Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Annual Report and Accounts

2010/11

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

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

Liverpool Heart and Chest Hospital NHS Foundation Trust

Annual Report and Financial Accounts 2010/11

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Our Vision

To be the premier integrated cardiothoracic healthcare organisation in the country by 2014

Our Mission

Excellent, Compassionate and Safe Care for every patient, every day

Message from the Chairman and Chief Executive

2010/11 was our first full year trading as a Foundation Trust, and what a remarkable year it has been! There have been many developments and achievements, some of which are detailed throughout this report.

The dedication, commitment and unrivalled skills of our excellent staff and volunteer workforce have taken us to new heights. For that we say a heartfelt 'Thank You' to each and every one of them.

We would also like to thank our Board of Directors, Council of Governors and growing number of Members, for their continued support and commitment in helping to steer the Trust forward and making it such a resounding success.

It has been a year of economic uncertainty and instability, which has brought with it many challenges for the Trust to overcome. However, the team spirit amongst the organisation has helped us to steer a course through these challenges, working together to develop creative ways of continuing to provide excellent, compassionate and safe care.

We have continued to enhance our standing and reputation as a tertiary Centre of Excellence both regionally and nationally, by gaining more outstanding awards of achievement. We were voted the top performing trust in the North West for the second year running for all three areas of cardiac surgery in the Advancing Quality Awards. The quality of our care has also been recognised by NHS Liverpool, who awarded us joint winners of the Patient Experience and Quality Improvement Award, and by patients during the Care Quality Commission survey who again named us as the top performing Trust in the country in the National Inpatient Survey. (On a visit to the Trust this year, Dame Jo Williams, Chair of the Care Quality Commission commented on the quality of the Trust through her own eyes). We have also received fantastic feedback from renowned peers during a recent National Lung Cancer Peer Review.

We have developed several new services this year, including the full roll-out of the Primary Angioplasty (PCI) service as well as the revolutionary Subcutaneous Implantable Cardiac Defribrillator (S-ICD) procedure, to improve the emergency treatment and overall life expectancy of heart failure patients.

In partnership with NHS Knowsley we have delivered a new one-stop community based Cardiovascular Disease service for residents across Knowsley, to better diagnose, treat, advise and manage cardiovascular disease. We were privileged to have the service opened by Professor Sir Bruce Keogh, Medical Director of the NHS, who combined the launch with a visit to our Trust.

At the end of 2010 we also had the pleasure of introducing a new Volunteering Service across the Trust. We introduced a team of volunteers to help provide a friendly face and help people find the location that they want to reach.

Being rated number 1 for overall patient care again is a great achievement for us however, we know that we can do even more, and want to keep pushing the boundaries of great care. That is why this year we have developed our innovative 'Patient Experience Vision' – which clearly describes what we want to achieve for our patients and staff by 2013. We have represented our Vision in the six steps of a patient's journey, to highlight how we will transform the way in which we deliver care in each of the steps. (The Vision will be explained in more detail later in the report).

In line with our patient vision, we continue to strive to provide the very best facilities for our patients. This year to strengthen that vision we have made several major improvements to the hospital. Amongst these improvements we have built a new private kitchen for our cystic fibrosis patients to aid their recovery, enabling them to have the very specialist food that they require, and have also introduced free wireless internet across the Trust, to help provide a home from home environment for our patients and their relatives. Our capital programme is also delivering an additional 10 beds as we continue our strategy of improving all of our patient facilities.

We have also continued to invest heavily in new technological advances to improve the way in which we deliver care for our patients. We have installed a new electronic referral system into the Trust, as well as a new electronic prescribing and medicines administration system. Both of these new systems will independently help us to make significant improvements to the way in which information about patients flows across the Trust.

Looking forward to the year ahead we have lots of exciting plans that will enable us to continue to strengthen our expertise and levels of clinical care. Amongst the plans is a major new research collaboration with the Brompton & Harefield NHS Foundation Trust and Imperial College London, which will see the creation of the 'Institute of Cardiovascular Medicine and Science', a new enterprise focused on bringing research through to clinical use as quickly as possible. We will also be looking to develop a new academic facility within the Trust, to enable pupils who wish to pursue a career in medicine to undertake work experience and mentorship from our nationally acclaimed consultant staff.

Neil Large, Chairman

Raj Jain, Chief Executive

A Year of Achievements

2010/11 has been another year full of remarkable achievements and successes for our Trust. This annual report highlights some of our achievements in more detail, however, here is a quick snap shot of some of those highlights:

☆ **Performance:**

- Advancing Quality results – Top performing Trust in the NW for heart attack, heart failure and, heart bypass surgery,
- NHS Liverpool Quality Awards – joint Winners for Patient Experience and Quality Improvement,
- National Lung Cancer Peer Review – exceptional feedback,
- National Inpatient Survey – Top in the country - Care Quality Commission,
- NHSLA assessment – achieved Level 3.

☆ **Innovation:**

- New pilot Volunteers Scheme,
- New Lung Cancer Screening Study rolled-out,
- New community-based Knowsley Cardio Vascular Disease Service,
- New Subcutaneous Implantable Cardiac Defribrillator S-ICD procedure rolled-out,
- Full roll-out of the Primary Angioplasty Service,
- American Society of Extracorporeal technology International Conference' – showcasing four of our research papers,
- Large Heart Failure Service and Cardiac-Rehab grants acquired.

☆ **Showcasing Technical Capabilities:**

- Annual Thoracic Aortic Aneurysm Patient – Physician Forum event,
- Live Primary Percataneous Coronary Intervention broadcasts to the 'Advanced Cardiovascular Intervention 2011' conference of peers in London,
- Visited by Professor Sir Bruce Keogh, NHS Medical Director,
- Visited by Dame Jo Williams, Chair, Care Quality Commission.

☆ **Estates Improvement:**

- New kitchen for cystic fibrosis patients,
- Free wireless internet for patients, relatives, visitors and staff,
- Creation of new 10 beds as part of the capital improvement plan.

☆ **IT Improvements:**

- New Electronic Referral System,
- New Electronic Prescribing and Medicines Administration System.

Our Patient Experience Vision

Our Trusts' Mission is to provide:

'**Excellent, Compassionate and Safe care for every patient, every day**'.

We recognise the true value of team working and fostering a team approach to bring about combined improvements in the level of care that we provide for our patients. This year we have built on the team working concept and worked with our staff to develop an innovative 'Patient Experience Vision' – a six stepped approach that we believe will enable us all collectively to enhance our patients' experience here at the hospital and in turn, help us to achieve our Mission.

We have represented our Vision in the six steps of a patient's journey, to help us transform the way that we deliver care as a joined up team:

We believe that we will have truly enhanced our patients' experiences during each step of their journey when each the following statements are truly reflective of our Trust:

Reputation: **"Why go anywhere else?"**
Everyone knows our name and patient's receive excellent, compassionate and safe care every time,

Arrival: **"They were expecting me"**
First impressions count. The welcome at the hospital is warm and friendly. Even car parking is easy,

Patient Contract: **"My care was planned with me and for me"**

Our promise to the patient and theirs to us,

Stay: **"They made me feel special"**
People are treated like old friends in a place that is more like a hotel than a hospital,

Treatment: **"They really know what they were doing"**
World class clinicians and leading edge treatment comes as standard,

After Stay: **"Their support really did continue and my quality of life got better"**
Our after care service equals the highest standards of those worldwide.

We have also developed a set of values and behaviours that we believe are essential for us all to adopt, in order for us to deliver the Vision and the Mission:

We recognise that we have to live and breathe our values of excellent, compassionate and safe care, to enable us to achieve the highest levels of care possible for our patients.

Our Hospital at a Glance

Liverpool Heart and Chest Hospital NHS Foundation Trust is the largest single site specialist adult cardiothoracic (heart and lung) hospital in the UK. Previously known as The Cardiothoracic Centre – Liverpool NHS Trust, we serve a population of over 2.8 million, with a geographical catchment area encompassing Liverpool, Merseyside, parts of Lancashire and Cheshire, North Wales and the Isle of Man.

We have been rated amongst the top performing Trusts in the country for the past five years for the quality of our patient care by the Care Quality Commission, and for our specialist cardiac services under the regional Advancing Quality programme. We are also acknowledged as the market leader in cardiothoracic (heart and lung) surgery, cardiology, respiratory medicine and diagnostic imaging, in the Merseyside, Cheshire and North Wales regions.

The Trust has an international reputation as a leader in interventional research, and is renowned across the UK for leading the way in the introduction of pioneering new theatre facilities, technological advances and procedures in medicine and surgery.

We have one of the largest critical care units in Europe, alongside state of the art laboratories and operating theatres, in which to treat our patients.

We have many claims to fame, some of which include;

- ☆ We are one of only three specialist heart and chest centres in the UK,
- ☆ We have the largest lung cancer unit in Cheshire and Merseyside,
- ☆ We have the largest group of specialist Heart Rhythm Consultants in the country,
- ☆ We are the largest centre for implanting pacemakers, and the third largest in Europe,
- ☆ We are the UK's number 1 centre for the rapid hospital to hospital transfer of urgent and emergency procedures for treating narrowings in the arteries around the heart,
- ☆ We developed the UK's first interchangeable operating theatre; enabling multiple procedures to be performed on a patient at the same time,
- ☆ We implanted the world's first and most advanced 'Altrua' pacemaker device, and
- ☆ We installed the first 'CARTO 3' imaging system, enabling surgeons to perform operations on patients with irregular heart beats more effectively.

Patient Care

We are totally dedicated to providing the very highest level of care for our patients. This year we have developed a Patient Experience Vision, which defines what excellent patient care looks and feels like, and suggests how everyone collectively across the Trust can help to achieve it by 2013, to enable us to deliver our corporate Mission.

Our commitment to providing our patients with the highest quality of care has again been recognised nationally this year:

- We successfully maintained our position as one of the top three trusts in the country for our outstanding levels of patient care in the national In-patient Survey (undertaken by The Care Quality Commission),
- We were recognised as the top performer in the region for the delivery of heart failure and coronary artery bypass grafting care, and joint top performer for heart attack care, under the North West regions 'Advancing Quality' improvement programme, and
- The high quality of care that we provide to our patients, and the dedication and commitment of our staff, was also recognised by NHS Liverpool through local quality awards,
- We were also again rated Excellent by the Patient Environment Action Team for our hospital setting.

This year we have continued to develop new methods of monitoring ourselves on the quality of the healthcare that we provide to our patients, to ensure that we retain these top quality ratings, including:

- The development of key quality indicators for all of the services that we provide, which are regularly monitored to enable us to understand the level of quality improvements that we have achieved,
- The development of a comprehensive quality assessment system in all of our wards and departments, so that staff receive regular feedback on the quality of care that they are delivering to our patients,
- The development of ward based quality dashboard monitoring systems to enable wards to monitor their own and results and those of their peers.

All the contracts for the services that we provide have quality measures included within them, which provide assurance to both our commissioners and the general public about the level of quality of the care that we will provide.

Earlier this year we were delighted to be visited by Dame Jo Williams, Chair of the Care Quality Commission. She was taken through the journey of a typical patient at the hospital and witnessed some of the cutting edge treatments provided by our Trust. Dame Williams said "I know by their reputation that Liverpool Heart and Chest Hospital view safety and patient satisfaction as their most important goals. From what I have seen and heard today, the hospital has a clear view of what it wants to deliver to its' patients and I am going away feeling inspired by the work that they are doing here to make that a reality".

Dame Jo Williams with Dr Dhiraj Gupta

Specialist Support Nurse Initiative

We have developed a pilot scheme this year to help enhance our patients' journey. Under the new scheme, a Specialist Support Nurse is assigned to an individual patient both before and once they are admitted into the hospital. The Specialist Support Nurse then visits the patient every day during their stay, checking that all of their treatment and care is going to plan. Following discharge the nurse monitors the patient's after care for a further 30 days. Feedback from patients after the first pilot has been very positive, and there have also been a reduced number of re-admissions amongst the patients involved in the scheme.

Patient Outcomes

We are regularly monitored externally on the level of care that we provide. One of the key national targets that we are monitored against is to ensure that all our patients can access our services which come within the set 18 week national timeline. This year we have again successfully met this 18 week target.

We are also monitored on the level of mortality within the hospital. We have again this year achieved excellent levels which compare well to our peers.

We had fewer cancelled operations than in previous years and, we increased the number of day cases that we performed in cardiology – pleasingly, we actually performed more Percataneous Coronary Intervention cases than any other Trust in the country.

We monitor ourselves internally on a monthly basis. In particular we measure our patient satisfaction levels. Patient surveys enable us to understand from a patient's perspective what our strengths are, and what areas we could build on to maximise patient care. We are pleased to report that this year we have achieved an overall score of 85%, for meeting patient expectations all of the time, which like previous years is above the target that we set ourselves.

Managing Risk Effectively

Our continued improvement and development of patient safety and the quality of care that we provide has resulted in us achieving our NHSLA assessments. Most recently we have achieved our Level 3 assessment, which has put us in the top 10% of Trusts in the country.

Falls Prevention

We have developed a programme this year to reduce the number of falls within the hospital by 10%. As part of the programme, a service improvement group identified five key areas in which changes could be made to patient care to reduce falls. The programme focussed initially on our surgical wards as well as one of the medical wards. Results at the end of the year suggest that the programme has been a huge success, with falls being reduced by 30% across the Trust. The programme will now be rolled out across the other areas of the Trust.

Infection Prevention

We pride ourselves on the cleanliness of our hospital, and constantly strive to provide the safest environment possible for our patients, and their relatives and carers. This year we managed to keep MRSA levels very low, with only two patients being affected, and we achieved below national targets for Clostridium Difficile hospital aquired infections.

Serious Untoward Incidents

We are also happy to report that there were no serious untoward incidents involving data loss or any breaches of confidentiality this year.

Handling Complaints

Learning from complaints plays a key role in enhancing our patient safety. This year 100% of our complaints were responded to within the agreed timeframe. All complaints were acknowledged within three working days, and complainants were asked how they would like their concerns responded to.

Directorates are required to demonstrate that they have learnt from the complaints and amended their services accordingly.

From September 2010 as part of the Trust's quality development for complaints management, we started to introduce a quarterly Complaints Review Panel for Non-Executive Directors. This new panel enables us to provide assurance to the Trust Board that complaints are being managed appropriately, learnt from, shared widely and embedded within the organisation.

Clinical Developments

We continuously work towards improving the quality of the clinical care that we provide, to make the healthcare that we deliver more:

- Safe, by minimising the risk and harm to service users,
- Timely, by ensuring access is appropriate to clinical need,
- Effective, by using treatments that are proven to work, resulting in improved health outcomes for patients and communities,
- Efficient, by getting the most out of the resources that we have,
- Equitable, by checking that what we do does not vary in quality because of personal characteristics such as age, gender, ethnicity, race, geographical location of socioeconomic status, and
- Patient centred, by taking into account the preferences and aspirations of our services users and the culture of their communities.

Our Clinical Quality Strategy has been developed to ensure that we continue to deliver real improvements in health outcomes for our patients, and remain a chosen Centre of Excellence.

New Clinical Services

This year we have developed and implemented lots of new and exciting services and made improvements to some of our existing services. Some of the new services that we have developed include:

- **Primary Angioplasty Service**

In June we fully rolled out the Primary Angioplasty Service, to enable patients from across Cheshire and Merseyside to benefit from this life saving treatment. Primary angioplasty (a small balloon catheter inserted into a coronary artery to unblock it) is used as an initial treatment in place of blood clot-dissolving drugs. There is wide consensus that it provides superior outcomes compared with thrombolysis (dissolving blood clots), provided that it can be delivered quickly. The service is available 24 hours every day, and initial results suggest that the service is proving extremely effective and has delivered excellent clinical outcomes for our patients.

- **Minimal Invasive Mitral Valve Surgery**

Minimal Invasive Mitral Valve Surgery commenced in the Trust at the beginning of 2011. Minimally invasive procedures remove the need to open up a patient's chest, and enables patients who would not normally be considered for surgery due to their clinical condition, be treated. Surgery and recovery times are much shorter than in traditional methods, and therefore is a benefit to both patients and the NHS as a whole.

- **Subcutaneous Implantable Cardiac Defribrillator Procedure**

In September, 61 year old John Nichols from Greasby on the Wirral, was selected to be the first patient in the North West (and one of the first nationally), to have a Subcutaneous Implantable Cardiac Defribrillator (S-ICD) fitted here at our Trust. We were heavily involved in the early development

and research stages of the S-ICD nine years ago, so it was fitting that we should be at the forefront again – being the first in the region to implant one of these life-saving new devices into one of our patients. The pacemaker is unique in the way that no leads are placed directly into the patient's heart, therefore minimising the risk of infection for the patient.

Showcasing our Clinical Capabilities

'Advanced Cardiovascular Intervention 2011', held in January this year, was the largest and most prestigious national meeting for UK interventional cardiology. During the meeting we were privileged to be chosen to perform live case demonstrations, which were beamed by satellite back to the audience of 600 delegates in London - heightening our status as a national leader in coronary intervention.

We were joined in Liverpool by visiting guest operators from Sheffield, Edinburgh and London who participated in the live procedures. We also hosted Prof. Patrick Serruys from the Netherlands, who is the leading figure in European interventional cardiology. During the live procedures comments and questions were posed to our clinicians by the distinguished panel of experts in London, enhancing peer recognition amongst colleagues.

New Technological Advances

We have installed a new electronic referral system into the Trust, as well as a new electronic prescribing and medicines administration system. Both of these new systems will independently help us to make significant improvements to the way in which information about patients flows across the Trust.

New Community-based Service

This year we have also started to deliver services in the community, to bring our services closer to peoples' homes.

- **Coronary Vascular Disease Service**

In April 2010 we rolled-out a new community-based Coronary Vascular Disease Service with NHS Knowsley, for the residents of Knowsley. The service aims to diagnose, treat, advise and manage cardiovascular disease in a one-stop shop setting, reducing the need for patients to be re-referred by other providers and improving the patient pathway.
We were privileged to have the service opened by Professor Sir Bruce Keogh, Medical Director of the NHS, who combined the launch with a visit to our Trust.
The patient feed back on the new service has been excellent.

**Dr. Joe Mills, Consultant Cardiologist with Mr Cawley,
the first patient to benefit from the new service in Halewood**

Health Promotion Activities

This year we have integrated all our health promotion activities to create a new Health Promotion Service. This new service aims to further improve the lifestyle of our patients, their relatives and carers, visitors and our staff.

We have launched an innovative public health campaign this the year:

- **From the Heart**

The 'From the Heart' campaign is designed to raise awareness of heart disease and stroke in women aged between 40-70 yrs in Liverpool, Knowsley and Sefton (which have some of the highest rates of premature death in women from cardiovascular disease in the country).

The four week campaign, launched in March 2011, centred around hairdressing salons – which were identified as one of the only places where women are able to relax and spend time thinking about themselves. More than 100 stylists across the salons were briefed in the causes and treatments of heart disease, enabling them to talk to their clients, and encourage them to seek medical help or change their lifestyles in order to live longer and healthier lives.

The multi-layered media campaign has received lots of regional coverage. Based on its anticipated success, it is hoped that the campaign will be rolled out to other parts of the region.

Research and Development

The Trust has an international reputation as a leader in interventional research. We are totally committed to the role of research and are firm believers in 'today's research is tomorrow's care'.

Research enables us to develop and maintain our position as a Centre of Excellence in the treatment of heart and chest diseases. We commission and conduct research which will create new and innovative services, and provide improvements in the quality of care that we provide for our patients.

This year we have continued to implement the Trusts' research strategy, and established four consultant-led research teams to achieve some really fantastic outcomes, including:

- We have launched three new major research trials backed by the National Institute of Health Research, to test strategies to improve patient care and minimise complications whilst receiving treatment,

- We have commissioned new areas of research in microwave detection, stem cell technology, stent materials and Marfan's Syndrome,

- We have been given a significant contribution (£340K) by the Comprehensive Local Research Network to grow our Clinical Trials Unit and the Research and Development Department; 13 research nurses have been funded and assigned to National Institute of Health Research-backed projects,

- A further £360K in National Institute of Health Research non-commercial grants has also been awarded to researchers at the Trust this year, and

- A major innovation grant has also been awarded to us that will enable us to develop a new method of managing patients with heart failure jointly between General Practitioners and hospital doctors.

We have continued to strengthen and develop new meaningful research collaborations with other hospitals and universities, and also with our commissioners and the Cheshire & Merseyside Cardiac Network, to enable us to conduct research which will provide real improvements and new services for our local residents.

One major research collaboration this year has been with the Brompton & Harefield NHS Foundation Trust and Imperial College London, which in 2011 will see the creation of the 'Institute of Cardiovascular Medicine and Science, an new enterprise focused on bringing research through to clinical use as quickly as possible.

We are also currently recognised as a lead organisation nationally for user involvement in research. This year we built on this foundation and developed new mechanisms to secure more patient involvement (as service users) in the planning and conduct of our research. Results from a research project created entirely by our service users were published in a peer-reviewed journal in June this year.

Our Cardiac Surgeons, Anaesthetists and Perfusionists also showcased the excellent capabilities of the Trust at the 'American Society of Extracorporeal Technology (Heart Lung Machines) International Conference'. This event is a world leading and cutting edge forum for new and developing ideas. Our team presented four papers, demonstrating our presence on the international research scene. Translating these new concepts into clinical practice will undoubtedly help improve patient care not only here at the Trust, but also around the rest of the world.

This year also saw the launch of a study to investigate if a lung cancer screening programme could be implemented effectively at hospitals and cancer centres across the UK. It was an honour for us to be invited to participate in such an important study which will help to tackle the single biggest killer in our region, and lead the way in cutting edge treatment for our patients.

Working with our Patients and Visitors

Feedback from our patients, their carers and relatives, and the general public, is really important to us in helping to shape and improve our services and the level of care that we provide.

Service Improvements following Patient Feedback

This year a really substantial service improvement has been developed as a result of feedback from patients about their perception of the information that was provided about their medication when they were discharged.

After listening to this feedback we have improved and standardised discharge drug information to ensure that every patient is consistently given adequate verbal and written information about their drugs (particularly about the side effects), and also rolled-out a 'teach back' technique. Patient satisfaction around drug information has since increased, and now more than 85% of our patients feel they have enough information about the side effects of drugs.

We have also started to routinely measure patient's feedback about their quality of life after their treatment here at the hospital, to enable us to better understand how well our treatments are meeting patient's ongoing health needs.

Improvements in Patient/Carer Information

All our patient information is produced in conjunction with a group of lay readers, who ensure that the content and style of the information that we provide is clear, understandable and as user-friendly as possible. For example, the Cardiac Surgery booklet has been reviewed, and now contains information about aneurysm surgery and more general information about a patient's stay at the hospital, as a result of feedback received from patients and carers.

Public and Patient Involvement Events

A patient Experience Based Design Day was held in October with around 50 patients, to enable us to gain an understanding of what our patients and their families expect from our Trust. During detailed discussions, we also highlighted our new Patient Vision and gained further valuable feedback on our proposals.
Since this event we have also contacted a further 3000 patients to gain their views about our new Vision.

We also held the first annual meeting of the Thoracic Aortic Aneurysm Patient-Physician Forum this year. The forum was organised by our specialist Aortic Aneurysm Team, to provide Marfan patients with a mixture of education and support for their conditions, whilst explaining possible treatment options for aneurysms of the aorta in the chest. Over 140 patients and relatives attended the really successful event.

Working with our Partners

We recognise the importance and true benefits of partnership working, particularly with commissioners (Primary Care Trusts, District General Hospitals and Local Authorities) and other service providers. It ensures that the health services we provide are as seamless, effective, cost efficient and fit for purpose as possible, to meet the health needs of our local population.

We work particularly closely with the North West Specialist Commissioners and with Health Commission Wales, to ensure that we develop the necessary capacity to deliver the right level of commissioned services, at the required time, and within the appropriate financial envelope.

We also retain strong links with the Cheshire and Merseyside Cardiac Network, the Cancer Network and the Cheshire and Merseyside Critical Care Network, to develop a co-ordinated approach to service development.

Developing Services Together

As mentioned previously, this year we have developed a new borough-wide integrated Community Cardio Vascular Disease Service with NHS Knowsley, to reduce health inequalities throughout the borough. The new service will help to prevent premature deaths from Cardio Vascular Disease through an improved one-stop shop process involving diagnosis, treatment, management and rehabilitation.

We have also this year started to widen our engagement with General Practitioners around the region. In April we held a General Practitioner event in conjunction with the Cheshire and Merseyside Cardiac Network, to jointly broaden our horizons and clinical knowledge around cardiology. Over 90 General Practitioners attended the event, listening to presentations and engaging in clinical debates with some of our most esteemed clinicians. This hugely beneficial educational forum has since been extended into more localised General Practitioner events, to enable a more in-depth personal understanding of our services and of the skills of our professionals, to enable better referral pathways for our patients.

Developing Joint Initiatives

Earlier this year, we formed a partnership, known as ‘The Famous 5’, with the other four specialist NHS tertiary centres in Merseyside; Alder Hey Children’s Hospital, Clatterbridge Centre for Oncology, Liverpool Women’s Hospital and the Walton Centre for Neurology, in an awareness raising campaign. The partnership aimed to highlight to the local population (through a multi-layered channel approach), the unusually rich concentration of quality speciality tertiary NHS providers in the region, and suggest the advantages of having such specialities on their doorstep.

It is anticipated that the partnership will continue next year, bringing with it further opportunities for joint initiatives, including joint promotional activities.

Our Staff

As at 31st March 2011 we employed 1379 staff totalling 1313.37 whole time equivalents.

Our success as a Foundation Trust continues to be as a result of the enormous commitment and dedication of our talented and highly skilled staff, who are respected both nationally and internationally for delivering pioneering procedures, driving innovation, and for providing outstanding levels of patient care.

Values and Behaviours

Our Trust Mission is to provide '**Excellent, Compassionate and Safe care for every patient, every day**'. We recognise that the only way we can achieve this mission is by fostering a real team effort between all of our staff, clinical and non-clinical.

In 2010 we worked with staff and managers to develop our Patient Experience Vision. We also worked with staff to develop a set of values and behaviours that we believe are essential in order to deliver the Vision and Mission.

We expect all staff to demonstrate our values and behaviours towards everybody who uses our services and to each other. Through our recruitment, induction and appraisal systems, our staff understand that it is not just what we do, but the way that we do it that is important.

Celebrating Success

In July we held our first 'Our Team's got Talent' Team of the Year Awards. They were a great success, with over 40 nominations from across the Trust showcasing the excellent work of all of our departmental teams. Ward A were crowned Team of the Year, for their continuous excellent performance and their ability to provide high quality patient care under pressure, with over 100 admissions and discharges per week. The Catheter Lab multi-disciplinary team and the Domestic team were both highly commended. We have also continued to recognise staff achievements in a number of other ways this year, including through our monthly staff recognition awards.

Ward A receiving their 'Team of the Year' Award

We have worked with staff to create events to enhance their motivation, well-being and morale, for example on Nurses Day. We also looked at subjects such as Equality, Diversity & Human Rights, Adult Learners Week and Health & Wellbeing at Work.

We continue to promote healthy lifestyle initiatives. In March 2011 a team of 26 runners from across the Trust took part in the Liverpool Half Marathon to raise money for our charity. There was a fantastic team spirit amongst all the runners, with colleagues supporting them to the finishing line. We hope to increase the number of runners next year and recapture the fun that was shared this year.

Our Runners…

We have also developed a handy 'Staff Handbook' this year to enable all members of staff to have a quick reference guide to our organisation. It highlights the history of the organisation and the Mission and Vision that we are working towards. It also suggests how everyone both as individual members of staff and as part of the organisational 'team' can help to deliver these results for our patients.

Learning and Development

We have enjoyed great success this year in supporting over 100 staff through an Apprenticeship Scheme. Nationally this achievement makes us one of the most successful trusts in terms of uptake numbers. However and more importantly, it has enabled some of our staff to develop new skills and to transfer to new roles within the Trust.

Our clinical staff have also excelled this year in their personal development. One Doctor of Medicine higher degree has been achieved, with a further three now registered. One new Allied Health Professional is currently registered for a Doctor of Philosophy, and numerous other members of the nursing staff are registered to complete Master of Science, and Master of Philosophy Higher Degrees.

Over 70 of our managers have commenced our Excellence in Management and Leadership programme this year, with the aim of supporting them to motivate their teams, and improve the experience of patients, families, carers and staff alike.

The Senior Nursing Team have also undertaken a process of Talent Mapping across the Trust, enabling us to identify which staff require additional support and development, and also to highlight staff who have the potential to develop into our future leaders.

Staff Satisfaction

Earlier in the year we undertook our annual Trust-wide staff survey. We stressed the importance of the survey and reminded staff of changes that were made as a result of their feedback last year. 63% of our staff filled out the survey, which was a similar result to last year and we are pleased to report was an 11% higher response rate than the national average.

For the third year running we undertook a full survey, enabling us to analyse the survey at a department level, so that managers can act on local feedback and focus on improvements specific to their own area.

We know that there are some areas within the Trust where response rates are lower than we would like. We will be working to understand the reasons why completion levels are so low and encourage completion the survey in the future.

	2009		2010	
Response rate	**Trust**	**National average**	**Trust**	**National average**
	64%	52%	63%	55%

Information from the survey has now been collated and all departments across the Trust have received an individual report, which indicates their results against the Trusts' overall performance. This analysis will also enable each department to monitor their progress against the 2009 survey, and highlight which areas they need to work on to improve. Progress on the action plans developed will be reported through directorate business meetings and the Workforce Committee.

The top four ranking scores for the 2010 survey are shown below:

	2009		2010		Trust improvement / deterioration
Top four ranking scores	**Trust**	**National average**	**Trust**	**National average**	
KF14: % of staff appraised with personal development plans in last 12 months	74%	65%	79%	68%	5 % improvement
KF13: % of staff having well structured appraisals	38%	35%	44%	36%	6% improvement
KF 8: % of staff working extra hours**	59%	67%	59%	65%	no change
KF 12: % of staff appraised in last 12 months	79%	76%	85%	79%	6 % improvement

** the lower the score the better

The bottom four ranking scores for the 2010 survey are shown below:

	2009		2010		Trust improvement / deterioration
Bottom four ranking scores	**Trust**	**National average**	**Trust**	**National average**	
KF 9: % of staff using flexible working options	64%	70%	52%	65%	12% deterioration
KF 37: % of staff believing the trust provides equal opportunities for career progression or promotion	90%	91%	84%	92%	6% deterioration
KF 11: % of staff receiving job-relevant training, learning or development in last 12 months	73%	77%	74%	79%	1% increase
KF 3: % of staff feeling valued by their work colleagues	76%	77%	74%	78%	2% deterioration

Staff satisfaction and motivation at work were rated as average (compared to below average in 2009). Our scores for feeling valued by colleagues and supported by immediate managers were below average. Both of these areas will be a key focus for us during 2011. We will work with staff through the Excellence in Management and Leadership Programme, and through the values and behaviours work, to ensure that we improve the working lives of our staff.

Throughout the year we have continued to work in partnership with trade unions, professional bodies and the Staff Forum to develop policies and practices to manage and support our staff in the workplace. Our Board of Directors has also regularly conducted walkabouts in wards and departments, speaking directly to staff and patients about our services, to understand how we can improve life at the Trust for staff and patients alike. We have also held a number of departmental team building events and focus groups, to enable staff to have a voice, to be recognised and valued, and to enhance motivation across the Trust.

We have briefed our management team and staff on the financial challenges facing the Trust. We have used existing forums such as Team Brief, and scheduled meetings as well as drop-in sessions, to encourage staff to provide ideas to enable us to improve efficiencies. We have also highlighted the potential impact that competition could have on our services and stressed the need for us to ensure that we constantly provide the highest quality services in the most cost effective, efficient way.

Workforce Key Performance Indicators

Our performance against the Workforce Key Performance Indicators is shown below. Disappointingly we saw a slight increase in the level of sickness absence, although the target that is set is a very challenging one. In 2011 we will implement a Health & Wellbeing Strategy which will include a range of health promotion initiatives in the workplace, to try and improve this health and well-being across the Trust.

No. of Staff	Sickness Absence 2010/11	Appraisal Coverage	Mandatory Training	Turnover
	4.22%	80%	83%	6.67%
Target	3.8%	85%	85%	10%

Equality and Diversity

We are committed to ensuring that equality, diversity and human rights considerations are at the centre of our organisation. These considerations are regularly monitored by the Trust's Workforce Committee, which is an assurance committee of the Board of Directors, and ensures that staff are not disadvantaged or discriminated against.

This year we have developed a revised Singe Equality Scheme to reflect changes in legislation, and support our Patient Experience Vision. We are currently in the process of consulting with our Members and local special interest groups on the proposed scheme. The consultation period ends in April 2011.

We have again assessed ourselves against the NHS North West Equality Performance Improvement Toolkit, to ensure that we are effective in the way that we monitor and collect quality assurance data; in our partnership working and effective engagement skills, in our delivery of evidence based Equality Impact Assessments and in the way that we train our staff. Liverpool Primary Care Trust has commended our progress to date and their feedback will inform our action points for this year.

Equality, Diversity & Human Rights (EDHR) issues are monitored by the Trust's Workforce Committee, which is an assurance committee of the Board of Directors. 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.

Staff who develop a disability during their employment are supported to continue working through rehabilitation and redeployment where appropriate. This may include training for a new role. Career progression is based upon an individuals ability to undertake a role. Where possible, reasonable

adjustments are made for staff with a disability and the Trust ensures that it meets all of its obligations in accordance with the Disability Discrimination Act.

Demographic Workforce Profile

	2009/10	%	2010/11	%
Age Band				
16 - 20	11	0.83%	12	0.87%
21 - 25	100	7.58%	102	7.40%
26 - 30	125	9.47%	142	10.30%
31 - 35	207	15.68%	196	14.21%
36 - 40	199	15.08%	204	14.79%
41 - 45	208	15.76%	216	15.66%
46 - 50	220	16.67%	220	15.95%
51 - 55	123	9.32%	153	11.09%
56 - 60	71	5.38%	77	5.58%
61 - 65	44	3.33%	45	3.26%
66 - 70	10	0.76%	10	0.73%
71 & above	2	0.15%	2	0.15%
Ethnicity				
White	1154	87.42%	1210	87.74%
Mixed	7	0.53%	14	1.02%
Asian or Asian British	117	8.86%	118	8.56%
Black or Black British	13	0.98%	13	0.94%
Other	29	2.20%	24	1.74%
Gender				
Male	349	26.44%	357	25.89%
Female	970	73.48%	1022	74.11%
Transgender	0	0.00%	0	0.00%
Recorded Disability	7	0.53%	38	2.76%
Total	**1,320**		**1,379**	

We have accurate information relating to ethnicity, gender and age. Information relating to the recruitment and selection of staff is analysed by ethnicity on a bi-annual basis and is reported to the Workforce Committee.

Health & Wellbeing

We support the national wellbeing agenda by providing a dedicated on site Occupational Health Service, which is available to all our staff. Our service also provides advice and support to managers in considering issues such as re-deployment of staff.

In addition, we also report on a number of health and safety key performance indicators to our Health and Safety Assurance Committee, for example, stress related absence and illness. This enables our managers to address any areas of concern, and in turn maximise the wellbeing of our staff, and support them to deliver our Patient Experience Vision.

Liverpool Heart and Chest Hospital Appeal

a matter of life and breath

Our Hospital Appeal

NHS funding ensures that we provide our patients with a first class service, but there is always a need for additional income so that we can further enhance patient care. This additional income is generated by our hospital's Appeal.

Despite the current economic climate, the level of support for our hospital's Appeal has continued to grow this year.

Staff support has intensified, particularly amongst our charity events. This year was a record breaker for our annual Hope Mountain Hike event - we raised the highest amount of money ever (£6,400) and also had the highest number of entrants taking part.

The Johnson Foundation donated a further £25,000 this year to support a full time research fellow in cardiology. Under the supervision of Consultant Cardiologist, Dr. Rod Stables, this project will focus on hypertrophic cardiomyopathy, an inherited heart condition that affects about 1 in 500 people in the UK.

Merseyrail have nominated our hospital as their Charity of the Year for 2011. Their staff are hoping to raise in excess of £75,000 so that we can develop our Minimal Access Mitral Valve Service. This new service is hugely beneficial to patients, so we are extremely grateful for this generous support.

Our Appeal Chairman, Alan Birchall (left) with Merseyrail's Managing Director, Bart Schmeink at their official Charity of the Year Reception

Our targets for 2011/12 are highly ambitious. Every penny received through our Appeal helps to support all aspects of our specialist services, for example, providing extra comfort on the wards, helping towards the purchase of key pieces of medical equipment, or supporting patient-centred research and developing our staff to improve their clinical techniques.

We would like to offer our sincere thanks to everyone who has continued to contribute towards the success of our Appeal. In particular, we would like to pay tribute to Mr. Alan Birchall, who has been the Chair of Liverpool Heart and Chest Hospital Appeal for ten years. Despite running his own highly successful business, Alan continues to devote an inordinate amount of time and energy to this voluntary role, promoting and raising much needed funds for our hospital.

Donations to our Appeal can be made by cheque, payable to 'Liverpool Heart & Chest Hospital NHS Foundation Trust' and sent to:

Liverpool Heart & Chest Hospital NHS Foundation Trust
Thomas Drive
Liverpool
L14 3PE

Quality Account Summary

This quality account takes a look at the year past and reflects upon the promises wee made to improve quality. We also review what our priorities are for the coming year.

We have met **all six** priorities we set ourselves last year. These were:

1. Reducing the number of deaths in-hospital
2. Improving the outcomes of care in heart attack, heart failure and bypass grafting patients (Advancing Quality)
3. Improving the experience of care for our patients
4. Improving discharge planning and communication
5. Improving the assessment of risk of blood clots (venous thromboembolism)
6. Improving care for patients with a threatened "heart attack" (acute coronary syndromes)

It has truly been a great year for improving the quality of care at our hospital.

We have made a long term commitment to improving the experience of care for our patients so this work continues in 2011/12. Improving discharge and communication remains a strong theme suggested by the people we work with, so work will continue under the banner of reducing readmissions. The third priority we have rolled over is reducing mortality. This is in keeping with the governments desire to improve outcomes (the final result of care) for patients, which will become a national focus in 2012/13. As a whole, these priorities reflect well the needs of our partner organisations, Foundation Trust members and our patients & carers.

This quality account also reassures readers regarding work that is a key enabler of quality, including clinical audit, research, data quality, workforce management and leadership. It draws upon the results from our survey work with patients and other quality improvement work supporting the different services and functions of the Trust. The quality account has also been the subject of discussion with our host Primary Care Trust, Local Involvement Networks, relevant Local Authority Overview & Scrutiny Committees and other interested parties such as the staff working in the Hospitals with whom we work.

Part 1: Statement on Quality from the Chief Executive Officer

It is my pleasure to introduce to you the third quality account to be published by the Liverpool Heart & Chest Hospital NHS Foundation Trust.

The Trust Board has a very strong commitment to quality which is reflected in our mission:

"Excellent, compassionate and safe care for every patient every day"

From this flows our vision which is:

"To be the premier integrated cardiothoracic healthcare organisation in the country"

This vision encapsulates our commitment to cardiothoracic (heart and chest) care as our core business but advances our desire to develop services which bridge the current divide between general practitioners, local district hospitals and us. This will allow us to reach further into the community and bring the high quality care enjoyed by our patients to more of the population.

To achieve this vision, we have developed seven strategic objectives:

1. **Deliver the 2013 Patient, and Family, Experience Vision.** This is our foremost objective and seeks to put the patient and their family at the very centre of the care we provide. We have developed a "story based" vision which describes what care will look like in 2013 (see appendix 1 for short version) and a six step based pictorial representation (below) as a key message.

2. **Develop integrated services across the local health economy:** We will deliver pathways of care that bring together (integrate) the current divide between general practitioners, hospital doctors and specialist doctors.

3. **Deliver tertiary cardiothoracic services to, and beyond, the Trust's traditional geography:** For some of the care we provide, we will deliver services that attract patients from across the UK and internationally.

4. **Adapt and innovate to manage the transition to being a "hotter" hospital:** We are treating more and more patients on an urgent or emergency basis. This will require extending the capability of the Trust to operate more services 24 hours a day, seven days a week.

5. **Develop a world class research function:** The aim is to become a national knowledge development centre, advancing the treatment of patients with cardiothoracic disease and influencing the new NHS National Commissioning Board.

6. **Maximise the opportunities to develop associated services:** The Trust will develop opportunities to enhance the provision of a range of smaller scale but significant operations, such as education and pharmacy.

7. **Increase the profitability of the private patient service:** The Trust's private patient services will enhance the reputation of the Trust with all commissioners and stakeholders and generate levels of profit that support the Trust's ambitions described in the Patient Vision, clinical service portfolio and research & education.

These objectives are influencing the values and behaviours we want our staff to exhibit in every interaction they have with every patient, carer or family member:

Key Achievements in 2010/11

We have developed and upheld these values throughout 2010/11 which has resulted in another year of considerable achievement, which included:

- Full roll out across the hospital of the patient experience vision
- Being voted best in the country by our patients for overall quality of care as assessed by our patients in the National In-Patients Survey
- Achievement of the National Health Service Litigation Authority (NHSLA) level 3 risk management standards which measure how safe our systems and processes of care are – this is the highest level currently achievable
- Joint winners for Patient Experience and Quality Improvement in the Liverpool Primary Care Trust Quality Awards
- Exceptional feedback on the quality of our lung cancer services from the National Lung Cancer Peer Review
- Excellent results from our environmental assessments
- The development of a new volunteers scheme
- Selection as one of only two national pilot sites for ground breaking research in screening for lung cancer
- Winner of major funding to take forward innovative heart failure services between the GP and hospitals
- Organiser of several prestigious medical conferences that were centred on sharing the expertise of Liverpool Heart & Chest clinicians with others from around the country
- The establishment of free wireless internet for patients, relatives, visitors and staff
- Introduction of a new Electronic Prescribing and Medicines Administration System (EPMA) which has made the delivery of medications for patients much safer
- A doubling in the size of our percutaneous coronary intervention service which provides the most effective emergency medical treatment for patients in the throes of a heart attack

- A continuation of our registration with the independent health regulator, the Care Quality Commission without any conditions (that is no concerns expressed or remedial action needed)
- Bringing our services directly into the heart of local communities by offering a new heart diagnostic and rehabilitation service in Knowsley.
- Delivery of the best heart attack, coronary artery bypass grafting and heart failure services in the region
- A doubling in our funding for research and innovation, which allows cutting edge treatments to be brought to our patients as early as possible
- Recognition of our Hospital as an exemplar site for learning from occasions when care has not gone according to plan
- Very low rates of infection shown by only two cases of MRSA and a well below target number of cases of Clostridium Difficile
- Low waiting times for treatment, reflected in around 19 of every 20 patients receiving their procedure within 18 weeks of referral by their General Practitioner
- All minimum standards of care met or exceeded as defined by the Department of Health

Despite this excellent performance, we remain ambitious to improve, and this quality account is the public statement of our commitment to this.

We have led an extensive consultation exercise with our own staff together with our Foundation Trust membership and the hospitals, 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 quality account 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

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Review of Priorities from 2010/11

Priority One: Reduce the number of deaths in-hospital

Category:

Safety

What:

Demonstrate continuous improvement in two of our high volume procedures where a correction for patient complexity is possible.

Why:

Mortality after treatment is a measure of the safety and effectiveness of systems and processes used in caring for patients. However, patient complexity is increasing every year meaning the wrong conclusions can be drawn from simply looking at raw mortality figures.

How much:

Maintaining the observed to expected mortality ratio under one.

By when:

March 2011

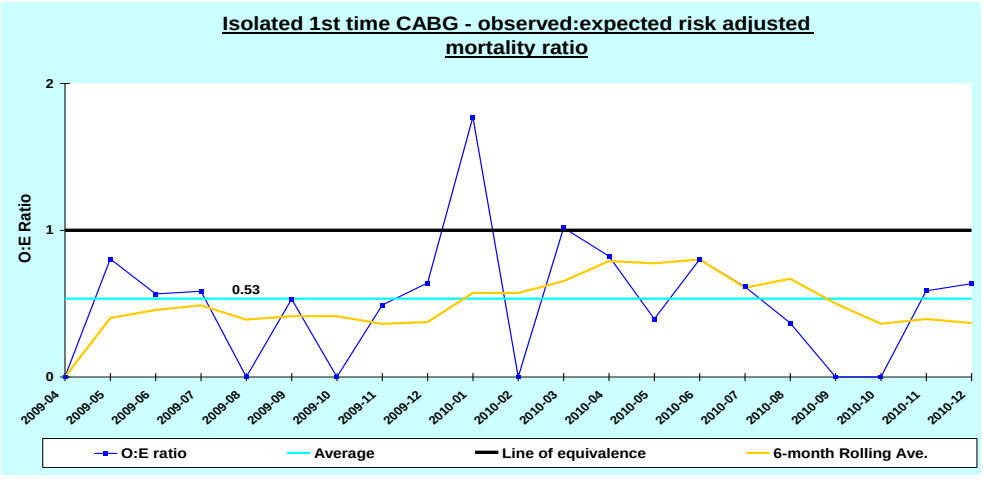
Who collects these data and how?

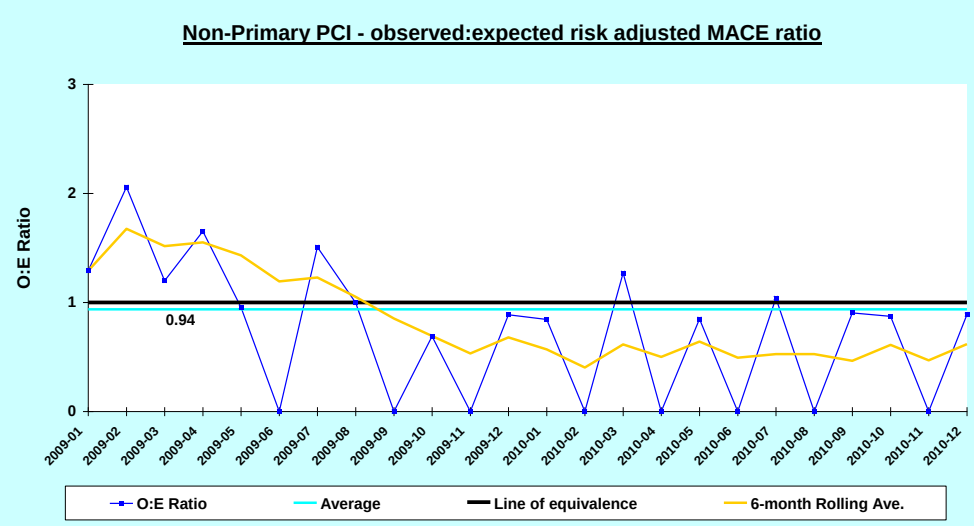
The Trusts clinical coders record on the Trust Patient Administration System the outcome of every patient at the time of discharge. The Clinical Quality Department collect clinical information which allows the correction of raw mortality figures for any pre-existing illness and its severity for each patient.

Result and meaning:

Achieved. The mortality ratio for each high volume procedure (heart bypass and stenting) has remained under one for the 12 months since monitoring began. This means that there were fewer patients dying than we expected from the illness profile of the patients we treated. This does not however cover all of 2010/11 as the information used to risk adjust our performance is complicated and time consuming to gather, and as such, these results run some three months behind.

Current status:





Last year, we said that we believed patients could 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.

Last years quality account also included a commitment to develop a method of identifying harm (which will include mortality) which is not expected as a consequence of the natural progression of the patients' disease. This has also been achieved by introducing a mortality review group which, despite its name, focuses on the identification of and learning from major lapses in clinical care (not just mortality). This year they have made recommendations about remote monitoring of patients following operation, the insertion and ongoing care of chest drains, and the resuscitation and ongoing care of patients suffering a cardiac arrest. This process was recognised during a visit to our hospital by the National Improvement Adviser as exemplar best practice which other Trusts should learn from.

Improvements achieved:

- Achieved 70% perfect care score for sepsis bundle (10% better than target)
- Embedded cross organisational learning from mortality reviews (see above)
- Reduced rates of post-operative bleeding

Keep as future priority?

Yes. A reduction in in-hospital death remains important for the future, particularly as the NHS begins to implement the Outcomes Framework.

Further improvements identified:

- We will publish our performance in mortality on our website
- Embed the good work undertaken by the Mortality Review Group
- Introduce a review of each major service line against the best clinical evidence available

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

How much:

> 98%

By when:

March 2011

Who collects this data and how?

Clinical Quality staff review the casenotes 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".

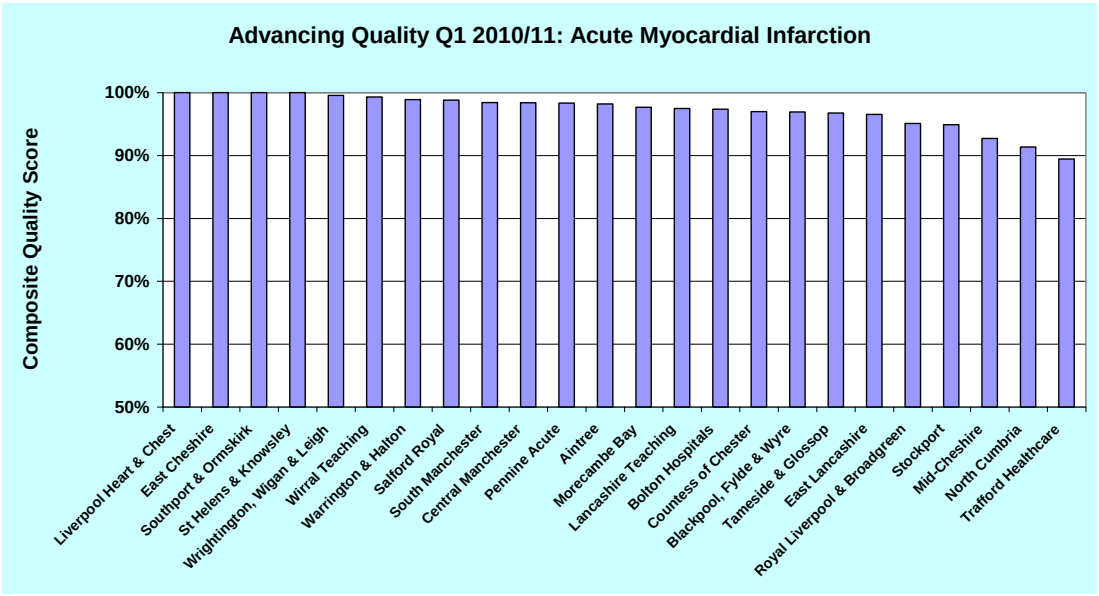
Result and meaning:

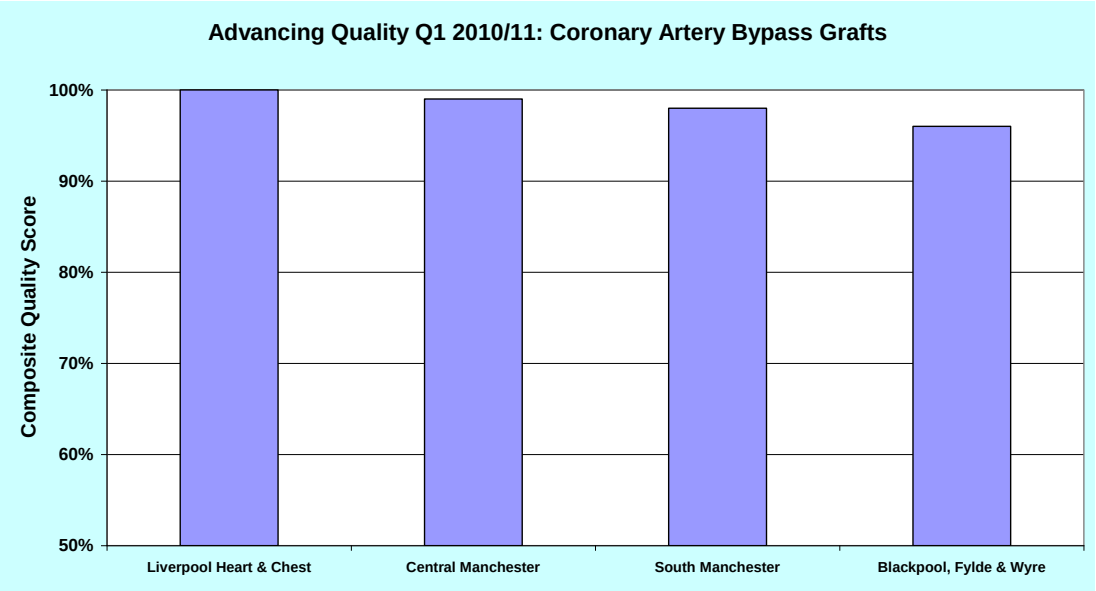
Achieved. Our hospital now leads the North West region in the delivery of the best quality care for heart attack (100% perfect care), heart bypass surgery (100% perfect care) and heart failure (98% perfect care).

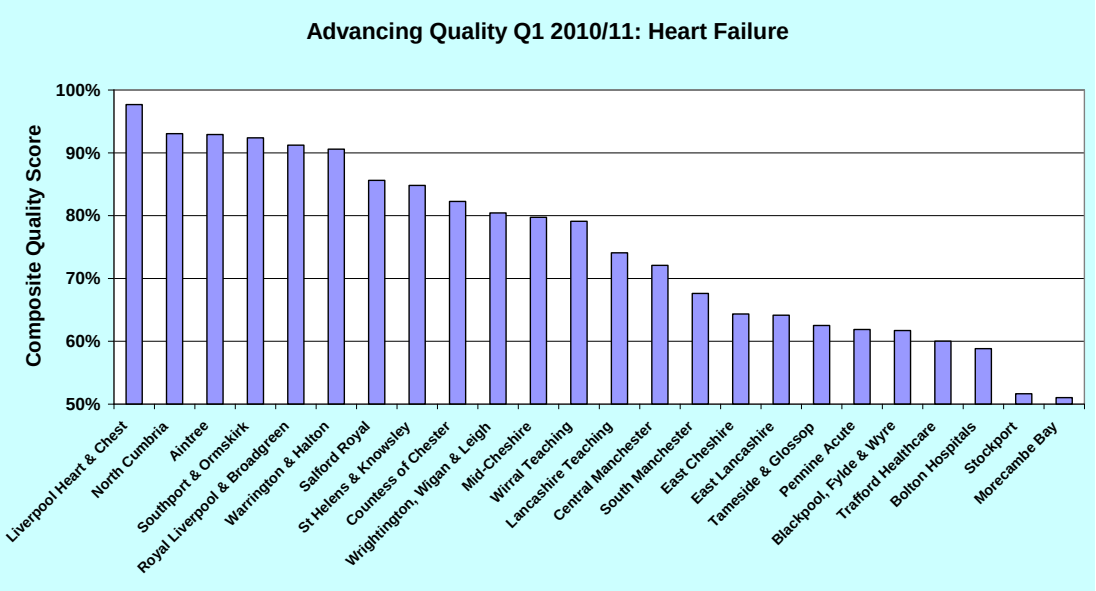
Keep as future priority?

No. As a consequence of this excellent performance, we have chosen to place our improvement effort in areas that will have a bigger impact for our patients**.** We will however continue to be involved in this project until it ceases in October 2011. Results for all Trusts are in the public domain and are available on http://www.advancingqualitynw.nhs.uk/patients.php

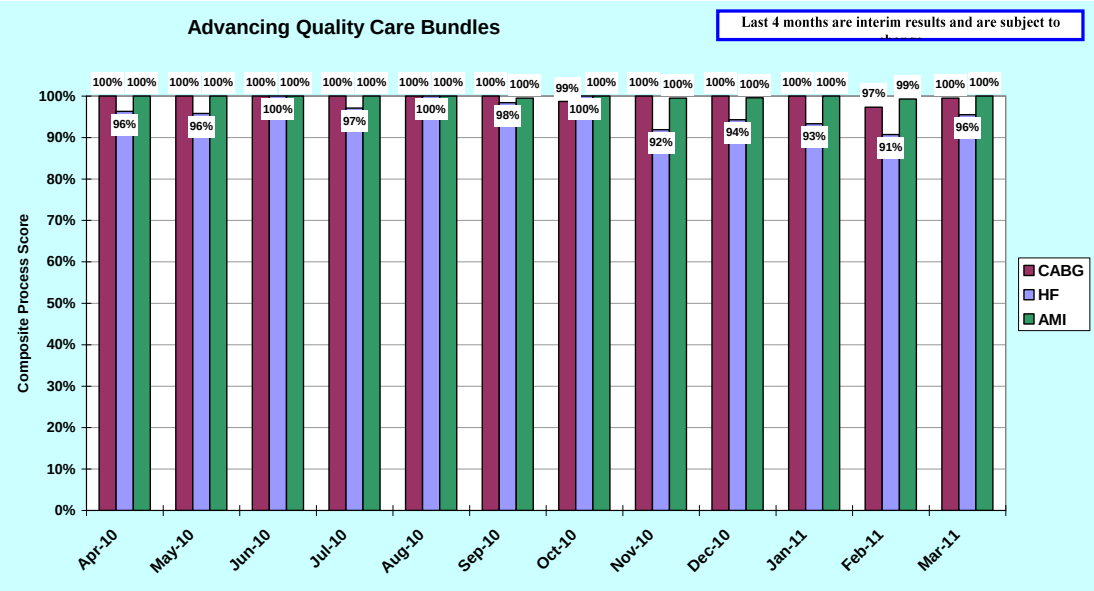
Current status:







The above results show the excellent performance of Liverpool Heart & Chest NHS Foundation Trust against other Trusts in the North West region providing the same services. From the latest available data, this Trust occupies first (or joint first) place on all eligible (cardiac) related measures. Please note, these results are a reflection of performance between April and June 2010, as more recent data are not yet available.



However, our local results (those collected before we submit them for comparison) are more up to date and demonstrate continued good performance. Please note however that the final three months are subject to continuous review until the final data is submitted, so these figures will likely improve further.

Improvements achieved:

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

Priority Three: 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 implement the first year of the plan

Who collects this data and how?

As a means of measuring impact of the plan, 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 Trusts participation in the

National In-patient and Out-patient surveys, the results of which are analysed by the Care Quality Commission.

By when:

March 2011

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. This plan has been delivered as a series of challenging projects, which has included:

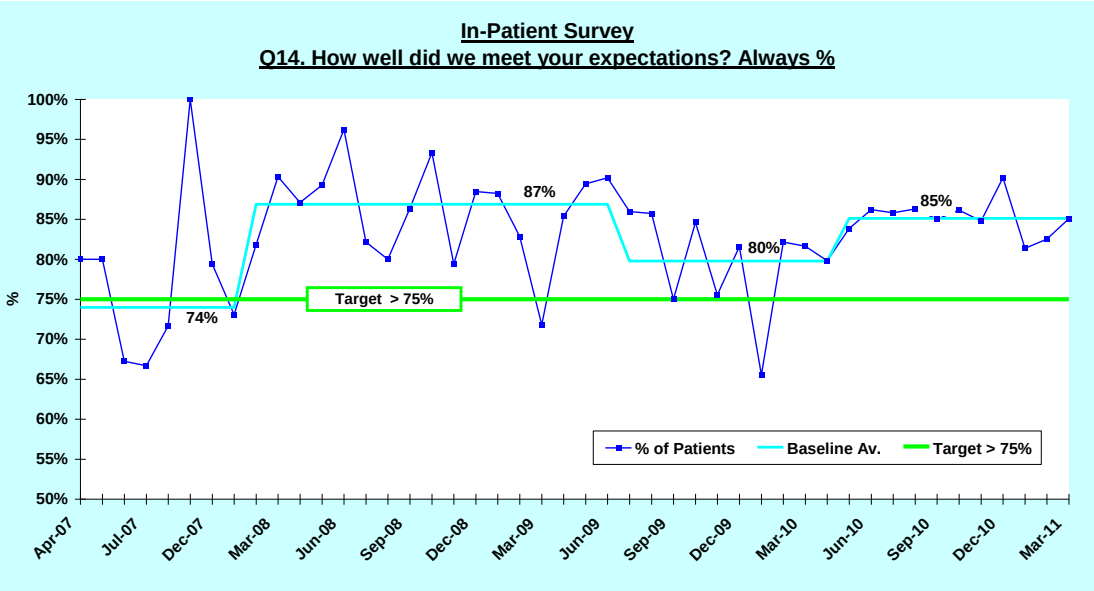
Project	Progress
Changing our culture – values and behaviours	Leadership development programme in place, values and behaviours embedded in our policies, appraisal and recruitment systems
Trialling the specialist support nurse	Proof of concept in a trial which has demonstrated improved experience, reduced length of stay and readmission rates when patients are supported throughout their stay and after discharge
Patient contract	Extensive consultation with patients, carers and staff over the content and structure of a document whose aim is to demonstrate the promises the Hospital is making to the patient about their care and what the patient can do themselves to get the best out of their treatment.
Review of the patient environment	Consultation event held between the Kings Fund, the Hospital and patients, carers and families on the design of areas of the Hospital that are scheduled for redecoration and refurbishment.
Introduction of comfort checks	Regular checks on the patient serving two principal purposes: delivery of high quality care and attentiveness to the patients needs.
A revised volunteers programme	Recruitment of over 40 volunteers who work with staff and patients providing a personalised and vital service.
Gold standard treatment	Commencement of a programme of internal review of major treatments against the very best in the world to ensure our standards of care deliver what our patients deserve.

Keep as future priority?

Yes. Even though we have achieved this priority, improving the patient experience remains the Trusts top ambition for the future. We have developed an ongoing, comprehensive delivery plan which takes us to 2013.

Current status:

The percentage of patients reporting that we meet their expectations **all of the time** is now very consistent, and always well above our target.



Other improvements achieved:

- Presented the patient experience strategy and implementation plan to the Trust Board
- Explored and developed a number of different methods of capturing feedback from the users of our services, and acted on the results
- Introduced a comprehensive ward and departmental based quality checking system as a replacement for the Nursing Assessment and Accreditation tool. This system reviews the quality of clinical care throughout all areas of the hospital
- Implemented a number of changes to the environment to reduce concerns raised regarding mixed sex accommodation
- Participated in the 2010 national in-patient survey and action planned the results
- Introduced a new set of questions in a twice yearly in-patient survey directly aligned to the delivery of those things deemed by the Care Quality Commission as important (the 16 quality and safety outcomes)

Further improvements identified:

- Fully implement the delivery plan arising from the second year of implementation of the patient experience strategy. This will include the further development and pilot testing of the patient contract for at least one major treatment, further testing of the specialist support nurses to be sure of their added value prior to making the role a permanent feature, comprehensive training and development of staff in patient experience, making good any gaps we identify in our treatments against best practice, making the improvements to the physical environment our patients and families have suggested, and the development of new methods of obtaining service user feedback.

Priority Four: Improve discharge planning and communication

Category:

Patient Experience

What:

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

Why?:

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

Who will collect these data and how?

Each year, the Trust participates in the national in-patients 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 was run again in the autumn of 2010 when the same questions were asked.

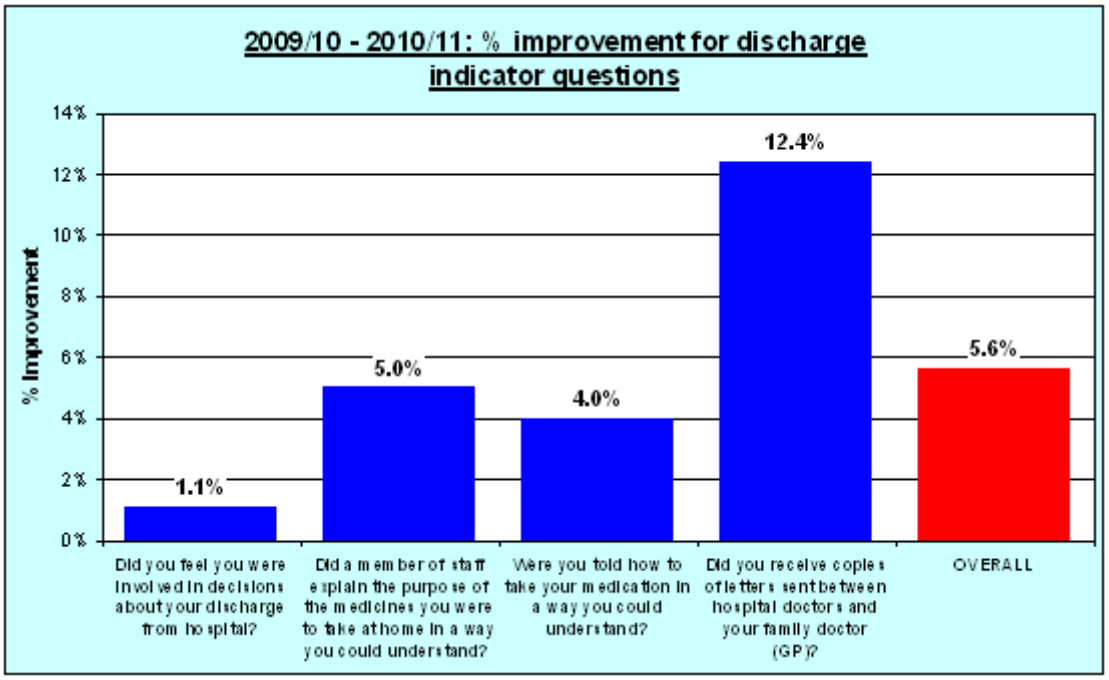
Keep as a future priority?

No. However, discharge planning is an essential component of reducing readmissions which will be a priority for 2011/12 (see new priorities section below).

Current status:

	LHCH 2010/11	**LHCH 2009/10**	**Most Recent National**
Average scores of discharge indicators not ranked in top 20% of performance from national in-patients survey	78.2%	72.6%	72.1%

The graph below shows the improvement in the four key questions from last year to this year.



Improvements achieved:

- Reviewed the function and performance of the discharge planning service and redesigned as appropriate
- Improved information for patients and carers about how to look after themselves once discharged, particularly with respect to medications.
- Increased opportunities for our Nurses to lead the discharge process
- Introduced systems to deliver electronic discharge summaries within 24 hours of discharge to GP's (system not yet active due to technical equipment being required in practices to receive these summaries)

Priority Five: Improve the assessment of risk of blood clot (venous thromboembolism)

Category:

Safety

What is the priority?

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

Why is it important?

Blood clots are responsible for a great many deaths in the NHS each year. Many of these deaths are preventable if the correct anti-clotting 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 on admission to hospital

By when?

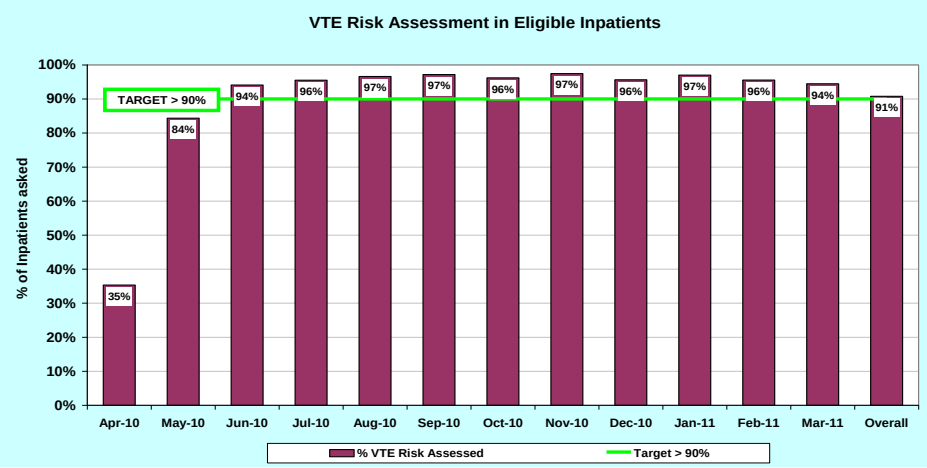
March 2011

Who will collect these data and how?

Whether a risk assessment is performed on admission or not is collected for each patient and entered onto the Patient Administration

System. Each month, results for all admitted patients are summarised, and a performance score derived

Current status:



Keep as a future priority?

Yes. The requirement to risk assess is a national initiative which commenced in April 2010 and this remains a national priority. We will go further by ensuring that patients assessed as at risk receive the correct treatment to reduce their risk.

Improvements achieved:

- Improved patient information to raise awareness amongst patients about the risks of blood clots (venous thromboembolism)
- Embedded a structured risk assessment tool into the admission process
- Educated doctors and nurses how to perform the risk assessment, and deliver the appropriate therapy

Further improvements identified:

- Continued education regarding risk assessment and prescribing on induction training for new staff.
- Explore the possibility of adding an anti-clotting regime to our new electronic prescribing system to automatically remind staff to provide the correct therapy
- Development of a care plan for patients who are prescribed anti-clotting stockings

Priority Six: Improve care for patients with a threatened "heart attack" (acute coronary syndrome)

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 a threatened heart attack.

Why is it important?

The delivery of effective care to all who have the capacity to benefit is an important part of the Trusts 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 (>99%) appropriate patients referred are accepted for transfer.

By when?

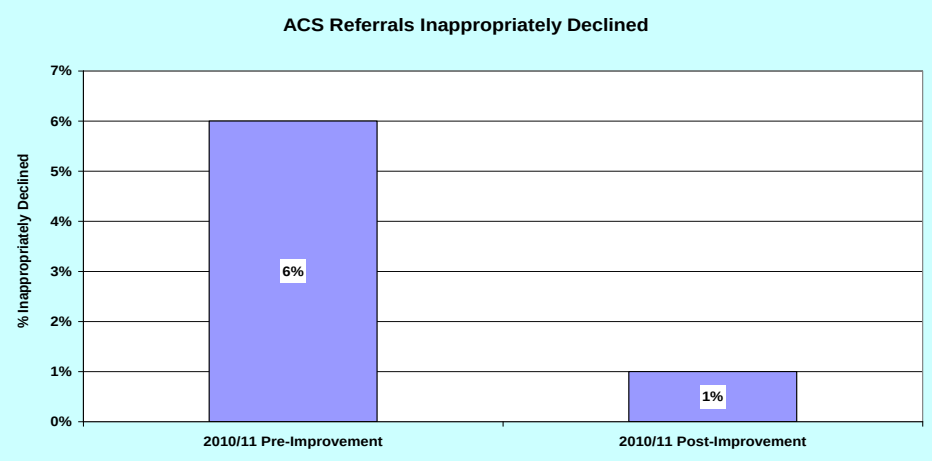
March 2011

Who collects these data and how?

When patients with a threatened heart attack are being referred, 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 have examined how many patients are refused transfer and whether these reasons are not explainable by the patient's inability to benefit alone.

Current status:

Achieved. The percentage of patients who are scheduled for transfer who are subsequently refused for reasons other than capacity to benefit is now 1% - that is, 99% of patients are accepted for transfer. As a consequence of improved performance, we have not continued to monitor this as a matter of routine.



Improvements achieved:

- Recirculated pathway to all doctors and ensure responsibilities are understood
- Improved ability for referring doctors to discuss with doctors at our hospital potential referrals and the capacity to benefit
- Undertook detailed review of patients not accepted for transfer to identify any inconsistencies in the application of the evidence-based guideline

Keep as a future priority?

No. However, as this priority emerged from our colleagues in the hospitals that refer patients to us, we will continue to ensure that we are meeting their needs by conducting a satisfaction survey each year which will ask, amongst other things, whether our adherence to the transfer guidelines remains acceptable to them.

Priorities for 2011/12

This section will review what the Trust is committing to improve **this** year.

From the review of performance in 2010/11, the Trust is pledging to continue the following work:

Priority One: Reduce the number of deaths in-hospital
We will maintain the commitment to a continuous improvement in risk adjusted mortality by keeping the observed to expected mortality ratio for balloon angioplasty and bypass surgery lower than one (that is, keeping the number of deaths fewer than expected).

Priority Two: Improve the assessment of and reduce the risk of blood clot (venous thromboembolism)
We will ensure that over 90% of our patients continue to receive a risk assessment on admission to hospital and that over 90% of those risk assessed receive the correct treatment to reduce their risk of a blood clot.

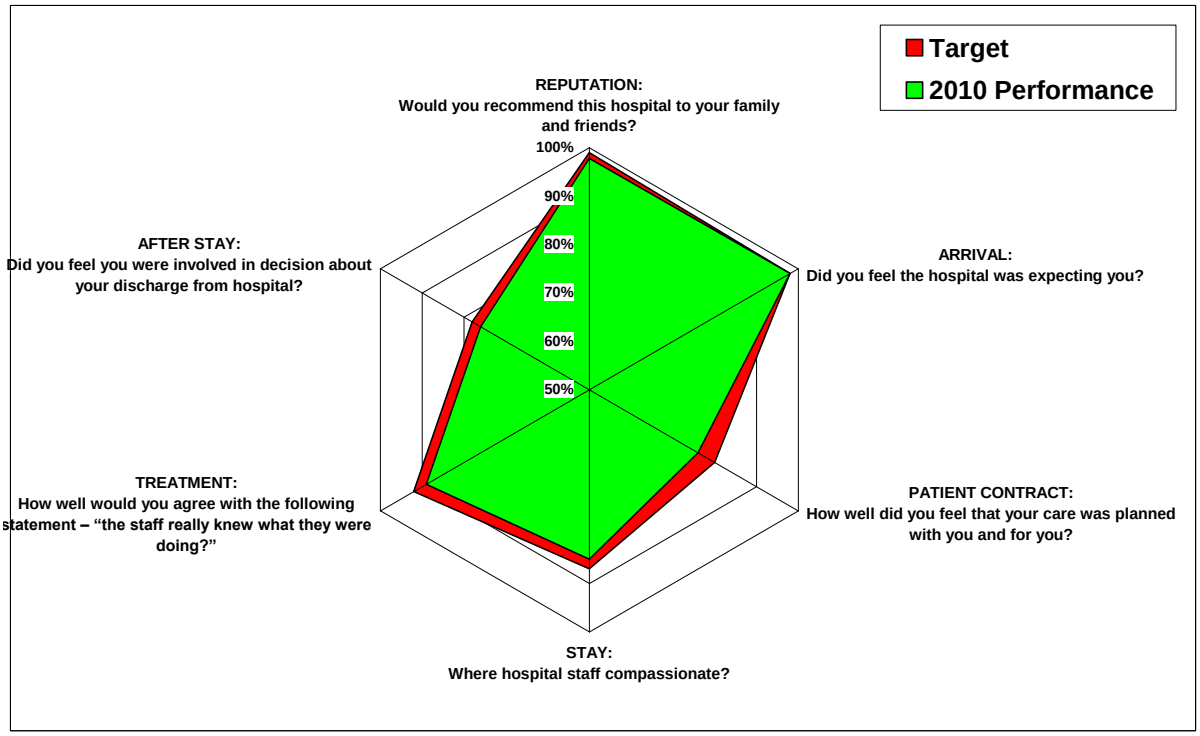
Priority Three: Improve the experience of care for our patients.
We will implement the second year of the plan and measure its impact from the results to six key questions:

1. The percentage of patients who are willing to recommend the Liverpool Heart & Chest Hospital NHS Foundation Trust to their family and friends (target 99%)
2. The percentage of patients who felt they were expected upon arrival (target 98%)
3. The percentage of patients who felt their care was fully planned with them and for them (target 80%)
4. The percentage of patients who report that the hospital staff were compassionate (target 87%)
5. The percentage of patients who report that the staff really knew what they were doing (target 92%)
6. The score from the national in-patient survey which reflects the number of patients who say they were involved in the decision about their discharge from hospital (target 78%)

Additionally, we will continue to monitor overall rates of satisfaction (see 2010/11 priorities above).

Current status:

Current performance against the targets set above is shown below.



What follows are the new **additional** priorities for improvement in 2011/12.

Priority Four: Ensure diabetic patients are referred to the Diabetes Specialist Nurse before their planned operation.

Category:

Effectiveness

What is the priority?

To ensure diabetic patients are referred to the Diabetes Specialist Nurse before their planned operation.

Why is it important?

Poorly controlled blood sugars in diabetic patients before a planned operation increases the risk of infection, leads to poor wound healing and lengthens hospital stay. Once identified from a test called HbA1C, the Diabetes Specialist Nurse can work with these patients to bring unstable or blood sugars under control in the time up to their operation. Approximately one quarter of patients receiving an operation at Liverpool Heart & Chest Hospital have diabetes.

How much will we improve?

Our target is to ensure 60% of patients with diabetes are referred to the Diabetes Specialist Nurse prior to receiving their planned operation.

By when?

March 2012

Who will collect these data and how?

The Diabetes Specialist Nurse is referred patients with diabetes following acceptance for an operation. The Clinical Quality Department determine from hospital computer systems the number of patients who have diabetes, and matches this up with the referrals. The result is expressed as the percentage of all patients who have diabetes who have been referred to the Diabetes Specialist Nurse.

Current status:

Pilot data has revealed only approximately 4% of patients with a poorly controlled blood sugar are currently referred to the Diabetes Specialist Nurse.

Improvements identified:

- Inclusion of the new diabetes pathway in the casenotes of every diabetic patient. This will prompt staff to refer to the Diabetes Specialist Nurse.
- Explore the creation of an electronic referral system which identifies out of range blood sugars from our blood tests and automatically alerts the Diabetes Specialist Nurse.

Priority Five: Improve attendance to cardiac rehabilitation classes for those patients resident in Knowsley

Category:

Effectiveness

What is the priority?

To improve attendance to cardiac rehabilitation classes for those patients resident in Knowsley. Knowsley has been singled out because Liverpool Heart & Chest Hospital provide this service as part of a community cardiovascular contract for this Primary Care Trust only.

Why is it important?

Cardiac rehabilitation following a major cardiac operation is known to be very effective in improving exercise capacity, promoting lifestyle change (such as stopping smoking, eating a healthy diet) and overcoming any anxiety and depression associated with the illness. Cardiac rehabilitation is known to be underused and as such there is a national “push” to improve attendance.

How much will we improve?

Our target is to ensure 75% of eligible patients attend the cardiac rehabilitation classes.

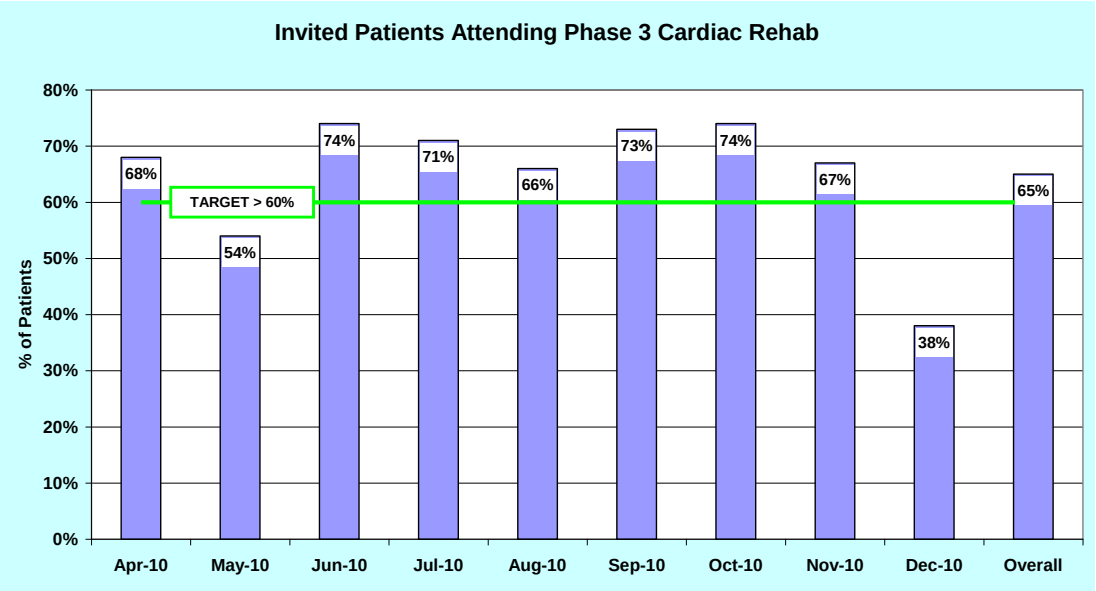
By when?

March 2012

Who will collect these data and how?

The Community Cardiovascular Disease Service Line Manager gathers the percentage of eligible patients attending the Knowsley cardiac rehabilitation class every month. This information is reported to Knowsley Primary Care Trust as part of performance monitoring against the contract.

Current status:



Improvements identified:

- Additional 'traditional' sessions available at different times in more locations
- Continued development of a greater choice of rehabilitation options e.g. wii fit, use of high tech pedometers for home use
- Expert patients at clinics to recommend the benefits of cardiac rehabilitation
- Reviewing bottlenecks and drop off of interest in the run up to starting cardiac rehabilitation
- Work with GPs to ensure they encourage patients to attend cardiac rehabilitation (e.g. letters on non attendance and patient progress, possible visits to GP surgeries, demonstration of the benefits from clinical data and research)

Priority Six: Reduce rates of readmission to our Hospital and to those with whom we work

Category:
Effectiveness

What is the priority?

To reduce the rates of readmission to our Hospital and to those with whom we work that occur within the first 30 days following discharge.

Why is it important?

A readmission requires an additional unplanned admission to hospital, often to receive healthcare related to the complaint that caused the original admission. This is not only an unsatisfactory experience for the patient, but does expose them to the risks of any repeated treatment, and hospital acquired infections. Moreover, the patients overall costs of care are increased.

How much will we improve?

Our target is to reduce the rate of readmission in patients who were originally admitted for a planned procedure by at least 25% and for those originally admitted for an unplanned procedure by 25% also.

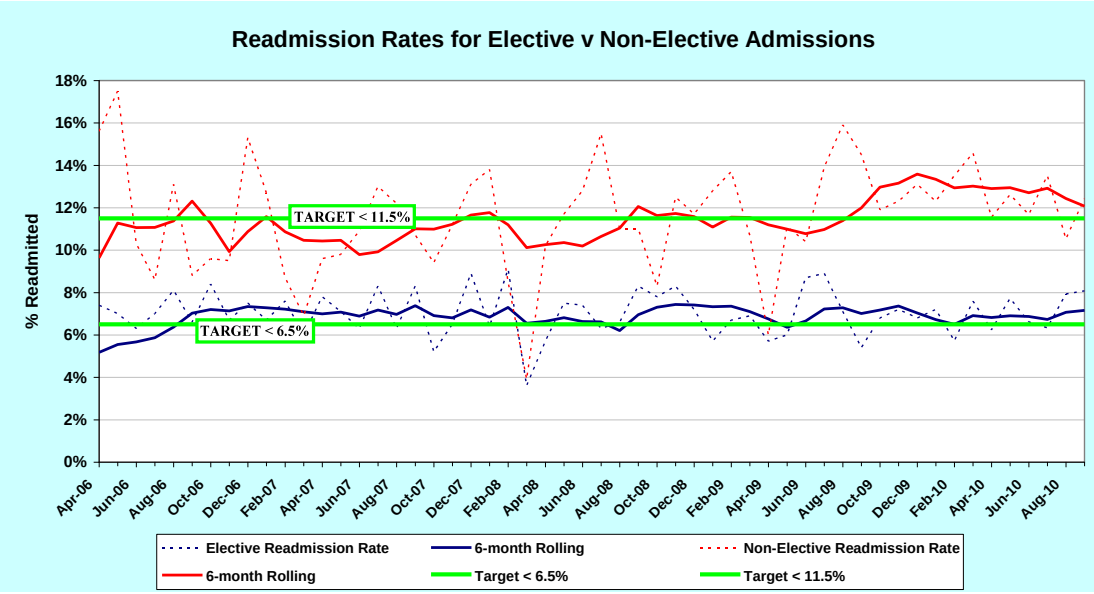
By when?

March 2012

Who will collect these data and how?

The Trust subscribes to an information service who measures the readmission of our patients to any English hospital. Unfortunately, this information takes time to be gathered and processed and as such runs approximately six months behind the present time.

Current status:



Improvements identified:

- Embed readmission risk assessment and appropriate action (follow up calls and / or referral to the Community Matron service as risk dictates)
- Continuous telephone help available from our expert staff 24 hours a day, seven days a week
- Implement hand held records for patients receiving treatment for heart attack
- Standardise the discharge process and introduce teachback – a structured way of ensuring patients are retaining information they will need once discharged
- Improve the timeliness and quality of the discharge letter for health care professionals who take over the discharged patients care
- Review whether our discharge letters (which normally follow a few weeks later) are adding value above the discharge summary (that the patient receives on discharge) and make the necessary changes to our processes
- Ensure we provide a copy of any letter exchanged between health care professionals to any patient who wish to receive them
- Explore the potential for community services to manage some patient complications outside of hospital

Please note: It is well known that ineffective discharge is one of the biggest causes of readmission. As such, some of the work above involves improving the discharge process yet further, despite it not being a priority on its own this year.

How our priorities were selected

In the pursuit of our goal to deliver the best outcomes and be the safest integrated healthcare organisation in the country, throughout 2010/11 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 priorities 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, new policy directives and quality incentive schemes (e.g. Commissioning for Quality & Innovation (CQUIN) and Advancing Quality)
3. Our quality, safety and patient experience Council of Governors sub-group, who are continuously identifying priorities from the Trust's 9,000 plus members.
4. Our members and the general public, who have provided suggestions for improvement throughout the year via focus groups and a structured questionnaire which is handed out at every "Medicine for Members" engagement event we have run in the local communities we serve
5. Our local involvement networks (LINkS), who have held a series of engagement events which has brought all Trusts in Liverpool into direct contact with the LINkS representatives from Liverpool, Knowsley and Sefton.
6. Issues raised by our patients arising from both national and local surveys.
7. Our key stakeholders (the doctors, nurses and managers from referring hospitals, our commissioners, patient self help groups, higher education institutions) who from two dedicated workshops (one held in Liverpool, the other in Wrexham, North Wales) identified a range of improvements they would like to see implemented which they felt would improve relationships with the Trust.

Priorities were shortlisted by the Executive Team based upon the gap in performance between LHCH 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 Trusts Clinical Quality Committee who recommended the final shortlist of priorities to the Trust Board. The Trust Board reviewed and agreed the priorities in April 2011.

This process was developed and tested last year, and has been further improved this year. Like last year however, the process has and resulted in two of the suggestions from stakeholders external to the Trust being accepted as priorities, namely:

1. Improve attendance to cardiac rehabilitation classes for those patients resident in Knowsley

2. Reduce rates of readmission to our Hospital and to those with whom we work

The readmission priority will also include work on discharge planning which emerged as a strong theme from our stakeholder engagement events.

Next year we will improve and extend this engagement process yet further through implementation of a defined engagement plan.

Review of services

During 2010/11 the Liverpool Heart & Chest Hospital NHS Foundation Trust provided and/or sub-contracted 11 NHS services.

Liverpool Heart & Chest Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 11 of these NHS services. The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by the Liverpool Heart & Chest Hospital NHS Foundation Trust for 2010/11.

Participation in Clinical Audits

During 2010/11, 11 national clinical audits and 2 national confidential enquiries covered NHS services that Liverpool Heart and Chest NHS Foundation Trust provides.

During that period Liverpool Heart and Chest NHS Foundation Trust participated in 73 % 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 NHS Foundation Trust was eligible to participate in, participated in, and for which data collection was completed during 2010/11, 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.

All National Clinical Audits recommended for 2010/11 (54 in total)

Audit Title	Eligible to participate Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
Peri- and Neonatal		
Perinatal mortality	No	Not relevant -This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Neonatal intensive and special care	No	Not relevant -This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Children		
Paediatric pneumonia Paediatric asthma Paediatric fever Childhood epilepsy Paediatric intensive care Paediatric cardiac surgery Diabetes	No	Not relevant -Paediatric services are not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Acute care		
Emergency use of oxygen.	Yes	LHCH intend to join the BTS national oxygen audit in the summer 2011.
Adult community acquired pneumonia.	No	Not relevant - Audit of the management of Community Acquired Pneumonia (CAP) in adults. Audit captures data relating to acutely ill medical patients admitted to hospitals. Such patients would be admitted to the A & E or Medical admissions unit at the local DGH
Non-invasive ventilation.	No	Not relevant - Audit captures patients admitted to hospital out of hours with conditions such as Cardiogenic pulmonary oedema and Acute Exacerbations of COPD as reasons for NIV. Such patients would be admitted to the A & E or Medical admissions unit at the Local DGH
Pleural procedures.	Yes	If audit is repeated LHCH medical directorate will consider participating. Unless criteria changes this audit is not applicable to the surgical directorate.
Cardiac arrest.	Yes	Registered (July 2010) and to begin collecting data(April 2011) in line with the release of a minor revision to the dataset
Vital signs in majors.	No	Not relevant - Audit is applicable to Emergency departments
Adult critical care.	Yes	Participating: 320 /320 (100%) submitted to ICNARC case mix programme
Potential donor audit.	No	Not relevant. From 1 April 2006, patients aged over 75 years and cardiothoracic Intensive Care Units have no longer been audited.
Long term conditions		
Diabetes.	No	Not relevant - This audit collects data for people with diabetes from primary care, secondary care and specialist paediatric units focussing on four key questions based on the diabetes NSF which are not relevant to LHCH, hence it is not appropriate to participate.
Heavy menstrual bleeding.	No	Not relevant - This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Chronic pain.	No	Not relevant - This audit is designed to look at the provision of services for chronic pain management in primary and secondary care. As a tertiary referral centre which provides a pain service for acute pain only, not

Audit Title	Eligible to participate Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
		appropriate for the LHCH to participate in this audit.
Ulcerative colitis & Crohn's disease.	No	Not relevant -This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Parkinson's disease.	No	Not relevant -This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
COPD.	No	LHCH do not admit COPD patients as emergencies, such patients get admitted to the A & E or Medical admissions unit at the Local DGH
Adult asthma.	No	This national audit is of care of acute asthma admissions in the UK. LHCH patients are not suitable for the asthma audit as acute asthma patients get admitted to the A & E or Medical admissions unit at the Local DGH
Bronchiectasis.	Yes	LHCH are reviewing criteria for eligibility and discussing future participation if appropriate
Elective procedures		
Hip, Knee and ankle replacements	No	This procedure is not undertaken at LHCH as a specialist tertiary trust for Heart and Lung disease
Elective surgery	No	Not relevant -The four clinical procedures covered in this audit are not undertaken at LHCH as a specialist tertiary trust for adult heart and lung disease
Cardiothoracic transplantation	No	This procedure is not undertaken at LHCH as a specialist tertiary trust for adult heart and lung disease
Liver transplantation	No	This procedure is not undertaken at LHCH as a specialist tertiary trust for adult heart and lung disease
Coronary Angioplasty	Yes	Participating: Cardiac interventions percutaneous coronary intervention (BCIS). A total of 2785 cases for 2010 (100%) have been submitted.
Peripheral vascular surgery	No	This procedure is not undertaken at LHCH as a specialist tertiary trust for Heart and Lung disease
Carotid interventions	No	Only undertaken concomitantly with cardiac surgery and submitted as part of Adult Cardiac Surgery Audit
CABG & valvular surgery	Yes	Participating: Adult cardiac surgery data submissions are undertaken every 12 weeks as required by CCAD. FY 10/11 Q1 460 Cases Submitted (100%) Q2 490 Cases Submitted (100%) Q3 423 Cases Submitted (100%) Q4 455 Cases to be submitted by 30/06/2011
Cardiovascular disease		
Familial hypercholesterolemia.	No	Not relevant -This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Acute myocardial infarction and other ACS.	Yes	Participating: 795/795 (100%). Data submission is due 31/05/2011 for remaining 2010/11 data to CCAD.
Heart failure.	Yes	Participating: 213/213 (100%) submitted to CCAD
Pulmonary hypertension.	No	Not relevant – LHCH are referred to Sheffield Specialised Services.
Acute stroke.	No	Not relevant as LHCH do not admit stroke patients as an

Audit Title	Eligible to participate Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
		acute event
Stroke care	No	Not relevant as LHCH does not admit patients following acute stroke
Renal disease		
Renal replacement therapy Renal transplantation Patient transport Renal colic	No	Not relevant -These services are not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Cancer		
Lung Cancer (NLCA)	Yes	Participating: 264/264(100%) have been submitted having been first seen at LHCH in 2010 as per this audit's criteria. 447/447 (100%) have been submitted for all patients undergoing surgery at LHCH for primary lung cancer These records will be allocated against the diagnosing hospital (location first seen) within the Lung cancer audit report.
Bowel Cancer	No	Not relevant -This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Head & Neck Cancer	No	Not relevant -This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Trauma		
Hip fracture Severe trauma Falls and non-hip fractures	No	Not relevant -a trauma service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
Psychological conditions		
Depression & anxiety Prescribing in mental health services National audit of Schizophrenia	No	Not relevant - Psychological services are not provided at LHCH as a specialist tertiary trust for Heart and Lung disease
Blood transfusion		
O negative blood use.	Yes	Participated: 15/15 (100%)
Platelet use.	No	Not relevant as this was specifically for Haematology patients

National Confidential Enquiries 2010-11

National Confidential Enquiries into Patient Outcome & Death		
Study title	**Eligible to participate Yes / No**	**If No: reason If Yes: % cases submitted**
Surgery in children	No	Not relevant - Service is not provided at LHCH as a specialist tertiary trust for Adult Heart and Lung disease
Peri-operative Care	Yes	Participating: 31 Data collection tools were completed by anaesthetists for procedures undertaken during the study period (1st March for a 1 week period) that met study criteria. 6 cases were selected by NCEPOD for questionnaire and case note extracts and these have been received and all returned. An organisational questionnaire is currently being completed for return by 23rd May 2011.
Cardiac Arrest	Yes	Participating: 3 Data collection tools were completed by the resuscitation officer for procedures undertaken during

		the study period (1st November 2011 for a 2 week period) that met study criteria. 3 cases were completed for the summary spreadsheet and subsequently selected by NCEPOD for questionnaire and case note extracts. These have been received and distributed to clinicians for submission. 2/3 submitted by 20/05/2011.
Bariatric surgery	No	Not relevant - Service is not provided at LHCH as a specialist tertiary trust for Adult Heart and Lung disease

A further 3 confidential enquiries were published during 2010/11 by NCEPOD, that involved data collection in 2009/10. Our participation in 2/3 namely, Parenteral Nutrition and Surgery in the Elderly were reported in our previous years quality account. The third study was in relation to Cosmetic Surgery, which is not relevant to LHCH.

Centre for Maternal and Child Enquiries (CMACE)
Reports published during 2010/11 have been presented at the Clinical Audit and Effectiveness Group throughout the year; none have been deemed relevant to NHS services Liverpool Heart and Chest NHS Foundation Trust provides.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI / NCISH)
Reports published during 2010/11 have been presented at the Clinical Audit and Effectiveness Group throughout the year; none have been deemed relevant to NHS services Liverpool Heart and Chest NHS Foundation Trust provides.

Other National Clinical audits

During 2010/11 Liverpool Heart and Chest NHS Foundation Trust participated in 3 other national clinical audits which require data submission during 2010/11 in addition to those described above.

Audit Title	Participated 2010/11	% cases submitted
Heart rhythm management (pacing and implantable cardiac defibrillators)	Yes	A total of 1496/1496 (100%) pacing and implantable cardiac defibrillators cases and 1448/1448 (100%) EPS cases have been submitted for the reporting period Jan 10 – Dec 10 .
Congenital Heart Disease	Yes	156/156 (100%) Congenital and 20/20 (100%) Infective Endocarditis Data submission is due 31/05/2011 for 2010/11data to CCAD
National Inpatient Survey	Yes	496/850 (58%) of consecutive inpatients identified in time period June/July 2010 responded and were included in the submission

Additionally, the Trust reviewed the results from the below published national clinical audits (but did not necessarily submit data during 2010/11). The improvements below are planned:

National Health Promotion in Hospitals Audit

- Introduce an integrated care pathway for health promotion
- Improve engagement of the 'no smoking' champions

- Increase the capacity of the smoking cessation team – recently agreed with Knowsley Fagends
- Implement lessons learnt from the pilot of the Heart Attack Recovery Pack

National Inpatient Survey

- Improve copying of letters to patients that are written to GP's
- Provision of additional medication Information for different groups of common medicines

National Oesophago-Gastric Cancer Audit

Work with referring Trusts to improve data completeness. Analysis of data completeness within the report is based on 'location first seen' and this disadvantages LHCH being a tertiary treatment centre.

National Heart Failure Audit 2010

Work in collaboration with the Heart Failure Network and Liverpool PCT in the implementation of the Liverpool Heart Failure Pathway (April 2011). Patient's outcomes and re-hospitalisation will be audited in future.

Work in collaboration to train General Practitioners. Our Heart Failure Nurse Specialists attend teaching sessions and are providing training to ward staff.

Use audit findings from the National Heart Failure audit to support the local improvements of heart failure services.

Heart Rhythm Devices: UK National Clinical Audit 2009 (published 2010)

Benchmark our Trust's performance against that of our local Cheshire and Merseyside Cardiac Network performance and compare this to both current national average and national target implant rates. This allows us to identify any populations that are underserved, and bring this to the attention of our commissioners.

National Confidential Enquiries into Patient Outcome & Death reports

Parenteral nutrition (published June 2010)

- Benchmark the nutrition service against best practice.
- Develop a protocol and supporting documentation to initiate Total Parenteral Nutrition
- Implement a framework to develop a nutrition team

An old age problem (published November 2010)

LHCH are meeting all the recommendations that fall under the following categories: Patient co-morbidities, pre-operative care, intraoperative care and post-operative care. However given our specialist nature, we do not have a care of the elderly service on site. Recommendations regarding

the need for input from medicine for the care of older people to support our surgical service therefore requires further work.

The reports of 59 local clinical audits were reviewed by the provider in 2010/11 and Liverpool Heart and Chest NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- Evaluate the impact of the Trust having invested financially in the medical engineering department to recruit a new member of staff to support the planned maintenance of medical equipment.

- Change the personal development review documentation to capture competence training requirements for all staff that use medical devices.

- Improve intensive care unit documentation to ensure patients have been reviewed twice per day, thereby capturing concerns and informing escalation of plans of care.

- Improve communication between the occupational health department and risk management in relation to needle stick injuries. Better dialogue between the two departments will help risk management to support staff members having such injuries.

- Implement the World Health Organisation (WHO) surgical safety checklist for pacing theatre

- Further embed the Trust's clinical audit process following changes in 2010

- Improve the utility of the spirometry database used by the pulmonary function team

- Introduce a new diagnostic heart failure clinic which will use a care pathway to document care provided that is in keeping with NICE guidelines.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Liverpool Heart & Chest Hospital NHS Foundation Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 869.

Compared to 2009/10, we have increased again our participation in studies supported by the National Institute of Health Research. This steady 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. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Liverpool Heart & Chest Hospital NHS Foundation Trust was involved in conducting 15 clinical research studies in the cardiovascular specialty, 9 clinical research studies in the cancer speciality, 7 clinical research studies in the critical care specialty, 5 clinical research studies in the respiratory specialty and 8 clinical research studies in quality of life / outcomes during 2010/11.

The improvement in patient health outcomes in Liverpool Heart & Chest Hospital NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatments for patients.

There were 64 of clinical staff participating in research approved by a research ethics committee at Liverpool Heart & Chest Hospital NHS Foundation Trust during 2010/11. These staff participated in research covering 5 medical specialties.

In the last three years, twenty publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. In the same period a total of 91 peer-reviewed publications have resulted from general research activity. Our engagement with clinical research also demonstrates Liverpool Heart & Chest Hospital NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques.

Research is an essential component of the Trust's activities. It provides the opportunity to generate new knowledge about new treatments or models of care truly deliver the quality improvements anticipated. Ongoing examples are:

- The Impact of Intraoperative Haemofiltration During On-Pump Cardiac Surgery to investigate whether the application of blood filtration (haemofiltration) therapy during the heart and lung bypass operation can lead to improvement in the overall intensive care stay and reduction in kidney injury for patients with known impaired kidney function. It is expected that this will have a greater impact on the treatment and a possible reduction in the prolonged hospital stay and treatment costs associated with these patients.

- A study of **Pu**lmonary **M**etastasectomy **i**n **C**olorectal **C**ancer (PULMICC). Some patients who have been treated for colorectal cancer go on to develop a spread in their lungs. In patients who are fit enough, current treatment includes removing the nodule(s) by surgery (metastasectomy). The patients offered this surgery are usually otherwise well and complications are uncommon but occasionally side effects from lung surgery can be severe. The PulMiCC study is investigating the benefits and possible harms of metastasectomy in patients with colorectal cancer that has spread to the lung.

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

Innovation - doing things differently or doing different things to achieve a step change in performance. This is another commitment that the Trust makes to

improving patient care. As well as the community cardiovascular disease service for the residents of Knowsley which started in 2010/11, the Trust has also embarked on a project that aims to improve care for heart failure patients by working in concert with general practitioners and hospital doctors. Each organisation shares responsibility for the patient's care, with the money for treatment flowing to where it is most needed in the heart failure pathway. Robust measures of performance identify where the focus is needed.

The adoption of innovative practice is governed by the Trust's Clinical Audit and Effectiveness Committee who ensures that new technologies are safe and effective before they are implemented in patient care. An example of an approved technology includes a new method for Intraoperative Spinal Cord Monitoring. Surgery to the main blood vessel feeding the body (descending aorta) carries a risk of paralysis as the blood supply to the spinal cord can be disrupted. The monitor measures the real-time effect of intervention on spinal cord function and significantly improves the margin of safety for these procedures, resulting in better outcomes and reduced costs of care.

Goals agreed with commissioners

A proportion of Liverpool Heart & Chest Hospital NHS Foundation Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between Liverpool Heart & Chest Hospital NHS Foundation Trust and Liverpool Primary Care Trust 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 2010/11 were to:

1. Improve the responsiveness to the personal needs of patients
2. Improve the assessment of risk of blood clots (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.

£1,057,898 was conditional upon achieving the above quality improvement and innovation goals; Liverpool Heart & Chest Hospital NHS Foundation Trust achieved most goals with an underachievement of nursing sickness (a high impact action), readmissions, discharge planning and smoking cessation which resulted in a 5.3% penalty on full payment.

The CQUIN indicators for Liverpool Heart & Chest Hospital NHS Foundation Trust in 2011/12 are to:

- Improve responsiveness to the personal needs of patients
- Reduce avoidable death, disability and chronic ill-health from blood clots (venous thromboembolism; VTE)
- Improve the outcomes and experience of care in heart attack, heart failure and bypass grafting patients (Advancing Quality)
- Implement “harm free care”, building upon last years high impact actions
- Build public health capacity in the workforce, particularly in smoking cessation, alcohol & drug abuse, and weight management
- Improve the transition of care for patients moving from children’s services into our adult services
- Improve the effectiveness of discharge planning
- Improve the dignity of care
- Reduce sternal wound infection rates following cardiac surgery
- Plan the improvement in experience of adult patients with congential heart disease

Further details of the agreed goals for 2010/11 and for the following 12 month period are available from http://www.lhch.nhs.uk/about-us/CQUIN.asp or upon request from Dr Mark Jackson, Associate Director Quality Improvement (e-mail Mark.Jackson@lhch.nhs.uk or telephone 0151 600 1332).

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 registered without externally imposed conditions. Liverpool Heart & Chest Hospital NHS Foundation Trust has never been subject to any conditions on registration.

The Care Quality Commission has not taken enforcement action against Liverpool Heart & Chest Hospital NHS Foundation Trust during 2010/11.

Liverpool Heart & Chest Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2010/11.

Data quality

Liverpool Heart & Chest Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

Developing program of education and awareness raising in data quality which comprises:

- Clear leadership and accountability for data quality which includes the quality of key data items such as ethnicity and other equality data, which in turn will improve our ability to identify and improve deficiencies in service
- Initiation of:

    - Data quality working groups in key administrative functions.
    - A data quality telephone support line, manned in office hours to support staff in all data input queries.
    - Programmes of data quality awareness sessions in wards and clinical areas.
- Identification of key topics each month to identify and resolve by:
    - Using 'message of the day' on key systems
    - Developing monthly Hot Topics e.g. Ward attenders/referral processes
- Work group reports/action plans available to all staff on the intranet; presentations and data quality personnel visits to the specific areas to offer support and guidance as required
- Improvement of the quality of data through development of a new data quality strategy that will improve the collection, storage, analysis, reporting and validation of information
- Awareness raising amongst patients e.g. posters in clinics throughout the trust 'why we collect your data'
- Promoting standards for better data quality. These standards define a framework of management arrangements that bodies can put in place, on a voluntary basis, to secure the quality of the data they use to manage and report on their activities and services
- Providing a drop in session and data quality clinics to support the understanding of key processes and initiatives.

Taken together, this work will ensure all we report is built upon a firm foundation of data quality which will allow us to be ever more confident in our statements regarding the quality of our services and the outcomes it generates.

In testimony to this, extracts from a Recent Audit Commission Report stated:

"The Trust has been proactive in progressing the recommendations from the 2009/10 audit and has maintained the action plan as a live document. Progress has been made against all recommendations, with five recommendations now fully implemented.

Work is ongoing in some areas. The recently appointed Data Quality Manager has been pro-active in reviewing and re-designing the data quality team structure to ensure better quality support across the Trust. Enhancing clinician involvement and ownership of data quality is also ongoing."

Indeed in May the Trust received a national award for its data quality.

NHS Number and General Medical Practice Code Validity

Liverpool Heart & Chest Hospital NHS Foundation Trust submitted records during 2010/2011 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 patients:

	For admitted patient care	For out patient care
Valid NHS number was:	98.4%	99.8%
Valid General Medical Practice Code was:	98.8%	99.7%

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's Information Governance Assessment Report score overall score for 2010/11 was 71% and was graded "green".

Clinical coding error rate

Liverpool Heart & Chest Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

The error rates reported in the latest (2009/10) published audit 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 – 0.4%

These results compare very favourably with other Trusts in Cheshire & Merseyside (see below – we are LH&C).

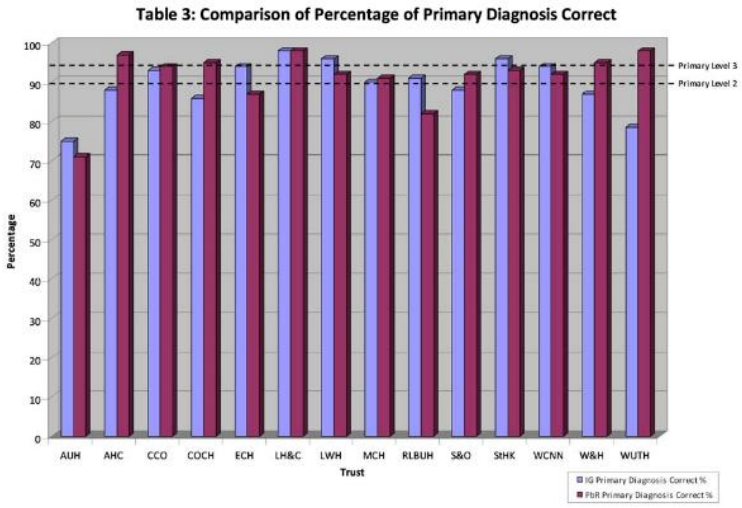


Table 4: Comparison of Percentage of Secondary Diagnosis Correct

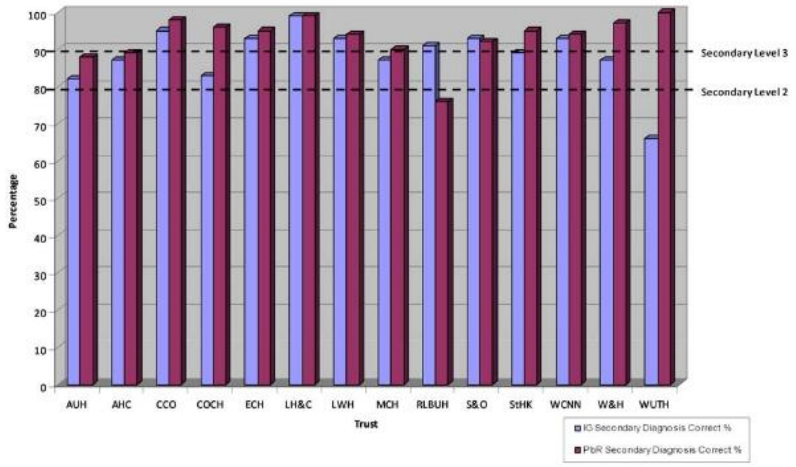


Table 5: Comparison of Percentage of Primary Procedure Correct

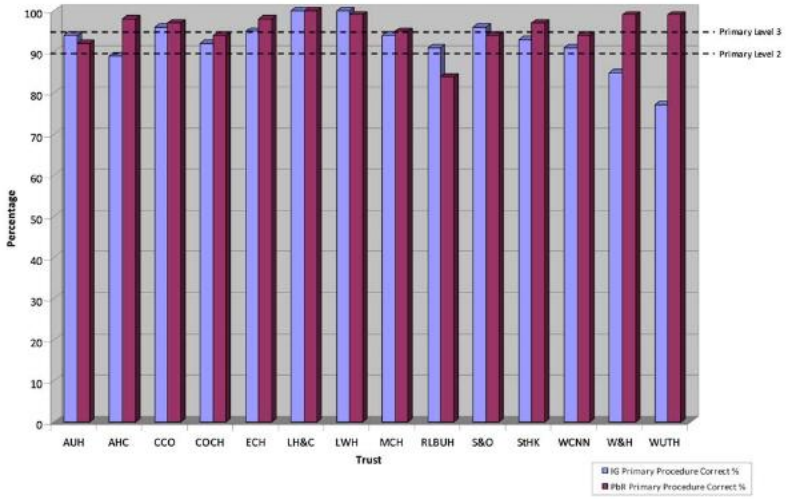
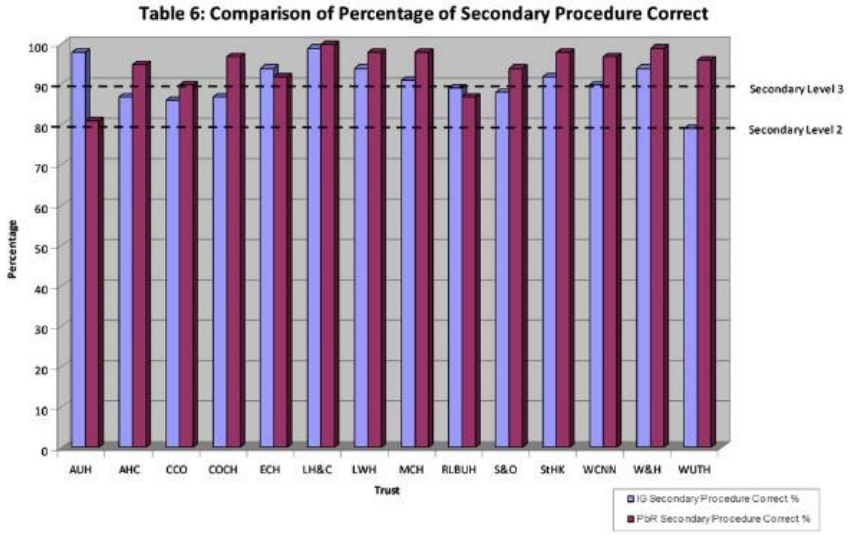


Table 6: Comparison of Percentage of Secondary Procedure Correct



Improvements in coding planned for this year include:

- Improved skill mix of clinical coding staff
- Improved clinician engagement – joint audits and joint meetings
- Clinical coding training Workshops – specific to LHCH

Part 3: review of quality performance (provider determination)

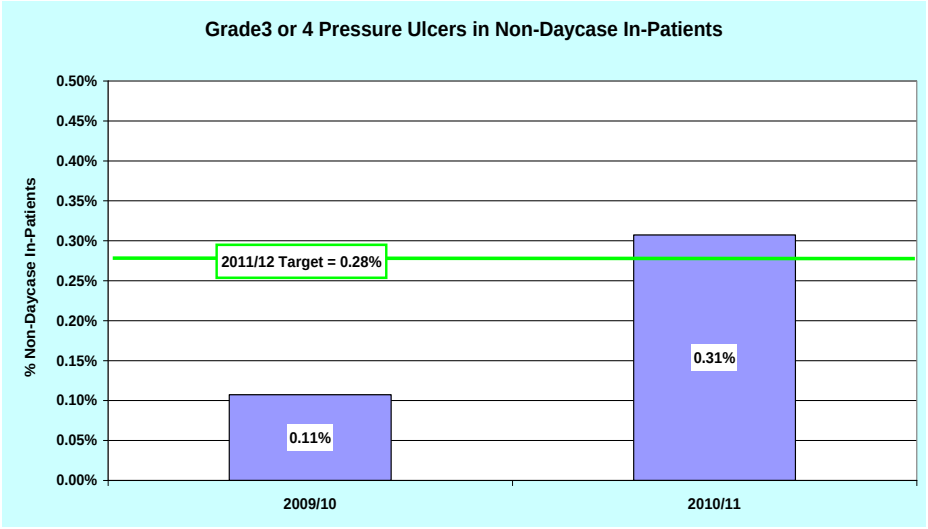
Performance Review

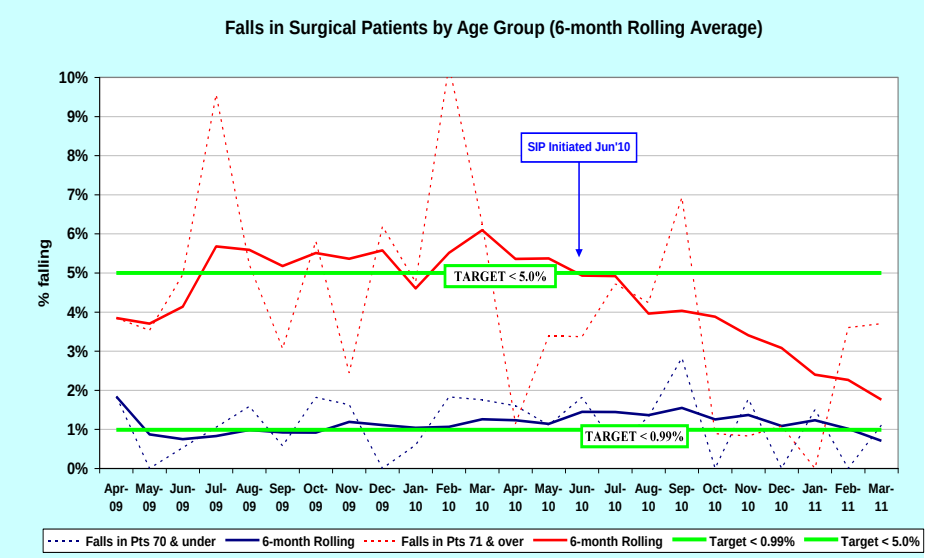
This section of the quality account presents an overview of performance in areas not selected as priorities for 2010/11. Presented are:

- Quantitative metrics, that is, aspects of safety, effectiveness and patient experience which we measure routinely to prove to ourselves the quality of care we provide. Some of these metrics are Commissioning for Quality & Innovation (CQUIN) indicators which are included in our contract with our commissioning Primary Care Trust.
- Qualitative findings, that is, themes emerging from comments provided by patients who have used our services.

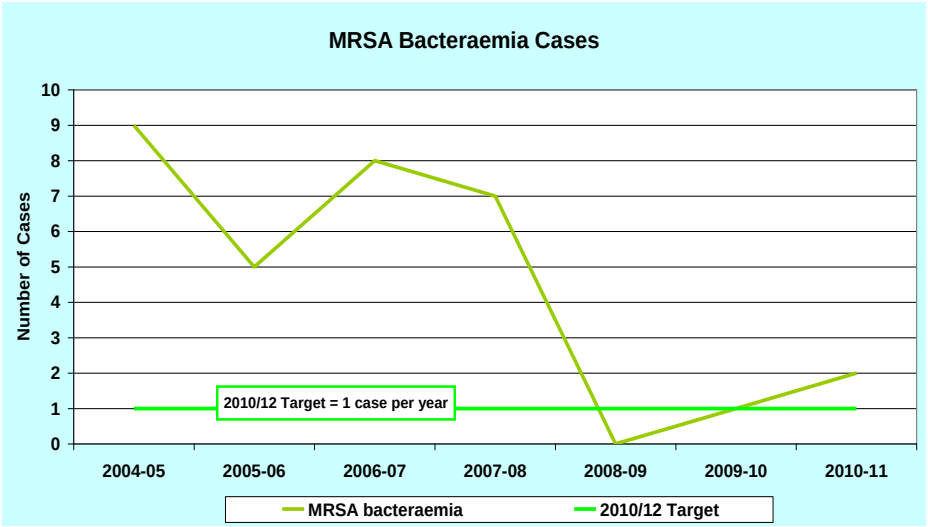
Quantitative Metrics

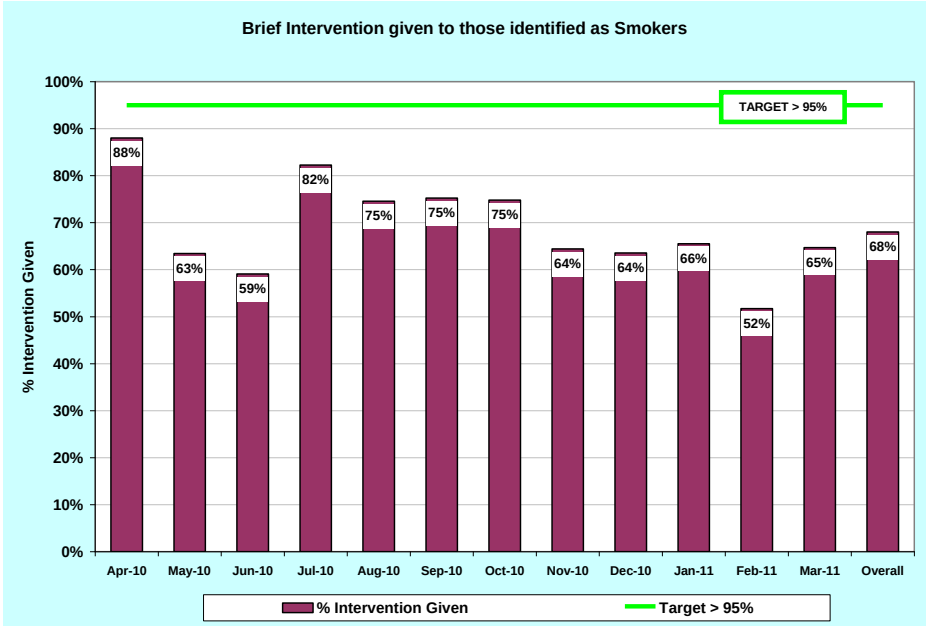
Safety			
Metric	Pressure ulcer incidence	**Organisation Wide or Service Specific**	Organisation Wide
Derived From	Incident reporting	**Why metric chosen**	Pressure ulcers are painful for patients and contribute to a negative patient experience. Nursing high impact action; local CQUIN indicator
How is data collected	Staff who observe a pressure ulcer report this via the Trusts risk management processes	**Improvements planned**	Continued staff education Mattress audits and bed replacement programme Trialling of new pressure relieving aids
LHCH Performance 2010/11	0.31%	**LHCH 2009/10**	0.11%
Interpretation of Results	The number of pressure ulcers suffered by patients has increased this year. However, we have had a major improvement initiative on this topic this year, which has brought more pressure ulcers to light than were reported previously. This is a direct consequence of improved awareness amongst staff. Additionally, the size of the pressure ulcers being reported now are much smaller making them easier to treat. The target on the graph is the one set for this year (going forward).		

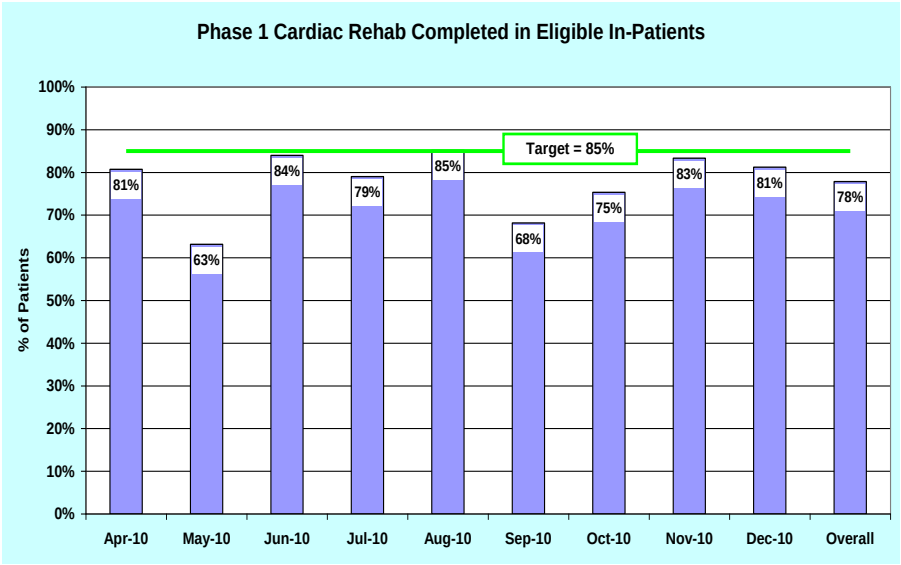


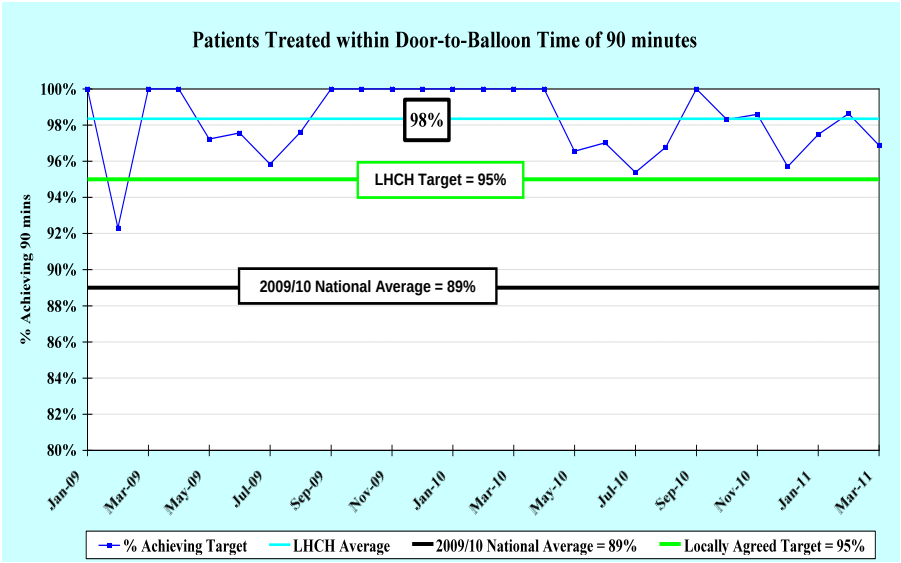
Safety				
Metric	No. patient falls	**Organisation Wide or Service Specific**	Organisation wide	
Derived From	Incident reporting	**Why metric chosen**	Falls have the potential to cause significant harm. Nursing high impact action; local CQUIN indicator	
How is data collected	Staff who witness or become aware of a fall report this via the Trusts risk management processes	**Improvements planned**	Falls risk assessment Care plan for those identified at risk Involvement of family in falls prevention	
LHCH Performance 2010/11	1.8%	**LHCH 2009/10**	2.7%	
Interpretation of Results	Falls has been the subject of a major improvement initiative this year. This has resulted in a dramatic reduction in falls in our elderly patients and a modest reduction in our younger patients.			

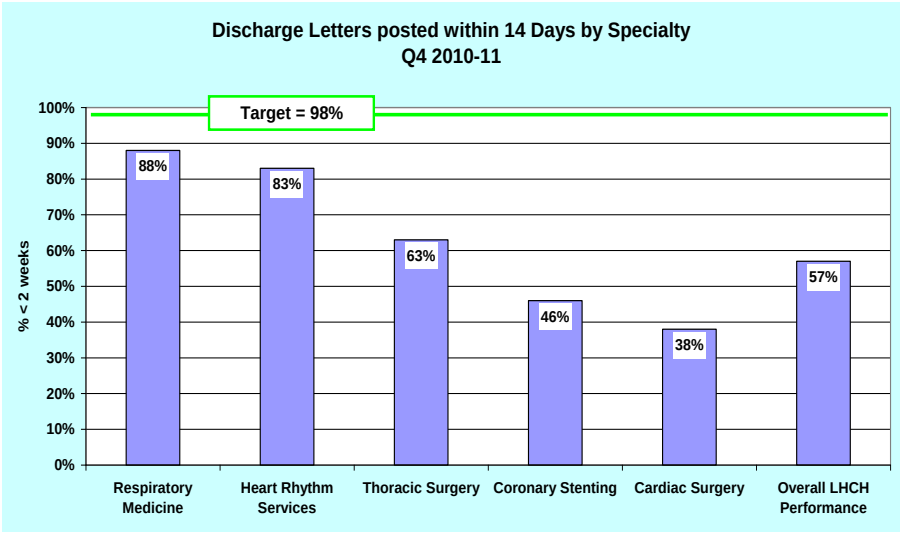
Safety			
Metric	Number of patients acquiring MRSA bacteraemia whilst in hospital	**Organisation Wide or Service Specific**	Organisation wide
Derived From	Infection prevention team	**Why metric chosen**	Major concern of patients; Department of Health priority
How is data collected	Monthly surveillance reported to health protection agency. National definitions of bacteraemia applied.	**Improvements planned**	Continued implementation of infection surveillance programme, strict hand hygiene and cleanliness, infection related care bundles, screening of thoracic surgery patients in peripheral clinics
LHCH Performance 2010/11	2 patients	**LHCH 2009/10**	1 patient
Interpretation of Results	We have seen the number of MRSA bloodstream infections increase to two patients this year. These two cases occurred very close together in time and have been subjected to a rigorous evaluation of the potential causes. No common factors were found. We remain under the target of 6 set by our regulator (Monitor). The target on the graph is the one set for this year (going forward).		

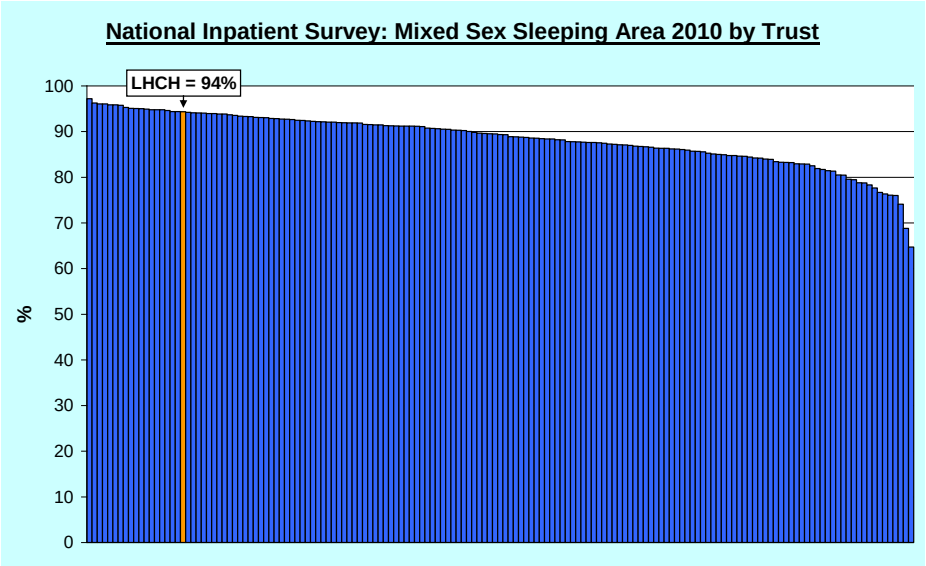


Effectiveness				
Metric	Percentage of patients receiving smoking cessation advice (brief intervention)	**Organisation Wide or Service Specific**	Organisation wide	
Derived From	Internal electronic referrals tool	**Why metric chosen**	Continuing to smoke after treatment greatly raises long term risks of death, heart attack and stroke	
How is data collected	When staff have identified a current smoker they should deliver advice and record this on the Trusts e-referral system	**Improvements planned**	Continued brief interventions training, feedback on performance. Local CQUIN indicator	
LHCH Performance 2010/11	68%	**LHCH 2009/10**	N/A	
Interpretation of Results	This is a new initiative for us and as such there is no previous data from last year. As we have not met the target set, we will continue to improve work on this indicator next year. We are putting on training for staff in how to take brief interventions forward with our patients and have put in place an improved monitoring system that lets our staff know how they are doing.			

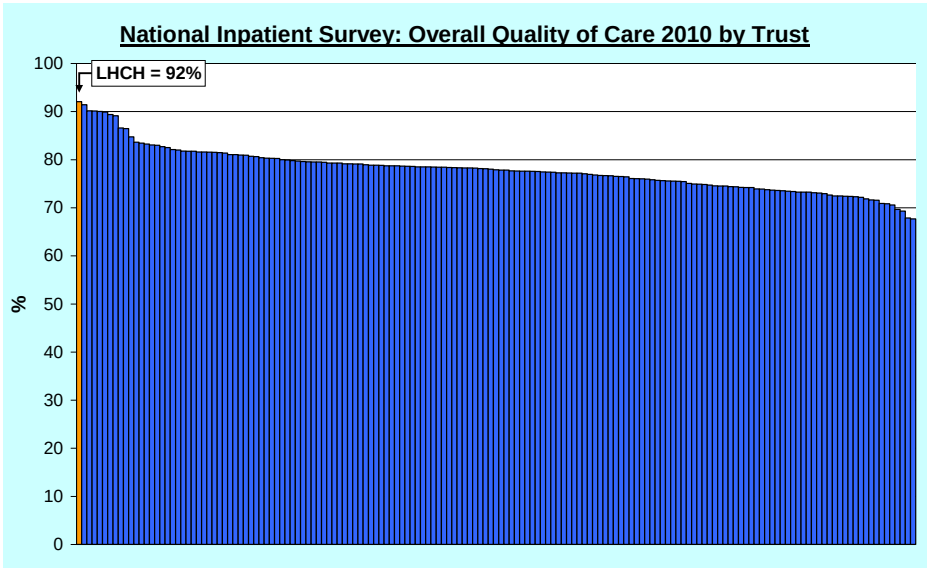
Effectiveness				
Metric	% patients completing phase one Cardiac rehabilitation	**Organisation Wide or Service Specific**	Organisation wide – phase 1;	
Derived From	Local audit figures	**Why metric chosen**	Promotes lifestyle change and reduces future risk of cardiac events such as heart attacks	
How is data collected	When in hospital, patients receiving heart treatments receive a comprehensive educational session about lifestyle and its importance in promoting future wellness. This data is sent to the Clinical Quality Department for analysis.	**Improvements planned**	Improve capacity of service and implement new commissioning framework for cardiac rehabilitation	
LHCH 2010/11	77.8%	**LHCH 2009/10**	87.6%	
Interpretation of Results	We have slightly underachieved the target set for this indicator. A new system by which cardiac rehabilitation is managed has been brought in recently, which provides an opportunity for us to review how we provide this service and make improvements. This will be taken forward over 2011/12.			

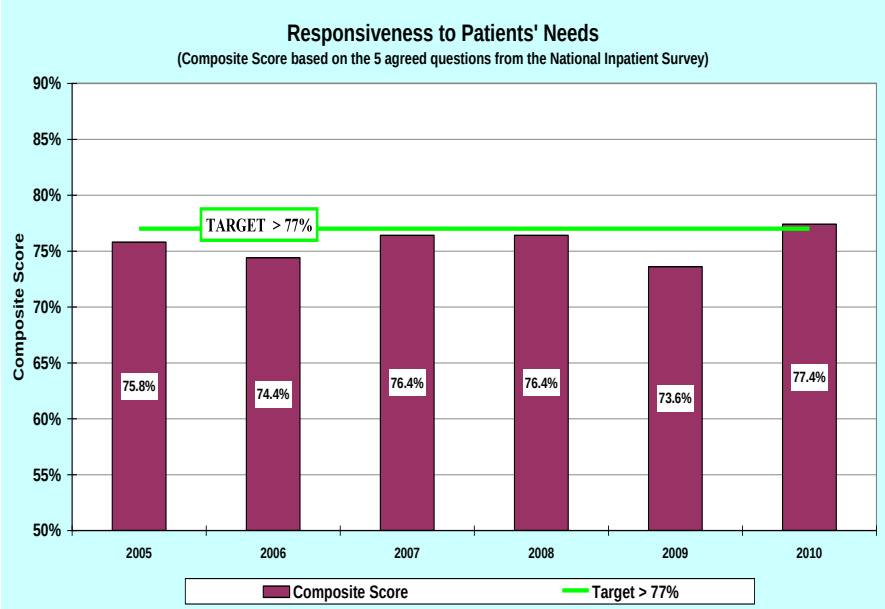
Effectiveness				
Metric	% patients with heart attack receiving treatment within 90 minutes of arrival (door to balloon time)	**Organisation Wide or Service Specific**	Service specific - Cardiology	
Derived From	Local audit figures	**Why metric chosen**	Service has expanded this year, so need to ensure good quality care has been maintained	
How is data collected	LHCH contribution to myocardial infarct national audit project (MINAP) collected into in house electronic database. National definition of performance measures used from MINAP.	**Improvements planned**	Performance is excellent so we aim to learn from each of the times performance is not perfect.	
LHCH 2010/11	98%	**LHCH 2009/10**	99%	
Interpretation of Results	We meet the target set on the vast majority of occasions. When it is missed it is usually down to one or two patients. As we are so keen to improve, we always conduct a detailed review of the circumstances un which any patient does not get their treatment within 90 minutes and learn from each occasion, improving our systems and processes along the way.			

Effectiveness				
Metric	% patients discharge letters written, typed and sent within 14 days of discharge	**Organisation Wide or Service Specific**	Service specific – Support Services	
Derived From	Local audit figures	**Why metric chosen**	Timely communication to other health care professionals is essential to ensure continuity of care	
How is data collected	Medical secretaries record the date of discharge, date dictation is completed and date typed and dispatched for discharge letters.	**Improvements planned**	Implement electronic dictation for all Doctors Feedback on performance	
LHCH 2010/11 Q4	57%	**LHCH 2010/11 Q2**	51%	
Interpretation of Results	We have not achieved the target set for this indicator. Timely communication is an important part of preventing readmissions. As such, we have plans to continue to improve this performance from introducing new technology that makes it easier to dictate the patient's letter at the time of discharge, rather than some time after.			

Patient Experience				
Metric	% patients who perceived they did not share a sleeping area with patients of the opposite sex.	**Organisation Wide or Service Specific**	Organisation wide	
Derived From	National patient survey results	**Why metric chosen**	Sharing sleeping areas threatens patients' dignity. National priority	
How is data collected	850 LHCH patients are invited to complete a questionnaire about their in-patient stay. Results are benchmarked with other Trusts in England.	**Improvements planned**	Improved estate Management of potential breaches in different locations and with screens Use of outdoor clothing as a substitute for gowns	
LHCH 2010/11	94.3%	**LHCH 2009/10**	93.6%	
Interpretation of Results	We are performing very well compared to the rest of the country on this indicator. We will however continue to make improvements to our estate which will improve our performance yet further.			

Patient Experience			
Metric	% patients reporting good or excellent overall quality of care– Inpatients	**Organisation Wide or Service Specific**	Organisation wide
Derived From	National patient survey results	**Why metric chosen**	This question is an overall measure of the patients experience
How is data collected	850 LHCH patients are invited to complete a questionnaire about their in-patient stay. Results are benchmarked with other Trusts in England.	**Improvements planned**	Patient experience delivery plan year 2 (see priorities section above)
LHCH 2010/11	92.1%	**LHCH 2009/10**	91.4%
Interpretation of Results	Our patients have voted is top in the country for the second time running on this overall quality of care question. Our patient experience vision will (hopefully) keep us in this position in years to come.		



Patient Experience				
Metric	Responsiveness to patients needs	**Organisation Wide or Service Specific**	Organisation wide	
Derived From	Average of 5 key questions drawn from the national patient survey results	**Why metric chosen**	Summary of overall experience of care. National CQUIN indicator	
How is data collected	850 LHCH patients are invited to complete a questionnaire about their in-patient stay. Results are benchmarked with other Trusts in England.	**Improvements planned**	Focus on improving discharge further, particularly: 1. Medication side effects 2. Who to contact with concerns after discharge	
LHCH 2010/11	77.4%	**LHCH 2009/10**	73.6%	
Interpretation of Results	The Trust met the 2% improvement target set by our commissioners. Improvements were most obvious in the way we prepare the patients for discharge with respect to their medication.			

Qualitative Findings

The themes below have been derived from feedback received from patients who have participated in the 2010 national in-patient survey and the 2010 local survey of whether, from the patient's perspective, the Trust is achieving the outcomes set by the Care Quality Commission. The top three good aspects of 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		Local Survey
Theme	**Quote**	**Theme**
Excellent care	"'Everything was good about my stay in hospital. Top marks for the care I received from doctors and staff. They were wonderful. Thank you from a very grateful patient"	Understanding of care and options for treatment
Teamwork and Communication	"'Excellent team work a part of medical and support staff"	Receipt of information in advance of treatment
Clean	"'I found the hospital very clean and all staff efficient and kind"	Staff introductions – knowing who is caring for them

Aspects of our service that require improvement

In-Patient Survey		Local Survey
Theme	**Quote**	**Theme**
Food	"'Basic good food at times poorly prepared and	Knowing how to report a complaint or concern

In-Patient Survey		Local Survey
Theme	**Quote**	**Theme**
	presented"	
Discharge process	"'Getting discharged always takes too long. This time I waited for medicine but previously I have also waited for a doctor"	Delivery of lifestyle advice and education
Medical contact	"Could see doctor who was actually treating you a bit more"	Awareness of expected date of discharge

Improvements planned

- Food – Continuous review of quality from the patients perspective
- Discharge process – A significant sub strand of the readmissions priority described above
- Medical contact – Audits of work round frequency and seniority of doctor in attendance
- Complaints & concerns – Posters and comments cards present in ward areas
- Lifestyle advice – Introduction of a structured document in the casenotes which guides the delivery of advice
- Expected date of discharge – Patients are now informed of this in the pre-admission clinic prior to being admitted.

Themes in Common with our Priorities Arising from Complaints

In 2010/11 the Trust received a total of 87 complaints. Of these, 10 were associated with the priorities set for improvement this year. These were:

- Communication (5)
- Discharge planning (5)

No complaint progressed to independent review by the Complaints Ombudsman; all were resolved locally with improvements tailored to the circumstances of the complainant's experience.

Metrics against Department of Health national priorities

National Targets and Regulatory Requirements	Target	2010/11	2009/10
Clostridium Difficile – meeting the Clostridium Difficile objective	18	5	15
MRSA – meeting the MRSA objective	1	2	1
Maximum waiting time of 31 days for subsequent treatments for all cancers	94%	95.4%	100%
Maximum waiting time of 62 days for first treatment for all cancers	85%	85.6%	88.5%
Referral to treatment times – admitted (95th percentile)	23 weeks	19 weeks	Not measured
Referral to treatment times – non-admitted (95th percentile)	18.3 weeks	17.1 weeks	Not measured
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	96.6%	98%
Maximum waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspected cancer referrals	93%	98.8%	99.4%
Screening all elective in-patients for MRSA	100%	147.8%	138.3%

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

Liverpool Primary Care Trust acts as host commissioner to Liverpool Heart & Chest Hospital. In 2010/11 we began meaningful engagement with Liverpool Local Involvement Network (LINkS). The Trust also supports a Council of Governors group which is dedicated to helping the Trust develop the quality account from the perspective of the public. We have an ongoing dialogue throughout the year with all of these groups about our quality account priorities and how we are doing in achieving them.

Statement from the Commissioning Primary Care Trust

In line with the NHS (Quality Accounts) Regulations Liverpool PCT is happy to receive the Quality Account for 2010/11 from Liverpool Heart & Chest NHS Foundation Trust.

As Director for Service Improvement and Executive Nurse for Liverpool PCT I have reviewed, the information contained within the account and verified this against data sources where this is available and can confirm that this is an accurate account of the quality of care in relation to the services provided. I have also reviewed the content of the account and can confirm that the Quality Account complies with the prescribed information, form and content as set out by the Department of Health. I believe that the account represents a fair and balanced view of the 20102011 excellent progress that Liverpool Heart & Chest NHS Foundation Trust has made against the identified quality standards. The Trust has complied with all contractual obligations and has made significant progress over the last year with evidence of improvements on key quality & safety measures. Liverpool PCT is encouraged by the quality improvements made over the previous 12 months.

Liverpool Heart & Chest NHS Foundation Trust has taken positive steps to engage with patients, staff and stakeholders in developing a comprehensive set of quality priorities and measures for the forth coming year 2011/12 and I personally applaud their continued commitment to sustainable quality improvements.

Trish Bennett
Director for Service Improvement & Executive Nurse

Statements from Local Involvement Networks (LINks)

Liverpool LINk Quality Accounts Commentary for Liverpool Heart and Chest Hospital NHS Foundation Trust 2010/11

The comments made here pertain to a draft document that was made available to LINk prior to Quality Account publication. This means that the published document may have already been amended in line with some of the suggestions made here.

Liverpool LINk welcomes the greater opportunity for engagement afforded by the timescales for production of Quality Accounts in 2011. This has enabled us to make the following evidence-based collective comments.

Through our sustained and positive engagement with the Liverpool Heart and Chest Hospital NHS Foundation Trust, Liverpool LINk has assured itself that throughout 2010/11, the Trust has effectively involved service users, staff and other stakeholders in evaluating the quality of its services relating to this Quality Accounts.

The Trust held a number of engagement events with focus groups which included the local people. This gave participants sufficient information regarding the possible priorities for the Trust and allowed them the opportunity to discuss and help choose the priorities in this Quality Account. The Trust has also taken steps with Liverpool LINk to ensure that engagement will be further boosted in the coming year. This Quality Account also acknowledges the Trust's close engagement with Liverpool LINk.

The document clearly sets out substantive quality achievements which have been made in the past year.

The CQUIN indicators in this Quality Account clearly show where the Trust needs to improve and were it is making progress on improving the quality of its services. This progress is to be applauded, however, in assessing this and any other Quality Account the public should note that CQUIN indicators are not additional to the work that the Trust is already committed to do by agreement with service commissioners.

LINk members have commented that the information given in the Quality Account regarding coding would likely be more useful if there was some additional information given as to how this compares with other trusts, and if information was given as to what if anything is being done to improve coding accuracy.

Information on how to obtain the Quality Account in accessible formats is not made explicit within the draft document LINk would expect this to be included in the published version.

The Quality Account might benefit from the addition of a contents page to help people navigate the document more easily.

Some LINk members have commented that there is over use of graphs and tables in the document and this is off-putting, however, others find this graphical approach very useful.

While recognising that there is always room for improvement, and that Quality Accounts are tools which are likely to undergo further development, and also not withstanding the comments Liverpool LINk has made pointing to where actual improvements could be made, this Quality Account is nevertheless exemplary in the both the level of information given and the clarity with which it is presented. The introduction and summary is a model of clarity that will enable the public to quickly and effectively gain a general understanding of the document.

Liverpool LINk has welcomed the open, cooperative and constructive dialogue with Liverpool Heart and Chest Hospital NHS Foundation Trust that has enabled Liverpool LINk members to both observe and participate in the Trust's development of this year's Quality Account. We hope to continue this positive relationship over the next 12 months.

Liverpool LINk Quality Accounts Commentaries are restricted in scope to commenting on issues pertaining to individual Quality Accounts. LINk remains engaged with the Trust in order to monitor the progress of the Quality Account and other quality considerations.

Endorsed by Liverpool LINk Core Group May 2011.

Footnote: As a consequence of this feedback, the Trust modified its quality account by including:

- Comparative data regarding clinical coding performance compared to other Trusts in Merseyside & Cheshire together with an action plan for improving coding going forward
- A statement on how the quality account may be obtained in other accessible formats
- A contents page to help the reader navigate through the document

<u>Statement from the Host Overview & Scrutiny Committee</u>

Liverpool Overview & Scrutiny Committee was unable to provide a statement on the quality account as the timeframe for consultation clashed with the local elections. However, all Trusts in Liverpool have been invited to the next Overview & Scrutiny Committee meeting on 30th June 2011 to begin the process of consultation.

Statement from the Trusts Council of Governors Quality Account Task & Finish Group

This group has been formed from the Quality, Safety & Patient Experience Sub-Group which was disbanded after their meeting on Monday 19th April 2011, and renamed as above.

We now include in our membership LINkS members and the general public. This widening of our sphere of involvement with the public is due to the Governors being more active in the community.

Having read the Quality Account, we are sure that its contents reflect all that is good and positive in such a committed organisation, and we are sure that the staff reflect this in their value and importance through their attitude to their work.

Finally, in the community our name is beginning to be better known and respected.

Enabling Quality Management Systems

The delivery of high quality care depends as much on the workforce, leadership and information management & 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.

Workforce factors

The Trust is committed to developing all employees to ensure they achieve their full potential. This is achieved through maintaining an effective system of Personal Development Review (PDR) and performance appraisal.

The PDR system, in conjunction with the Knowledge and Skills Framework (KSF), is designed to encourage both personal and job role development whilst at the same time helping to ensure that the Trust's strategic objectives are achieved.

The PDR Appraisal process provides an opportunity for staff members to reflect, and receive feedback, on their current performance and their application of knowledge and skills within their role. The Trust is therefore committed to ensuring that all employees have a PDR at least once a year and have a Personal Development Plan (PDP) which supports their individual learning and development needs.

Staff new to their role will have an appraisal after one year in post; however, an objective setting meeting will take place within three months of the new staff member taking up post.

The PDR / Appraisal process supports the identification of training and development needs for all staff members, taking into account the needs of the organisation, managers and individuals in such a way that all will benefit.

Medical staff that are responsible for assessing the performance of peers have all undertaken appraisal training. The Trust has developed an appraisal system based on the assessment tool "Assessing the Quality of Medical Appraisal for Revalidation" (AQMAR) which includes 360 degree appraisal and assessment against the five recommended domains of practice.

The Trust participates in the annual NHS Staff Survey each year. The results are used to inform decision making and planning both at the Trust and local department levels, and are key to gauging levels of staff engagement and satisfaction. Response rates have improved considerably in recent years, making the information more representative and meaningful.

Year	2006	2007	2008	2009	2010
Response Rate	37%	38%	63%	64%	63%

From these data, the Trust has demonstrated an on-going increase in the percentage of staff receiving an appraisal (Q8a 2009 – 79% vs. 2010 - 84%; national average 80%). 63% of staff stated that their appraisal/review helped them to improve how they did their job (Q8b) in comparison to 61% in 2009 (national average 59%).

The Trust also engages with staff through the Staff Forum, Partnership Forum, Local Negotiating Committee, Human Resources Policy Group and the Occupational Health User Group on issues that affect them.

Planning and developing the workforce

During our stakeholder engagement process, the provision of comprehensive education and training emerged as a strong theme for focus in the Quality Account.

In 2009 the Trust commenced the development of a comprehensive education strategy. This encompasses review of all planning, commissioning and delivery of learning and development process. An education plan identifies key priorities and targets for each Directorate. This leads to the Learning Needs Analysis which focuses on essential and mandatory training in line with requirements of a key NHS risk reduction accreditation system (NHSLA). All learning and development is scheduled to facilitate staff release to attend and to minimise impact on patient care.

The Trust continues to review its workforce plans to ensure its services are delivered efficiently and effectively. As an example, the Trust has supported 4 cohorts of Trainee Assistant Practitioners (TAPS) in a range of Clinical Departments. The TAPS have undertaken training and competency assessment from a range of disciplines including physiotherapy, dietetics and

health promotion to support effective cross boundary working. There is significant support for staff development in all areas including clinical, administrative, estates and ancillary departments to maximise patient safety and experience. A total of 129 staff have accessed the Trusts apprenticeship scheme since November 2009.

Workforce plans are developed by each Directorate in partnership with senior members of the Finance and Human Resources teams. The process is led in each Directorate by the General Manager, supported by their Assistant Director of Nursing, Service Line Clinical Leads (Consultant medical staff), Service Line Managers, Information Leads, the Human Resources Manager and Directorate Accountant. These plans are used to inform each Directorate's Annual Plan and overall Trust plans to ensure that workforce requirements are matched to planned service delivery and any proposed changes to service provision and ways of working.

The effectiveness of our workforce is tracked using a number of key performance indicators:

Metric	2008/09	2009/10	2010/11
Sickness Absence %	5.6%	3.9%	4.2%
Turnover %	11.4%	9.6%	6.7%
Temporary Staff Spend	£1,445,323	£1,359,012	£ 1,317,657

Although sickness rates have increased marginally from the previous year, they still compare favourably with the other major Trusts in the local area:

Liverpool Women's Hospital	4.05%	Aintree University Hospitals	5.22%
Wirral University Teaching Hospitals	4.23%	Royal Liverpool & Broadgreen University Hospitals	5.25%
Walton Centre	4.30%	Clatterbridge	5.26%
LHCH	**4.35%**	Alder Hey	6.27%
Liverpool PCT	4.67%	Mersey Care	6.57%

- *data for Nov 2010 taken from NHS iView*

Turnover has fallen significantly over the last two years. The Trust' own internal target is 10% and current turnover rates are comfortably below this target. Temporary staff spend (agency & bank use) has also shown a downward trend in recent years. 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 an 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 student nurses and students from other professions allied to medicine. Students evaluate their experience within the trust after they have left and this is collated by the Higher Education Institutes and sent to the Trust on a quarterly basis to the Practice Education Facilitator.

All student evaluations are shared with ward/departmental managers, the Learning and Development Steering group and the quarterly Mentor Link group. Any feedback that needs to be improved upon is managed using the educational audit process to improve the quality of the student experience.

During the period September 2009 and September 2010 the trust had 83 base Trust students.

- The number of base trust students who failed a placement at our hospital during this period was 5
- The number of base Trust students who were discontinued during this period was 5:
  - 1 discontinued at fitness to practice panel
  - 4 stepped off program or academic failure
- The number of students who suspended from the program during this period was 5;
  - 2 who went on maternity leave
  - 3 who deferred continuing on the program temporarily

Staff engagement

In addition to appraisal and personal development planning as tools for staff engagement, all staff should receive 'Team Brief' every month. This is the mechanism whereby information is cascaded down throughout the Trust to ward and department meetings, and it is also an opportunity for staff to feed their views upwards.

Our annual NHS Staff Survey results have shown a year on year improvement in staff engagement indicators:

Staff Survey Question / Metric	2008	2009	2010
Overall staff engagement (maximum score = 5)	not featured	3.78	3.80
Staff agreeing they feel satisfied with quality of work and patient care they are able to deliver (%)	72%	84%	85%

Staff agreeing they are satisfied with their job (maximum score = 5)	3.33	3.54	3.55
Staff agreeing they are able to contribute to improvements at work (%)	55%	59%	61%

In terms of collective arrangements, the formal mechanism for consultation with staff side is through the Partnership Forum which is the regular formal meeting between staff side representatives and senior managers of the Trust. Staff side representatives are also members of the Workforce Committee and the Human Resources Policy Review Group. Elected employee representatives also form part of the Trust's Council of Governors. The Trust's Management of Organisational Change Policy sets out the formal consultation arrangements for involving staff affected by any proposed changes.

The Trust strongly supports the involvement of our Foundation Trust members, patients, their relatives, carers and the general public in the continued improvement and development of the hospital and the services we provide. Our aim is to ensure that their views are taken into consideration on a regular and ongoing basis.

It is recognised that most meaningful community engagement will come through existing groups and forums or new groups created specifically to support the engagement. However it is important that our scope of engagement also allows space for input from individuals, service users and patients who may wish to become involved from time to time in specific issues of concern (Dialogue of Equals – 2008). Our stakeholder engagement around identifying priorities for inclusion in the Quality Account is evidence of our commitment to this way of working.

The Customer Care Team provides help and advice to patients, their relatives and carers. The team has a number of areas of responsibility within the Trust and these include complaints management, the production of patient information and supporting patients who require extra support including those with learning disabilities.

The enhancement of our Volunteer Service provides an opportunity to maximise the resource and resultant benefits to patients that may be accrued by aligning voluntary work to delivery of the an excellent patient experience (as described in the Trusts patient vision). Our volunteers are appropriately selected and adequately trained to provide an invaluable contribution to the patient experience and act as a useful resource to paid staff. This well managed and effective volunteering scheme will also (potentially) provide social benefits through the provision of pathways into paid work.

Patients and relatives can inform the Trust of their views by completing one of the 'Comments, Concerns & Compliments Cards' – these are available in alternative formats by request and are available throughout the Trust.

Patient and relatives are also encouraged to share their stories and experiences by contributing their "story". Each directorate is required to collate at least two stories per month and these are shared with staff to help embed organisational learning.

Health and well being

The Trust's Wellbeing strategy is being launched in April 2011. This brings together the work the Trust has already put in place to support the health and well being of its staff. To date this work has included a range of events and initiatives including lifestyle assessments, smoking cessation support, free staff gym and vaccination programmes. Moreover, the Trust has been recognised by the World Health Organisation as a Health Promoting Hospital.

The results of the staff survey reflect the Trust's ongoing commitment to improving the health and well being of its staff:

Staff Survey Questions	2008	2009	2010
Overall health (over the last four weeks) was excellent, very good or good	question not asked	76%	79%
In general my job is good for my health	question not asked	44%	43%
My immediate manager takes a positive interest in my health and well being	question not asked	49%	50%

percentages are those staff answering strongly agree or agree

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. To this end, the Excellence in Management & Leadership programme commenced in November 2009 and to date 75 managers have participated. It is designed to strengthen the skills and knowledge of new and existing managers across the organisation by providing a tailored approach to career development, talent management and succession planning for the future. A mixture of theoretical and practical learning is used to provide managers with the skills and knowledge which empower them to improve their management & leadership abilities. All modules delivered within the programme have been aligned to the delivery of the Trust Patient Experience Vision.

In addition the programme is linked to tangible service improvement through the delivery of practical redesign projects designed to make a difference to health outcomes and improve patient and staff satisfaction. These include:

- Reduction in incidence of pressure ulcers
- Improved discharge planning
- Improved staff morale
- Development of the community spirometry service

Empowering staff

In order to capitalise on every opportunity to improve, staff must feel empowered to make changes in their own working environment. This is achieved using the service improvement function within the Trust. Following identification of a good idea from staff to work upon, it is turned into a formal project using a recognised (A3) methodology. Each project is assigned an Executive sponsor to ensure the project aligns with the Trust strategy, a project lead to enable and facilitate effective ongoing management and a project team, consisting of frontline clinicians. Support is given from the Service Improvement team in utilising effective service improvement tools and techniques. Projects are nurtured throughout their lifecycle through monthly presentation to the Executive team at Service Improvement Board.

Numerous projects were undertaken in 2010/11 with the aim to improve the quality in the services our patients receive. For example the right bed, right time project in Cardiology is on track to deliver a 22% reduction in length of stay on Coronary care unit. The project team consisting of frontline clinicians have resolved issues in patient flow and have demonstrated benefits from nurse led discharge to improve the experience for our patients.
The Documentation review project engaged almost all Trust departments, and achieved efficiencies in reducing the number of documents and standardising those that remain. This will make our care safer as there will be no confusion in the minds of staff which document to use, and it will ensure that every patient gets all of the care intended.

The falls project has been highly successful due to the engagement and commitment of nursing staff to trial and review tools and techniques to reduce the risk of falls. The project has also facilitated an increase in quality of care through staff undertaking a review of patients' needs at regular comfort checks (see patient experience priority above).

The new Volunteers project has achieved many early wins. The Trust now has a sustainable strategy for recruiting and enabling volunteers to develop skills, confidence and satisfaction in roles which meet their specific needs. Patients are greeted and supported by volunteers as they arrive at the hospital. In other areas volunteers support clinical staff to improve the patient's experience. The project team have engaged with a local sixth form college to facilitate 16-18 year olds into the volunteer role with good effect (see patient experience priority above).

Productive Ward

The productive ward series began across all ward areas in September 2008, with the project phase completing in April 2010. Nursing staff were engaged to achieve the four dimensions of patient safety, patient experience, staff well being and efficiency of care. All ward areas saw an increase in time to directly care for patients, improved quality in ward handovers, patient observations, patient hygiene needs, and medicines administration – all facets of improved quality of care. Staff well being and satisfaction also improved as staff felt empowered to develop ideas, own and sustain change.

Quality of the environment in which care is delivered

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. This is validated annually as a national exercise across England. The Trust score for 2010/11 was:

Environment – Excellent
Food – Excellent
Privacy & Dignity – Excellent

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

The Trust has also participated in a pilot evaluation of the Premises Assessment Model (PAM). Areas assessed were rated as green – meeting the required standard for finance/value for money, safety, effectiveness, patient experience and Board governance.

Links between quality and resources

Information resources – quality in measurement

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. Clinical databases, populated by the clinicians at the point of delivery of clinical care which capture detailed data about a patients disease and treatment
3. The data warehouse, which integrates a number of clinical and financial information systems with the PAS
4. Service line reporting, which brings together administrative, clinical and financial information so that productivity as well as quality can be assessed.

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 and reliable. In 2010/11, the Trust went further in improving these systems by:

1. Participating in external audits of data quality supporting key elements of our PAS system, Advancing Quality and our involvement in a number of national audits.
2. Introducing a data quality grading system that evaluates the quality of the data upon which important decisions about the Trusts business are made
3. Creating a formal Data Quality Committee who regularly reviews the quality of data in use within the Trust and ensures there is a programme of regular data quality improvement in place.

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 NHS 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 improved its capacity and capability in benchmarking further through purchase of “Dr Foster” a well recognised benchmarking tool which is now in use in comparing our performance with those of our peers.

Aligning quality and your 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, the Quality, Innovation, Productivity and Prevention (QIPP) challenge, 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 2011/12 through the Trust and beyond:

- Bidding for the contract to deliver a community based chronic obstructive pulmonary disease service for Knowsley Primary Care Trust. Income from this contract will depend upon the delivery of a suite of quality indicators should we be successful.
- We are the leads for the City's QIPP challenge in cardiac care. This has provided the opportunity to redesign current pathways to be efficient, cost effective and most importantly high quality. These have been accepted by Liverpool Primary Care Trust and 2011/12 will see the implementation of these pathways across our local health economy. Savings from this work are estimated at £2.8 million.
- 2010/11 saw the award of a major innovation grant to the Trust for the development of an integrated approach to the delivery of heart failure services. This project is now well underway and promises to revolutionise care to this needy group of often under treated patients.

Taken together, these three new initiatives as well as the successes reported in last years quality account are propelling the Trust towards achievement of its ambition to become an integrated healthcare organisation.

That said, we continue to be forward looking as a Trust and annually revise our business plans and strategies taking account of new opportunities to remain unassailable in the delivery of an excellent, compassionate and safe care for every patient, every day. 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. Work done in 2010/11 in the reduction of readmissions with our colleagues in community care is an excellent example of this work in action.

Acknowledgements

The Board 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
- Liverpool Primary Care Trust Quality staff
    - Leigh Thompson-Greatrex - Head of Clinical Quality Improvement, Liverpool Primary Care Trust
    - Karen Wallace – Senior Project Manager, 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:
    - Ken Blasbery
    - Pat Firby (Non-Executive Director)
    - Stephanie Greenway
    - David Hicks

    - Vera Hornby
    - Mandy Jones
    - Bashir Matata
    - Debbie Mawson
    - Tony Roberts
    - Roy Stott
    - Judy Wright
    - Menna Wyn-Harland
- Stakeholders who participated in our prioritisation events:
    - Dr Ted Rose, Consultant Physician, Warrington & Halton Hospitals NHS Foundation Trust
    - Sarah Clarke, Manager, Cheshire & Merseyside Critical Care Network
    - Sophia Nelson, General Practitioner
    - Tony Novotny - Quality Project Manager, Liverpool Primary Care Trust
    - Sue McGorry, CVD Commissioner, Liverpool Primary Care Trust
    - David Graham, Dean, Mersey Deanery
    - Linda Phippard - Service Manager, Royal Liverpool & Broadgreen University Hospitals
    - Paul McCann, Public Health Specialist Registrar, Halton & St Helens Primary Care Trust
    - Hilary Grant, Liverpool Primary Care Trust
    - Catrin Hanks, Network Manager, North Wales Cardiac Network
    - Roy Griffiths, Member Wrexham Health Support Group
    - Gwyndaf Owen, Member Wrexham Health Support Group
- Attendees at the Quality Account priorities focus group (drawn from the Trusts membership):
    - Alan Guthrie
    - Caroline Jackson
    - Jean Redfern
    - Michael Dibben
    - Ron Thompson
- Liverpool Local Involvement Network (LINk) Members:
    - Dr Eric Toke & John Roberts (Liverpool LINk Health and Social Care Ambassadors to Liverpool Heart and Chest Hospital NHS Foundation Trust)
    - Andrew Lynch, Network Development Officer, Liverpool LINk Support
- Patients, carers and members of the public who have participated in our programme of surveys, focus groups and medicine for members events.

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, or should any reader require the Quality Account in any additional more accessible format then please contact Dr Mark Jackson, Associate Director – Quality Improvement (email Mark.Jackson@lhch.nhs.uk or telephone 0151 600 1332).

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

A Vision for Patient Experience
April 2013

"Why go anywhere else?"

"Even before I arrived at the hospital entrance I knew I was going to be in safe hands. Everyone says Liverpool Heart and Chest is a great hospital but what greeted me that day still took me by surprise.

The appointment had been arranged to fit in with my schedule and I'd already received a Welcome Pack telling me what to expect from arrival to discharge, but walking into the state-of-the-art building and being met personally by someone who was there just for me took this far beyond a "typical hospital visit".

"They were expecting me"

From the named Support Nurse who will be at the other end of the phone whenever needed, to spending time with the world-class Consultant explaining personally what will happen in the procedure; From the Patient Contract that outlines exactly what our patients can expect throughout their stay, to the agreed Aftercare Plan that allows them to return home feeling safe and secure; Our Vision is for patients to feel that: ***"My care was planned with me and for me"***

Our vision is 100% inclusion; making our patients and their families feel involved in every step of their tests and treatment. We want to alleviate as much fear as possible, ensuring patients feel comfortable and supported throughout their stay and simply taking the time to chat to them because we know it makes a difference.

"They made me feel special."

"They really know what they were doing"

You don't win accolades such as *'Best Overall Patient Care in England'* without getting a lot of things right, but now we want to take things to another level. Not only offering clinical excellence and first rate patient care, but nutritious food that promotes recovery in an environment that is clean and modern, infection free, easily accessible, smartly decorated and with satellite TV - in fact, something akin to a five-star hotel that happens to offer the very best cardiothoracic care in the UK.

"After I got home I imagined that every twinge or feeling of discomfort was going to send me back into hospital but I was able to speak to my Support Nurse who was happy to answer all my questions and concerns. Being able to talk to such a dedicated and knowledgably member of staff relieved all my fears and I was able to continue my rehabilitation with peace of mind, knowing that LHCH staff would be there for me".

"Their support really did continue and my quality of life got better."

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.

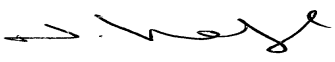
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- 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 2011 ..Date.....Chairman

...24th May 2011 Date.....Chief Executive

Business Review

Activity at out Trust is funded from both elective and emergency referrals from surrounding District General Hospitals, clinicians and General Practitioners. The total annual turnover for the Trust for 2010/11 was £103 million, which was derived from various sources, including: £70 million from the North West Specialist Commissioning Group, £16 million from Health Commission Wales, £383K towards research and development, £3million from the North West Strategic Health Authority for healthcare training (nurse and doctor training) and £3 million from private patients.

This year has been a testing year financially for both ourselves and every other trust across the country. The national public spending issues and the Department of Health's response of a target of £20bn savings over a three year period, along with the uncertainty of the general election, led us to approve a financial plan with a £0.5m surplus. This was still viewed as stretching given the expected reductions in activity levels, inflationary cost pressures, and the changes introduced by the Department of Health, which directly impacted upon our income levels.

Trends and Future Factors affecting the Trust

The continuing national financial constraints and annual cost saving expectations, expected reduction in clinical activity and inflationary cost pressures, will all remain a theme over the coming years, and in turn remain a risk and create much uncertainty for our Trust. Whilst we have robust systems, plans and procedures in place to limit the impact of these factors on the organisation, we must remain vigilant and enhance our business acumen to meet these challenges head on.

The newly elected Government's plans to reform the commissioning practices within the NHS will in themselves create another level of uncertainty and potential risk for the Trust. Under the new NHS reforms, 2011/12 will see the emergence of new General Practitioner Consortia who will take over the commissioning role previously held by Primary Care Trusts. As a result, the strong business relationships that have been developed with the Primary Care Trusts across the region will largely dissapear. We now have to start to enhance our stakeholder engagement plans to quickly build solid business relationships with the new consortia, heightening awareness of our Trust and the excellent quality services that we provide, to ensure that commissioning of our services continue in years to come.

There is also likely to be an increased threat of competition for some of the services that we currently provide. Local District General Hospitals across the region are looking to start providing some of the less complex cardiac procedures that we have historically provided as a tertiary centre. We will look to further enhance our profile and excellent clinical results and reputation

amongst commissioners, and demonstrate that for the majority of these procedures we remain the most efficient and safe hospital in the region. Commissioners have recently announced that they will be commissioning the TAVI procedure across the region. This is positive news for the Trust, and should enable us to build on the existing successes from our current service, previously only accessed by patients from North Wales.

We are also currently looking into possibilities to develop new community services around the region, taking our services to the patients.

Analysis of Financial Performance

The Trusts' actual performance for the year is ahead of plan, with a reported surplus of £1m as summarised in the table below:

	Plan	**Actual**	**Change**
	£M	£M	£M
Income	103.9	105.2	1.3
Costs			
Pay	57.3	55.9	1.4
Direct-Non Pay	34.4	35.4	-1.0
Overheads	5.7	6.4	-0.7
Operating Surplus	**6.5**	**7.5**	**1.0**
Net Finance Costs	6.0	6.4	-0.4
Surplus	0.5	1.1	0.6

As highlighted, income is marginally above plan (1.2%). Our inpatient activity (our key revenue source) was above plan by 0.7%, with Surgical Directorate Inpatient activity being 2% above plan, whilst outpatient activity was 6% above plan.

Private patient revenues were above plan, with strong results in the final months of the year. Our non-patient revenues, such as training, research and services provided to other Trusts, for example, pharmacy services and radiology, also exceeded plan.

Costs

Our pay costs were significantly below plan, with staff numbers (fte) 109 below plan in March. This was particularly pleasing as activity was ahead of plan and the Trust met its' Monitor governance targets for safety and clinical quality.

Direct non pay costs were above plan. This was a result of higher than planned amounts of clinical consumables and devices being purchased due to our increased levels of clinical activities, and also the increase in VAT charges to 20% in January.

Overhead costs were above plan due to the increase in VAT, along with the increases in energy costs and additional IT costs to support the first phase of the IT strategy.

The Trust continues its capital investment program across the hospital covering improvements to the buildings and estate, new medical equipment and in technology and other support facilities. The total capital investment for the year was £5.7m. Within this financial envelope the money was split several ways: site development £1.7m, IM & T £1.2m, new medical equipment £0.8m, replacement medical equipment £0.5m, estates maintenance £0.8m and Cath Lab 2 refurbishment £0.7million.

The Trust had a year end cash balance of £17.3m which was ahead of plan, reflecting the additional surplus, improved working capital and capital expenditure being re-phased.

Financing

Under the Terms of Authorisation the Trust has an approved borrowing limit and working capital facility which is set out in the table below:

	Limit	**Utilised**
	£000's	**£000's**
Prudential Borrowing Limit	18,500	335
Working Capital Facility	7,600	0
Total Prudential Borrowing Limit	24,100	335

The working capital facility is a two year facility which expires in November 2011. The Trust has not used any of this facility this year. We are currently considering whether to renew this type of arrangement for a further period.

The Trust manages its' financing activities in accordance with its' approved Treasury Management Policy, which is reviewed and approved by the Investment Committee.

Key Financial Performance Indicators

The table below shows the Trusts' performance against Monitors' performance measures, which both determine the Monitor Risk Rating and are used by the Board to oversee the overall financial performance. The Trust achieved an overall rating of 3 which was on plan.

Performance against Key Indicators	FT Risk Score Plan	FT Risk Score Actual
Underlying Performance		
EBITDA Margin	3	3
Achievement of Plan		
EBITDA achieved	5	5
Financial Efficiency		
Return on Assets	3	3
I&E Margin	2	2
Liquidity		
Liquidity Ratio*	4	4
Weighted Average Rating	3	**3**

Going Concern

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, they continue to adopt the going concern basis in preparing the accounts.

Conclusion

Despite the very challenging year, the Trust has exceeded the financial plans set by the Board, as approved by Monitor. We will now look to build on this platform with robust plans for 2011/12. These plans will see a continued investment in our workforce and infrastructure, to further develop and enhance our services and patient experience, and ensure that the Trust is best placed to excel in the coming years.

In so far as each of our Directors is aware there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware.

Each Director has taken all steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information, and to establish that the NHS Foundation Trust's auditor is aware of that information.

Environmental Sustainability

This year we have developed a Carbon Management Plan in conjunction with the Liverpool Carbon Collective. We have worked with partner agencies to ensure that the plan meets all of our needs and also those of the local environment. The plan which will start to be rolled-out next year, will enhance the Trust's 'green' credentials, reducing our energy expenditure, and by working with other Trusts, will provide the City of Liverpool with real benefits in terms of a sustainable future.

We hope that by thinking 'green' we will demonstrate our ability to be a good corporate citizen through:

- Investment in engineering solutions – investing in efficient technology, the need for energy will be reduced, leading to a reduction in consumption,
- Site Development – during building improvements and refurbishment work such as window replacement and thermal insulation,
- Raising Awareness – changing attitudes and behaviours of our staff. We will also continue to develop and promote a sustainable travel plan, and
- Policy and Procedures – embedding carbon reduction into the management of the Trust.

This will enable Liverpool Heart and Chest Hospital to really make a difference to people's health and wellbeing, in it's role as an employer, consumer, a manager of energy, water, waste and transport, and as a community neighbour.

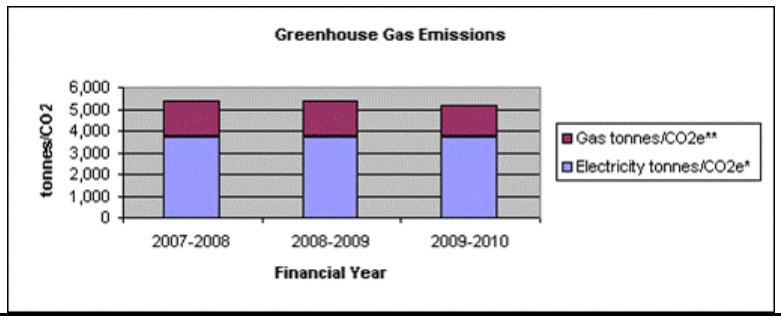
Analysis using other Key Performance Indicators

(2010/11 data still to be advised)

SUSTAINABILITY REPORTING

Organisation Sustainability Report for the Year ended 31st March 2010

	2007-2008	2008-2009	2009-2010	Graphical Analysis
	Kw/hr			
Annual Electrical Consumption	6,873,003	6,873,003	6,873,003	
Electricity tonnes/CO2e*	3,739	3,739	3,739	
Annual Gas Consumption	5,865,842	5,963,769	5,243,414	
Gas tonnes/CO2e**	1,625	1,652	1,452	
	Miles			



Corporate and Social Responsibility

The Trust has continued to support health promotion events and careers fairs with local schools. We have also provided supervised work experience opportunities in both clinical and non-clinical departments.

In March 2011 we recruited 15 students to our first Access to Medicine Programme. This is a great opportunity for both the students and the Trust, and offers work experience and mentorship from consultant staff for pupils who wish to pursue a career in medicine.

In November 2010 we launched a pilot Volunteer Scheme, recruiting over 40 volunteers from a wide range of backgrounds, including sixth form students undertaking work experience placements. Feedback on the new scheme has been extremely positive and the volunteers have made a real difference to our patients and staff.

Feedback from patients, relatives and staff has included:

- ☻ **"What a valuable service"**

- ☻ **"Thanks for looking after me on my way to and from the clinic – what a difference it made"**

- ☻ **"Speaking to the volunteer on the ward made such a difference to my day"**

Volunteer feedback has also been very positive:

- ☻ **"I enjoy being here so much that I arrived half an hour before my due time….escorting patients in that time makes it seem so worthwhile"**

- ☻ **"Help from all the staff is great"**

- ☻ **"I like to feel I am putting something back into society and this is perfect".**

Monitor's Risk Ratings

Monitor is the Independent Regulator of Foundation Trusts appointed by the Secretary of State for Health. The Trust submits quarterly reports to Monitor who review these and assign a set of Risk Ratings. These Risk Ratings are published both quarterly and annually, indicating the level of risk that the Trust will fail to comply with in the Terms of its' Authorisation. The Risk Ratings cover the following areas:
Finance - rated 1 to 5 with 1 representing the highest level of risk,
Governance - rated red, amber-red, amber-green or green,
Mandatory Services -rated red, amber or green,
Last year 2009/10 there was an additional rating which is now removed.

Summary of Rating Performance

The tables below highlight the rating performance for each of the quarters this year, and the two quarters in 2009/10 (following the Trusts' authorisation on December 1st 2009).

2010/11					
	Annual Plan	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Finance	**3**	**3**	**4**	**3**	**3**
Governance	Green	Green	Amber-Green	Amber-Green	Green
2009/10					
	Annual Plan	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Finance	**4**	N/A	N/A	**4**	**4**
Governance	Green	N/A	N/A	Green	Green
Mandatory Services					

The Trust achieved a rating of Green for the full year and in two of the quarters within the year. In Quarter 2 the rating was amber/ green where the Trust did not meet the 62 day cancer wait target for the quarter and in Quarter 3 the target was amber/green where the 31 day cancer wait target was not met for the quarter. For the full year both these targets were achieved.

Analysis of Rating Performance

● **Finance**
The Trust achieved a rating of 4 in 2009/10. For 2010/11 given the growing concerns over public debt levels and the expected reductions in government spending, the Trust approved an Annual Plan with a Risk Rating of 3. The Trust has met or exceeded this rating in each period. The significance of achieving a Risk Rating of 3 or above is indicated by the table below.

● **Governance**

The Trust achieved a rating of Green in each of the quarters this year, with the exception of Quarter 3 where a Governance rating of Amber was achieved. This rating was due to the Trust not meeting the 31 day cancer wait target for second or subsequent treatment.

Rating	Description	Implications
Rating 5	Achieving weighted average of 5 across assessed components and no over-riding rules applied	Quarterly/six-monthly* monitoring
Rating 4	Achieving weighted average of 4 across assessed components and no over-riding rules applied	Quarterly monitoring
Rating 3	May be some regulatory concerns in one or more components, but significant breach of Authorisation is unlikely	Quarterly monitoring, however monthly monitoring in case of deteriorating trend or recovering from a 2 rating Supplementary information if required
Rating 2	Risk of significant breach of Authorisation	Monthly monitoring with supplementary information and service line information Remedial plan may be required Potential for intervention under section 52 of the Act
Rating 1	Very likely to be in significant breach of Authorisation	As with rating 2 (above) and likely intervention under section 52 of the Act

Statement of Compliance with the NHS Foundation Trust Code of Governance

The Board of Directors and the Council of Governors are committed to continuing to operate according to the highest standards of corporate governance. The Trust is compliant with the principles and provisions of the NHS Foundation Trust Code of Governance.

The Board of Directors meets formally seven times each year in order to effectively discharge its duties. As well as developing strategy, the Board regularly reviews performance against all regulatory and contractual obligations and has established effective governance structures to secure compliance with Care Quality Commission Outcomes, NHS Litigation Authority standards and to ensure effective risk management processes.

All Directors have responsibility to constructively challenge the decisions of the Board and Non Executive Directors scrutinise the performance of the Executive and Associate Directors in meeting the Trust's agreed objectives and targets. There is a robust performance management process in which governors are involved in the appraisal of the Chairman which is led by the Senior Independent Director. The Chairman reviews the performance of the Non Executive Directors and the Chief Executive. Each Executive/Associate Director's performance is reviewed by the Chief Executive.

The Board of Directors regularly reviews its balance of skills to ensure that these are appropriate to the requirements of the Trust. A policy on the composition of the Board of Directors has been approved by the Council of Governors.

The Chairman has ensured that the Board of Directors and Council of Governors work together effectively and that directors and governors receive appropriate, accurate and timely information that is required for them to effectively discharge their respective duties.

The Council of Governors represents the interests of public and staff members and of partner organisations and our governors adhere to the Trust's values and code of conduct.

The Council of Governors holds the Board of Directors to account for the performance of the Trust and receives quarterly assurance reports. Governors are consulted on forward plans, through a programme of presentations from lead clinicians, involvement in the development of the brand and supporting values and behaviours that support delivery of our vision for patient experience. The strategic objectives were reviewed at a joint development day for directors and governors and the views of governors taken into account in setting the strategic direction.

Members of the Board of Directors regularly attend meetings of the Council of Governors in order to develop an understanding about the

views of governors. Feedback is sought from members via bi-annual member newsletters and use of on line surveys.
The Council of Governors meets formally on a quarterly basis and has nominated a Senior Governor.

The Trust has provided training and development to enable directors and governors to update their skills and knowledge of the trust and its obligations, to support their roles on respective boards and committees.

The Trust maintains a register of interests, detailing company directorships and other significant interests held by directors or governors. In 2010/11 the Chairman had no other significant commitments that conflict or impact upon his ability to meet his responsibilities as Chair.

The Board of Directors and Council of Governors review the respective registers on an annual basis to identify and potential conflicts of interest affecting their day to day responsibilities. No such conflicts of interest have been identified.

At the at the start of each Board / Council meeting the Chairman routinely asks all members to declare any interests that relate to the scheduled agenda items, in order that they withdraw from the discussion on any matter where there is a potential conflict. Any such declarations are recorded in the minutes.

The Register of Interests is available to the public and can be accessed on request by writing to the Trust Secretary, Executive Offices, Liverpool Heart and Chest Hospital NHS Foundation Trust, Thomas Drive, Liverpool L14 3PE.

Our Council of Governors

Role and Composition
The Council of Governors has responsibility for representing the interests of our members and partner organisations in discharging its statutory duties which are:

- To appoint and, if appropriate, remove the Chairman,
- To appoint and, if appropriate, remove the other Non Executive Directors,
- To decide the remuneration and allowances , and other terms and conditions of office, of the Chairman and other Non Executive Directors,
- To approve the appointment of the Chief Executive,
- To appoint and, if appropriate, remove the auditor,
- To receive the annual report and account and any report on these provided by the auditor,

- To hold the Board of Directors to account for the performance of the organisation, ensuring that the Board does not breach the terms of authorisation, and
- To feedback information about the Trust, its vision and its performance to the constituencies and partner organisations that elected or nominated them.

Our Council of Governors comprises 27 governors of which:

- 14 are elected by the public from 4 defined classes – Merseyside (6 seats); Cheshire (4 seats) ; North Wales (3 seats); and Rest of England and Wales (1 seat);
- 6 are elected by our staff from 4 defined classes – qualified nurses and unqualified nurses (2 seats); Non Clinical (2 seats); Allied Healthcare Professionals, Technical and Scientific (1seat); and Registered Medical Practitioners (1 seat);and
- 7 have been nominated from partner organisations (1 seat each from the following):
    - Liverpool Primary Care Trust
    - Liverpool City Council
    - Northwest Specialist Services Commissioning Team
    - Betsi Cadwaladr University Health Board
    - Liverpool John Moores University
    - Cystic Fibrosis Trust
    - Friends of Robert Owen House

The names of those who have served as governor in 2010/11 are listed in the attendance report at the end of this section.

Our initial governors serve a first term of office of either two or three years; and then three year terms thereafter, should they offer themselves and are successful for re-election or re-nomination. However, governors will cease to hold office if they no longer reside within the area of their constituency (public governors); are no longer employed by our Trust (staff governors); or are no longer supported in office by the organisation that they represent (nominated governors).

Governor Development

The Trust provides many opportunities for governors to be actively involved and we feel this work makes a real difference to our patients and wider community.

- Governors are involved in reviewing, updating and delivering our membership strategy, recruiting new members and ensuring that our member communication is effective,
- Governors have organised and supported community events including ‘Medicine for Members’ meetings ,
- Governors are closely involved in helping to determine the priority areas for improving quality, safety and patient experience,

- Governors have supported key trust initiatives such as 'More than a Workplace' (including short listing of nominations for annual staff awards); development of our brand, vision and values,
- Governors have participated in joint work with the Board to develop strategic plans,
- Governors have worked with Board members to develop the format and content of performance monitoring reports for the Council of Governors,
- Governors have participated in a governance group convened under the leadership of the Chairman to review the constitution of Liverpool Heart and Chest Hospital NHS Trust and recommend a number of changes that were approved at the Annual Members Meeting 2010 and subsequently ratified by Monitor.

In addition to the above, the Trust has encouraged development through provision of training and support including induction for new governors, attendance at external governor development events, provision of seminars on key topics such as measuring financial performance, and clinical innovations and developments, individual discussions with the Chairman and Trust Secretary, provision of 'walkabouts' and tours of the hospital. The Chairman hosts an informal lunchtime meeting every quarter and issues a monthly bulletin to governors to keep them abreast of current news and issues. We have conducted an evaluation of the Council of Governors and used questionnaire feedback to identify and respond to development needs.

Elections

The Board of Directors can confirm that elections for public and staff governors held in 2010/11 were conducted in accordance with the election rules as stated in the constitution and approved by Monitor. During the course of the year two uncontested seats were filled following the resignation of a Public Governor in the North Wales area and a Staff Governor in the non clinical staff group.

Governor Attendance at Council of Governor Meetings 2010/11

Governor Name	Council of Governor Meeting Dates 2010/11			
	14th June 2010	13th September 2010	6th December 2010	7th March 2011
Public Constituency				
Merseyside				
Kenneth Halligan	x	✓	✓	✓
Vera Hornby	✓	✓	✓	✓
Mandy Jones	✓	✓	✓	x
Debbie Mawson	✓	x	✓	✓
Paula Pattullo	✓	✓	✓	✓
Roy Stott	✓	✓	x	✓
Cheshire				
Kenneth Blasbery	x	✓	✓	✓
Michael Brereton	✓	✓	✓	✓

Governor Name	Council of Governor Meeting Dates 2010/11			
	14th June 2010	13th September 2010	6th December 2010	7th March 2011
David Hicks	✓	✓	x	✓
Judith Wright	✓	✓	✓	✓
North Wales				
Stephanie Greenway	x	x	x	x
Roy Griffiths	✓	x	✓	✓
Catrin Hanks	✓	x	✓	x
Rest of England and Wales				
John (Tony) Roberts	✓	✓	✓	✓
Staff Constituency				
Qualified Nurses and Unqualified Nurses				
Peter Hannaford	✓	✓	✓	✓
Neville Rumsby	✓	✓	✓	✓
Non Clinical				
Ron Arrowsmith	✓	✓	x	x
Anthony Grimes	✓	✓	✓	✓
Allied Health Professionals, Technical and Scientific				
Bashir Matata	✓	✓	✓	✓
Registered Medical Practitioners				
Johan Waktare	x	✓	✓	x
Nominated Governors:				
Trish Bennett (Liverpool PCT)	x	x	x	x
Glenda Corkish (FRoH)	x	x	x	x
Jon Develing (NWSCT)	✓	x	✓	x
Menna Harland (LJMU)	x	✓	x	✓
Carol Law (CFT)	x	✓		
Richard McLinden (LCC)	✓	x	x	x
Lynsey Morton (CFT)				x
Wyn Thomas (BCWHB)	x	x	x	x

Our Board of Directors

Role and Composition
The Board of Directors is collectively responsible for the exercise of the powers and performance of the Trust and specifically:

- Ensures that the Trust complies with its terms of authorisation, constitution, mandatory guidance and contractual and statutory duties,
- Provides effective and proactive leadership of the Trust within a robust governance framework of clearly defined internal controls and risk management processes,
- Sets the strategic direction, and approves the annual plan, taking into account the views of governors,
- Sets the Trust's vision, values and standards of conduct and behaviour, ensuring that its obligations to stakeholders, including patients and members are met,
- Ensures the quality and safety of services, research and education and application of clinical governance standards including those set by Monitor, the Care Quality Commission, NHS Litigation Authority and other relevant bodies.

The Board of Directors comprises a Non Executive Chairman, five independent non executive directors and four executive directors – a Chief Executive, Medical Director, Director of Nursing and Director of Finance.

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 provide an appropriate balance of skills and have the necessary skills, qualities and experience to meet the requirements of the Board in effectively discharging its responsibilities. This includes the requirement for the Chair of the Audit Committee to hold a relevant financial qualification and have recent financial experience. The Board has reviewed the balance, completeness and appropriateness of the membership of the Board and confirmed that these met its requirements in 2010/11. In 2009, the Board underwent extensive external assessment in preparation for foundation trust status. This was followed up in 2010 by an internal evaluation exercise, supplemented by an appraisal of individual directors undertaken by the Chair and Chief Executive. The Senior Independent Director led the governors in a process to appraise the Chair. The Council of Governors has also reviewed the policy on the composition of the Board of Directors.

The Board and Audit Committee has also evaluated the effectiveness of Board Committees in accordance with its Board Assurance Framework Policy. The Chairman leads and ensures the effectiveness of the Board of Directors and Council of Governors, ensuring effective engagement and working relationships between the two Boards.

The Chief Executive leads the executive and associate directors and the organisation.

The **Non Executive Directors** in 2010/11 were:

Name	Position	Date appointed	Expiry of current term of office
Neil Large Qualified accountant and diverse NHS career spanning 40 years	**Chairman**	1st December 2009 *	13th October 2013
Patricia Firby Registered nurse with 25 years experience in nurse education MSc in Social Research Methods	**Senior Independent Director and Deputy Chair**	1st December 2009 *	28th February 2013
Robert Toomey Qualified accountant and doctorate in economic history with experience of board level roles in a number of private sector organisations	**Non Executive Director and Chair of Audit Committee**	1st December 2009 *	30th April 2013
Bridget Leek BSC in Mathematics and Fellow of Institute of Actuaries with 10 years senior level experience in the financial industry.	**Non Executive Director**	1st December 2009 *	31st May 2013
David Bricknell Master in Research and PhD in strategic decision making with a career in the legal industry.	**Non Executive Director**	2nd March 2010	1st March 2013
Geoffrey Appleton LLB (Hons) and MA in Criminolgy with extensive experience in legal and personnel roles.	**Non Executive Director**	2nd March 2010	1st March 2013

* The initial Chairman (Neil Large) and initial Non Executive Directors (Patricia Firby, Robert Toomey and Bridget Leek) 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.

The Council of Governors appointed David Bricknell and Geoffrey Appleton and determined that their terms of office should be for a period of 3 years.

The Chairman and all non executive directors are considered independent in respect of the criteria for independence set out in the NHS Foundation Trust's Code of Governance.

All Non Executive Directors, with the exception of the Chairman are members of the Audit Committee.

All Non Executive Directors, including the Chairman, are members of the Nominations and Remuneration Committee (for Executive appointments).

The **Executive Directors** in 2010/11 were:

Name	Position
Raj Jain BA (Hons) with previous NHS Board level experience as Executive Director for Workforce and Service Improvement and FT Project Director at Salford Royal NHS FT.	**Chief Executive**
Glenn Russell Consultant Anaesthetist (Member of Liverpool Society of Anaesthetists) with extensive experience in cardiac anaesthesia both in the UK and overseas.	**Medical Director and Deputy Chief Executive**
Hazel Holmes BSc; MA and registered nurse. Previous roles have included Deputy Director of Nursing at Salford Royal NHSFT and Acting Director of Nursing at the Royal Liverpool and Broadgreen University Hospital Trust. Awarded Florence Nightingale Leadership Scholarship in 2010.	**Director of Nursing**
Aaron Cummins BA(Hons); CPFA with previous experience at a senior level holding Deputy Director of Finance posts at Robert Jones and Agnes Hunt as well as this Trust prior to being promoted to Director of Finance in 2009. Currently Chair of the Foundation Trust Network Finance Directors Forum.	**Director of Finance**

Attendance at Board of Director Meetings 2010/11

Director	27th April 2010	21st May 2010	27th July 2010	22nd October 2010	30th November 2010	25th January 2011	29th March 2011
Neil Large (Chair)	✓	✓	✓	✓	✓	✓	✓
Raj Jain	✓	✓	✓	✓	✓	✓	✓
Patricia Firby	✓	✓	✓	✓	✓	✓	✓
Robert Toomey	✓	✓	✓	✓	✓	✓	✓
Bridget Leek	✓	✓	✓	✓	✓	✓	✓
David Bricknell	✓	✓	✓	✓	x	x	✓
Geoffrey Appleton	✓	✓	✓	✓	✓	✓	✓
Glenn Russell	✓	✓	✓	✓	✓	✓	✓
Hazel Holmes	✓	✓	✓	✓	✓	✓	✓
Aaron Cummins	✓	✓	✓	✓	✓	✓	✓

Audit Committee

The Audit Committee is a committee of the Non Executive Directors (excluding the Chairman) and is chaired by Robert Toomey.

The Committee met on 7 occasions during 2010/11.

Attendance at Audit Committee meetings 2010/11:

Member	20th April 2010	3rd June 2010	20th July 2010	20th Sept 2010	22nd Nov 2010	21st Feb 2011	22nd March 2011
Robert Toomey (Chair)	x	✓	✓	✓	✓	✓	✓
Patricia Firby	✓	✓	✓	✓	✓	✓	✓
Bridget Leek	✓	✓	✓	✓	✓	x	✓
David Bricknell	✓	✓	x	✓	✓	✓	✓
Geoffrey Appleton	✓	✓	✓	✓	✓	✓	x

The key responsibility 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 good governance in the delivery of the organisation's objectives. The work of the Audit Committee in 2010/11 has been to review the effectiveness of the organisation and its systems of governance, risk management and internal control through a programme of work involving the scrutiny of assurances provided by internal audit, external audit, local counter fraud officer, trust

managers, finance staff and the clinical audit team along with reports and reviews from other external bodies.

An annual work programme is set at the start of the year along with agreement of the internal audit and counter fraud work plans, with provision to meet contingency requirements. The work programme incorporates a rolling programme of scheduled reviews of the work of the Board's Assurance Committees and attendance by each Committee Chair. The Audit Committee meets privately with the auditors on at least one occasion each year.

The Audit Committee reports to the Board of Directors through review of minutes, 'hot topics' reports and an annual report.

The Chair of the Audit Committee provides a quarterly report on the work of the Audit Committee to the Council of Governors. A group of governors and audit committee members met in July 2010 to assess the performance and recommend re-appointment of the external auditor for a further 12 month period. Recommendations were made and supported at the Council of Governors meeting held on 13th September 2010.

This group also developed a policy for the provision of non audit services by the external auditor, in recognition of the need to safeguard auditor objectivity and independence. This policy was subsequently approved by the Audit Committee and the Council of Governors. During 2010/11 the auditor has not been engaged in any non audit activity.

The Audit Committee reviews its effectiveness annually through use of a questionnaire and workshop following which a report and action plan is produced and provided to the Board of Directors for review.

Nominations Committees

The Trust has established two Nominations Committees – one dealing with nominations for Non Executive appointments (including the Chair) and the other with nominations for Executive appointments.

Nominations Committee (Non Executive)
Membership: Chaired by Neil Large with membership comprising the Deputy Chair and not less that three elected governors from the public constituency (If the Chair is being appointed, the Committee would comprise the Deputy Chair, one other Non Executive Director and not less than three elected governors from the public constituency).

Nominations Committee (Executive)
Membership: Chaired by Neil Large with all other Non Executive Directors as members.

During 2010/11 there have been no Board Director vacancies and therefore no requirement for either Nomination Committee to convene with regard to nominations.

Our Members

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

Public Membership

Public membership is open to everyone living in England and Wales over the age of 16. Our Trust operates on an 'opt in' basis. The public constituency is divided into four 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), and

- Rest of England and Wales.

Staff Membership

Our staff membership is open to any individual who is employed by the Trust under a contract of employment which has no fixed term, or who has been continuously employed by the Foundation Trust under a contract of employment for at least 12 months.Our Trust operates on an 'opt out' basis. The staff constituency is divided into four classes to reflect our 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 Foundation Trust membership.

Membership Strategy

We remain committed to making every effort to reach all groups within our membership communities. Our emphasis is on encouraging an active and engaged membership that is representative of our patient population, rather than focussing on increasing the number of members that we have. Our membership strategy is focused on targeting areas of under representation, which is highlighted by comparing our membership profile with demographic data on our catchment population. The composition of our Council of Governors also 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. It continues to be led by the Council of Governors' Membership and Communications Group, which is chaired by an elected public Governor. Quarterly reports from this group are provided to the full Council of Governors. Plans are in place to review and update the membership strategy, which will be formally approved by the Council of Governors in June 2011.

This year the group has made great progress in continuing to refine its approach in developing the Trust as a membership organisation, in terms of our catchment and patient populations, and the profile of our members. The key focus of the group is to build and sustain a representative membership through effective communication and engagement.

Our 2010 priorities have included:
● Improving member representation in the geographical areas of North Wales and Cheshire, whilst working on improving the engagement of members with Governors,

● Continuing to run a successful programme of 'Medicine for Members' events throughout our catchment areas, at which clinical specialists hosted talks and discussions in local community settings. The events were also an ideal opportunity for our Governors to engage with their members,

● Holding a number of staff and public open surgeries to encourage interaction between Governors and their members,

● Producing a membership newsletter to communicate with members,

● Inviting a sample of members to participate in a focus group to help shape our quality account priorities for next year, and

● Inviting our members to participate in a new pilot volunteers scheme which was launched across the Trust.

Membership Profile

The table below shows the number of members at 31st March 2011 and illustrates the growth of public membership over the last 12 month period.

Constituency			
Public Constituency	**As at 1st April 2010**	**As at 31st March 2011**	**Increase (%)**
Cheshire	**2,219**	**2,250**	**+1%**
Merseyside	**4,849**	**4,842**	**-1%**
North Wales	**1,601**	**1,778**	**+11%**
Rest of England and Wales	**506**	**804**	**+59%**
Total – Public Constituency	**9,145**	**9,674**	**+6%**
Staff Constituency	**1,266**	**1,305**	**+3%**

The public membership target of 9,000 members for this financial year set by the Board of Directors has been exceeded, with 9,674 members achieved by 31st March 2011. The Trust also remains on track to achieve the target of 10,000 by 31st March 2012. The focus for membership recruitment continues to be in ensuring that the Trust is improving representation of members, rather than growing numbers per se. Recruitment activity has been focused specifically on these areas.

Members who wish to contact their elected Governor to 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

Remuneration Report

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 Pat Firby Non-Executive Director
Mrs Bridget Leek Non-Executive Director
Mr Rob Toomey Non-Executive Director
Mr Geoffrey Appleton Non-Executive Director
Mr David Bricknell Non-Executive Director

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 April 2010 to 31st March 2011, the Committee met once on 30th November 2010.

All members with the exception of Mr Bricknell attended the meeting.

The committee considered the remuneration of the Executive and Associate Directors of the Trust.

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.

In determining Directors remuneration, the committee took account of the performance of each director against agreed objectives. The pay ranges were agreed in 2009 and were not subject to an inflationary uplift for 2010.

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 1.7 to the Annual Accounts and details of senior employees remuneration can be found on page four of the remuneration report.

The Council of Governors Nomination and Remuneration Committee

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

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

Up until September 2010 the Committee comprised the Trust's

- Chair (not present for discussions about personal remuneration)
- Deputy Chair (not present for discussions about personal remuneration)
- 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.

The membership of the Committee was amended following approval of a revised constitution in October 2010, to include greater representation of not less than 3 public governors.

During the period 1st April 2010 to 31st March 2011, the Committee met once on 13 September 2010 and recommended an increase in the remuneration of the Chair. The recommendation was accepted by the Council of Members. However, the Chair declined to take the increase.

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	28.02.2013	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	01.03.2013	1 month
Dr. David Bricknell	02.03.2010	01.03.2013	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 April 2010 to 31st March 2011 and includes Board Directors.

Year ended 31st March 2011			
Name and Title	**Salary (Bands of £5,000) £000's**	**Other Remuneration (Bands of £5,000) £000's**	**Benefits in Kind (£'s)**
R Jain - Chief Executive	135-140	0-5	5,500
G Russell - Medical Director	20-25	165-170	0
A Cummins - Director of Finance	90-95	0-5	400
H Holmes - Director of Nursing	95-100	0-5	3200
P N Large - Chair	35-40	0-5	0
P Firby - Non Executive Director	10-15	0-5	0
R Toomey - Non Executive Director	10-15	0-5	0
B Leek - Non Executive Director	10-15	0-5	0
G Appleton - Non Executive Director	10-15	0-5	0
D Bricknell - Non Executive Director	10-15	0-5	0

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 31st March 2011 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31st March 2011 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31st March 2011 £000	Cash Equivalent Transfer Value at 31st March 2010 £000	Real Increase /(decrease) 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	85-90	451	465	-14	0
G Russell - Medical Director	0-2.5	2.5-5	50-55	150-155	946	1007	-61	0
A Cummins - Director of Finance	0-2.5	5-7.5	5-10	25-30	80	79	1	0
H Holmes - Director of Nursing	2.5-5	10-12.5	25-30	75-80	278	287	-9	0

2009/10 1st December 2009 to 31st March 2010			
Name and Title	Salary (Bands of £5,000) £000's	Other Remuneration (Bands of £5,000) £000's	Benefits in Kind (£'s)
R Jain - Chief Executive	40-45	0-5	1000
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

Benefits in kind relate to the provision of leased vehicles

Calculations for the real increase in pension, lump sum and CETV are based on the increase accrued for the full year from 1st December 2010 to 31st March 2011.

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

Cash Equivalent Transfer 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 contingnet spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.time.

Real Increase in CETV

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

In his budget of 22 June 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfers factors. The new CETV factors have been used in these calculations and are lower than the previous factors used. As a consequence the value of the CETVs for some members may have fallen since 31/03/2010.

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Liverpool Heart and Chest Hospital 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 the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the 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 at Liverpool Heart and Chest Hospital NH Foundation Trust and 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: 6th June 2011**

Independent auditor's report to the Council of Governors 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 year ended 31 March 2011 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 in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Council of Governors of Liverpool Heart and Chest Hospital NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Council of Governors those matters I am required to state to it in an auditor's report and for no other purpose. 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 this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor
As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements
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's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters
In my opinion:
- 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
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception
I have nothing to report in respect of the Annual Governance Statement on which I report to you if, in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements.

Certificate
I certify that I have completed the audit of the accounts of Liverpool Heart and Chest Hospital NHS Foundation Trust 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
Audit Commission
2nd Floor, Aspinall House
Aspinall Close
Middlebrook
Horwich
Bolton
BL6 6QQ
6 June 2011

Annual Governance Statement 2010/11

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.

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 2011 and up to the date of approval of the Annual Report and Accounts.

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.

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, Clinical Quality Committee, Finance & Performance Committee, Workforce Committee and Patient Experience

Committee along with their sub committees provides the mechanism for managing and monitoring risk throughout the Trust and reporting through to the Board.

This structure is supported by robust governance processes within Directorates. General Managers ensure that reporting and review of risk registers within their Directorates occurs at least twice a year. Directorate Risk Registers are reviewed by the Risk Management Committee at least twice a year with the Assurance Framework being presented at least three times before review by the Board of Directors.

The Audit Committee oversees the systems of internal control and overall assurance process associated with managing risk.

- **Training**

Risk management training is provided as detailed within the Trust's Learning Needs Analysis through the corporate and local induction programmes for new staff and thereafter by attendance at Mandatory Training.

Risk management awareness and briefing sessions are provided to the Board of Directors and to senior managers. The Trust's line management arrangements are designed to support staff and managers in dealing with risk issues and there is advice and guidance available to staff from the Trust risk management team and specific specialist advice from the appropriate staff.

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).

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 assessment 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 risk 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 continual 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.

The system of internal control relating to Information Governance and Data Quality risk is managed through the Trusts Board Assurance System which includes Executive Accountability and a clear performance monitoring and management process. Any risks identified are captured via the finance directorate risk register and reported to the Risk Management Committee three times a year with any risks triggering the escalation threshold reported to the Board of Directors twice yearly.

Independent assurance is provided by the Audit Commission's PbR Data Assurance Framework review - for inpatients the Trust ranks consistently as one of the best performing Trusts in the country. The recent reference cost exercise also indicates that the Trust is performing well.

The Trust also completes the Information Governance Toolkit self-assessment on an annual basis with the process followed being subject to review by Internal Audit and the submission reviewed by the Finance and Performance Committee prior to approval by the Board of Directors. At the time of writing, the Trust has submitted its 2010 self assessment as being compliant with the minimum standards released in September 2010. This is subject to attaining appropriate levels of training for staff in this area, a target that has been extended to 30th June 2011 nationally. The Trust has also developed an action plan to take forward improvements identified during the audit process.
The Trust has not experienced any Serious Untoward Incidents involving the loss or corruption of Data or Information and no alleged breaches of the Data Protection Act have been reported to the Information Commissioners Office.

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 registration requirements of the Care Quality Commission (CQC). All clinical wards and departments participate in an assessment process aligned to the CQC's essential standards of quality and safety, based around observation of practice, review of relevant KPIs and feedback from patients and families. Any concerns are identified, moderated through Directorate governance arrangements and added to the risk register for appropriate management and review. Compliance reports are reviewed by the relevant Board Assurance Committees.

The Trust openly encourages incident reporting to ensure that all learning is captured both locally and organisationally and where appropriate, changes in practice are implemented. Incident reporting culture is monitored closely by Directorates along with monthly directorate review of reported incidents. The Board receives an integrated claims, complaints and incidents report on a monthly basis.

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

Review of 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.

The financial plan is developed through a robust process of 'confirm and challenge' meetings with Directorates and Departments to ensure best use of resources. All Cost improvement plans are impact assessed through a Board Assurance Committee prior to approval to determine and mitigate any adverse impact on quality and safety.

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.

The Audit Committee oversees a programme of 'deep dives' carried out by internal audit into the operations of directorates and departments and the external auditor provides an annual value for money opinion as part of their annual report.

Annual 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 in the NHS Foundation Trust Annual Reporting Manual.

In the pursuit of our goal to deliver the best outcomes and be the safest integrated healthcare organisation in the country, throughout 2010/11 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, new policy directives and quality incentive schemes (e.g. Commissioning for Quality & Innovation (CQUIN) and Advancing Quality),
3. Our quality, safety and patient experience Council of Governors sub-group, who are continuously identifying priorities from the Trust's 9,000 plus members,
4. Our members and the general public, who have provided suggestions for improvement throughout the year via focus groups and a structured

questionnaire which is handed out at every 'Medicine for Members' engagement event we have ran in the local communities we serve,
5. Our local involvement network (LINkS), who have held a series of engagement events which has brought all Trusts in Liverpool into direct contact with the LINkS representatives and members of the general public,
6. Issues raised by our patients arising from both national and local surveys,
7. Our key stakeholders (the doctors, nurses and managers from referring hospitals, our commissioners, patient self help groups, higher education institutions) who from two dedicated workshops (one held in Liverpool, the other in Wrexham, North Wales) 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 LHCH 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 which recommended the final shortlist of priorities to the Board. The Board reviewed and agreed the priorities in April 2011.

This process was developed and tested in 2010/11 and resulted in two suggestions being accepted as priorities, namely:

1. Improvements in discharge planning and communication (a priority rolled over into 2011/12 also)
2. Improvements in care for patients with a threatened 'heart attack' (acute coronary syndromes), a priority fully achieved in 2010/11.

Last year also saw the first external audit of the Quality Account, which attracted significant assurance and was reported as being a balanced view of the Trust's performance on quality. Recommendations made were largely centred on improvements in data quality process and policy; significant improvements have been made in this regard during 2010/11 with the reconvening of the data quality committee, together with the implementation of several policies and procedures.

The Trust prides itself as being at the cutting edge of quality reporting (citation in Lord Darzi's 'One Year On' report, 2009). Quality metrics are a regular feature of the Trust's Clinical Quality Committee agenda where a bespoke clinical quality dashboard is reviewed to ensure progress against key quality metrics are being made.

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, clinical audit and executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual report and other performance information available to me. My

review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Risk Management Committee and Clinical Quality Committee and a plan to 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 principal objectives have been reviewed. The head of internal audit has provided me with an opinion of 'significant assurance' 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 organisation's principal objectives.

My review is also informed by external audit, audit by the National Health Service Litigation Authority, assessments of compliance with the Care Quality Commission's 'Essential Standards Quality and Safety' 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, Clinical Quality 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,
- NED review of complaints,
- Review of clinical audit , patient survey and staff survey information,
- Assurance Committee review of compliance with NHSLA standards and CQC essential standards of quality and safety,
- Internal audits of effectiveness of systems of internal control.

Conclusion

No significant control issues were identified in 2010/11, however the following control issues remain a risk and are being monitored and managed closely:

I. Cancer targets – the Trust breached the 62 day cancer target in Quarter 2 and the 31 day cancer target in Quarter 3 and this has resulted in 'amber-green' governance ratings from Monitor for two successive quarters. In the case of the 62 day target, timely referral to this trust is heavily dependent upon the referring hospital; and in the case of the 31 day target, the small numbers of patients treated leaves little headroom for the Trust in managing the pathway in accordance with clinical need given that a number of these patients have co-morbidities that need to be managed before cancer treatment can start. The Board has undertaken a root cause analysis of all breaches and has received assurance that all patients were treated appropriately irrespective of the target and that their care was not compromised; also that the administrative and management processes are effective. Whilst every attention is given to ensuring that these targets are met and acknowledging their importance in terms of patient care, the key factors that have resulted in breach remain a risk as the trust has limited direct influence.
II. The financial health of the Trust's commissioners- the Trust has been working to further strengthen relationships with its Commissioners and to establish protocols to better manage demand and minimise financial risk without detriment to patient safety or the financial viability of the trust. The nature of the current economic climate and the significant structural change means that the financial health of our commissioners and their ability to pay for the levels of activity demanded is likely to remain a key risk for the foreseeable future.

Action to improve the control of the above risks has been progressing throughout 2010/11 and is regularly reviewed by the Board.

Signed: ……
Chief Executive 6th June 2011

PUBLIC INTEREST DISCLOSURES

Declaration of Executive and Non Executive Directors' Private Interests

1st April 2010 – 31st March 2011

Non Executive Directors	Declaration of Interests
Neil Large/Chair	Member of Finance Committee, Hospice of the Good Shepherd Chester. Board of Trustees, Tarporley Cottage Hospital. Member of Finance & Risk Management Committee, University of Chester. Company Secretary/Director, Eaton Golf Club. Liverpool Community Provider Services – son employed as an Accountant.
Patricia Firby	Lay member of the oversight Sub-Committee for Human Embryonic Stem Cell Research at the University of Liverpool. Member of the North West Embryonic Stem Cell Centre Advisory Board at the University of Manchester.
Rob Toomey	Director, Edward Billington & Son. Director, Central Tin Containers. Director/Trustee, Emmaus Liverpool Secretary, Mill Marquee Limited. Member of the University of Liverpool Investment Advisory Committee.
Bridget Leek	Director, Steve Leek Limited (Trading as Designed by U) Governor, Parkgate Primary School
Geoffrey Appleton	Chair of Cheshire West & Chester Adult Safeguarding Board. Managing Trustee Liverpool Cathedral Foundation Trust. Honorary Secretary to the Athenaeum, Liverpool. Training Consultant for Isle of Man Magistrates. Governor of Cowley International Language College. Trustee Director, St Helens CAB.
David Bricknell	Trustee of Ruskin Lodge, St Helens (respite care home). Trustee of Thornton Jospice.

Executive Directors	Declaration of Interests

Raj Jain Chief Executive	None
Dr Glenn Russell Medical Director & Consultant Anaesthetist	None
Hazel Holmes Director of Nursing	None
Aaron Cummins Director of Finance	None

Audit Opinion and Report

Independent Assurance Report to the Council of Governors of Liverpool Heart and Chest Hospital NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Council of Governors of Liverpool Heart and Chest Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Liverpool Heart and Chest Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter
I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:
- Board minutes for the period April 2010 to May 2011;

- papers relating to quality reported to the Board over the period April 2010 to May 2011;
- feedback from the commissioners dated May 2011;
- feedback from the governors dated May 2011;
- feedback from LINks dated May 2011;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS complaints Regulations 2009, dated April 2011;
- the national patient survey 2010;
- the national NHS staff survey 2010;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 17 April 2011; and
- Care Quality Commission quality and risk profiles dated September 2010, October 2010, November 2010, December 2010, February 2011 and March 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information. This report, including the conclusion, has been prepared solely for the Council of Governors of Liverpool Heart and Chest Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Liverpool Heart and Chest Hospital NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and Liverpool Heart and Chest Hospital NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion
Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Julian Farmer
Officer of the Audit Commission
Audit Commission
2nd Floor, Aspinall House
Aspinall Close
Middlebrook
Horwich
Bolton
BL6 6QQ
6 June 2011

Section 2

Annual Accounts

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

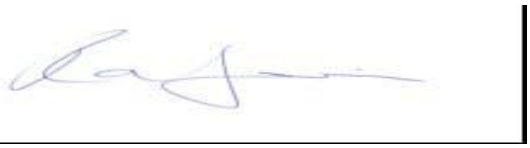
The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS 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 Annual 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 Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- 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* .

Signed…. 

Chief Executive Date: 6th June 2011

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

Summarisation schedules numbers 1 to 39 and the WGA schedules for 2010/11 are attached.

Finance Director Certificate

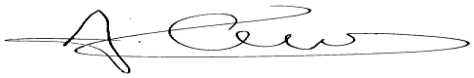
1. I certify that the attached FTC schedules have been compiled and are in accordance with:

- The financial records maintained by the NHS Foundation Trust; and

- Accounting standards and policies which comply with the *NHS Foundation Trust Financial Reporting Manual* 2010/11 issued by Monitor, the Independent Regulator of NHS Foundation Trusts

2. I certify that the FTC schedules are internally consistent and that there are no validation errors.

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

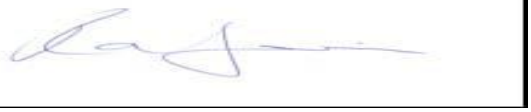


Aaron Cummins
Finance Director
June 2011

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
June 2011

Data entered below will be used throughout the workbook:

Trust name:	Liverpool Heart and Chest Hospital NHS Foundation Trust
This year	for period ended 31st March 2011
Last year	31st March 2010
This year ended	31st March 2011
Last year ended	31st March 2010
This year commencing:	1st April 2010

Liverpool Heart and Chest Hospital NHS Foundation Trust - Accounts for period ended 31st March 2011

Foreword

The accounts for the year ended 31st March 2011 have been prepared by Liverpool Heart and Chest Hospital NHS Foundation Trust under Schedule 7, Sections 24 and 25 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.

Signed 

Chief Executive

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31st March 2011

	NOTE	2010/11 £000	Dec 2009-Mar 2010 £000
Revenue			
Operating Income	7	**101,323**	**32,517**
Other operating revenue	8	**4,997**	**1,495**
Operating expenses	11	**-103,633**	**-33,209**
Operating surplus (deficit)		**2,687**	**803**
Finance costs:			
Investment Revenue	17	**118**	**27**
Other gains and (losses)	18	**0**	**0**
Finance costs	19	**-42**	**-21**
Surplus/(Deficit) for the financial period		**2,763**	**809**
Public dividend capital dividends payable		**-1,730**	**-638**
Retained surplus/(deficit) for the period		**1,033**	**171**
Other comprehensive income			
Revaluation gains/(losses) and impairment losses on property, plant and equipment		1,019	-1,420
Increase in the donated asset reserve due to the receipt of donated assets		0	44
Reduction in the donated asset reserve in respect of depreciation, impairment and/or disposal of donated assets		-147	-50
Total comprehensive income for the period		**1,905**	**-1,255**

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

The Trust has revalued its Estate at 31st March 2011, as a consequence:

Operating income includes a reversal of previous impaiments of £988k.

Operating expenses includes an amount of £659k.

The normalised surplus position over the financial year excluding impairments is £704k

The notes on pages 6 to 38 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31st March 2011

	NOTE	31st March 2011 £000	31st March 2010 £000
Non-current assets			
Property, plant and equipment	21	**58,386**	56,619
Intangible assets	22	**183**	44
Total non-current assets		**58,569**	56,663
Current assets			
Inventories	26	**4,026**	2,803
Trade and other receivables	27	**2,606**	3,282
Cash and cash equivalents	30	**17,264**	13,708
		23,896	19,793
Non-current assets held for sale	31	**0**	0
Total current assets		**23,896**	19,793
Total assets		**82,465**	76,456
Current liabilities			
Trade and other payables	32	**(12,089)**	(8,123)
Borrowings	33	**(220)**	(352)
Provisions	37	**(670)**	(720)
Other liabilities	38	**(2,156)**	(1,632)
Net current assets/(liabilities)		**8,761**	8,966
Total assets less current liabilities		**67,330**	65,629
Non-current liabilities			
Borrowings	33	**(170)**	(374)
Provisions	37	**0**	0
Other liabilities	38	**0**	0
Total assets employed		**67,160**	65,255
Financed by taxpayers' equity:			
Public dividend capital		**62,799**	62,799
Retained earnings		**(5,859)**	(6,909)
Revaluation reserve		**9,001**	7,999
Donated asset reserve		**1,219**	1,366
Total Taxpayers' Equity		**67,160**	65,255

The financial statements and notes on pages 2 to 38 were approved by the Board on and signed on its behalf by:

Signed: .. Chief Executive) Date: ……6th June 2011

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 2010 on Authorisation					
Total Comprehensive Income for the year	62,799	-7,080	9,408	1,383	66,510
Retained surplus/(deficit) for the year	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 31st March 2010	62,799	-6,909	7,999	1,366	65,255
Changes in taxpayers' equity for 2010-11					
Total Comprehensive Income for the period:					
Retained surplus/(deficit) for the period.	0	1,033	0	0	1,033
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	1,019	14	1,033
Asset disposals	0	73	-73	0	0
Increase in the donated asset reserve due to receipt of donated assets	0	0	0	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	0	0	0	-161	-161
Transfer between reserves	0	-56	56	0	0
Balance at 31st March 2011	62,799	-5,859	9,001	1,219	67,160

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31st March 2011

	NOTE	for period ended 31st March 2011 £000	for 4 months to 31st March 2010 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**2,687**	803
Depreciation and amortisation		**5,153**	1,338
Impairments		**659**	527
Reversal of impairments		**(988)**	
Transfer from donated asset reserve		**(147)**	(38)
(Increase)/decrease in trade and other receivables		**561**	2,557
(Increase)/decrease in inventories		**(1,223)**	737
Increase/(decrease) in trade and other payables		**3,310**	(1,617)
Increase/(decrease) in other current liabilities		**524**	1,629
Increase/(decrease) in provisions	37	**(50)**	142
Tax (paid)/received		**0**	0
Net cash inflow/(outflow) from operating activities		**10,486**	6,078
Cash flows from investing activities			
Interest received		**118**	27
(Payments) for property, plant and equipment	21	**(5,055)**	(984)
Net cash inflow/(outflow) from investing activities		**(4,937)**	(957)
Net cash inflow/(outflow) before financing		**5,549**	5,121
Cash flows from financing activities			
Capital element of finance leases		**(336)**	(126)
Interest element of finance lease		**(42)**	(21)
PDC dividend paid		**(1,615)**	(1,083)
Net cash inflow/(outflow) from financing		**(1,993)**	(1,230)
Net increase/(decrease) in cash and cash equivalents		**3,556**	3,891
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**13,708**	9,817
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	30	**17,264**	13,708

NOTES TO THE ACCOUNTS

1. Accounting Policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the *Foundation Trust Annual Reporting Manual (FT ARM)* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *FTARM 2010/11* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *FReM* 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 Prior Period Comparatives

The Trust received its authorisation as a Foundation Trust from Monitor from 1st December 2009 Accounts were prepared for the 4 month period 1st December 2009 to 31st March 2010 which provide the prior year comparator information for the accounts for the current reporting period

1.3 Acquisition 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 body to another.

1.4 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 effects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Foundation 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 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 in the foreseeable future.

Compliant with the NHS Foundation Trust Annual Reporting Manual

The Financial statements have been prepared in accordance with the 2010/11 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)

1.4.2 Key Sources of Estimation Uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amount 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 Foundation 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 or where relevant locally agreed prices.

Asset Valuation - The Foundation Trust appointed an independent valuer to value its land and buildings at March 31st 2011 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 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 the appeal.

Short term employee benefits - The Foundation Trust has calculated a provision for untaken holiday pay which was based on a 90% sample of all employees in 2009/10. The Foundation Trust has recalculated a provision for 2010/11 which is based on a sample of 15% of staff which has confirmed that the original holiday pay accrual is adequate.

1.5 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Foundation Trust is from contracts with commissioners in respect of healthcare services. Revenue relating to patient care spells that are part-completed at the year-end is calculated and where material is 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.
Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Interest revenue is derived from balances held in the Office of Paymaster General Account which transferred during the year to Government Banking Services and on short term deposits with commercial banks.All investments have been undertaken in accordance with the Foundation Trust's Treasury Management Policy.

1.6 Expenditure on 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 annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

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

1.7 Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Foundation Trust commits itself to the retirement, regardless of the method of payment.

1.8 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the
• it is expected to be used for more than one financial year; and
• the cost of the item can be measured reliably.
• the item has cost of at least £5,000; or
• Collectively, a number of items have a cost of at least £5,000 and individually have 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 e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset 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 accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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

1.9 Property, Plant and Equipment (continued)

Until 31st March 2008, the depreciated replacement costs of specialised assets have 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 and Foundation Trusts must apply these new valuation requirements by 1st April 2010 at the latest. The NHS Foundation Trust has revalued its Estate on 31st March 2010 and 31st March 2011 under this method.

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 31st March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and deprecation of historic cost. From 1st 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. In accordance with IAS 16 (Property, Plant and Equipment) this credit is limited as the reversal cannot exceed the previous impairment charge net of additional depreciation chargeable on the unimpaired asset. A transfer is made between the revaluation reserve and retained earnings to adjust for excess depreciation being the difference between depreciation on the carrying (actual) value and its historic cost.

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
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally Generated Intangible Assets
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:

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

1.10 Intangible assets (continued)

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

• the Foundation Trust intends to complete the asset and sell or use it;

• the Foundation Trust has the ability to sell or use the asset;

• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

• adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and

• the Foundation Trust can measure reliably the expenses attributable to the asset during development

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.11 Depreciation

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).

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Foundation Trust, respectively.

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

1.12 Revaluation Gains and Losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.13 Impairments

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.

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.14 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;

- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

The Foundation Trust does not currently hold any assets which are classified as held for sale

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

1.15 Borrowing Costs

Borrowing costs are recognised as expenses as they are incurred

1.16 Donated Assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

1.17 Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.
The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.
The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

1.18 Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.19 Leases of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately

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

1.20 Government Grants

Government grants are grants from Government bodies other than income from Primary Care Trusts, NHS Trusts and NHS Foundation Trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

The Foundation Trust does not currently have any Government grants.

1.21 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. The Foundation Trust has purchased Auto Implantable Cardiac Defibrillators (AICDs) prior to the increase in VAT to 20% and has valued this stock at cost plus VAT at 17.5%. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.22 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.

1.23 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.
The Foundation Trust has made specific provisions for liabilities for third parties legal claims and to issues associated with Equal Pay Claims

1.24 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 38 but is not recognised in the NHS Foundation Trust's accounts.

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

1.25 Non-Clinical Risk Pooling

The NHS 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 when the liability arises.

For buildings and contents, the Foundation 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 Foundation Trust includes Group Accident Scheme insurance , Commercial Combined insurance, Directors and Officers Liability insurance and Goods in Transit (excluding marine) insurance , The annual premium and any excesses payable are charged to operating expenses when the liability arises.

1.26 EU Emissions Trading Scheme

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

1.27 Contingencies

A contingent asset is a possible asset that arises from past events and whose existence will only be confirmed by 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.

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 payment is remote.

Where the time value of money is material, contingencies are disclosed at their present value.

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

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

1.28 Financial Assets (continued)

Available for Sale Financial Assets
The Foundation 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.

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.

1.29 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.

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

1.30 Corporation Tax

The introduction of corporation tax has been postponed for Foundation Trusts until 1.4.2011

The Foundation Trust derives income from Private patient work in accordance with the terms of its Authorisation from Monitor. Authorised private healthcare services fall under Section 14(1) of the Health and Social Care Act 2008 as goods and services relating to the provision of healthcare and are not therefore taxable.

Other non patient related trading activities such as the provision of catering for staff and patients and car parking are provided by third parties who recharge the Foundation Trust and these are treated as an expense.

As a consequence the Foundation Trust has determined that it has no Corporation tax liability.

1.31 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.

1.32 Foreign Exchange

The functional and presentational currencies of the Foundation Trust are sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Foundation Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at ‘fair value through income and expenditure’) are translated at the spot exchange rate on 31 March;
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.33 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Foundation Trust has no beneficial interest in them. Details of third party assets are given in Note 46 to the accounts.

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

1.34 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.35 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).

1.36 Subsidiaries

Subsidiary entities are those over which the Foundation Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.
The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Foundation Trust's financial year are obtained from the subsidiary and consolidated.
Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material.
Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.
For 2010/11 : NHS charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor.

1.37 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.

2 Operating Segments

The Foundation Trust has one segment for the provision of healthcare which generated income of £106.32m

	2010/11	4 months to 31st March 2010
	£000	£000
The main sources of income received were:-		
North West Specialist Commissioning Team	**70,386**	24,206
Health Commission Wales	**17,191**	5,434

Healthcare Segment

	2010/11	4 months to 31st March 2010
	£000	£000
Income	**106,320**	34,012
Surplus/(Deficit)	**1,033**	171
Net Assets:	**67,160**	65,255

3 Income generation activities

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

4 Operating Income analysed by type	2010/11	4 months to 31st March 2010
	£000	£000
Elective income	**49,261**	15,759
Non elective income	**30,222**	10,119
Outpatient Income	**8,888**	3,202
Other NHS clinical income*	**8,656**	2,278
Private patient income	**2,993**	877
Other non-protected clinical income	**1,303**	276
Total Income from activities	**101,323**	**32,511**
Research & Development	**566**	275
Education & Training	**2,756**	880
Charitable & other contributions to expenditure		23
Transfer from Donated Asset reserve in respect of depreciation on donated assets	**161**	38
Reversal of impaiments of Property, plant & equipment	**988**	
Other Income	**526**	285
Total other operating income	**4,997**	**1,501**
Total Operating income	**106,320**	**34,012**

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

5 Analysis of Other NHS Clinical Income	2010/11	4 months to 31st March 2010
	£000	£000
Drugs and Devices - Non Contracted	**881**	248
NHS Trust Income - SLA's	**1,521**	469
PCT Income - Non Contracted	**1,753**	257
Cystic Fibrosis Inpatients	**3,789**	1,304
Non recurent H1N1 funding	**600**	
Patient transport service	**112**	
	8,656	**2,278**

6 Private Patient Income	2010/11	4 months to 31st March 2010	Base Year 2002/03
		£000	£000
Private Patient Income	**2,993**	**877**	2,876
Total Clinical Income	**101,323**	**32,511**	54,831
Proportion of private patient income as a percentage of Clinical Income	**3.0%**	**2.7%**	**5.2%**

Section 44 of the National Health Service Act 2006 requIres that the proportion of Private Patient Income to the total patient related Income of the NHS Foundation Trust should not exceed its proportion whilst the body was an NHS Trust in 2002/03 (the Private Patient Cap). The Foundation Trust is compliant with this requirement during the year..

7 Operating Income analysed by source

	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
NHS Foundation Trusts	**286**	82
NHS Trusts	**1,930**	482
Strategic Health Authorities	**0**	12
Primary Care Trusts	**78,719**	25,581
NHS Other	**11**	8
Local authorities	**4**	0
Non NHS:		
- Private patients	**2,994**	877
- Overseas patients (non reciprocal)	**7**	0
- Other*	**17,372**	5,469
	101,323	32,511

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

8 Other Operating Revenue

	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Research & Development	**566**	275
Education and training	**2,756**	880
Charitable and other contributions to expenditure	**0**	23
Transfer from donated asset reserve in respect of depreciation on donated assets	**161**	38
Loss on disposal of other tangible fixed assets	**0**	
Reversal of impairments of property, plant and equipment	**988**	
Other income*	**526**	285
	4,997	1,501

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

9 Analysis of Other Operating Revenue - Other income

	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Estates recharges		72
Pharmacy sales		6
Staff accommodation rentals	**18**	2
Clinical tests		26
Clinical excellence awards	**500**	171
Other	**8**	8
	526	285

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

	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Income from Activities - Mandatory Services	93,753	31,358
Income from Activities - Non-Mandatory Services	7,570	1,153
	101,323	**32,511**

10 Revenue

Revenue is predominantly from the supply of services. Revenue from the sale of goods is not material.

11 Operating Expenses

	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Services from NHS Foundation Trusts	**271**	62
Services from NHS Trusts	**4,253**	1,329
Services from other NHS bodies	**134**	35
Employee Expenses- Executive directors	**238**	79
Employee Expenses- Non-executive directors	**74**	19
Employee Expenses- Staff	**55,527**	17,380
Drugs costs	**4,181**	1,250
Supplies and services - clinical (excluding drug costs)	**27,006**	9,023
Supplies and services - general	**1,388**	481
Establishment	**828**	231
Research and Development	**10**	
Transport	**67**	21
Premises	**1,876**	618
Increase/(decrease) in bad debt provision	**140**	37
Depreciation on property, plant and equipment	**5,126**	1,338
Amortisation on intangible assets	**27**	
Impairments of property, plant and equipment	**659**	527
Reversal of Impairments of property, plant and equipment	**0**	
Audit fees	**65**	58
Other auditor's remuneration	**0**	2
Other audit services	**20**	
Clinical negligence	**429**	129
Legal fees	**109**	119
Consultancy costs	**139**	56
Training courses and conferences	**314**	109
Patient travel	**123**	41
Car parking and Security	**248**	61
Insurance	**102**	34
Other services, eg external payroll	**0**	36
Losses, ex gratia & special payments	**71**	17
Other	**208**	117
	103,633	33,209

12 Audit Fees and Other Remuneration	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Statutory Audit	**65**	58
Other Auditors remuneration	**20**	
Financial reporting evaluation		2
	85	**60**

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

13 Operating leases

The Foundation Trust has leases on 3 cars covering 3 year agreements commencing from June 2009, June 2010 and February 2011. The Foundation Trust also has a lease agreement on a van commencing from May 2007 for a period of 5 years. In addition the Foundation Trust has photocopiers under 5 year agreements.

13.1 As lessee

Payments recognised as an expense	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Minimum lease payments	**37**	7
Contingent rents	**0**	0
	37	7

Contingent rent on excess mileage on the 3 leased cars is as follows;

	Excess Mileage	Excess mileage charge excl VAT
Lease car 1	10000	10p per mile
Lease car 2	11000	6p per mile
Lease car 3	20000	14.49p per mile

Total future minimum lease payments	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Payable:		
Not later than one year	**26**	17
Between one and five years	**24**	19
After 5 years	**0**	0
Total	**50**	36

There are no future sublease payments expected to be received

13.2 As lessor

The Foundation Trust does not have operating leases as a lessor.

14 Employee costs and numbers

14.1 Employee costs

	Year ended 31st March 2011			4 months to 31st Mar 2010		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
				£000	£000	£000
Salaries and wages	**46,359**	**45,707**	652	14,646	14,311	335
Social Security Costs	**3,415**	**3,324**	91	1,092	1,045	47
Employer contributions to NHS Pension scheme	**4,668**	**4,668**	0	1,441	1,441	0
Other pension costs	**0**	**0**	0	0	0	0
Termination benefits	**0**	**0**	0	0	0	0
Agency and contract staff	**1,324**	**0**	1,324	280	0	280
Employee benefits expense	**55,766**	**53,699**	**2,067**	17,459	16,797	662
Of the total above:						
Charged to capital	0					
Employee benefits charged to revenue	0					
	0					

14.2 Average number of people employed

	Year ended 31st March 2011			4 months to 31st Mar 2010		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	**180**	**130**	**50**	124	122	2
Administration and estates	**271**	**263**	**8**	245	241	4
Healthcare assistants and other support staff	**217**	**214**	**3**	229	219	10
Nursing, midwifery and health visiting staff	**510**	**495**	**15**	502	472	30
Scientific, therapeutic and technical staff	**209**	**200**	**9**	178	174	4
Social care staff	**6**	**3**	**3**	3	0	3
Other	**2**	**1**	**1**	8	8	0
Total	**1,395**	**1,306**	**89**	1,289	1,236	53

14.3 Management and Administration Costs

	Year ended 31st March 2011	1st Dec 2009 - 31st March 2010
	£000	£000
Management costs	**5,399**	1,690
Income	**106,320**	34,012
Percentage of Management Costs to Income	**5.08%**	4.97%

14.4 Staff Sickness Absence

	Year ended 31st March 2011	1st Dec 2009 - 31st March 2010
Days Lost (Long Term)	**13,382**	3,385
Days Lost (Short Term)	**8,222**	2,605
Total Days Lost	**21,604**	**5,990**
Total Staff Years	**1,306**	1,191
Average working days lost	**16.5**	5
Total Staff Employed in Period (Headcount)	**1,540**	**1,317**
Total Staff Employed in Period with no absence (Headcount)	**660**	**908**
Percentage Staff with no Sick Leave	**42.86%**	**68.94%**

Average working days lost has been adjusted to reflect a 4 month reporting period in 2009/10.

15 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. The latest published valuation was 7 years ago as it related to the period 1st April 1999 to 31st March 2004 This document was published in December 2007 and is available on the NHS Pensions Agency website.

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:

15 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

Early payment of a pension, with enhancement in certain circumstances, is available to members of the 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)

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

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.

16 Retirements due to ill-health

For the year ended 31st March 2011 there were nil early retirements from The NHS Foundation Trust agreed on the grounds of ill-health.(Period from 1st December 2009 to 31st March 2010 nil retirements)

17 Investment Revenue	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Interest revenue:		
Bank accounts	118	27
Total	118	27

18 Other Gains and Losses

There are no other gains or losses

19 Finance Costs	Year ended 31st March 2011 £000	4 months to 31st March 2010 £000
Interest on obligations under finance leases	42	21
Total	42	21

20 Better Payment Practice Code

20.1 Better Payment Practice Code - measure of compliance	Year ended 31st March 2011		4 months to 31st Mar 2010	
	Number	£000s	Number	£000s
Total Non-NHS trade invoices paid in the period	33,571	44,582	9,716	12,955
Total Non NHS trade invoices paid within target	32,169	43,522	9,332	12,164
Percentage of Non-NHS trade invoices paid within target	95.8%	97.6%	96.0%	93.9%
Total NHS trade invoices paid in the period	999	13,369	430	5,784
Total NHS trade invoices paid within target	880	10,470	400	3,961
Percentage of NHS trade invoices paid within target	88.1%	78.3%	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.

20.2 The Late Payment of Commercial Debts (Interest) Act 1998	Year ended 31st March 2011 £000	4 months to 31st Mar 2010 £000
Amounts included within other interest payble arising from claims made under this legislation.	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	0

21 Property, plant and equipment

2010/11:	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 1st April 2010	3,235	41,504	519	584	22,608	3,396	2,096	73,942
Additions purchased	0	1,773	0	1,065	2,114	563	18	5,533
Additions donated	0	0	0	0	0	0	0	0
Reclassifications	0	80	0	(494)	297	117	0	0
Revaluations	0	0	0	0	264	0	0	264
Impairments	0	759	10	0	0	0	0	769
Disposals	0	(12)	0	0	(5,450)	0	0	(5,462)
At 31st March 2011	**3,235**	**44,104**	**529**	**1,155**	**19,833**	**4,076**	**2,114**	**75,046**
Depreciation at 1st April 2010	0	0	0	0	13,543	2,538	1,242	17,323
Impairments	0	(329)	0	0	0	0	0	(329)
Charged during the year	0	1,292	27	0	3,164	454	189	5,126
Disposals	0	(12)	0	0	(5,448)	0	0	(5,460)
Depreciation at 31st March 2011	**0**	**951**	**27**	**0**	**11,259**	**2,992**	**1,431**	**16,660**
Net book value								
Purchased	3,235	42,776	207	1,155	7,665	1,084	670	56,792
Finance Leased	0	0	0	0	375	0	0	375
Donated	0	377	295	0	534	0	13	1,219
Total at 31st March 2011	**3,235**	**43,153**	**502**	**1,155**	**8,574**	**1,084**	**683**	**58,386**

21.1 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 2011	**3,235**	**39,578**	**0**	**0**	**0**	**0**	**0**	**42,813**
NBV - Unprotected Assets at 31st March 2011	**0**	**3,575**	**502**	**1,155**	**8,574**	**1,084**	**683**	**15,573**
Total at 31st March 2011	**3,235**	**43,153**	**502**	**1,155**	**8,574**	**1,084**	**683**	**58,386**

Protected assets are used in the provision of mandatory services. Unprotected assets relate to dwellings and the land associated with them

21.2 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 1st 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	(420)	(13)	(557)	0	7	0	(983)
Revaluations	0	(83)	0	0	0	0	0	(83)
Impairments	0	(1,334)	(3)	0	0	0	0	(1,337)
At 31st March 2010	**3,235**	**41,504**	**519**	**584**	**22,608**	**3,396**	**2,096**	**73,942**
Depreciation at 1st Dec 2009	0	0	0	0	12,870	2,396	1,179	16,445
Impairments	0	527	0	0	0	0	0	527
Reclassifications	0	(970)	(13)	0	0	0	0	(983)
Charged during the year	0	443	13	0	673	142	63	1,334
Depreciation at 31st March 2010	**0**	**0**	**0**	**0**	**13,543**	**2,538**	**1,242**	**17,323**
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 31st March 2010	**3,235**	**41,504**	**519**	**584**	**9,065**	**858**	**854**	**56,619**

21.3 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 31st 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

21.4 Property, Plant and 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 2011.

The following table discloses the range of remaining economic lives of various assets

Economic Lives of Fixed Assets	Min life Years	Max life Years
Buildings exc dwellings	1	55
Dwellings	22	38
Assets under Construction & POA	5	25
Plant & Machinery	0	11
Information Technology	0	5
Furniture and Fittings	0	10

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.
Following a review of lives of equipment assets the Trust has relifed assets with an original useful life of 15 years to 7 years. This is consistent with the useful life assigned to current purchases of large value equipment assets of at least £10,000.

The Financial impact of the change from 15 years to 7 years life for Plant and Machinery assets costing over £10k was an increase in depreciation of £1.06m.

22 Intangible assets

2010/11:	Computer software - purchased	Total
	£000	£000
Gross cost at 1st April 2010	219	219
Additions	166	166
Gross cost at 31st March 2011	**385**	**385**
Amortisation at 1st April 2010	175	175
Charged during the year	27	27
Amortisation at 31st March 2011	**202**	**202**
Net book value		
Purchased	183	183
Donated	0	0
Total at 31st March 2011	**183**	**183**

2009/10:	£000	£000
Gross cost at 1st Dec 2009	219	219
Gross cost at 31st March 2010	**219**	**219**
Amortisation at 1st Dec 2009	168	168
Charged during the year	7	7
Amortisation at 31st March 2010	**175**	**175**
Net book value		
Purchased	44	44
Donated	0	0
Total at 31st March 2010	**44**	**44**

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.

22.1 Revaluation Reserve Balance for Intangible Assets

There is no Revaluation Reserve for Intangible Assets

23 Impairments

The Foundation Trust engaged the Valuation Office Agency to revalue its estate using Modern Equivalent Asset methodology effective from 31st March 2011. There has been an overall upward revaluation by £1.098m,

Within this sum there has been ;-

- reversal of prior year impairments of £988k which have been credited to income..
- negative impairments of £659k charged to expenditure.
- upward revaluations of (not previously impaired) purchased buildings of £918k credited to the revaluation reserve.
- Negative impairments charged to the revaluation reserve of £163k. .
- Net upward revaluations of donated buildings of £14k, which have been credited to the donated asset reserve.

24 Revaluation Reserve

2010/11:	Revaluation Reserve - intangibles	Revaluation Reserve - Property, plant and equipment	Total Revaluation Reserve
	£000	£000	£000
Revaluation reserve at 1st April 2010	0	7,999	7,999
Impairments	0	755	755
Revaluations	0	264	264
Asset disposals	0	(73)	(73)
Other reserve movements	0	56	56
At 31st March 2011	**0**	**9,001**	**9,001**
2009/10:			
Revaluation reserve at 1st December 2010	0	9,408	9,408
Impairments	0	(1,337)	(1,337)
Revaluations	0	(83)	(83)
Other Reserve Movements	0	11	11
At 31st March 2010	**0**	**7,999**	**7,999**

The revaluation of £264k relates to the receipt of an Ensite velocity system which has been revalued upwards to current cost after the Trust attained legal title as part of a consumables agreement.

25 Capital commitments

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

	31st March 2011	31st March 2010
	£000	£000
Property, plant and equipment	**881**	**393**
Intangible assets	**0**	0
Total	**881**	**393**

26 Inventories

26.1. Inventories

	31st March 2011	31st March 2010
	£000	£000
Finished Goods	**4,026**	2,803
Total	**4,026**	2,803
Of which held at net realisable value:	**0**	0

26.2 Inventories recognised in expenses

	31st March 2011	31st March 2010
	£000	£000
Inventories recognised as an expense in the period	**28,069**	**9,371**
Total	**28,069**	**9,371**

27 Trade and other receivables

27.1 Trade and other receivables

	Current	
	31st March 2011	31st March 2010
	£000	£000
NHS receivables	**1,141**	2,028
Other receivables	**865**	553
Provision for impaired receivables	**(240)**	(109)
Prepayments	**349**	329
Accrued income	**275**	0
PDC receivable	**51**	166
Other receivables	**165**	315
Total	**2,606**	3,282

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 overdue for payment or impaired, whose terms have been other than contracts with main commissioners which are invoiced 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	31st March 2010 £000	31st March 2011 £000
Balance at start of period	**109**	72
Increase in provision	**140**	37
Amounts utilised	**(9)**	0
Unused amounts reversed	**0**	0
Balance at end of period	**240**	109

27.3 Impaired receivables past their due date	31st March 2010 £000	31st March 2011 £000
By up to three months	**118**	37
By three to six months	**0**	0
By more than six months	**122**	72
Total	**240**	109

The Foundation Trust does not hold collateral in respect of any outstanding receivables

27.4 Receivables past their due date but not impaired	31st March 2010 £000	31st March 2011 £000
By up to three months	**334**	569
By three to six months	**177**	137
By more than six months	**99**	72
Total	**610**	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	31st March 2010 £000	31st March 2011 £000
Balance at start of period	**13,708**	9,817
Net change in year	**3,556**	3,891
Balance at end of period	**17,264**	13,708
Made Up Of		
Cash at commercial banks and in hand	**14**	119
Cash with the Government Banking Service	**17,250**	13,589
Other current investments	**0**	0
Cash and Cash Equivalents as in Statement of Financial Position	**17,264**	13,708
Bank overdraft	**0**	0
Cash and Cash Equivalents as in Statement of Cash Flows	**17,264**	13,708

Cash includes £800k overpaid by Commissioners on contracts

31 Non-Current Assets Held for Sale

There are no Non Current Assets held for sale.

32 Trade and other payables	Current 31st March 2011 £000	31st March 2010 £000
Receipts in Advance	**(2)**	(2)
NHS payables	**2,029**	1,688
Other trade payables - revenue	**2,208**	2,048
Other trade payables - capital	**999**	343
Taxes payable	**1,132**	1,093
Other payables	**858**	421
Accruals	**4,865**	2,532
Total	**12,089**	8,123

33 Borrowings

	Current		Non-current	
	31st March 2011	31st March 2010	**31st March 2011**	31st March 2010
	£000	£000	**£000**	£000
Finance lease liabilities	**220**	352	**170**	374
Total	**220**	352	**170**	374

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 £25k at 31st March 2011.

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease	
	31st March 2011	31st March 2010	**31st March 2011**	31st March 2010
	£000	£000	**£000**	£000
Within one year	**242**	393	**220**	351
Between one and five years	**173**	397	**170**	374
After five years	**0**	0	**0**	0
Less future finance charges	**(25)**	(65)	**0**	**0**
Present value of minimum lease payments	**390**	725	**390**	725
Included in:				
Current borrowings	**220**	351	**220**	351
Non-current borrowings	**170**	374	**170**	374
	390	725	**390**	725

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 2011 the Foundation Trust has a commitment to extend the lease on a Blood gas analyser for a period of 3 years from 29th March 2011 at a monthly rental of £810 per quarter.

37 Provisions

	Current		Non-current	
	31st March 2011	31st March 2010	**31st March 2011**	31st March 2010
	£000	£000	**£000**	£000
Legal claims	**30**	35	**0**	0
Other	**640**	685	**0**	0
Total	**670**	720	**0**	0

	Legal claims	**Other**	**Total**
	£000	**£000**	**£000**
At 1st April 2010	35	685	**720**
Arising during the year	20	51	**71**
Used during the year	-12	-96	**-108**
Reversed unused	-13	0	**-13**
At 31st March 2011	30	640	**670**
Expected timing of cash flows:			
Not later than one year	30	640	**670**
later than one year and not later than five years	0	0	**0**
later than five years	0	0	**0**

37 Provisions (continued)

The Foundation Trust has total provisions at 31st March 2011 of £670k. Within this total the largest provisions are in respect of issues associated with Equal Pay Claims which is included within Other provisions.

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 expected to be settled within 1 year but may exceptionally take 2 years to settle.

£1.567m is included in the provisions of the NHS Litigation Authority at 31st March 2011 in respect of clinical negligence liabilities of the Foundation Trust.

38 Other Liabilities

	Current	
	31st March 2011	31st March 2010
	£000	£000
Deferred Income	**1,570**	1,092
NHS Pension Scheme Liability	**586**	540
Payment received on account	**0**	0
	2,156	1,632

39 Contingencies

39.1 Contingent Liabilities

	31st March 2011	31st March 2010
		£000
Other contingent liabilities	**(14)**	(23)
Total	**(14)**	(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 Income & Expenditure	**Loans and receivables**	**Total**
	£000	**£000**	**£000**
Trade and other receivables excluding non financial assets at 31st March 2011	0	2,410	2,410
Other Investments	0	0	0
Other Financial Assets	0	0	0
Cash and cash equivalents	0	17,265	17,265
Total at 31st March 2011	0	19,675	19,675
Trade and other receivables excluding non financial assets at 31st March 2010	0	3,110	3,110
Other Investments	0	0	0
Other Financial Assets	0	0	0
Cash and cash equivalents	0	13,708	13,708
Total at 31st March 2010	0	16,818	16,818

40.2 Financial liabilities

	At fair value through Income & Expenditure	**Other financial liabilities**	**Total**
	£000	**£000**	**£000**
Borrowings excluding Finance lease liabilities at 31st March 2011	0	0	0
Obligations under finance leases	0	390	390
Trade and other payables excluding non financial assets	0	10,735	10,735
Provisions under contract	0	670	670
Total at 31st March 2011	0	11,795	11,795
Borrowings excluding Finance lease liabilities at 31st March 2010	0	0	0
Obligations under finance leases	0	351	351
Trade and other payables excluding non financial assets	0	6,849	6,849
Provisions under contract	0	714	714
Total at 31st March 2010	0	7,914	7,914

Provisions under contract are held at book value

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 Foundation 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.

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 £26.1m of which £18.5m related to long term borrowing and £7.6m to a Working Capital Facility.

The Foundation Trust has borrowings of £390k against this limit . The table below confirms that the Foundation Trust was within the approved ratios.

	Year ended 31st March 2011			**4 months to 31st March 2010**		
	Actual Ratios	**Limits 2010/11**		**Actual Ratios**	**Limits 2010/11**	
Minimum dividend cover times	**4.30**	>1	met	**4.15**	>1	met
Minimum Interest cover times	**178.9**	>3	met	**127.0**	>3	met
Minimum debt service cover times	**20.1**	>2	met	**18**	>2	met
Maximum debt service to revenue	**0.4%**	<2.5%	met	**0.4%**	<2.5%	met

The Trust has an approved working capital facility of £7.6m with the Royal Bank of Scotland. This facility was formally made available from 21st April 2010 following satisfaction of Agreement requirements.

43 Movement in Taxpayers Equity

2010/11

	£000
Taxpayers' equity at 1st April 2010	**65,255**
Surplus for the financial period	1,033
Gains/losses from revaluation/indexation of purchased fixed assets	755
Revaluation upwards of Ensite velocity system	264
Movement on Donated Asset reserve	-147
Taxpayers' equity at 31st March 2011	**67,160**

4 Months to 31st March 2010

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**

44 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 2011 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 £75k for the year ended 31st March 2011. 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	2,707	53		
South West Strategic Health Authority				8
Primary Care Trusts				
Ashton Leigh & Wigan PCT	465	1	2	
Birmingham East & North PCT	465		66	
Bolton PCT	21			
Bradford & Airedale PCT	10			
Bury PCT	5			
Camden PCT	20		19	
Central & Eastern Cheshire PCT	43		12	
Central Lancashire PCT	19		9	
County Durham PCT	7			
Derbyshire County PCT	99			
Halton& St Helens PCT	75		16	
Hampshire PCT	32		25	
Heywood, Middleton & Rochdale PCT	89		67	
Hull Teaching PCT	8			
Kirklees PCT	17			
Knowsley PCT	1,875		26	
Liverpool PCT	2,475	137	219	46
Leeds PCT	40		6	
Manchester PCT	65		7	
North Staffordshire PCT		29		
North Yorkshire & York PCT	100		3	
Oldham PCT	39		34	
Salford PCT	138		1	
Sandwell PCT	21			
Sefton PCT	74		19	
Sheffield PCT	14		9	
South East Essex PCT	33			
Stockport PCT	2		17	
Tameside & Glossop PCT	8			
Trafford PCT	34		30	
Wandsworth Teaching PCT	8		5	
Warrington PCT	171		4	
West Sussex PCT	8			
Western Cheshire PCT	72,927		18	728
Wirral PCT	102		30	
NHS Trusts				
East Cheshire NHS Trust		14		
Liverpool Community Health NHS Trust	86		77	
North West Ambulance Service NHS Trust		111		
Royal Liverpool & Broadgreen University Hospitals NHS Trust	2,079	5,431	141	1,679
Southport & Ormskirk Hospitals NHS Trust	75	59	11	2
St Helens & Knowsley Hospitals NHS Trust	102	23	6	63
Foundation Trusts				
Aintree University Hospitals NHS Foundation Trust	84	146	57	11
Alder Hey Childrens NHS Foundation Trust	7	137	7	14
Blackpool Fylde and Wyre Hospitals NHS Foundation Trust		29		
Central Manchester University Hospitals NHS Foundation Trust	8	2	8	3
Clatterbridge Centre for Oncology NHS Foundation Trust	10	2	4	
Countess of Chester Hospital NHS Foundation Trust	41		72	1
Lancashire Teaching Hospitals NHS Foundation Trust	2	2	2	3
University Hospital of South Manchester NHS Foundation Trust			15	
Warrington & Halton Hospitals NHS Foundation Trust	94		47	
Wirral University Teaching Hospitals NHS Trust	47		28	35
NHS Business Services Authority		1,688		139
NHS Shared Business Services		196		
NHS Litigation Authority		484		

44 Related Party Transactions (continued)

In addition, The Foundation Trust has had a number of material transactions with other Government Departments and other

	Income £000s	Expenditure £000s	Receivables £000s	Payables £000s
Audit Commission		85	143	1,132
Care Quality Commission		15		
Department of Health	18			
Knowsley Metropolitan Borough Council		9		
HM Revenue & Customs			143	1,132
NHS Pension Scheme		4,668		586
Health Commission Wales	5,429			1

The Foundation Trust has also received revenue payments from a number of charitable funds. Some of the agents of the Corporate trustee are members of the Trust Board
Liverpool Heart and Chest Hospital Charity is an umbrella charity made up of 33 funds with a combined balance at 31st March 2010 of £2.07m.

The Foundation Trust has benefited during the year from donations from Charitable Funds
At 31st March 2011 the amount due from the charity was £1k. The Foundation Trust has received benefits from Charitable funds of approximately £200k.

45 Third Party Assets

The Trust held £599 cash at bank and in hand at 31 March 2011 (£573 - at 31st March 2010) which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

46 Intra-Government and Other Balances

	Current receivables £000	Current payables £000
Balances with other Central Government Bodies	0	0
Balances with Local Authorities	1	0
Balances with NHS Trusts and Foundation Trusts	476	1,786
Balances with English Primary Care Trusts	679	774
Balances with RAB Special Health Authorities	0	147
Balances with NHS WGA Bodies	0	586
Balances with other WGA Bodies	144	1,132
Balances with Public Corporations and Trading Funds	0	0
Intra Government balances	1,300	4,425
Balances with bodies external to Government	1,306	7,664
At 31st March 2011	**2,606**	**12,089**

Balances with other Central Government Bodies	0	0
Balances with Local Authorities	0	0
Balances with NHS Trusts and Foundation Trusts	1,244	1,548
Balances with English Primary Care Trusts	930	37
Balances with RAB Special Health Authorities	23	103
Balances with NHS WGA Bodies	0	540
Balances with other WGA Bodies	173	1,152
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 31st March 2010	**3,282**	**8,123**

47 Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. In the year ended 31st March 2011 the Foundation Trust had 50 separate losses and special payments, totalling £85,011 (period from 1st December 2009 to 31st March 2010 12 payments totalling £37,353).

48 Exit packages

NHS Foundation Trusts are required to report on exit packages agreed with staff during the year.
Comparative prior period information is provided in brackets.

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

The cost of ill-health retirements falls on the relevant pension scheme, not the Foundation Trust, and are not included in this disclosure.

2010/11

	a	b	c	d	e
1	Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost)	Number of departures included in (b) and (c) where special payments have been made (special payment element totalled
2	<£20,001			3 at total cost of £36,792	
3	£20001-£40,000			2 at total cost of £77,071	
4	£40001-£100,000				
5	£100,001-£150,000				
6	£150,001-£200,000				
7	Total number of exit packages by type (total cost)				
8				Total number (and cost) of exit packages	Total number of special payments (and total cost of special payment element)
				5 at total cost of £113,861	

There were no payments associated with Exit packages in the period 1st December 2010 to 31st March 2011

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