool, L14 3PE.
The Council of Members is required to meet at least four times per year and has met twice since authorisation - Monday 7th December 2009 and Monday 1st March 2010. Specific details of individual attendance at these meetings are detailed in the following table:

Council Member	Council of Member – Meeting dates		Summary : Proportion of meetings attended
	7th December 2009	1st March 2010	
PUBLIC CONSTITUENCY – ELECTED COUNCIL MEMBERS			
Merseyside:			
Edward Barnes	X	N/A (Deceased February 2010)	0/1
Kenneth Halligan	X	✓	½
Vera Hornby	✓	✓	2/2
Mandy Jones	x	✓	1/2
Paula Pattullo	✓	✓	2/2
Roy Stott	✓	✓	2/2
Cheshire:			
Kenneth Blasbery	✓	✓	2/2
Michael Brereton	✓	✓	2/2
David Hicks	✓	✓	2/2
Judith Wright	✓	✓	2/2
North Wales:			
Stephanie Greenway	X	X	0/2
Catrin Hanks	✓	✓	2/2
Malcolm McAdam	X	N/A (Resigned 15.2.10)	0/1
Stephanie Greenway	X	X	0/2
Rest of England and Wales:			
John Roberts	✓	✓	2/2
STAFF CONSTITUENCY :			
Qualified Nurses and Unqualified Nurses:			
Peter Hannaford	✓	✓	2/2
Neville Rumsby	✓	✓	2/2
Non Clinical :			
Carol Birch	✓	N/A (Resigned 28.1.10)	1/1

Anthony Grimes	X	X	0/2
Allied Healthcare Professionals, Technical and scientific:			
Bashir Matata	✓	✓	2/2
Registered Medical Practitioners:			
Dr. Johan Waktare	✓	✓	2/2
NOMINATED COUNCIL MEMBERS			
Wyn Thomas	X	X	0/2
Jon Develing	✓	X	1/2
Trish Bennett	X	✓	½
Cllr. Roger Johnston	X	X	0/2
Menna Harland	✓	X	½
Carol Law	✓	✓	2/2
Glenda Corkish	✓	X	½

All Board Members have a standing invitation to attend Council of Members meetings and utilise this opportunity to update the Council on key issues and service developments and receive advice on setting the Trust strategy. The Chairman briefs the Board of Directors on the work of the Council of Members and its working groups on a quarterly basis.

The Chairman provides an informal opportunity to meet with Council Members in between each quarterly meeting.

Our Membership

As a Foundation Trust we are committed to ensuring that our membership is representative of the population in which we serve.

Public Membership

Public membership is open to everyone living in England and Wales over the age of 16. The Trust operates on an 'opt in' basis. The public constituency is divided into 4 geographical areas to reflect the population our hospital serves.

The areas for the Public Constituency are:

- Merseyside (Districts of Knowsley, Liverpool, Sefton, St Helens and Wirral, including all electoral wards in those Districts)
- Cheshire (Districts of Chester, Congleton, Crewe and Nantwich, Ellesmere Port and Neston, Macclesfield, Vale Royal, Warrington and Halton, including all electoral wards in those Districts)
- North Wales (Districts of Conwy, Denbighshire, Flintshire, Gwynedd, Isle of Anglesey and Wrexham, including all electoral wards in those Districts)
- Rest of England and Wales

Staff Membership

Staff membership is open to any individual who is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months. The Trust operates on an 'opt out' basis. The staff constituency is divided into 4 classes to reflect its workforce.

The areas for the Staff Class are:

- Qualified and unqualified nurses (being health care assistants or their equivalent and student nurses)
- Non-clinical staff
- Allied healthcare professionals, technical and scientific staff
- Registered medical practitioners

To date, no members of staff have opted out of FT membership.

Membership Strategy

We remain committed to making every effort to reach all groups within our membership communities. Our emphasis is upon encouraging an active and engaged membership that is representative of our population rather than increasing the membership size. Therefore our membership strategy is focused on targeting areas of under representation highlighted by comparing our membership profile with demographic data on our catchment population. The composition of our Council of Members reflects our patient population and hence our membership profile.

The membership community of Liverpool Heart and Chest Hospital NHS Foundation Trust is drawn from the public and staff constituencies described above.

Our Membership Strategy was determined by the Board prior to authorisation as an NHS Foundation Trust and is now led by The Council of Members' Membership and Communications Group which is chaired by an elected public Council Member.

The group is continuing to refine its approach as to how the Trust should develop as a membership organisation in the context of our catchment population and the profile of our members. The key focus of the group is to build and sustain a representative membership.

Currently priorities include improving member representation in North Wales and working to improve the engagement of members with Council Members. The Trust has organised a successful programme of 'Medicine for Members' events at which clinical specialists have hosted talks and discussion in local community settings. The Trust also produces a twice yearly newsletter for its members and has recently invited a sample of members to participate in e-surveys on the Trust's vision for patient experience and our quality account indicators.

Membership Profile

The table below shows the number of members at 31st March 2010 and illustrates the growth of public membership over the last 12 month period.

Constituency			
Public Constituency	**As at 1st April 2009**	**As at 31st March 2010**	**Increase (%)**
Cheshire	**1,510**	**2,215**	**+ 47%**
Merseyside	**4,513**	**4,843**	**+ 7%**
North Wales	**1,222**	**1,597**	**+ 31%**
Rest of England and Wales	**473**	**505**	**+ 7%**
Total – Public Constituency	**7,718**	**9,160**	**+ 19%**
Staff Constituency	**1,352**	**1,187**	**- 8%**

The public membership targets set by the Board of Directors have been exceeded (7500 public members by 31st March 2010 increasing to 9,000 by 31st March 2011). The focus for membership recruitment continues to be in ensuring that the Trust is fully representative of the areas we serve. In particular, much progress has been made in increasing the number of members located within the catchment areas of North Wales and Cheshire where the membership has increased since 1st April 2009 by 31% and 47% respectively.

Members who wish to contact their elected Council Member or raise an issue with the Board of Directors and members of the public who wish to become members should contact:

Membership Office
Liverpool Heart and Chest Hospital NHS Foundation Trust
Thomas Drive
Liverpool
L14 3PE
Tel: 0151 600 1410
Email: membership.office@lhch.nhs.uk

8. Remuneration Report

8.1 The Remuneration and Succession Committee

The Remuneration and Succession Committee meets at least annually, or as required to make decisions, regarding remuneration and conditions of service for Executive Directors including the Chief Executive and to make recommendations on any matters relating to terms of employment and remuneration of Associate Directors.

The membership is as follows:

Mr Neil Large Chairman (Chair of Committee)

Mrs Patricia Firby - Non Executive Director
Mrs Bridget Leek - Non Executive Director
Dr Robert Toomey – Non Executive Director
Mr Mike Hewitt – Non Executive Director (resigned 28th February 2010)
Mr Geoffrey Appleton – Non Executive Director (commenced 2nd March 2010)
Dr David Bricknell – Non Executive Director (commenced 2nd March 2010)

The Chief Executive is in attendance (except for matters concerning their employment and conditions).

The Associate Director of Human Resources and Organisational Development is in attendance (except for matters concerning their employment and conditions) for professional advice and administrative support.

During the period 1st December 2009 to 31st March 2010, the Committee met on 15th December 2009 and 26th March 2010.

All members were present at both meetings.

The Committee has oversight of arrangements for termination of employment for Executive and Associate Directors and other senior managers. In determining Directors remuneration, the Trust took account of remuneration of Directors at similar Foundation Trusts, using data sourced from the IDS NHS Boardroom Pay Report 2009 and the Foundation Trust Network. Consideration was also given to the comparative level of pay of other senior managers employed on Agenda for Change terms and conditions of service.

Executive and Associate Directors participate in annual performance development reviews and appraisals. Remuneration is linked to the achievement of individual performance objectives determined from organisational objectives.

Executive Directors are not employed under fixed term contractual arrangements and are required to give six months notice under the terms of their employment.

There have been no special arrangements or awards for senior managers in the reporting period.

Contractual arrangements for Executive Directors

Name	Contract Commencement Date	Contract expiry date	Provision for compensation for early termination	Notice Period
Mr R Jain Chief Executive	01.04.2008	N/A	None	6 months
Dr G Russell Medical Director	01.04.2008	31.03.2012	None	3 months
Mr A Cummins Director of Finance	01.08.2009	N/A	None	6 months
Mrs H Holmes Director of Nursing	01.08.2008	N/A	None	6 months

Both Employees and Employer contribute to the NHS Pension Scheme. Accounting policies for pensions and other retirement benefits are set out in note 1.6 to the Annual Accounts and details of senior employees remuneration can be found on page 3 of the remuneration report.

8.2 The Council of Members Nomination and Remuneration Committee

The Council of Members Nomination and Remuneration Committee meet as required to recommend candidates for the posts of Non Executive Directors, including the Chair and Deputy Chair, to the Council of Members.

The Committee also has responsibility for making recommendations to the Council of Members for the remuneration, other terms and conditions and allowances of Non Executive Directors.

The Committee comprises the Trust's

Chair
Deputy Chair
1 Elected Council Member (David Hicks)
1 Nominated Council Member (Carol Laws)
Up to 2 additional Council Members (Mike Brereton and Paula Pattullo) may be in attendance along with relevant external advisors.

During the period 1st December 2009 and 31st March 2010, the Committee met twice on 1st February 2010 and 1st March 2010. All members attended these meetings

Contractual arrangements for Non Executive Directors

Name	Contract Commencement Date	Contract Expiry Date	Notice Period
Neil Large Chair	14.10.2009	13.10.2013	1 month
Pat Firby Deputy Chair	01.03.2009	28.2.2013	1 month
Rob Toomey	01.05.2009	30.04.2013	1 month
Bridget Leek	01.06.2009	31.05.2013	1 month
Geoffrey Appleton	02.03.2010	01.03.2014	1 month
Dr. David Bricknell	02.03.2010	01.03.2014	1 month
Mike Hewitt	01.03.2007	28 .02.2010	1 month

Only the information included in the salaries and allowances and pension entitlements tables has been subject to external audit. The information shown in the tables is in respect of the period 1st December 2009 to 31st March 2010 and includes Board Directors.

1. Salary and other remuneration of Senior Managers

Name and Title	2009/10 - 1st April to 30th November		
	Salary (Bands of £5,000) £000's	Other Remuneration (Bands of £5,000) £000's	Benefits in Kind
R Jain - Chief Executive	40-45	0-5	1,000
G Russell - Medical Director	5-10	50-55	0
A Cummins - Director of Finance	30-35	0-5	0
H Holmes - Director of Nursing	30-35	0-5	0
P N Large - Chair	10-15	0-5	0
P Firby - Non Executive Director	0-5	0-5	0
M Hewitt - Non Executive Director (Left February 2010)	0-5	0-5	0
R Toomey - Non Executive Director	0-5	0-5	0
B Leek - Non Executive Director	0-5	0-5	0
G Appleton - Non Executive Director (Started March 2010)	0-5	0-5	0
D Bricknell - Non Executive Director (Started March 2010)	0-5	0-5	0

2. Pension Benefits

Name and Title	Real increase in Pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Cash Equivalent Transfer Value at 30 November 2009 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
R Jain - Chief Executive	0-2.5	5-7.5	25-30	75-80	465	440	25	0
G Russell - Medical Director	0-2.5	0-2.5	45-50	145-150	1008	1003	5	0
A Cummins - Director of Finance	0-2.5	0-2.5	5-10	20-25	79	69	10	0
H Holmes - Director of Nursing	0-2.5	5-7.5	20-25	65-70	287	268	19	0

Calculations for the real increase in pension, lump sum and CETV are based on the increase accrued for the full year from 1st December 2009 to 31st March 2010.

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

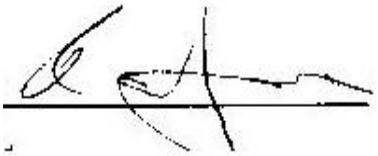
8.3 Cash Equivalent Transfer Value

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 members 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 the 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.

8.4 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 pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.



Raj Jain
Chief Executive
3rd June 2010

Statement of the Chief Executive's responsibilities as the accounting officer of Liverpool Heart and Chest Hospital NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed Liverpool Heart and Chest Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Liverpool Heart and Chest Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

- make judgements and estimates on a reasonable basis

- state whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual have been followed and disclose and explain any material departures in the financial statements

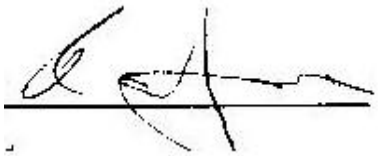
- prepare the financial statements on a going concern basis

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Raj Jain



Chief Executive **Date: 3rd June 2010**

Liverpool Heart and Chest Hospital NHS Foundation Trust Statement on Internal Control

1. Scope of Responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Liverpool Heart and Chest Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically. The system of internal control has been in place in Liverpool Heart and Chest Hospital NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Leadership and Accountability

I am responsible for risk management across all organisational, financial and clinical activities and I am Chair of the Risk Management Committee. I have delegated responsibility for the co-ordination of operational risk management to the Director of Nursing who is supported by the Deputy Director of Nursing & Governance. There are clearly defined risk and clinical governance structures within the Directorates.

The Risk Management Strategy provides a framework for managing risks across the organisation which is consistent with best practice and Department of Health guidance. The Strategy provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation. The Strategy sets out the role of the Board and Standing Committees together with the individual responsibilities of the Chief Executive, Executive Directors, managers and all staff in managing risk. In particular, the Risk Management Committee along with its sub committees for Health and Safety and Infection Prevention & Control provides the mechanism for managing and monitoring risk throughout the Trust and reporting through to the Board. The Audit Committee oversees the systems of internal control and overall assurance process associated with managing risk.

Training

Risk management training is provided through the induction programme for new staff and incorporates details of the Trust's risk management systems and processes. This is augmented by local induction organised by line managers.

Annual mandatory training for all staff covers a variety of risk management processes including health and safety, manual handling, resuscitation and blood transfusion.

Through the appraisal and personal development plan process, managers will identify training for individual roles when necessary.

The Directorate Governance structures are there to facilitate organisational learning and to share good practice.

The Trust has mechanisms to act upon alerts and recommendations made by all relevant central bodies such as the National Patient Safety Agency (NPSA), National Health Service Litigation Authority (NHSLA) and the Health and Safety Executive (HSE).

4. The Risk and Control Framework

Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks throughout the organisation and these are documented on risk registers. These risks are then analysed in order to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found while higher scoring risks are managed at progressively higher levels within the organisation. Achieving control of the higher scoring risks is given priority over lower scoring risks. Risk control measures are identified and taken to reduce the risks potential for harm. Some control measures do not require extra funding and these are implemented as soon as practicably possible, however, where risk control requires extra funding then a risk funding process determines how best to use the organisation's financial resources to control that risk. Risk funding can direct funds to further risk control measures or it may decide to transfer the risk to others such as NHS Insurance Schemes or sharing the risk in the contracts drawn up with others. The whole mechanism is a continually iterative process.

In order to provide evidence in support of the Statement on Internal Control the Trust has a Board Assurance Framework, which is based on six key elements:

- Clearly defined principal objectives agreed with stakeholders together with clear lines of responsibility and accountability;
- Clearly defined principal risks to the achievement of these objectives together with assessment of their potential impact and likelihood;
- Key controls by which these risks can be managed, this includes involvement of stakeholders in agreeing controls where risks impact on them;
- Management and independent assurances that risks are being managed effectively;

- Board reports identifying that risks are being reasonably managed and objectives being met together with gaps in assurances and gaps in risk control;
- Board action plans which ensure the delivery of objectives, control of risk and improvements in assurances.

Information governance risks are managed as part of this process and assessed using the Information Governance Tool kit. The register is updated with the currently identified information risks.

The system of internal control of data quality risks is managed through the Trust's Board Assurance system. Risks to data quality are added to the finance and information risk register, which is reviewed by the Risk Management Committee three times a year. In addition, independent assurance is provided by the Audit Commission's PbR (Payment by Results) Data Assurance Framework review and the Information Governance Toolkit self- assessment review by internal audit.

The system of internal control of Quality Account risks is managed through the Trust's Board Assurance system. Risks are added to the appropriate clinical service risk register. Higher ranking risks are reviewed by the Clinical Quality Committee on a monthly basis through which control actions are agreed and monitored.

The Foundation Trust is fully compliant with the core standards for better health.

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

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

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

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

The financial plan is approved by the Board and submitted to Monitor. The plan, including forward projections, is monitored in detail by the Finance and Performance Committee on a monthly basis with key performance indicators and monitor metrics reviewed by the Board. A full copy of the monthly integrated finance and performance report is issued to all Board Directors. The Trust's resources are managed within the framework set by the Governance Manual, which includes Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

Whilst as a Foundation Trust there is no requirement to undertake the annual Auditors Local Evaluation (ALE) the Trust has agreed a work plan with external auditors to carry out an annual review within their Framework for Economy, Efficiency, Effectiveness and Delivery (FrEEED).

Directorate and corporate departments are responsible for the delivery of financial and other performance targets via a performance management framework incorporating service reviews with the Executive Team.

6. Review of effectiveness

As Accounting Officer I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Risk Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principle objectives have been reviewed. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work through reviews by the Standing Committees and the Audit Committee. The assurance framework/risk register is reviewed by the Board of Directors three times a year and it provides me and the Board with evidence of the effectiveness of controls in place to manage risks to achieving the organisations principle objectives.

My review is also informed by external audit, audit by the National Health Service Litigation Authority and periodic audits of compliance with the Standards by the Care Quality Commission (formerly the Health Care Commission) and other external inspections, accreditations and reviews.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Risk Management Committee and the other Standing Committees of the Board. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Processes are well established and ensure regular review of systems and action plans on the effectiveness of the systems of internal control through:

- Board review of Board Assurance Framework, risk register and action plans;
- Audit Committee scrutiny of controls in place;
- Review of serious incidents and learning by the standing committees, including those for Risk Management and Clinical Quality;
- Review of progress in meeting the Standards of the Healthcare Commission's Standards for Better Health by the standing committees;
- Internal audits of effectiveness of systems of internal control.

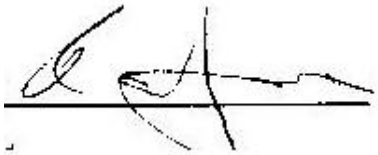
No significant control issues were identified, however, the following control issues, not amounting to significant control issues, are noted:

I. The 2008 Staff Satisfaction Survey prevented the Trust from achieving an 'Excellent' rating for clinical quality in 2008-2009. Significant work to improve levels of staff satisfaction during 2009-2010 has resulted in improved performance in the 2009 survey.

II. Performance in Quarters 1 and 2 of 2009-2010 against the target for cancelled operations presented a risk to achieving the national target. Service improvement work has significantly reduced the level of cancelled operations in Quarters 3 and 4.

Action to improve the control of all of the above risks has been progressing throughout 2009-2010 and the effectiveness of these improvements has been reviewed by the Board.

Raj Jain



Chief Executive **Date: 3rd June 2010**

Public Interest Disclosures

Declaration of Executive and Non-Executive Directors' Private Interests

1st December 2009 to 31st March 2010

Non Executive Directors	Declaration of Interests
Neil Large	Trustee of Tarporley Cottage Hospital (Voluntary) Chester University – external advisor Audit and Risk Management Committee (voluntary) Hospice of the Good Shepherd, Finance Committee (voluntary). Director of Eaton Golf Club. Son employed as an Accountant with Liverpool Provider Service.
Patricia Firby	Lay member of the oversight Sub-Committee for Human Embryonic Stem Cell Research at the Universities of Liverpool and Manchester
Rob Toomey	Director – Edward Billington & Son Director – Central Tin Containers Director/Trustee – Emmans Liverpool Secretary – Mill Marquee Ltd Member of University of Liverpool Advisory Committee
Bridget Leek	Director SL Embroidery
Geoffrey Appleton	Managing Trustee: Liverpool Cathedral, Centenary Foundation Trust. Honorary Secretary, The Athenaeum, Liverpool
Dr. David Bricknell	Trustee of the Pilkington Family Trusts
Mike Hewitt	Director of Carnoy Limited
Executive Directors	**Declaration of Interests**
Raj Jain Chief Executive	None
Dr. Glenn Russell Medical Director and Consultant Anaesthetist	Chairman of the Mersey School of Anaesthesia and Perioperative Medicine (Charity under the umbrella of the Trust)
Hazel Holmes Director of Nursing	None
Aaron Cummins Director of Finance	None

FTC Summarisation Schedules for Liverpool Heart and Chest Hospital NHS Foundation Trust

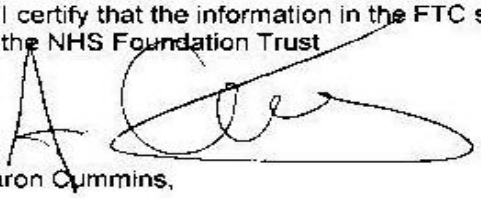
Summarisation schedules numbers iFTC01 to iFTC38 and recFTC01 to recFTC04 for the period 1st December 2009 to 31st March 2010 are attached.

Finance Director Certificate

1. I certify that the attached FTC schedules have been compiled and are in accordance with:
- The financial records maintained by the NHS foundation trust; and
- Accounting standards and policies which comply with the *NHS Foundation Trust Financial Reporting Manual* 2009/10 issued by Monitor, the Independent Regulator of NHS Foundation Trusts

2. I certify that the FTC schedules are internally consistent and that there are 2 validation errors which have been discussed with Monitor and our external auditors and which have arisen due to part year authorisation as a Foundation Trust

3. I certify that the information in the FTC schedules is consistent with the financial statements of the NHS Foundation Trust



Aaron Cummins,

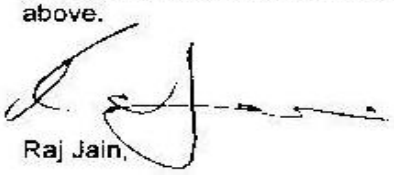
Director of Finance

3rd June 2010

Chief Executive Certificate

1. I acknowledge the attached FTC schedules, which have been prepared and certified by the Finance Director, as the FTC schedules which the Foundation Trust is required to submit to Monitor, the Independent Regulator of NHS Foundation Trusts.

2. I have reviewed the schedules and agree the statements made by the Finance Director above.



Raj Jain,

Chief Executive

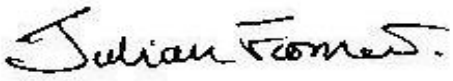
3rd June 2010

Independent Auditors Report to Liverpool Heart and Chest Hospital NHS Foundation Trust on the NHS Foundation Trust Consolidation Schedules.

I have examined the NHS Foundation Trust consolidation schedules (FTCs) numbered iFTC01 to iFTC35 and recFTC01 to recFTC04 of Liverpool Heart and Chest Hospital NHS Foundation Trust for the period from 1 December 2009 to 31 March 2010 which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to the Board of Liverpool Heart and Chest Hospital NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 1 of the Health and Social Care (Community Health and Standards) Act 2003 (the Act) and for no other purpose.

In my opinion these summarisation schedules are consistent with the statutory financial statements on which we have issued an unqualified opinion.

Signature:  Date: 7 June 2010

Name: Julian Farmer

Address: Audit Commission
First Floor, Block 4
The Heath Business and
Technical Park
Runcorn
WA7 4PQ

Independent Auditor's report to the Council of members of Liverpool Heart and Chest Hospital NHS Foundation Trust

I have audited the financial statements of Liverpool Heart and Chest Hospital NHS Foundation Trust for the period ended 31 March 2010 under the National Health Service Act 2006. 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. These financial statements have been prepared under the accounting policies set out within them.

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

- the table of salaries and other remuneration of senior managers and related narrative notes on page 101 and
- the table of pension benefits and related narrative notes on page 102.

This report is made solely to the Board of Governors of Liverpool Heart and Chest Hospital NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the commentary on the financial performance 'operational and financial review 2009-2010' included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's Statement on Internal Control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Annual Reporting Manual 2009/10. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I are aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the welcome from the Chairman, the Chief Executive's Statement, Background Information, Directors' Report, the sections on the Board of Governors, the Board of Directors and Council of Members, and the un-audited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited includes an assessment of the

significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report subject to audit have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

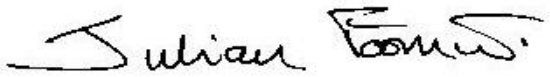
Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of Liverpool Heart and Chest Hospital NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the period then ended in accordance with the accounting policies adopted by the Trust;
- the financial statements and the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the commentary on the financial performance included within the Directors' Report 'operational and financial review 2009-2010' included in the annual report, is consistent with the financial statements.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Julian Farmer
Officer of the Audit Commission

First Floor, Block 4

The Heath Business and Technical Park

Runcorn

Cheshire

WA7 4PQ

7 June 2010

Useful Links

Liverpool Heart and Chest Hospital NHS Trust	www.lhch.nhs.uk
NHS Choices	www.nhs.uk
NHS Direct	www.nhsdirect.nhs.uk
National Institute for Innovation and Improvement	www.institute.nhs.uk
Patient Safety First	www.patientsafetyfirst.nhs.uk
National Institute for Health and Clinical Excellence	www.nice.org.uk
Department of Health	www.dh.gov.uk
Care Quality Commission	www.cqc.org.uk
Patient Opinion	www.patientopinion.org.uk
Equality and Human Rights Commission	www.equalityhumanrights.com
NHS Counter Fraud Service	www.nhscounterfraud.nhs.uk

Useful Publications

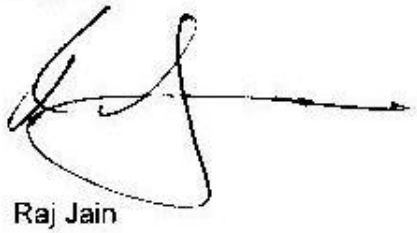
High Quality Care for All – NHS Next Step Review Lord Darzi	Department of Health www.dh.gov.uk
NHS Constitution	Department of Health
NHS 60 The Operating Framework – High Quality Care for All	Department of Health
Healthier Horizons for the North West	NHS North West www.northwest.nhs.uk
A New Health Service 2010 Year of Health and Wellbeing	Liverpool Primary Care Trust www.liverpoolpct.nhs.uk

Annual Accounts Foreword

These accounts for the 4 months ended 31st March 2010 have been prepared by Liverpool Heart and Chest Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts has, with the approval of the Treasury, directed

Liverpool Heart and Chest Hospital NHS Foundation Trust was licensed by Monitor to become a Foundation Trust on 1st December 2009. At that date the assets and liabilities of Liverpool Heart and Chest Hospital NHS Trust transferred to the Foundation Trust

Signed



Raj Jain

Chief Executive

Date: 3rd June 2010

Data entered below will be used throughout the workbook:

Trust name:	Liverpool Heart and Chest Hospital NHS Foundation Trust
This year	for 4 months to 31st March 2010
Last year	1 Dec 2009
This year ended	31 March 2010
Last year ended	30 Nov 2009
This year commencing:	1 Dec 2009

STATEMENT OF COMPREHENSIVE INCOME FOR THE 4 MONTHS ENDED 31st March 2010

	NOTE	Dec 2009-Mar 2010 £000
Revenue		
Operating Income	4	**32,517**
Other operating revenue	8	**1,495**
Operating expenses	11	**-33,209**
Operating surplus (deficit)		**803**
Finance costs:		
Investment Revenue	18	**27**
Other gains and (losses)	19	**0**
Finance costs	20	**-21**
Surplus/(Deficit) for the financial period		**809**
Public dividend capital dividends payable		**-638**
Retained surplus/(deficit) for the period		**171**
Other comprehensive income		
Revaluation gains/(losses) and impairment losses on property, plant and equipment		-1,420
Increase in the donated asset reserve due to the receipt of donated assets		44
Reduction in the donated asset reserve in respect of depreciation, impairment and/or disposal of donated assets		-50
Total comprehensive income for the period		**-1,255**

Income and Operating Surplus are derived from the Foundation Trust's continuing operations

Operating expenses includes an amount of £527k relating to the impairment of Assets arising on the revaluation of the Estate on 31st March 2010.

The normalised surplus position over the 4 month period is £698k

The notes on pages 6 to 35 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT
31 March 2010

	NOTE	**31 March 2010 £000**	30 Nov 2009 £000
Non-current assets			
Property, plant and equipment	22	**56,619**	58,567
Intangible assets	23	**44**	51
Total non-current assets		**56,663**	58,618
Current assets			
Inventories	26	**2,803**	3,540
Trade and other receivables	27	**3,282**	5,673
Cash and cash equivalents	30	**13,708**	9,817
		19,793	19,030
Non-current assets held for sale	31	**0**	0
Total current assets		**19,793**	19,030
Total assets		**76,456**	77,648
Current liabilities			
Trade and other payables	32	**(8,123)**	(9,705)
Borrowings	33	**(352)**	(392)
Provisions	37	**(720)**	(43)
Other liabilities	38	**(1,632)**	(3)
Net current assets/(liabilities)		**8,966**	8,887
Total assets less current liabilities		**65,629**	67,505
Non-current liabilities			
Borrowings	33	**(374)**	(460)
Provisions	37	**0**	(535)
Other liabilities	38	**0**	0
Total assets employed		**65,255**	66,510
Financed by taxpayers' equity:			
Public dividend capital		**62,799**	62,799
Retained earnings		**(6,909)**	(7,760)
Revaluation reserve		**7,999**	10,088
Donated asset reserve		**1,366**	1,383
Total Taxpayers' Equity		**65,255**	66,510

The financial statements and notes on pages 2 to 35 were approved by the Board on and signed on its behalf by:

Signed: ….  ……(Chief Executive) Date: 3rd June 2010

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Total £000
Changes in taxpayers' equity for 2009-10 (Part Year)					
Balance at 1st December 2009 on Authorisation	62,799	-7,080	9,408	1,383	66,510
Total Comprehensive Income for the period:					
Retained surplus/(deficit) for the period.	0	171	0	0	171
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	-1,420	0	-1,420
Increase in the donated asset reserve due to receipt of donated assets	0	0	0	44	44
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	0	0	0	-50	-50
Transfer between reserves			11	-11	0
Balance at 31 March 2010	62,799	-6,909	7,999	1,366	65,255

STATEMENT OF CASH FLOWS FOR 4 MONTHS TO 31ST MARCH 2010

31 March 2010

	NOTE	for 4 months to 31st March 2010 £000
Cash flows from operating activities		
Operating surplus/(deficit)		**803**
Depreciation and amortisation		**1,338**
Impairments and reversals		**527**
Transfer from donated asset reserve		**(38)**
Interest paid		**0**
(Increase)/decrease in trade and other receivables		**2,557**
(Increase)/decrease in inventories		**737**
Increase/(decrease) in trade and other payables		**(1,617)**
Increase/(decrease) in other current liabilities		**1,629**
Increase/(decrease) in provisions	37	**142**
Tax (paid)/received		**0**
Net cash inflow/(outflow) from operating activities		**6,078**
Cash flows from investing activities		
Interest received		**27**
(Payments) for property, plant and equipment	22	**(984)**
Net cash inflow/(outflow) from investing activities		**(957)**
Net cash inflow/(outflow) before financing		**5,121**
Cash flows from financing activities		
Capital element of finance leases		**(126)**
Interest element of finance lease		**(21)**
PDC dividend paid		**(1,083)**
Net cash inflow/(outflow) from financing		**(1,230)**
Net increase/(decrease) in cash and cash equivalents		**3,891**
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**9,817**
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	30	**13,708**

NOTES TO THE ACCOUNTS

1. Accounting Policies

Monitor has directed that the the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts . The accounting policies 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 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation 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.

1.3.1 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.

True and Fair View
NHS financial statements should give a true and fair view of the state of affairs of the reporting body at at the end of the financial year and of the results of the year.
Section 393 of the Companies Act 2006 requires that directors must not approve accounts unless they are satisfied that they give a true and fair view.

Going Concern
The Accounts have been prepared on the basis that the Foundation Trust is a Going Concern and will be for the foreseeable future.

Compliant with the NHS Foundation Trust Annual Reporting Manual
The Financial statements have been prepared in accordance with the 2009/10 Foundation Trust Annual Reporting Manual (FTARM). The Accounting Policies contained in the FTARM apply International Financial Reporting Standards as adapted or interpreted for an NHS Foundation Trust.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.3.2 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

The Foundation Trust has made assumptions in the following areas where there is an element of uncertainty.

Income - The Foundation Trust income is largely derived from the contracts it has with its principal commissioners with a significant amount being earned under the PBR rules and guidelines set by the Department of Health. Under PBR income is based upon the activity recorded by the Foundation Trust and agreed with the Commissioner in accordance with the national timetable for agreeing contract income. The Trust has based this part of its income on the amounts agreed with the commissioning organisation or where not yet agreed, on its estimate of the activity and the related national tariff.

Asset Valuation - The Foundation Trust appointed an independent valuer to value its land and buildings at March 31st 2010 in accordance with the requirements of IAS16 Property, Plant and Equipment. These values have been reflected in the accounts.

Provisions - The Foundation Trust has made provisions for potential claims in respect of Equal Pay legislation under Agenda for Change. The amount of provision brought forward at December 1st was £535k. Part of the claim relates to a challenge to Agenda for Change under the Sex Discrimination Act. A test case on this issue was held in November 2008 and dismissed the claim made. The decision however may be subject to appeal. The provision has been retained pending the outcome of any appeal.

1.4 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 Foundation Trust is from Commissioners for Health Care Services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to the expected total length of stay. These amounts are only adjusted for where considered material.

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

Interest revenue is mainly derived from balances held either with the Office of Paymaster General Account or on short term deposit with commercial banks undertaken in accordance with the Foundation Trust's Treasury Management Policy.

1.5 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, The cost of leave earned but not taken by employees at the end of the financial year is recognised in the financial statements to the extent that employees are permitted to carry leave into the following year.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Foundation 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 Foundation 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 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 Foundation 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 subsequent accumumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

Notes to the Accounts - 1. Accounting Policies (Continued)

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS Trusts must apply these new valuation requirements by 1 April 2010 at the latest. The NHS Foundation Trust revalued its Estate on 31st March 2010.

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease 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. 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 Foundation 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 Foundation 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

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

Notes to the Accounts - 1. Accounting Policies (Continued)

- 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 and properties under construction 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 Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Foundation 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 the shorter of estimated useful lives and lease contract term, based on the Capital Value at inception of the Lease, less any residual values (which are transferred back to the lessor).

At each reporting period end, the Foundation 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.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset

Notes to the Accounts - 1. Accounting Policies (Continued)

1.13 Leases

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

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 a reduction of the lease obligation so as to achieve a constant rate on 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. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

1.14 Inventories

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

1.15 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 Foundation Trust's cash management.

1.16 Provisions

Provisions are recognised when the Foundation 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.

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.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where The Foundation Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.16 Provisions (Continued)

A restructuring provision is recognised when the Foundation 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 arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

The Foundation Trust has made specific provisions for liabilities for third parties legal claims and to issues associated with Equal Pay Claims

1.17 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to the NHSLA which in return receives assistance with the costs of claims arising. 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 Foundation Trust is disclosed at **note 38.**

1.18 Non-Clinical Risk Pooling

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation 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.

For buildings and contents, the Trust also has 'top up' insurance provided through a commercial insurer that insures from the NHSLA cover limit of £1m to total reinstatement value. The annual premium is charged to operating expenses when the liability arises.

Other commercial insurance held by the Trust includes Directors Liability. The annual premium and any excesses payable are charged to operating expenses when the liability arises.

1.19 EU Emissions Trading Scheme

The Foundation Trust is not a member of the EU Emission Trading Scheme

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Foundation 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 Foundation 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.21 Financial Assets

Financial assets are recognised when the Foundation 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 initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through income and expenditure; 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.

Financial Assets and Financial Liabilities held at 'Fair Value Through Income & Expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

The Trust does not hold any of this class of assets or liabilities.

Available for Sale Financial Assets
The Trust does not hold any of this class of assets.

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

The Foundation Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS Debtors, accrued income and other debtors.

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.21 Financial Assets (continued)

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 through a provision for impairment of receivables or directly to expenditure as appropriate.

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

1.22 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the Foundation 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 Foundation Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other Financial Liabilities

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

1.23 Corporation Tax

HM Treasury has decided to defer the planned implementation of legislation bringing NHS Foundation Trusts in to charge to corporation tax on profits generated on their commercial activities. As a result NHS Foundation Trust will not become taxable on their profits with effect from April 2010.

Any wider legislative changes will not be introduced before the Finance Bill in 2011.

1.24 Value Added Tax

Most of the activities of the Foundation 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.

1.25 Foreign currencies

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.26 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 40 to the accounts.

1.27 Public Dividend Capital (PDC) and PDC Dividend

Public dividend capital represents taxpayers' equity in the NHS Foundation Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Foundation 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 Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts. For the period of these accounts the charge has been apportioned on a time basis between the period as a Foundation Trust (4 months) and the period prior to this.

1.28 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Foundation Trust's not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 Subsidiaries

Material entities over which the Foundation Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Foundation Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

For 2009/10, in accordance with the directed accounting policy from the Secretary of State, the Foundation Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.30 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Foundation Trust has adopted all International Financial Reporting Standards which are relevant and appropriate for the preparation and presentation of Financial Statements.

1.31 Prior Year Comparatives

The NHS Foundation Trust came into existence on 1st December 2009 and therefore prior year comparatives for income and expenditure items are not relevant.

2. Operating Segments

The Foundation Trust has one segment for the provision of healthcare which generated income of £34.012m for the 4 month period.

The main sources of income received were:-

	£m
North West Specialist Commissioning Team	24,206
Health Commission Wales	5,434

	Healthcare Segment 4 months to 31 Mar 2010 £000
Income	34,012
Surplus/(Deficit)	171
Net Assets:	65,255

3. Income generation activities

The Foundation Trust does not have any material income generation activities.

4. Operating Income analysed by category	4 months to 31 Mar 2010 £000
Elective income	15,759
Non elective income	10,119
Outpatient Income	3,202
Other NHS clinical income*	2,278
Private patient income	877
Other non-protected clinical income	276
NHS Injury Scheme (was RTA)	6
	32,517

**Other NHS Clinical Income is analysed in note 5 below*

5. Analysis of Other NHS Clinical Income	4 months to 31 Mar 2010 £000
Drugs and Devices - Non Contracted	248
NHS Trust Income - SLA's	469
PCT Income - Non Contracted	257
Cystic Fibrosis Inpatients	1,304
	2,878

7. Operating Income analysed by source

	4 months to 31 Mar 2010 £000
NHS Foundation Trusts	**82**
NHS Trusts	**482**
Strategic Health Authorities	**12**
Primary Care Trusts	**25,581**
NHS Other	**8**
Non NHS:	
- Private patients	**877**
- NHS Injury Scheme (was RTA)	**6**
- Other*	**5,469**
	32,517

** Other Operating Income consists of income received from Health Commission Wales*

8. Other Operating Revenue

	4 months to 31 Mar 2010 £000
Research & Development	**275**
Education and training	**880**
Charitable and other contributions to expenditure	**23**
Transfer from donated asset reserve in respect of depreciation on donated assets	**38**
Other income*	**279**
	1,495

**Other Operating revenue Income is analysed in Note 9 below*

9. Analysis of Other Income

	4 months to 31 Mar 2010 £000
Estates recharges	**72**
Pharmacy sales	**6**
Staff accommodation rentals	**2**
Clinical tests	**26**
Clinical excellence awards	**171**
Other	**2**
	279

9.1 Income from activities arising from manadatory and non-mandatory services

	4 months to 31 Mar 2010 £000
Income from Activities - Mandatory Services	31358
Income from Activities - Non-Mandatory Services	1153
	32,511

10. Revenue

Revenue is predominantly from the supply of services. Revenue from the sale of goods is immaterial.

11. Operating Expenses	4 months to 31 Mar 2010 £000
Services from NHS Foundation Trusts	**62**
Services from NHS Trusts	**1,329**
Services from other NHS bodies	**35**
Employee Expenses- Executive directors	**79**
Employee Expenses- Non-executive directors	**19**
Employee Expenses- Staff	**17,380**
Drugs costs	**1,250**
Supplies and services - clinical (excluding drug costs)	**9,023**
Supplies and services - general	**481**
Establishment	**231**
Transport	**21**
Premises	**618**
Increase/(decrease) in bad debt provision	**37**
Depreciation on property, plant and equipment	**1,338**
Impairments of property, plant and equipment	**527**
Audit fees	**58**
Other auditor's remuneration	**2**
Clinical negligence	**129**
Legal fees	**119**
Consultancy costs	**56**
Training courses and conferences	**109**
Patient travel	**41**
Car parking and Security	**61**
Insurance	**34**
Other services, eg external payroll	**36**
Losses, ex gratia & special payments	**17**
Other	**117**
	33,209

12. Audit Fees and Other Remuneration	4 months to 31 Mar 2010 £000
Statutory Audit	58
Financial reporting evaluation	2
	60

There is no limited liability agreement in place with the external auditors (Audit Commission).

13. Operating leases

The Foundation Trust has a lease agreement for a car which commenced in June 2009 with its predecessor body for a period of 35 months. In addition the Foundation Trust has photocopiers under 5 year agreements.

13.1 As lessee

Payments recognised as an expense	4 months to 31 Mar 2010 £000
Minimum lease payments	**7**
Contingent rents	**0**
	7

Contingent rent is the excess mileage charge of 10p per mile once an annual mileage of 10,000 miles has been exceeded.

Total future minimum lease payments	4 months to 31 Mar 2010 £000
Payable:	
Not later than one year	**17**
Between one and five years	**19**
After 5 years	**0**
Total	**36**

There are no future sublease payments expected to be received

14 Salary and Pension Entitlements of Senior Managers

14.1 Salary entitlements for the period December 2009 to March 2010

Name and Title	2009/10 - 1st December 2009 to 31st March 2010		
	Salary (Bands of £5,000) £000's	Remuneration (Bands of £5,000)	Benefits in Kind (£'s)
R Jain - Chief Executive	40-45	0-5	1,000
G Russell - Medical Director	5-10	50-55	0
A Cummins - Director of Finance	30-35	0-5	0
H Holmes - Director of Nursing	30-35	0-5	0
P N Large - Chair	10-15	0-5	0
P Firby - Non Executive Director	0-5	0-5	0
M Hewitt - Non Executive Director (Left February 2010)	0-5	0-5	0
R Toomey - Non Executive Director	0-5	0-5	0
B Leek - Non Executive Director	0-5	0-5	0
G Appleton - Non Executive Director (Started March 2010)	0-5	0-5	0
D Bricknell - Non Executive Director (Started March 2010)	0-5	0-5	0

*Dr D Bricknell commenced on 2nd March 2010
**G Appleton commenced on 2nd March 2010

Name and title	Real increase in pension at age 60 (bands of £2,500) £0	Real increase in pension lump sum at aged 60 (bands of £2,500) £0	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) £0	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) £0	Cash Equivalent Transfer Value at 31 March 2009 £0	Cash Equivalent Transfer Value at 30 November 2009 £0	Real increase in Cash Equivalent Transfer Value £0	Employer's contribution to stakeholder pension £0
R Jain – Chief Executive	0-2.5	5-7.5	25-30	75-80	465	440	25	0
G Russell – Medical Director	0-2.5	0-2.5	45-50	145-150	1008	1003	5	0
A Cummins – Director of Finance	0-2.5	0-2.5	5-10	20-25	79	69	10	0
H Holmes – Director of Nursing	0-2.5	5-7.5	20-25	65-70	287	268	19	0

As Non- Executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive directors.

Cash Equivalent Transfer Value

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 members accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by 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 the 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 Insitiute 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 pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

15. Employee costs and numbers

15.1 Employee costs

	4 months to 31 Mar 2010		
	Total	Permanently Employed	Other
	£000	£000	£000
Salaries and wages	**14,646**	**14,311**	**335**
Social Security Costs	**1,092**	**1,045**	**47**
Employer contributions to NHS Pension scheme	**1,441**	**1,441**	**0**
Other pension costs	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**
Agency and contract staff	**280**	**0**	**280**
Employee benefits expense	**17,459**	**16,797**	**662**
Of the total above:			
Charged to capital	0		
Employee benefits charged to revenue	0		
	0		

15.2 Average number of people employed

	4 months to 31 Mar 2010		
	Total	Permanently Employed	Other
	Number	Number	Number
Medical and dental	**124**	**122**	**2**
Administration and estates	**245**	**241**	**4**
Healthcare assistants and other support staff	**229**	**219**	**10**
Nursing, midwifery and health visiting staff	**502**	**472**	**30**
Scientific, therapeutic and technical staff	**178**	**174**	**4**
Social care staff	**3**	**0**	**3**
Other	**8**	**8**	**0**
Total	**1,289**	**1,236**	**53**

15.3 Management and Administration Costs

The Management costs of the Foundation Trust for the 4 months to 31st March 2010 were £1.690m and amounted to 4.97% of Trust Income of £34.012m

15.4 Staff Sickness Absence

	1st Dec 2009 - 31st March 2010
Days Lost (Long Term)	3,385
Days Lost (Short Term)	2,605
Total Days Lost	**5,990**
Total Staff Years	1,191
Average working days lost	5
Total Staff Employed in Period (Headcount)	**1,317**
Total Staff Employed in Period with no absence (Headcount)	**908**
Percentage Staff with no Sick Leave	**68.94%**

16. 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, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

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

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

In 2008-09 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:

16. Pension costs (continued)

Annual Pensions

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".

Pensions Indexation

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.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

17. Retirements due to ill-health

For the period December 2009 to March 2010 there were nil early retirements from The NHS Foundation Trust agreed on the grounds of ill-health.

18. Investment Revenue	**4 months to 31 Mar 2010 £000**
Interest revenue:	
Bank accounts	27
Total	27

19. Other Gains and Losses

There are no other gains or losses

20. Finance Costs	**4 months to 31 Mar 2010 £000**
Interest on obligations under finance leases	**21**
Total	**21**

21. Better Payment Practice Code

21.1 Better Payment Practice Code - measure of compliance	**4 months to 31 Mar 2010 Number**	**£000s**
Total Non-NHS trade invoices paid in the period	9,716	12,955
Total Non NHS trade invoices paid within target	9,332	12,164
Percentage of Non-NHS trade invoices paid within target	96.0%	93.9%
Total NHS trade invoices paid in the period	430	5,784
Total NHS trade invoices paid within target	400	3,961
Percentage of NHS trade invoices paid within target	93.0%	68.5%

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

The Foundation Trust has signed up to the Government's 10 day payment commitment.

21.2 The Late Payment of Commercial Debts (Interest) Act 1998	**4 months to 31 Mar 2010 £000**
Amounts included within other interest payble arising from claims made under this legislation.	**0**
Compensation paid to cover debt recovery costs under this legislation	**0**
Total	**0**

22. Property, plant and equipment

2009/10:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 Dec 2009	3,235	43,131	535	704	22,163	3,148	2,096	75,012
Additions purchased	0	208	0	437	403	241	0	1,289
Additions donated	0	2	0	0	42	0	0	44
Reclassifications	0	550	0	(557)	0	7	0	0
Impairments	0	(1,334)	(3)	0	0	0	0	(1,337)
At 31 March 2010	**3,235**	**42,557**	**532**	**584**	**22,608**	**3,396**	**2,096**	**75,008**
Depreciation at 1 Dec 2009	0	0	0	0	12,870	2,396	1,179	16,445
Impairments	0	610	0	0	0	0	0	610
Charged during the year	0	443	13	0	673	142	63	1,334
Depreciation at 31 March 2010	**0**	**1,053**	**13**	**0**	**13,543**	**2,538**	**1,242**	**18,389**
Net book value								
Purchased	3,235	41,118	228	584	7,684	858	824	54,531
Finance Leased	0	0	0	0	722	0	0	722
Donated	0	386	291	0	659	0	30	1,366
Total at 31 March 2010	**3,235**	**41,504**	**519**	**584**	**9,065**	**858**	**854**	**56,619**

22.1 Analysis of Property, plant and equipment

Net Book Value	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Information technology	Furniture & fittings	Total
NBV - Protected Assets at 31st March 2010	**3,235**	**38,**	**138**	**0**	**0**	**0**	**0**	**0** **41,373**
NBV - Unprotected Assets at 31st March 2010	**0**	**3,366**	**519**	**584**	**9,065**	**858**	**854**	**15,246**
Total at 31 March 2010	**3,235**	**41,504**	**519**	**584**	**9,065**	**858**	**854**	**56,619**

Protected assets are used in the provision of mandatory services. Unprotected assets relate to dwellings and the land associated with them

22.2 Property, Plant and Equipment (cont.)

The Trust has benefitted from expenditure of **£44k** from Charitable funds in the period December 2009 to March 2010. This expenditure relates mainly to the purchase of medical equipment.

Professional valuations are carried out by the District valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.The Trust has had its land and buildings revalued using Modern Equivalent Asset methodology at 31st March 2010.

The following table discloses the range of economic lives of various assets

Economic Lives of Fixed Assets	Min life Years	Max life Years
Software Licences	2	5
Buildings exc dwellings	15	55
Dwellings	23	38
Plant & Machinery	2	15
Information Technology	5	8
Furniture and Fittings	5	15

The Foundation Trust has not written down any assets to recoverable amount nor has there been reversals of such write downs in the year.
The Foundation Trust holds all property at an existing use valuation and does not have open market valuations which are materially different from these valuations.
The Foundation Trust does not hold any temporarily idle assets.

23. Intangible assets

2009/10:	Computer software - purchased	Total
	£000	£000
Gross cost at 1 Dec 2009	219	219
Gross cost at 31 March 2010	**219**	**219**
Amortisation at 1 Dec 2009	168	168
Charged during the year	7	7
Amortisation at 31 March 2010	**175**	**175**
Net book value		
Purchased	44	44
Donated	0	0
Total at 31 March 2010	**44**	**44**

The Foundation Trust's intangible fixed assets consists of purchased software only .

The useful lives of these assets ranges from 2 to 5 years.

Intangible fixed assets held form operational use are valued at historic cost and are depreciated over the estimated useful life of the asset on a straight line basis. The carrying value of intangible fixed assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over a shorter of the term of the licence and their useful economic lives.

23.1 Revaluation Reserve Balance for Intangible As

There is no Revaluation Reserve for Intangible Assets

24. Impairments

The Foundation Trust engaged the Valuation Office Agency to revalue its estate using Modern Equivalent Asset methodology effective from 31st March 2010. There has been an overall impairment of £2.079m as a consequence of this revaluation . £527k of this impairment has been charged against income and expenditure with the balance of £1.552m offset against positive revaluation balances in the revaluation reserve.

25. Capital commitments

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

	31 March 2010	30 Nov 2009
	£000	£000
Property, plant and equipment	**393**	282
Intangible assets	**0**	0
Total	**393**	**282**

26. Inventories

26.1. Inventories	**31 March 2010**	30 Nov 2009
	£000	£000
Finished Goods	**2,803**	3,540
Total	**2,803**	3,540
Of which held at net realisable value:	**0**	0

26.2 Inventories recognised in expenses	**31 March 2010**
	£000
Inventories recognised as an expense in the period	**9,371**
Total	**9,371**

27. Trade and other receivables

27.1 Trade and other receivables	**Current**	
	31 March 2010	30 Nov 2009
	£000	£000
NHS receivables	**2,028**	2,869
Other receivables	**553**	610
Provision for impaired receivables	**(109)**	(72)
Prepayments	**329**	962
Accrued income	**0**	1,199
PDC receivable	**166**	
Other receivables	**315**	105
Total	**3,282**	5,673

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.
Other trade receivables consists of transactions with Health Commission Wales (for the provision of patient care services in Wales), Insurance companies and private individuals for the provision of private patient care services and recharges from charitable funds. These are considered to be good quality receivables.

The Foundation Trust does not have financial assets that would otherwise be past due or impaired, whose terms have been renegotiated other than contracts with main commissioners which are billed at a standard amount each month based on an agreed level of activity. There may be credit notes issued periodically during the year where activity has been less than contracted or additional invoices where activity has exceeded contracted performance

27.2 Provision for impairment of receivables	31 March 2010 £000
Balance at 1st December 2009	**72**
Increase in provision	**37**
Amounts utilised	**0**
Unused amounts reversed	**0**
Balance at 31 March	**109**

27.3 Impaired receivables past their due date	31 March 2010 £000
By up to three months	**37**
By three to six months	**0**
By more than six months	**72**
Total	**109**

The Foundation Trust does not hold collateral in respect of any outstanding receivables

27.4 Receivables past their due date but not impaired	31 March 2010 £000
By up to three months	**569**
By three to six months	**137**
By more than six months	**72**
Total	**778**

The Foundation Trust does not hold collateral in respect of any outstanding receivables

28. Other financial assets

The Foundation Trust has no other Financial Assets

29. Other current assets

The Foundation Trust has no other Current Assets

30. Cash and Cash Equivalents	31 March 2010 £000
Balance at start of period	**9,817**
Net change in year	**3,891**
Balance at end of period	**13,708**
Made Up Of	
Cash at commercial banks and in hand	**119**
Cash with the Government Banking Service	**13,589**
Other current investments	**0**
Cash and Cash Equivalents as in Statement of Financial Position	**13,708**
Bank overdraft	**0**
Cash and Cash Equivalents as in Statement of Cash Flows	**13,708**

31. Non-Current Assets Held for Sale

There are no Non Current Assets held for sale.

32. Trade and other payables

	Current	
	31 March 2010	30 Nov 2009
	£000	£000
Receipts in Advance	**(2)**	0
NHS payables	**1,688**	1,037
Other trade payables - revenue	**2,048**	2,633
Other trade payables - capital	**343**	27
Taxes payable	**0**	1,052
Other payables	**1,514**	1,932
Accruals	**2,532**	3,024
Total	**8,123**	9,705

Other payables include includes outstanding pensions contributions at 31st March 2010 of £540k (30th November 2009 £532k)

33. Borrowings

	Current		Non-current	
	31 March 2010	30 Nov 2009	**31 March 2010**	30 Nov 2009
	£000	£000	**£000**	£000
Finance lease liabilities	**352**	392	**374**	460
Total	**352**	392	**374**	460

34. Finance lease obligations

The Foundation Trust has entered into lease arrangements for medical equipment associated with the new Site Development. These leases started from the final quarter of 2005/06 and extend for a period of 5 to 7 years. There is no contingent rent arrangement within these lease agreements. The lessor has the benefit of the residual value of the assets as these assets are returned at the end of the lease agreement. The leases agreements require the Foundation Trust to maintain assets at a certain condition and they have to be returned to the lessor in a reasonable condition. This risk is managed by the Foundation Trust, through Insurance cover and Maintenance Contracts.

The difference between the future minimum lease payments and their present value is the interest rate implicit in the lease which is £65k at 31st March 2010.

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease	
	31 March 2010	30 Nov 2009	**31 March 2010**	30 Nov 2009
	£000	£000	**£000**	£000
Within one year	**393**	447	**351**	393
Between one and five years	**397**	493	**374**	460
After five years	**0**	0	**0**	0
Less future finance charges	**(65)**	(87)	**0**	**0**
Present value of minimum lease payments	**725**	853	**725**	853
Included in:				
Current borrowings	**351**	393	**351**	393
Non-current borrowings	**374**	460	**374**	460
	725	853	**725**	853

The Foundation Trust does not have sublease arrangements.

35. Finance lease receivables (i.e. as lessor)

The Foundation Trust does not have finance leases as a lessor.

36. Finance Lease Commitments

The Foundation Trust entered into finance lease agreements in 2005/06 for periods of 5 to 7 years. At 31st March 2010 the Foundation Trust had no new finance lease commitments.

37. Provisions

	Legal claims £000	Other £000	Total £000
At 1 Dec 2009	31	547	**578**
Arising during the year	21	150	**171**
Used during the year	-14	-12	**-26**
Reversed unused	-3	0	**-3**
At 31 March 2010	35	685	**720**
Expected timing of cash flows:			
Not later than one year	35	685	**720**
later than one year and not later than five years	0	0	**0**
later than five years	0	0	**0**

The Foundation Trust has total provisions at 31st March 2010 of 720k. Within this total the largest provisions are in respect of issues associated with Equal Pay Claims.

The timing of payments is dependent on the outcome of the appeals process following a test case on the national issues associated with Agenda for Change which was heard in February 2009, however this is likely to be within 12 months.

The Foundation Trust has a provision for Liability to Third Parties legal claims which is advised by the NHS Litigation Authority. These claims are generally settled within 1 to 2 years.

£907k is included in the provisions of the NHS Litigation Authority at 31st March 2010 in respect of clinical negligence liabilities of the Foundation Trust.

38. Other Liabilities

	Current	
	31 March 2010	30 Nov 2009
	£000	£000
Deferred Income	**1,092**	0
NHS Pension Scheme Liability	**540**	0
Payment received on account	**0**	3
	1,632	3

Deferred Income and Pension Liability in the accounts at 30th November, were included in taxes payable. However they have been reclassified under Other Liabilities to 31st March 2010.

39. Contingencies

39.1 Contingent Liabilities	**4 months to 31 Mar 2010**
	£000
Other (specify)	**(23)**
Total	**(23)**

The Foundation Trust is advised by the NHS Litigation Authority of the full estimated liability associated with Liability to Third Party Schemes. This liability is adjusted by applying a percentage probability to the full liability to calculate an amount to be provided. The difference between the full liability and the amount provided is recorded as a contingent liability

The contingent liability is reviewed each year as part of the advice from the NHSLA on the value of provisions in respect of legal claims

39.2 Contingent Assets

The Foundation Trust does not have any contingent assets .

40. Financial Instruments

40.1 Financial assets	**At fair value through profit and loss**	**Loans and receivables**	**Total**
	£000	**£000**	**£000**

40.3 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with primary care trusts and the way those Primary Care Trusts are financed, The Foundation 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 Foundation 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 Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's standing financial instructions and policies agreed by the Board of Directors. The Foundation Trust's treasury activity is subject to review by The Trusts internal auditors.

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

Interest Rate Risk

The Foundation Trust has minimal borrowings in the form of a small number of leased assets which are based on rates of interest fixed at the time of entering into the lease agreements. The Foundation Trust funds its capital programme from internally generated funds, therefore does not have any other loans and so the Trust is not exposed to significant interest-rate risk.

Credit Risk
Because the majority of the Foundation Trust's income comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity Risk
The Foundation Trust's operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament . The Foundation Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

40.4 Maturity of Financial Liabilities

The Foundation Trust has no Financial Liabilities

41. Events After the Reporting Period

The Foundation Trust has had no material events after the end of the reporting period. 1

42. Prudential Borrowing Limit

Liverpool Heart and Chest Hospital NHS Foundation Trust is required to comply and remain within a Prudential Borrowing Limit (PBL)

This is made up of two elements:

(a) The maximum cumulative amount of long term borrowing.

This is set by reference to five ratio tests set out in Monitor's Prudential Borrowing Code. The Financial Risk Rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the Long Term Borrowing Limit.

(b) The amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Foundation Trust has a PBL of £25.3m of which £17.7m related to long term borrowing and £7.6m to a Working Capital Facility.

The Foundation Trust has borrowings of £726k against this limit . The table below confirms that the Foundation Trust was within the approved ratios.

	Actual Ratios	**Limits 2009/10**	
Minimum dividend cover times	**4**	>1	met
Minimum Interest cover times	**127**	>3	met
Minimum debt service cover times	**18**	>2	met
Maximum debt service to revenue	**0.4%**	<2.5%	met

On 31st March 2010 the Trust had an approved working capital facility of £7.6m with the Royal Bank of Scotland. This facility has been formally made available from 21st April 2010 following satisfaction of Agreement requirements.

43. Movement in Taxpayers Equity

	£000
Taxpayers' equity at 1st December 2009	**66,510**
Surplus for the financial period	171
Gains/losses from revaluation/indexation of purchased fixed assets	-1,420
Movement on Donated Asset reserve	-6
Taxpayers' equity at 31st March 2010	**65,255**

45. Related Party Transactions

Liverpool Heart and Chest Hospital NHS Foundation Trust is a public interest body authorised by Monitor, the Independent Regulator for NHS Foundation Trusts.

During the period to 31st March 2010 none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Liverpool Heart and Chest Hospital NHS Trust. One of our associate directors is married to a director of Halton & St Helens PCT. The income from this PCT totals £28k for the period December 2009 to March 2010. Neither party has had any involvement in the commissioning process.

The Department of Health is regarded as a related party. During the year Liverpool Heart and Chest Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income £000s	Expenditure £000s	Receivables £000s	Payables £000s
North West Strategic Health Authority	892	1		
Primary Care Trusts				
Ashton Leigh & Wigan PCT	89		22	
Birmingham East & North PCT	302		18	
Bradford & Airedale PCT	23		5	
Bury PCT	26			
Central & Eastern Cheshire PCT	15		19	
Central Lancashire PCT	108		29	
Darlington PCT	17			
Halton& St Helens PCT	28	8	22	
Knowsley PCT	38		22	
Liverpool PCT	901	20	57	37
Manchester PCT	6			
North Staffordshire PCT			73	
Sefton PCT	24		168	
South East Essex PCT	19		59	
South Staffordshire PCT	15			
Warrington PCT	68		11	
Western Cheshire PCT	24,099		388	
Wirral PCT	8		4	
NHS Trusts				
North West Ambulance Service NHS Trust		38		4
Royal Liverpool & Broadgreen University Hospitals NHS Trust	742	1,607	1,142	1,420
Southport & Ormskirk Hospitals NHS Trust	19	29	5	7
St Helens & Knowsley Hospitals NHS Trust	37		4	1
Foundation Trusts				
Aintree University Hospitals NHS Foundation Trust	21	28	9	
Alder Hey Childrens NHS Foundation Trust		37	2	31
Blackpool Fylde and Wyre Hospitals NHS Trust		11		
Countess of Chester Hospital NHS Foundation Trust	6		29	1
Lancashire Teaching Hospitals NHS Foundation Trust		21		
University Hospitals Bristol NHS Foundation Trust				
Taunton and Somerset NHS Foundation Trust		10		
Warrington & Halton Hospitals NHS Foundation Trust	36	293	42	41
Wirral University Teaching Hospitals NHS Trust	18	161	9	35
NHS Business Services Authority		612		103
NHS Shared Business Services		199		
NHS Litigation Authority		88		

In addition, The Foundation 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:

46. Intra-Government and Other Balances	Current receivables £000	Current payables £000
Balances with other Central Government Bodies	1,126	1,832
Balances with Local Authorities	0	0
Balances with NHS Trusts and Foundation Trusts	1,244	1,548
Balances with Public Corporations and Trading Funds	0	0
Intra Government balances	2,370	3,380
Balances with bodies external to Government	912	4,743
At 31 March 2010	**3,282**	**8,123**
Balances with other Central Government Bodies	1,773	35
Balances with Local Authorities	0	0
Balances with NHS Trusts and Foundation Trusts	1,287	1,349
Balances with Public Corporations and Trading Funds	0	0
Intra Government balances	3,060	1,384
Balances with bodies external to Government	2,613	8,321
At 1st December 2009	**5,673**	**9,705**

47. Losses and Special Payments

NHS Foundation Trusts are requried to record cash payments and other adjustments that arise as a result of losses and special payments. In the period December 2009 to March 2010 the Foundation Trust had 12 separate losses and special payments, totalling £37,353.

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