

Annual Report and Accounts

2011/12



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

Liverpool Heart and Chest Hospital NHS Foundation Trust Annual Report and Accounts 2011/12

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

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Chair and Chief Executive's Foreword

2011/12 has been another successful year for Liverpool Heart and Chest Hospital with both patients and independent organisations rating us highly for the quality of care we provide.

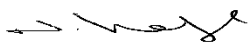
Central to everything we do is our commitment to the Patient and Family Experience Vision. During the year we have continued to make changes to how we deliver services, which, however small, make a huge difference to how patients experience care. We are delighted that our volunteers are now providing a really valuable service across the hospital and we have over 60 volunteers supporting staff and patients.

Creating the right environment to support recovery and healing is vital to us, and the Board has given a commitment to invest £7.1 million on relocating and refurbishing two wards. This will be a ground breaking development to enhance the healing environment for patients and staff.

Another significant initiative during the year was the launch of our Staff Experience Vision. This was developed in consultation with staff and managers and sets out the Trust's commitment to staff. The recently published 2011 staff survey results confirm the continuous improvement in how staff feel about working in the Trust.

As a hospital that regards research and teaching as essential to the delivery of high quality patient care, we were delighted to enter into a unique collaboration with Royal Brompton and Harefield NHS Foundation Trust and Imperial College London to launch the Institute of Cardiovascular Medicine and Science. Our joint aim is to deliver better patient outcomes through advances in diagnosis, management and treatment of cardiovascular disease.

We have continued to enhance our standing and reputation as a tertiary centre of excellence both regionally and nationally and look forward in the year ahead to strengthening our expertise and clinical care even further.



Neil Large
Chairman



Raj Jain
Chief Executive

Key achievements of 2011/12

- 100% of patients confirmed they would recommend Liverpool Heart and Chest Hospital to their family and friends
- 91% said the care we provided exceeded their expectations
- We were top again in the North West in the Advancing Quality results for our heart attack treatment, health failure care and heart bypass surgery
- In collaboration with Royal Brompton and Harefield NHS Foundation Trust and Imperial College London, we launched a unique research institute, called the Institute of Cardiovascular Medicine and Science
- In the Care Quality Commission's inpatient survey, we were confirmed number 1 in the country for overall patient care
- Full roll out across the hospital of the patient experience vision and implementation of the staff experience vision
- Completion of the roll out of the Electronic Prescribing and Medicines Administration System (EPMA) which has made the delivery of medications for patients much safer
- A continuation of our registration with the independent health regulator, the Care Quality Commission without any conditions and receipt of an excellent report from their unannounced inspection in February 2012.
- Achievement of all Cancer waiting time targets
- Achievement of all 18 week waiting time targets by specialty
- The lowest mortality rate in the country for aortic surgery, 10% versus the average national of 22.8%.
- Bringing our services directly into the heart of local communities by offering a new respiratory diseases management service in Knowsley in addition to the heart disease service already in place.
- Embedding our volunteers scheme, which started last year
- Selection as one of only two national pilot sites for ground breaking research in screening for lung cancer
- Organiser of several prestigious medical conferences that were centred on sharing the expertise of Liverpool Heart and Chest clinicians with others from around the country
- A significant increase in our funding for research and innovation, which allows cutting edge treatments to be brought to our patients as early as possible

1. Directors report

This report is prepared in accordance with:

- Sections 415 to 418 of the Companies Act 2006 (section 415(4) and (5) and section 418(5) and (6) do not apply to NHS foundation trusts)
- Regulation 10 and Schedule 7 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (“the Regulations”)
- Additional disclosures required by the *FReM*
- Additional disclosures required by Monitor.

1.1 Business Review and Operating and Financial Review

Key Business Activities

Activity carried out by the Trust is funded from both elective and emergency referrals from surrounding District General Hospitals, General Practitioners and Clinicians from across the country. Our core services are Cardiology and Chest Medicine, Cardiac and Thoracic Surgery and the provision of Primary Care services for chronic long term conditions.

The total annual turnover for the Trust was £106.8m for 2011/12, an increase of 0.6% from 2010/11 reflecting continuous growth in the demand for our services in recent years.

	2009/10	2010/11	2011/12	2Year Growth %
Inpatients-Surgery	3,572	3,604	3,356	(6.0%)
Cardiology	8,555	8,858	9,186	7.1%
Outpatients	59,257	62,794	64,226	7.9%

This was derived from a number of key contracts; £71.1m from the North West Specialist Commissioning Group, £14.9m from the Welsh Specialised Services Commissioners, £3.0m from our Private Patient work, £2.7m from Education and Training and £0.7m in support of our Research and Development activities.

The table above illustrates the growth in activity over the past three years. This growth has been planned with commissioners and also reflects the Trust’s recent successes in securing additional contracts to deliver end to end care for local patients suffering with Chronic Obstructive Pulmonary Disease (COPD) and the management of Cardiovascular Disease (CVD) services.

Following the approval of a revised Research Strategy, 2011/12 has seen a significant increase in the Research and Development portfolio at the Trust as the Board’s ambitions to grow this area of the business gain momentum. A significant development taken forward in 2011/12 has been the creation of a Commercial Joint Venture between ourselves, Royal Brompton and Harefield NHS Foundation Trust and Imperial College London in forming the Institute of Cardiovascular Medicine and

Science (ICMS). It is a fairly unique and innovative partnership in the NHS that will further the Board's ambitions to grow our reputation for excellence, quality and safety through our research work.

Throughout 2011/12, the Trust has continued to achieve good success with regards to its ambitions to deliver the Patient Experience Vision by March 2013 (finishing first in the country for “overall patient care” in the national staff survey), achieving most of its quality and safety measures, continuing to invest in its estate and facilities, maintain and building good relationships with stakeholders and solid financial performance.

Analysis of 2011/12 Financial Performance

The Trust's financial plans for 2011/12 required the delivery of a surplus of £365k (after the achievement of a £5m cost improvement programme). The Trust actually achieved a surplus of £588k as summarised in the table below:

	2011/12 Plan	2011/12 Actual	Variance
	£	£	£
Income	106,365	106,799	434
Costs			
Pay	(59,088)	(57,802)	1,286
Direct Non-Pay	(34,779)	(36,351)	(1,572)
Overheads	(6,161)	(5,939)	222
Operating Surplus	6,338	6,707	370
Net Finance Costs	(5,973)	(6,119)	(146)
Surplus	365	588	224

Income is above plan for 2011/12 by £0.4m or 0.4%. This has been driven by a number of factors:

The North West Specialist Commissioning contract over performed by £1.2m, a major factor being both the volumes and casemix of ICDs fitted with activity being above plan for both dual and CRT-D devices (£652k). Cardiac surgery over performed significantly, but this higher throughput was not reflected in over performance in critical care where shorter average length of stay led to an under-performance (£248k) in terms of critical care income. However this may be a due to shorter critical care stays facilitating greater throughput in theatres.

The Welsh Contract under performed by (£1.2m) predominantly based on an under performance in surgery (£379k) and this depressed activity combined with fewer long-stay critical care patients led to an under performance in critical care (£337k). The accelerated repatriation of complex devices has led to an under performance on both the devices (£319k) and pacing (£217k).

Private patient income under performed by (£0.4m). This is driven by below plan activity for Aortic and Cardiac Surgery, which has been mitigated in part by a pricing increase, following a review of prices in the last quarter of the financial year.

Other income under performed by (£0.2m). This is due to the delay in purchase of an MRI Scanner, for which there was additional planned income and costs. However the delay resulted in a loss of contribution from the planned additional activity. Also the contract for the provision of Pharmacy Services to Royal Liverpool and Broadgreen University Hospital NHS Trust was terminated from January 2012, which resulted in the loss of income.

	2009/10	2010/11	2011/12	Growth
	£m	£m	£m	%
Income	100.5	105.2	106.8	6.3
Total Costs	(98.0)	(104.1)	(106.1)	8.3
Net Surplus	2.6*	1.0	0.6	(76.9)

*nb. For comparison purposes the 2009/10 costs exclude the impact of an impairment of (£8.9m)

Costs and Cost Improvement Programme

Our costs in 2011/12 were above plan by (£0.2m) or (0.2%) driven by a higher than anticipated level of activity for some of our procedures that incur high non pay costs e.g. pacing and devices. This has been offset by a lower than anticipated spend on pay as our services were delivered with increasing efficiency and a delay in the launch of our community COPD service.

Pay costs were significantly below plan, with staff numbers of 60 FTE (4%) below plan in March. This is despite inpatient activity being 2.3% above plan.

Direct non pay costs were above plan due to the higher than planned activity for devices, valves and other consumables.

Overhead costs were slightly lower than plan due to new part year contracts being less than anticipated.

The Trust also delivered a Cost Improvement Programme (CIP) of £5.3m or 5% of its operating expenditure over the period key areas of savings can be split as follows:

CIPs by Cost Category	
Category	£000's
Income	456
Pay	2,120
Non Pay	2,764
Total	5,340

Key enabling strategies that produced 2011/12 cost savings include procurement, working practice review, quality review, intelligent stock management solution, additional income and Service Line Reporting review.

CIP schemes are identified by Directorates and are subject to Executive Team "Confirm and Challenge" sessions. Then the schemes approved are subject to further review at Assurance Committees (Workforce, Clinical Quality, and Patient and Family Experience).

Capital Investments and Cash flow

During the 2011/12 financial year, the total capital investment in improving the hospital facilities was £8m. £2.68m was spent on estates improvements, including upgrading the Maple Suite Private Patients facility, refurbishing the operating theatres, and a new 10 bed extension to Cedar Ward.

Work has also begun on the major site development to create the new Oak Ward, Day Ward, and Research facilities.

A new MR scanner has been purchased for £1.6m, with a further £1.88m spent on other medical equipment, including two oscillator ventilators, two anaesthetic machines, equipment for minimally invasive thoracic procedures, and three VAC therapy machines to enable faster post-operative healing.

In addition, £1.84m has been spent on improving the Trust's IT Infrastructure, including the commencement of the Electronic Patient Record scheme, replacement servers, and a Trust-wide PC replacement programme.

2011/12 Capital Programme Summary	
Category	£m
Estate Improvements	2.680
New MR Scanner	1.600
Medical Equipment	1.880
Information Technology	1.840
Total	8.000

Research – as part of its research strategy and building on the partnership formed in creating the Institute of Cardiovascular Medicine and Science, the Trust has invested in a new research facility – due for completion in 2012. This investment has been supported by £500k of donations from charitable funds raised by supporters of the Trust in recent years.

After funding the capital programme outlined above, the Trust has a closing cash balance of £17.5m as at 31st March 2012, which was ahead of plan and reflects a higher than planned surplus coupled with a slight reduction in planned capital spend due to slippage on some schemes. This cash will be carried forward to fund the investment of circa £13m capital spend planned for 2012/13.

Financing

Under its terms of authorisation, the Trust has an approved borrowing limit and a working capital facility (similar to an overdraft facility) which is detailed in the table below.

	Limit	Utilised
	£m	£m
Prudential Borrowing Limit (PBL)	19.8	1.1
Working Capital Facility	7.6	0.0
Total Borrowing Limit	27.4	1.1

The Trust changed the provider of its Working Capital Facility in December 2011, following a robust tendering process approved by the Board of Directors – the facility is now provided by Barclays Bank. The Trust has had no call to use this facility over the period.

Financing activities are managed in accordance with the Trust's approved Treasury Management Policy which is reviewed by the Investment Committee and approved annually by the Board of Directors.

Monitor Key Financial Indicators

Financial Risk Ratings	Plan	Actual
Underlying Performance – EBITDA Margin	3	3
Achievement of Plan – EBITDA Achieved	5	5
Financial Efficiency – Return on Assets	2	3
I&E Margin	2	2
Liquidity Ratio	4	4
Weighted Average Rating	3	3

The table above illustrates the Trust's performance against its planned Financial Risk Ratings (FRR) under the Monitor Compliance Framework. The Trust achieved an FRR of 3 overall in 2011/12 which was in line with plan.

Going Concern

The Board of Directors has a reasonable expectation that the Trust has adequate resources to continue its operations for the foreseeable future. For this reason the accounts continue to be prepared under the going concern basis.

Conclusion

Despite another financially challenging year, the Trust has continued to perform above the financial plans set by the Board, as approved by Monitor. Plans for 2012/13 have been set and aim to build upon this year's strong performance, with a significant investment in the Trust's Estate and the development of Electronic Patient Records, which will underpin the delivery of further efficiencies, improve quality of care and improve the patient experience.

In so far as each of the Trust Directors is aware, there is no relevant audit information of which the Trust's Auditors are 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 Trust's Auditor is aware of that information.

Environmental matters:

The Trust continues to follow its Environmental Strategy which aims to:

- Identify and implement environmentally responsible practices and procedures
- Reduce the Trust's carbon footprint
- Ensure that the Trust achieves compliance with relevant legislation and regulatory standards and guidance.

In November 2011, the Trust achieved recognition from "The Carbon Trust" for its participation in the Public Sector Carbon Management Programme to drive cost efficiencies and cut carbon emissions to reduce the risk of dangerous climate change. This was achieved by producing a 5 year Carbon Management Plan (CMP), which received Board approval. The CMP identified a number of projects and processes which will help achieve the required carbon reduction. An update on progress of this plan was presented to the Corporate Readiness Committee in March 2012.

1.2 Enhanced quality governance reporting

The Trust has a well-developed risk management system in place that captures risks at operational and strategic levels within ward, departmental and directorate risk registers where explicit criteria exist for escalation ultimately to the Executive Team and the board of directors.

The Executive Team reviews all escalated risks and if considered major, places them on the Executive risk register and on the agenda of one of our five Board Assurance Committees for ongoing review until the risk is downgraded.

The principal committees dealing with risks to quality and safety are the Clinical Quality Committee and the Patient and Family Experience Committee. Both committees draw on a multitude of assurances that include clinical audits, externally produced national reviews benchmarked to local practice and bespoke dashboards that track ongoing improvement against relevant quality and safety indicators, chosen from their relevance to the objectives we have set ourselves either in our annual plan, key strategies or CQUIN and quality account priorities.

We are a high performing hospital so concerns with quality and safety are a rarity. Across the last 12 months, there are only two live risks the Trust has had to actively manage:

Emergency readmissions – the national drive to reduce readmissions and to enhance patient experience have been the two key drivers for the service improvement work. Led by the Executive Nurse, the operational teams have diagnosed, planned and implemented changes that should address the drivers. An example of the changes include: teachback of discharge medication and instructions to patients and their carer or relative; a 24/7 Recovery Advice helpline to support patients with information or to bring them back to the hospital for assessment by our specialist. Whilst these initiatives have resulted in some modest improvement, they have been insufficient to achieve our targets. As such, attention will focus in

2012/13 to better influencing the readmission threshold in DGHs together with improving the quality and timeliness of communications.

Clostridium Difficile – We were over trajectory in Quarter 3 and have exceeded the target in Quarter 4. We have been, and continue to do everything we can to keep CDifficile levels to a minimum, but we believe we are suffering from being close to or at an irreducible minimum that naturally arises from good antibiotic practice rather than inability to contain an outbreak.

The Board of Directors is continuously reviewing and improving its assurance systems. We have recently introduced a new monitoring system for emergency readmissions that utilises data drawn directly from SUS, providing as real time data as is possible given the natural lag in this indicator. Systems and processes for measuring and monitoring CDifficile are to be audited by our external auditor as part of this year's quality account submission. We expect to augment our developmental plan for the governance of quality with recommendations from our internal auditors arising from their review of our approach to the quality governance framework. Further detail on quality governance and quality is described in the Quality Report section of this document.

The Trust formally reviewed its approach to quality governance using Monitor's quality governance framework for the first time last year following its publication in March 2011. This assessment revealed the Trust to be compliant with the framework but a number of small opportunities arose for improvement in its approach to the governance of quality:

- Update the Trust's clinical quality strategy to focus on a smaller number of areas for improvement
- Recirculate and reinforce the Raising Concerns Policy
- Improve the business planning process with respect to the selection of indicators
- Improve the Trust's integrated performance report
- Standardise internal communications with respect to quality
- Run an educational session for Board members on accountability for clinical quality
- Improve our integrated care pathways
- Utilise our data on patient harm more effectively
- Develop a Trustwide approach to data quality.

There are no material inconsistencies between the annual and quarterly Board statements required by the Compliance Framework, the quality report, and annual report and reports arising from the Care Quality Commission. Indeed the Care Quality Commission was very complimentary of the care delivered by this Trust following their unplanned visit in February 2012.

Patient care

Performance against the Commissioning for Quality & Innovation (CQUIN) schemes:
Responsiveness to Patients' Needs – full payment
Venous Thromboembolism – full payment
Advancing Quality care bundles – full payment

Pressure Ulcers – full payment
Patient Falls – full payment
Patient Dietetics – full payment
Care of the Dying Pathway – full payment
Nursing Attendance at Work – full payment
Nurse Led Discharge – full payment
Urinary Tract Infection – full payment
Smoking cessation strategies – partial payment
Satisfaction with Congenital Heart Disease services – full payment
Patient Discharge – partial payment
Surgical Wound Infection – full payment

Overall the Trust recovered 96.5% of its full CQUIN allocation.

Performance against Quality Account priorities:

- Reduce the number of deaths in-hospital – improvements fully delivered
- Improve the assessment of and reduce the risk of blood clot (venous thromboembolism) – improvements fully delivered
- Improve the experience of care for our patients – improvements fully delivered
- Ensure diabetic patients are referred to the Diabetes Specialist Nurse before their planned operation – improvements fully delivered
- Improve attendance to cardiac rehabilitation classes for those patients resident in Knowsley – improvements fully delivered
- Reduce rates of readmission to our hospital and to those with whom we work – improvements partially delivered

Further information about the Trust's performance is available in the Quality Report.

1.3 Any new or significantly revised services

During 2011, we launched a second community service in Knowsley to provide Chronic Obstructive Pulmonary Function services. In addition, we opened a new 10 bedded ward area on Cedar Ward to improve how we manage the patient pathway for Upper GI and thoracic surgery. Previously patients would have been admitted to the surgical admissions unit. Now the additional bed capacity means that they have a one-stop shop approach on Cedar Ward.

As part of the Patient and Family Experience Vision, the Board has committed £7.1 million investment to upgrading and relocating two wards, to create a more healing environment and improved facilities for patients and their families.

1.4 Working with our Patients and Visitors

The Trust recognises that patients and families have experience, expertise, insights, and perspectives that can be invaluable to bringing about transformational change in health care and enhancing quality and safety. So that we understand the true experiences of our patients and families, we use various methods such as patient and relative stories, focus groups, surveys and engagement events throughout the year to capture experiences and themes.

Last year, we held a number of engagement events to engage patients and families in the redevelopment of Oak Ward and Day Ward. This involved patients and

families creating mood boards and articulating the look and feel of the new wards. A mock up room was developed based on the feedback of patients and families. The redevelopment project is expected to be completed by winter 2012/2013.

Building on the work of The King's Fund, we have engaged with patients and families in improving the environment of wards and departments. There is now great deal of evidence about the critical importance to patients, relatives and staff of the environment of care. It not only supports recovery but is also an indicator of people's perception of the quality of care. Engagement has been conducted via a range of methods such as patient and family events, one to one interviews, and focus groups on Amanda Unit, Elm Ward, Cedar Ward, Birch Ward and Critical Care Unit to enhance the healing environment through the experiences of patients and families. The projects are overseen by the Patient and Family Advisory Board for the Environment on a bi-monthly basis. The Trust is now progressing to implementing the improvements; these include refreshing rooms, bathrooms and bays with colours and furnishing agreed with patients and families through engagement.

In addition to the above engagement events, we also held four events to learn from the experiences of patients and families in order to improve our services. Engagement events are attended by staff, patients, carers, and relatives, Non-Executive Directors, Executive Directors, Governors and Trust Volunteers

Examples of improvements as a result of engagement events are:

Concern: The doors to bathrooms and toilets were too heavy after surgery.

Outcome: The weight of the doors has been adjusted and patients have reported positive experiences.

Concern: Showers were too powerful to use after open heart surgery.

Outcome: Shower heads have been changed to ensure patients are able to adjust the power of the shower sprinkle.

Concern: Directions within the hospital are confusing.

Outcome: The Trust has improved signage within the hospital and also introduced volunteers who support patients, families and visitors.

Concern: Lounge and waiting area for patients and families was not comfortable

Outcome: We have improved the facilities in the lounge for patients and families.

Engaging with external organisations

During the year, the Trust strengthened relationships with external partners to ensure that patients and families are effectively and meaningfully engaged. We work closely with the LINK/HealthWatch and have established a work plan which includes quarterly onsite visits by the LINK to capture feedback from patients independently. Further information is detailed in the Quality Account.

Improvements in patient/carers information

During the year, the Trust's branding has been agreed for all patient and carer information. Since then, the cardiac surgery booklet has been reviewed to include additional information and an information booklet for patients who are awaiting transfer from other Trusts for surgery is in development. This includes what to expect

from our Trust, information about the hospital and information regarding the different types of surgery.

An outpatient information pack has been produced and tested out with the patients to provide all the information patients need to know when attending for an appointment.

We have listening and learning comment cards now available in the Knowsley community CVD service.

Information on complaints handling

We aim to deliver care and services to the highest standards but recognise that if expectations are not met that we will receive complaints. We recognise that we can learn from the complaints we receive and thereby improve the quality of our services. We strive to assist people in presenting their concerns and complaints about our services and care and in achieving a satisfactory resolution and outcome to their complaints. The importance of properly managing complaints in the NHS is recognised at the highest level and this is reflected our complaints policy and procedure.

All staff are required to resolve concerns and complaints received by patients, relatives and their carers in the first instance and must provide a speedy resolution to the issues raised. When complaints are received by or escalated to the Customer Care Team they act as facilitators to resolve the complaint quickly, efficiently and fairly.

The Trust received 58 complaints from 1st April 2011 to 31st March 2012. This is a 34% decrease in the number of complaints received in comparison to the previous year. 100% of complaints were responded to within the negotiated timeframe.

The above figures demonstrate that we have a strong complaints management process in place and robust governance to ensure that actions that have arisen following complaints are monitored closely to ensure implementation. All changes are part of a continual process of learning from experience and striving for continual improvement. We not only use complaints for information but also map this against other sources of patient feedback and experience such as our monthly inpatient satisfaction survey so we have real time patient feedback to help us to provide the best possible care for our patients. Each Directorate Governance Committee receives a monthly report detailing the complaints received, the key issues and any actions taken. All action plans are monitored through this committee until actions are completed. The Committees also receive the number and themes of customer care contacts and any actions taken to prevent these escalating into a complaint.

We also have a quarterly Complaints Review Panel headed by 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.

Stakeholder relations

We have continued to work in partnership with Knowsley PCT and Council on providing our community CVD and COPD services to residents in Knowsley.

2. Remuneration Report

Year ended 31st March 2012			
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	5749
G Russell - Medical Director	25-30	165-170	0
A Cummins - Director of Finance	90-95	0-5	3009
H Holmes - Director of Nursing	95-100	0-5	4008
M Jackson - Director of Research & Informatics *	10-15	0-5	0
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

* M Jackson commenced as Director of Research and Informatics on 1st February 2012

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	5500
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

Benefits in kind relate to the provision of leased vehicles.

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 2012 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31st March 2012 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31st March 2012 £000	Cash Equivalent Transfer Value at 31st March 2011 £000	Real Increase /(decrease) in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
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R Jain - Chief Executive	7.5-10	27.5-30	35-40	115-120	677	451	226	0
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G Russell - Medical Director	2.5-5	10-12.5	50-55	160-165	1086	946	140	0
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A Cummins - Director of Finance	0-2.5	2.5-5	10-15	30-35	124	80	44	0
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H Holmes - Director of Nursing	0-2.5	5-7.5	25-30	80-85	376	278	98	0
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M Jackson - Director of Research and Informatics*	0-2.5	0-2.5	20-25	70-75	441	385	9	0
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* M Jackson commenced as Director of Research and Informatics on 1st February 2012

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another

pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Pay Multiples

Reporting entities are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2011/12 was £195K (2010/11, £193k. This was 5.7 times (2010/11) the median remuneration of the workforce, which was £34k, (2010/11 £36k).

In 2011/12, nil (2010/11, nil) employees received remuneration in excess of the highest paid director.

Total remuneration includes salary, non- consolidated performance related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.



Chief Executive

Date: 30th May 2012

3. Statement of Accounting Officer's Responsibilities

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*.



Chief Executive

Date: 30th May 2012

4. 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. In 2011/12 the Board convened two "additional" meetings to deal with specific matters (pursuant to paragraph 4.3.2 of the Standing Orders for the Practice and Procedure of the Board of Directors).

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.

In 2011/12 the Board re-designed its Board Assurance Framework and associated processes. The Board undertook a comprehensive review of these new arrangements in November 2012 and this demonstrated improvement and added value in the way in which the Board operates.

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 undertake the annual appraisal of the Chair which is led by the Senior Independent Director. In 2011/12, governors rated the Chair's performance as "outstanding". In addition, the Chair reviews the performance of each 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. This policy was reviewed and updated in March 2012

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 through the receipt of quarterly assurance reports on all key targets, including those relating to quality and safety, patient experience and financial performance. Governors receive the minutes of the meetings of the Board of Directors (redacted) and these are also published on the Trust's website. Members of the Board of Directors attend the Council of Governors' quarterly meetings in order to present information requested and / or respond to any questions raised by the governors. These meetings are held in public.

Governors are actively engaged in developing and signing off the Trust's forward plans (strategy and annual plan), through a programme of presentations from lead clinicians, involvement in the review of strategic objectives, regular presentations on the estates strategy, receipt of feedback from patients via the use of patient stories and review of customer care reports as well as hospital walkabouts and engagement with members, through patient surveys, newsletters and direct contact.

Attendance at meetings of the Council of Governors by Board Directors also enables the Board 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. A full members' survey was conducted in 2011 and governors have reviewed the results and developed an action plan in response to this.

The Council of Governors meets formally on a quarterly basis and has nominated a Senior Governor. In 2011/12 this was David Hicks.

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. This includes an annual induction day for new governors (and existing governors) and an annual development day for governors and directors as well as bespoke training to meet specific development needs. The Board of Directors holds at least four scheduled Development Days each year.

The Trust maintains a register of interests, detailing company directorships and other significant interests held by directors or governors. In 2011/12 the Chair 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 any 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.

At the end of each meeting the Board seeks further assurance by confirming the legality of the decisions it has made.

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.

4.1 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 accounts 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
- 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 – registered and non-registered 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 (PCT)
 - Liverpool City Council (LCC)
 - Northwest Specialist Services Commissioning Team (NWSCT)
 - Betsi Cadwaladr University Health Board (BCUHB)
 - Liverpool John Moores University (LJMU)
 - Cystic Fibrosis Trust (CFT)
 - Friends of Robert Owen House (FRoH), Isle of Man.

The names of those who have served as governor in 2011/12 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).

Elections were held for 8 seats on the Council of Governors in 2011, in respect of those seats held by initial governors for a period of 2 years and vacancies arising from governor resignations.

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
- The Chair hosts an informal lunch meeting with governors every 3 months, providing an opportunity for open discussion and meeting the development needs of the Council of Governors
- Governor walkabouts with the Chair and Trust Secretary and 1:1 meetings between the Chair and individual governors as well as an annual induction event allow personal development needs to be addressed
- 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 our Staff Experience Vision (including short listing of nominations for annual staff awards); and our Vision for Patient and Family Experience
- Governors have participated in joint work with the Board to develop strategic plans and review and improve ways of working
- 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 Chair to review the constitution of Liverpool Heart and Chest Hospital NHS Foundation Trust and recommend two changes that were approved at the Annual Members Meeting 2011 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 Chair and Trust Secretary, provision of walkabouts and tours of the hospital. The Chair 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 identified an action plan to develop governors to fulfil an extended role in the future, as required by proposed legislation.

Elections

The Board of Directors can confirm that elections for public and staff governors held in 2011/12 were conducted in accordance with the election rules as stated in the constitution and approved by Monitor.

Constituency / Class	No. seats	Governor/s elected
Public:		
Merseyside	3	Debbie Mawson (re-elected – 2 nd term until AMM 2014)
		Paula Pattullo (re-elected – 2 nd term until AMM 2014)
		Roy Stott (re-elected – 2 nd term until AMM 2014)
Cheshire (uncontested)	2	Michael Brereton (re-elected – 2 nd term until AMM 2014)
		Judith Wright (re-elected – 2 nd term until AMM 2014)
North Wales	1	Caroline Jackson (new – 1 st Term until AMM 2014 – fills vacant seat, following the resignation of Stephanie Greenway, May 2011)
Staff:		
Non Clinical (uncontested)	1	Christine Bell (new – 1 st Term until AMM 2014 – fills vacant seat, following the resignation of Ron Arrowsmith in June 2011)
Qualified & Unqualified Nurses (re-named „Registered and non-registered“ nurses, November 2011)	1	David Foulkes (new – 1 st Term until AMM 2014– replaces Neville Rumsby)

The above governors have all been elected / re-elected for 3 years and their tenures will complete at the end of the 2014 Annual Members Meeting.

In January 2012, a further seat in the public constituency (North Wales) was filled by Michael Bowyer, who was next highest polling candidate in the above elections. This followed the resignation in November 2011 of Catrin Hanks, public governor (North Wales). Michael Bowyer will hold office until the end of the 2012 Annual Members Meeting.

Governor Attendance at Council of Governor Meetings 2011/12

Governor Name	Council of Governor Meeting Dates 2011/12
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	6 th June 2011	26 th September 2011	5 th December 2011	5 th March 2012
Public Constituency				
Merseyside				
Kenneth Halligan	✓	X	X	X
Vera Hornby	✓	✓	✓	✓
Mandy Jones	✓	X	X	✓
Debbie Mawson	✓	X	✓	✓
Paula Pattullo	✓	✓	✓	✓
Roy Stott	✓	✓	✓	✓
Cheshire				
Kenneth Blasbery	✓	✓	✓	✓
Michael Brereton	✓	✓	✓	✓
David Hicks	✓	✓	✓	✓
Judith Wright	✓	✓	✓	✓
North Wales				
Roy Griffiths	✓	✓	✓	✓
Catrin Hanks	X	X		
Caroline Jackson			✓	✓
Michael Bowyer				✓
Rest of England and Wales				
John (Tony) Roberts	✓	✓	✓	✓
Staff Constituency				
Registered Nurses and Non-Registered Nurses				
Peter Hannaford	✓	✓	✓	✓
Neville Rumsby	✓	X		
David Foulkes			X	X
Non Clinical				
Ron Arrowsmith	X			
Anthony Grimes	X	✓	✓	✓
Christine Bell			✓	X
Allied Health Professionals, Technical and Scientific				
Bashir Matata	X	✓	✓	X
Registered Medical Practitioners				
Johan Waktare	X	✓	✓	✓
Nominated Governors:				
Trish Bennett (Liverpool Primary Care Trust)	X	X	X	X
Glenda Corkish (Friends of Robert Owen House)	✓	X	✓	✓
Jon Develing (North West Specialist Services Commissioning Team)	X	X	✓	X

Governor Name	Council of Governor Meeting Dates 2011/12			
	6 th June 2011	26 th September 2011	5 th December 2011	5 th March 2012
Menna Harland (Liverpool John Moores University)	X	✓	✓	X
Lynsey Morton (Cystic Fibrosis Trust)	✓	✓	X	X
Jake Morrison (Liverpool City Council)	✓	X	✓	✓
Vacant (Betsi Cadwaldr University Health Board)				

Notes:

Jake Morrison (Liverpool City Council) replaced Richard McLinden w.e.f 1.6.11

Wyn Thomas (Betsi Cadwaldr University Health Board) resigned in June 2011 and the seat remains vacant – this is due to major re-structuring of the health system in North Wales

4.2 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 Chair, five independent Non-Executive Directors and five Executive Directors – a Chief Executive, Medical Director, Director of Nursing, Director of Finance and a Director of Research and Informatics (the latter is a new post effective from 31st January 2012).

The Board has been supported by four non-voting Associate Directors during 2011/12. The structure of the Executive team has recently been reviewed and going forward will comprise the five Executive Director posts (previously four) and two Associate Director posts, one of which includes the role of Trust Secretary.

The independent advice of the Trust Secretary is accessible to all Directors and governors in relation to all matters associated with the business of the Board of Directors or Council of Governors. The Trust Secretary holds a professional qualification and has successfully completed the FTN / Cass Business School Development Programme for NHS Company Secretaries; as well as participating in relevant professional networks that enable best practice to be shared.

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 appropriate clinical leadership and 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 has refined these through the restructuring of the Executive team during 2011/12 in order to ensure the best mix of skills to meet the future needs and priorities of the Trust. The Board is currently working with governors on a succession plan for the Non-Executive Directors to ensure continuity and the right balance of skills for the future ahead of current non-executive tenures ending in 2013.

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. In 2011/12 the Board introduced a new Board Assurance Framework, revised the structure and operation of its Standing Committees and strengthened its risk management and assurance processes and through this work challenged and improved the effectiveness of the Board.

The Senior Independent Director has led the governors in a process to appraise the Chair. The Council of Governors has also reviewed the policy on the composition of the Non-Executive Directors. The Chair will oversee an evaluation of the Board of Directors once changes to the Executive team structure have been embedded and the Non-Executive Director succession plan agreed.

The Board and Audit Committee have evaluated the effectiveness of Board Committees in accordance with the new Board Assurance Framework Policy. The Chair 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 2011/12 were as follows:

Name	Position	Date appointed	Expiry of
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			current term of office
Neil Large <i>Qualified accountant and diverse NHS career spanning 40 years</i>	Chairman	1 st December 2009 *	13 th October 2013
Patricia Firby <i>Registered nurse with 25 years' experience in nurse education, MSc in Social Research Methods</i>	Senior Independent Director and Deputy Chair	1 st December 2009 *	28 th February 2013
Robert Toomey <i>Qualified accountant and doctorate in economic history with experience of board level roles in a number of private sector organisations</i>	Non-Executive Director and Chair of Audit Committee	1 st December 2009 *	30 th April 2013
Bridget Leek <i>BSC in Mathematics and Fellow of Institute of Actuaries with 10 years senior level experience in the financial industry.</i>	Non-Executive Director	1 st December 2009 *	31 st May 2013
David Bricknell <i>Master in Research and PhD in strategic decision making with a career in the legal industry.</i>	Non-Executive Director	2nd March 2010	1 st March 2013
Geoffrey Appleton <i>LLB (Hons) and MA in Criminology with extensive experience in legal and personnel roles.</i>	Non-Executive Director	2 nd March 2010	1 st 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 in 2009/10 and determined that their initial terms of office should be for periods of three 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 2011/12 were as follows:

Name	Position
Raj Jain <i>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.</i>	Chief Executive
Glenn Russell <i>Consultant Anaesthetist (Member of Liverpool Society of Anaesthetists) with extensive experience in cardiac anaesthesia both in the UK and overseas.</i>	Medical Director and Deputy Chief Executive
Hazel Holmes <i>MA (distinction), BA (Hons), Dip HE 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 Scholarship in 2010.</i>	Director of Nursing
Aaron Cummins <i>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.</i>	Director of Finance
Mark Jackson (w.e.f 31st January 2012) <i>BSc(Hons); PhD. Previous roles in medical research prior to joining the Trust where a number of roles in research and quality have been held prior to being promoted to Director of Research and Informatics.</i>	Director of Research and Informatics

Attendance at Board of Director Meetings 2011/12

Director	26th April 2011	21st May 2011	6th June 2011*	26th July 2011	21st October 2011	29th November 2011	16th December 2011*	31st January 2012	27th March 2012
Neil Large (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	X
Raj Jain	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patricia Firby	✓	✓	✓	✓	✓	✓	✓	✓	✓
Robert Toomey	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bridget Leek	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Bricknell	✓	✓	✓	✓	✓	✓	✓	X	✓
Geoffrey Appleton	✓	✓	X	✓	✓	✓	✓	✓	✓
Glenn Russell	✓	✓	X	✓	✓	✓	✓	✓	✓
Hazel Holmes	✓	✓	X	✓	✓	✓	✓	✓	✓
Aaron Cummins	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mark Jackson								✓	✓

** Additional meetings called pursuant to paragraph 4.3.2 of the Standing Orders for the Practice and Procedure of the Board of Directors*

4.3 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 2011/12.

Attendance at Audit Committee meetings 2011/12

Member	19th April 2011	6th June 2011	19th July 2011	11th Oct 2011	21st Nov 2011	17th Jan 2012	19th March 2012
Robert Toomey (Chair)	✓	✓	✓	✓	✓	✓	✓
Patricia Firby	✓	✓	✓	✓	✓	✓	X
Bridget Leek	✓	✓	✓	✓	✓	✓	✓
David Bricknell	✓	✓	✓	X	✓	✓	✓
Geoffrey Appleton	✓	X	✓	✓	✓	✓	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 2011/12 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 Executive 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, BAF Key Issues, 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 2011 to assess the performance and recommend re-appointment of the external auditor for a further 12 month period, up until abolition of the Audit Commission after completion of 2011/12 audits. The Trust will need to market test and appoint a new auditor during 2012 in readiness for the 2012/13 audit.

Recommendations were made and supported at the Council of Governors meeting held on 26th September 2011.

There is a policy in place for the provision of non audit services by the external auditor, in recognition of the need to safeguard auditor objectivity and independence. During 2011/12 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.

4.4 Nominations and Remuneration Committees

The Trust has in place two Nominations and Remuneration Committees – one dealing with nominations (and remuneration) for Non-Executive appointments (including the Chair) and the other with nominations (and remuneration) for Executive appointments.

Nominations & Remuneration Committee (Non-Executive)

Membership: Chaired by Neil Large with membership comprising the Deputy Chair and not less than 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).

There have been no appointments of Non-Executive Directors in 2011/12. There have been no changes (or uplifts) to the remuneration of the Chair or Non-Executive Directors in 2011/12.

The Committee met on one occasion in 2011/12 on 20th February 2012. Both the Chair and Deputy Chair were present along with four elected governors. The Trust Secretary was in attendance.

The Committee reviewed and updated the Policy on the Composition of Non-Executive Directors, considered the succession plan for Non-Executive Directors and the process for undertaking the Chair's annual appraisal. Following this meeting, recommendations were made to and supported by the Council of Governors in March 2011.

Nominations & Remuneration Committee (Executive)

Membership: Chaired by Neil Large with all other Non-Executive Directors as members.

The Committee met on two occasions in 2011/12.

Attendance at Nominations and Remuneration Committee (Executive) in 2011/12:

Member	16.12.11	27.3.12
Neil Large (Chair)	✓	x
Patricia Firby	✓	✓
Robert Toomey	✓	✓
Bridget Leek	✓	✓
David Bricknell	✓	✓
Geoffrey Appleton	✓	✓

The work of the Committee in 2011/12 has involved a review and re-structuring of the Executive team to meet the requirements of the Trust's strategic ambitions and to develop the team in order to:

- i) strengthen the Board through the development of Executive leadership in research, informatics and non-medical clinical education.
- ii) enhance capacity within the Executive team to lead and manage service and cost improvement to secure future financial viability

In respect of Board of Director appointments, the Committee approved:

- i) The increase in number of Executive Directors from four to five, to include a new role of Director of Research and Informatics
- ii) The role description and associated pay scale for the post of Director of Research and Informatics
- iii) Recruitment to the post of Director of Research and Informatics via a restricted internal appointment process involving a panel interview comprising the Chair, Chief Executive and a Non-Executive Director. The reason for not going to open advert was due to the

fact that the role was previously carried out successfully by an Associate Director and the Committee determined that Executive Director leadership was now needed for these functions in order to meet its strategic ambitions for research and informatics and, in view of the importance of the recently incorporated Institute of Cardiovascular Medicine and Science.

Following the resignations in 2011/12 of the Director of Finance and Director of Nursing as a result of both directors being successful in applications to new appointments, the Committee approved the role descriptions, processes for identifying suitable candidates and selection processes, including composition of interview panels for these appointments. Both posts were subject to open advert.

The following appointments were made to the Board of Directors in 2011/12:

- Mark Jackson, Director of Research and Informatics, with effect from 31st January 2012
- David Jago was appointed as Director of Finance, to succeed Aaron Cummins. Aaron Cummins remained in post throughout 2011/2 and will leave the Trust on the 1st of June 2012. David Jago will take up post at a date to be agreed in 2012/13

It is expected that an appointment will be made to the post of Director of Nursing in April 2012. Hazel Holmes remained in post as Director of Nursing throughout 2011/12.

The remainder of the Committee's work in 2011/12 involved confirmation of individual performance reviews undertaken by the Chair in respect of the Chief Executive and the Chief Executive in respect of all other executive team members; the Committee noting the continuing success of the organisation in relation to delivery of the annual plan.

The Committee also determined that there would be no inflationary pay increase applicable to executive pay in 2011/12.

4.5 Membership

We are committed to ensuring that our members are representative of the population we serve. Anyone living in England and Wales over the age of 16 is eligible to become a public member. The public constituency is divided into four geographical areas:

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

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

- Registered and non-registered 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 membership.

Membership strategy

We believe that our membership makes a real contribution to improving the health of our communities and our emphasis is on encouraging an active and engaged membership.

Our Council of Governors is responsible for reviewing the Membership Strategy and making recommendations to the Board of Directors, who approve revisions to the strategy. The Council of Governors contribute to and support the strategy in relation to membership with the support of the Trust's Membership Office. The Membership Strategy is monitored by the Membership and Communications sub group of the Council of Governors, which is chaired by an elected Public Governor.

During the year, we reviewed and updated the Membership Strategy in order to:

- Grow a membership that is representative of our patient population rather than increasing membership size.
- Continually increase the quality of engagement and participation through involving members in all sectors of the communities we serve - we will specifically seek feedback from recent patients and families in order to ensure a balanced perspective in delivering our goals.
- Communicate with members in accordance with their personal involvement preferences. This will ensure that the Trust achieves effective membership communications for a minimal cost whilst achieving value for money.

Our target for public membership was to reach 10,000 by 31st March 2012 which we are delighted to have achieved.

Our Governors are encouraged to engage within their own constituencies, including any community groups they are involved with, and are supported by the Trust's Membership Office to improve this engagement. For example, we have organised a series of highly successful "Medicine for Members" events at which clinical specialists have hosted talks and discussion in local community settings. These events also provide Governors with an opportunity to meet with members.

We have also attended a number of events including Freshers Fairs and community events such as disability action day and a mela.

During the year, we carried out a membership survey and were delighted to find that 99% of those that participated in the survey recognised and believed in our mission statement “Excellent, safe, compassionate care for every patient, every day.” 98% said they would recommend this hospital to their family and friends and would be happy with the standard of care if their friend or relative needed treatment. We also noted some areas where we needed to make changes, such as improving the signage in and around the hospital and creating a new doorway to allow easier access to the parking area for people with disabilities.

Membership profile

Constituency			
Public Constituency	As at 1st April 2011	As at 31st March 2012	Increase/Decrease (%)
Cheshire	2,250	2,305	+2%
Merseyside	4,842	5,005	+3%
North Wales	1,778	1,859	+16%
Rest of England and Wales	804	700	-13%
Total – Public Constituency	9,674	10,057	+4%
Staff Constituency	1,305	1,320	+1%

Members who wish to contact their elected Governor to raise an issue with the Board of Directors, or 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

5. Quality report

Introduction to Liverpool Heart and Chest Hospital NHS Foundation Trust

Liverpool Heart and Chest Hospital NHS Foundation Trust is a single site specialist hospital serving the population of 2.8 million people resident in Cheshire, Merseyside, North Wales and the Isle of Man. It provides the full range of heart and chest services with the exception of organ transplantation. Throughout 2011/12, this included:

1. Procedures used to visualise the coronary arteries and treat narrowings using balloons and stents (coronary angiography and intervention)
2. The implantation of pacemakers and other devices and treatments used to control and restore the normal rhythm of the heart (arrhythmia management)
3. Procedures used to bypass narrowings, replace the valves of the heart or deal with other problems of the major vessels in the chest (cardiac surgery)
4. Procedures used to treat all major diseases of the chest including lung removal and surgery to the food pipe (thoracic surgery)
5. Drug management of asthma, chronic obstructive pulmonary disease and cystic fibrosis (respiratory medicine)
6. Community cardiovascular and chronic obstructive pulmonary care for the residents of Knowsley.

We have been rated the top performing Trust in the country for the past six 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. We also have a developing reputation in the delivery of high quality community cardiovascular and chronic obstructive pulmonary services.

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. In 2011/12, we formed the Institute of Cardiovascular Medicine and Science, a new strategic partnership with the Brompton & Harefield Hospitals NHS Foundation Trust and Imperial College London to further advance our research.

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.

Quality Account Summary

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

We have fully met **five** of the six priorities we set ourselves last year. These were:

1. Reducing the number of deaths in-hospital
2. Improving the assessment of risk of blood clot (venous thromboembolism)
3. Ensuring diabetic patients are referred to the Diabetes Specialist Nurse before their planned operation.
4. Improving attendance to cardiac rehabilitation classes for those patients resident in Knowsley
5. Improving the experience of care for our patients

We have had partial success in meeting our target for:

6. Reducing rates of readmission to our hospital and to those with whom we work

It has been another good year for improving the quality of care at our hospital.

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 and 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 and 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 ten change programmes:

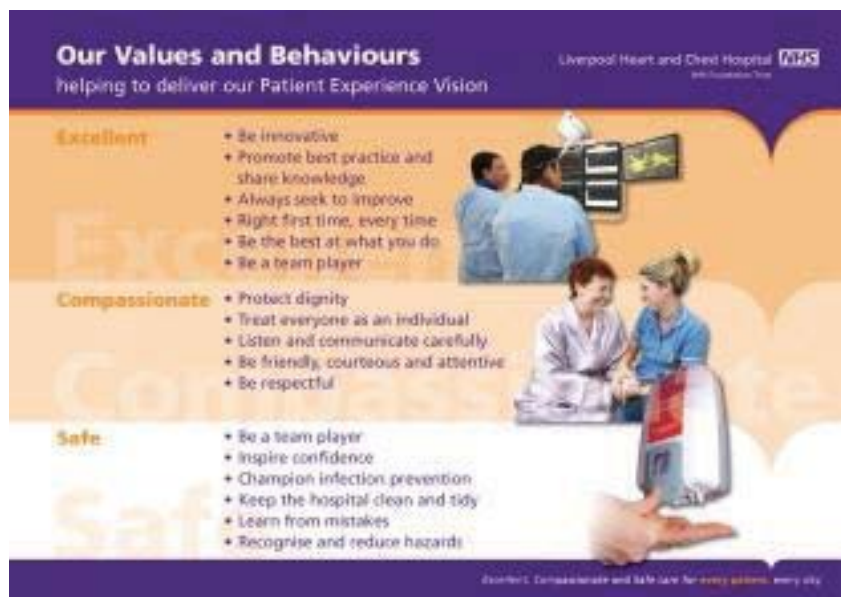
1. Deliver the best cardiothoracic clinical quality outcomes and the safest cardiothoracic healthcare in the country.
2. Deliver an excellent, compassionate and safe experience to patients and their families.



3. Deliver the 2014 portfolio of tertiary and integrated services.

4. Deliver a sustainable profit that ensures long term financial security.
5. Deliver research of the highest quality into new and improved therapies, techniques and models of care.
6. Develop effective relationships with key stakeholders to deliver exceptional care to patients across the entire pathway.
7. Maximise income from charitable funds and develop an innovative volunteer strategy.
8. Maximise the potential of the LHCH healthcare team by creating an environment that facilitates life-long learning and continuous improvement.
9. Develop a workforce capable of delivering excellent, compassionate and safe patient care every day.
10. Improve the quality of staff and patient experience through the deployment of innovative, customer focused information technology solutions.

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 2011/12

We have developed and upheld these values throughout 2011/12 which has resulted in another year of considerable achievement, which included:

- Full roll out across the hospital of the Patient Experience Vision and implementation of the Staff Experience Vision

- Being voted best in the country by our patients for overall quality of care as assessed by our patients in the National Inpatient Survey for the sixth year running
- Completion of the roll out of the Electronic Prescribing and Medicines Administration System (EPMA) which has made the delivery of medications for patients much safer
- 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) and receipt of an excellent report from their unannounced inspection in February 2012. The Trust was inspected on five standards, and found to be fully compliant in all of them.
- Most minimum standards of care met or exceeded as defined by the Department of Health.
- Achievement of all cancer waiting time targets
- Achievement of all 18 week waiting time targets by specialty
- The lowest mortality rate in the country for aortic surgery, 10% versus the average national of 22.8%.
- Delivery of the best heart attack, coronary bypass grafting and heart failure services in the region. 100% of our patients confirmed they would recommend Liverpool Heart and Chest Hospital to their family and friends and 91% said the care we provided exceeded their expectations
- Bringing our services directly into the heart of local communities by offering a new respiratory diseases management service in Knowsley in addition to the heart disease service already in place.
- Embedding our volunteers scheme, which started last year
- Selection as one of only two national pilot sites for ground breaking research in screening for lung cancer
- Organiser of several prestigious medical conferences that were centred on sharing the expertise of Liverpool Heart and Chest clinicians with others from around the country
- A significant increase in our funding for research and innovation, which allows cutting edge treatments to be brought to our patients as early as possible
- In collaboration with Royal Brompton & Harefield NHS Foundation Trust and Imperial College London, the launch of a unique research collaboration, called the Institute of Cardiovascular Medicine and Science.

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 2011/12

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 2012

Who collects these data and how?

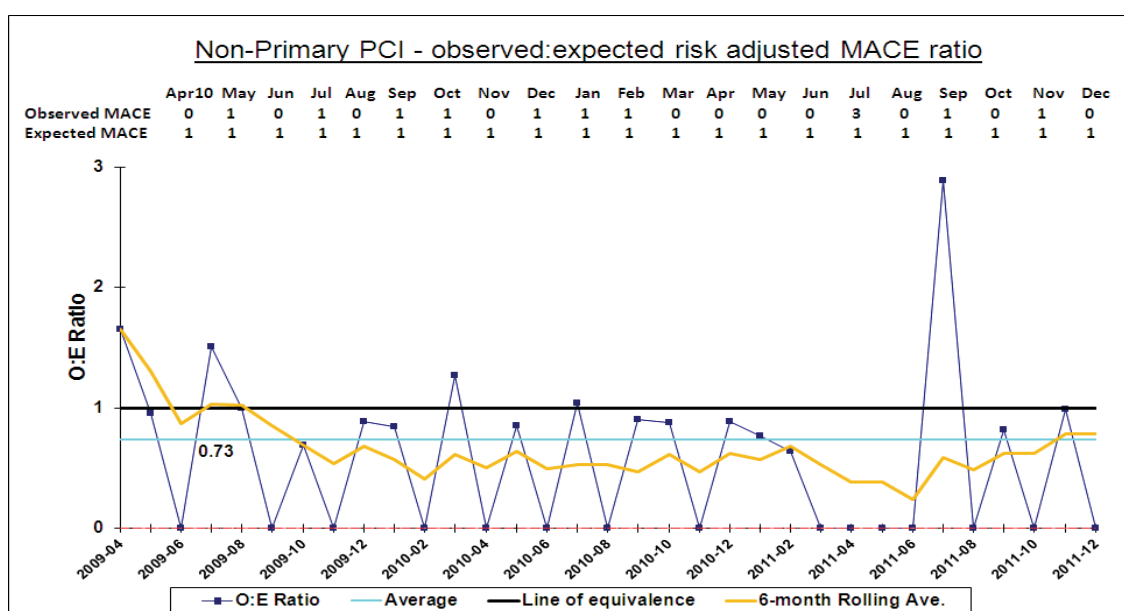
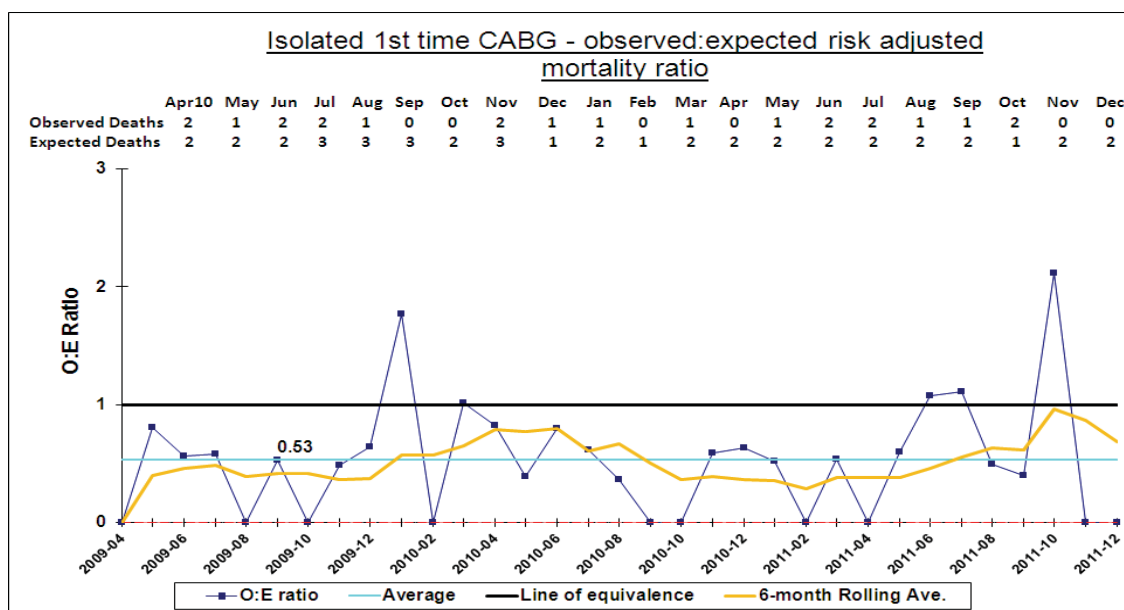
The Trust's clinical coders record on the Trust Patient Administration System the outcome of every patient at the time of discharge. The Clinical Quality Department collect clinical information which allows the correction of raw mortality figures for any pre-existing illness and its severity for each 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 2011/12 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:

Achieved. Both procedures have successfully kept the ratio of observed to expected deaths below one.



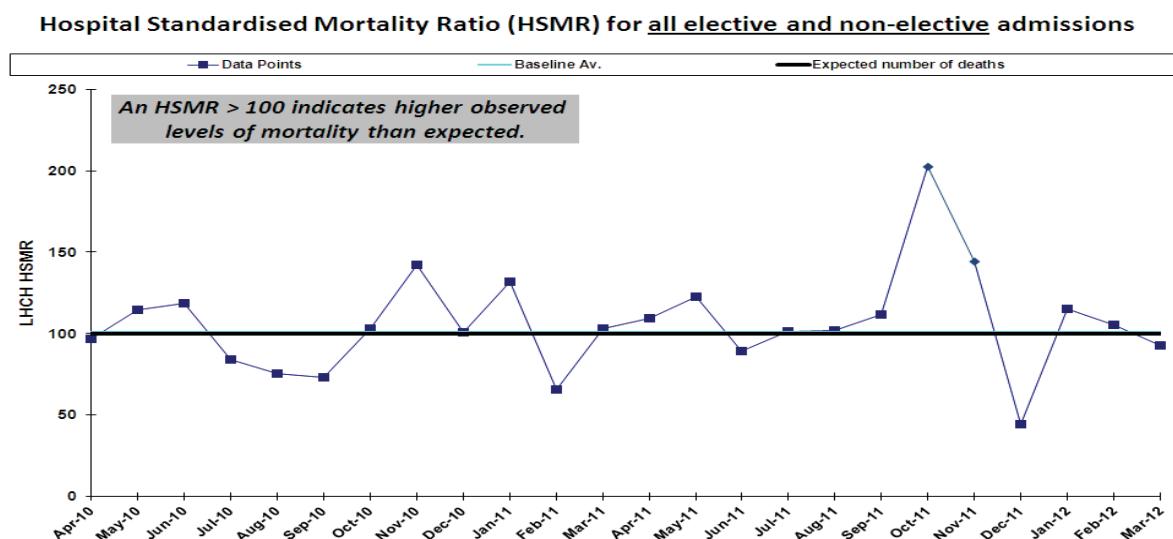
The charts represent our mortality as a ratio between the observed cases to what was expected for the period. The target is set at 1, with anything above it indicating higher mortality than expected, and anything below indicating lower than expected. The reader should look at the yellow line which represents the trend over the preceding 6 consecutive months. At the top of both graphs we have included the actual numbers of observed and expected deaths following comments from the LINKs group. For 2011 we have seen 11 deaths from cardiac bypass while the expected number was 22; similarly, the observed number of adverse events from stenting was 7 versus an expected 12.

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. This is still the case. However, last year's 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).

Improvements achieved:

- Embedded cross organisational learning from mortality reviews (see above)
- Introduced a review of each major service line against the best clinical evidence available
- Publication of our performance in mortality on our website
- Responded to concerns raised by some external stakeholders regarding our focus on just two procedures by developing a Hospital Standardised Mortality Ratio, which takes account of all deaths occurring within the Trust, and reports them in the same way (that is observed to expected) as those of heart bypass and stenting (see chart showing HSMR for all inpatients below)



Keep as future priority?

No. A reduction in in-hospital death remains important for the future, but it has now become business as usual for our Trust. It will continue to be monitored by the Board of Directors as part of the Trusts monthly integrated performance report.

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.

Category:

Safety

What is the priority?

Improve the assessment of risk of blood clots (venous thromboembolism) on admission to the hospital and ensure that patients at risk receive the appropriate treatment.

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, and provision of the therapy reduces the patient's risk of suffering either a clot in their leg or a clot in their lung.

How much will we improve?

Our target is to ensure more than 90% of our patients are risk assessed on admission to hospital and 90% of patients at risk receive the correct treatment.

By when?

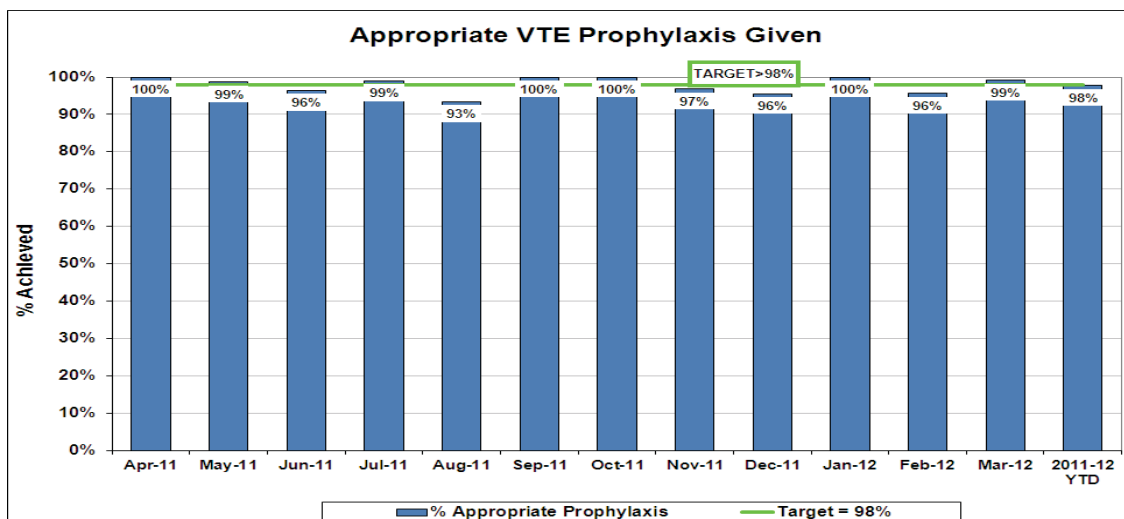
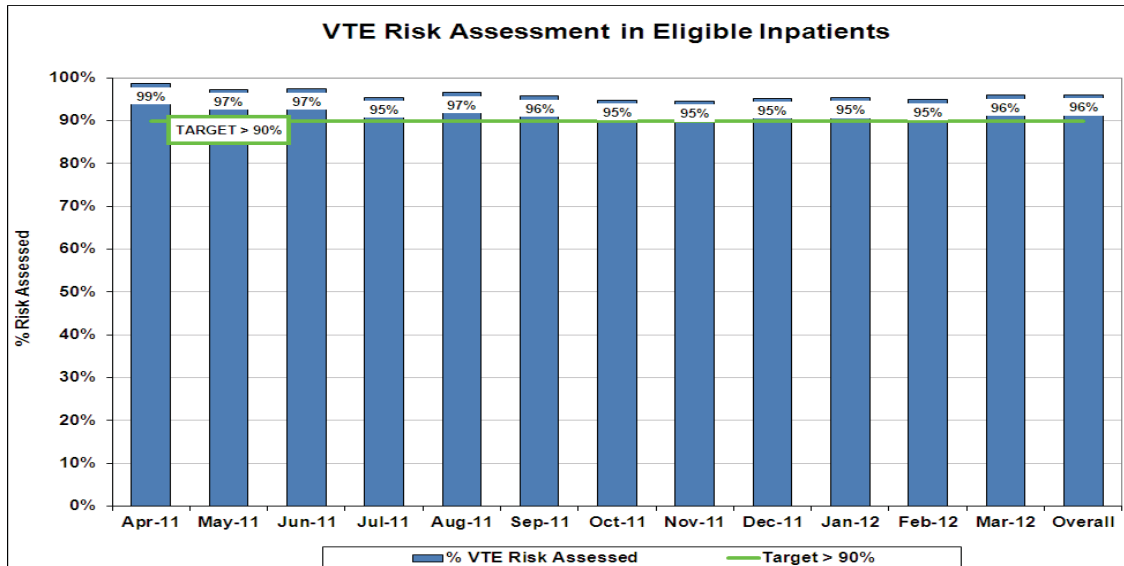
March 2012

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. A ward based audit is conducted of a sample of patients to estimate what percentage of at risk patients receive either a blood thinning drug and / or elasticated stockings that prevent blood clots forming in the leg.

Current status:

Achieved. More than 90% of patients have been risk assessed and received the correct therapy for minimising the risk of a blood clot.



Improvements achieved:

- Continued education regarding risk assessment and prescribing on induction training for new staff.
- Anti-clotting regime added to our electronic prescribing system to automatically remind staff to provide the correct therapy
- Development and implementation of a care plan for patients who are prescribed anti-clotting stockings.
- Established specialist nurses in all areas to ensure care plan is adhered to
- Improved patient information to raise awareness amongst patients about the risks of blood clots (venous thromboembolism)

Keep as a future priority?

No. The requirement to risk assess and deliver appropriate treatment is now a national initiative that has been incorporated into the Trust's quality contract and will continue to be monitored by our commissioners as part of commissioning for quality and innovation (CQUIN; see *Part 2, Review of Services, Goals Agreed with Commissioners*).

Priority Three: 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 and 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.

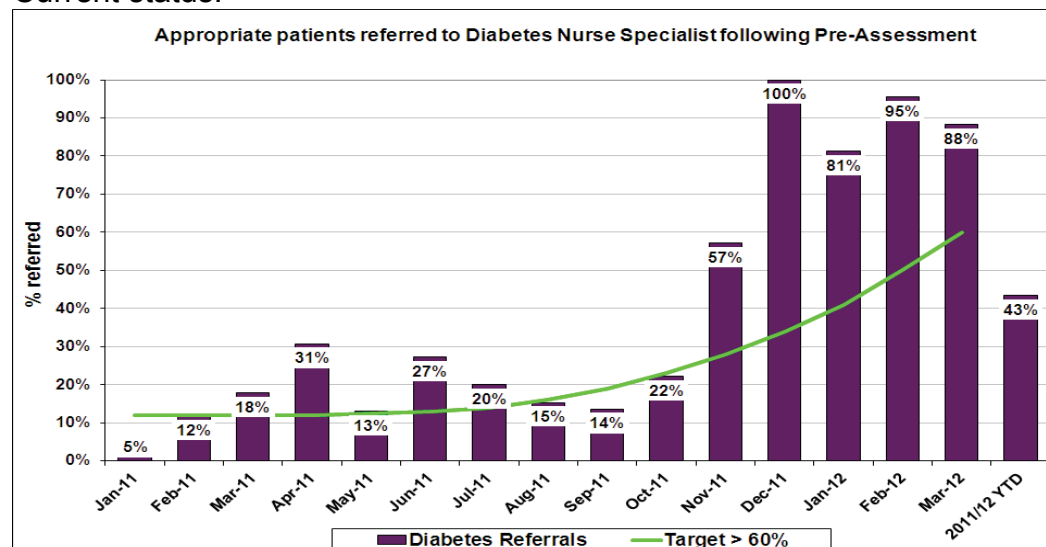
By when?

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 these are matched up with the referrals. The result is expressed as the percentage of all patients who have raised blood sugars who have been referred to the Diabetes Specialist Nurse.

Current status:



Achieved. The graph above demonstrates that 88% of appropriate patients were reviewed by the Diabetes Specialist Nurse in March 2012. The introduction of an electronic system to identify appropriate patients and automatically alert the Diabetes Nurse has allowed us to be consistently above target (green line) since November 2011.

Keep as a future priority?

No. We have achieved our targets for the referral of patients identified with high blood sugars. We need to now ensure that we improve the chances of patients receiving the test that identifies them as having a high blood sugar. This will become our new priority for diabetes care in 2012/13 (see *Part 2, Priorities for 2012/13, Priority Two: Improve the coverage of outpatients receiving a blood sugar test*)).

Improvements achieved:

- Inclusion of the new diabetes pathway in the casenotes of every diabetic patient. This has prompted staff to refer to the Diabetes Specialist Nurse.
- Created an electronic referral system which identifies out of range blood sugars from our blood tests and automatically alerts the Diabetes Specialist Nurse.
- Implementation of the Diabetes Steering Group with good multidisciplinary representation, including the community outreach service.

Priority Four: 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 and Chest Hospital provides 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.

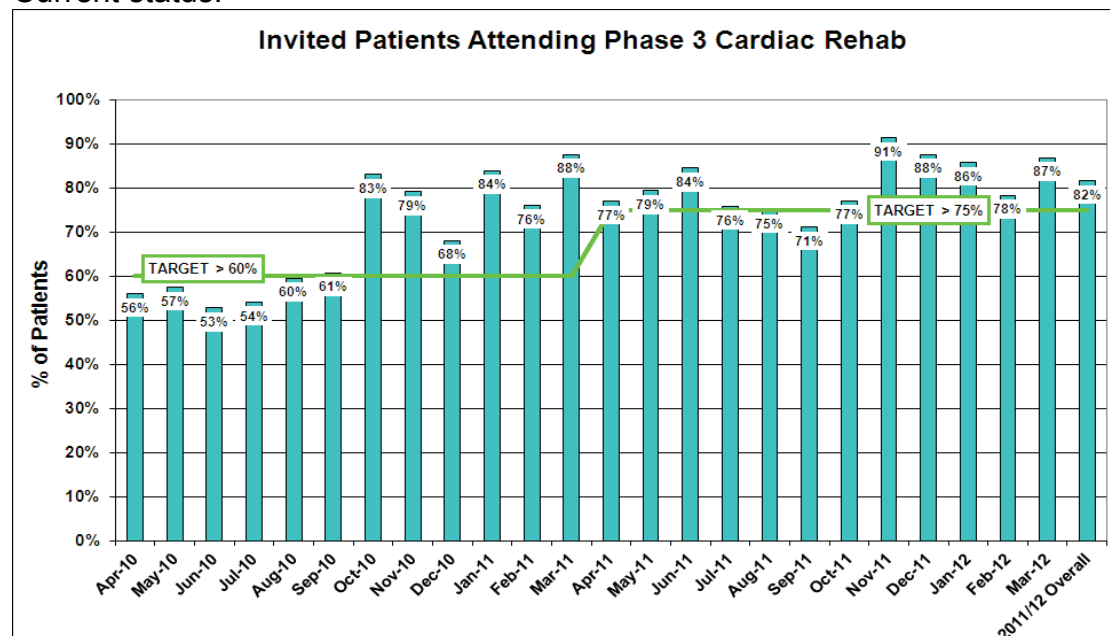
By when?

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:



We have achieved and exceeded our target. The level of referrals to the cardiac rehabilitation service is at 82% for 2011/12. This has been greatly improved by the introduction of the electronic referral system introduced in November 2011.

Improvements achieved:

- Introduction of electronic referral system which allows staff on the ward to quickly and easily refer to cardiac rehabilitation on the computer
- Additional, traditional, cardiac rehabilitation sessions have been made available at different times in more locations in Knowsley to improve access for patients; we have changed the times to suit the patients' needs, offered a home programme monitoring using computer technology and the internet, and also follow up telephone support.
- Developed a greater choice of rehabilitation options e.g. We offer use of gym sessions, supervised walking session, home exercise programme
- Using ex-patients who have benefited from the scheme to encourage others to attend
- Reviewed bottlenecks and drop off of interest in the run up to starting cardiac rehabilitation and put processes in place to increase uptake such as arranging transport to venues, follow up calls and prompts.
- Worked with GPs to ensure they encourage patients to attend cardiac rehabilitation (e.g. from supplying them with letters regarding non-attendance and patient progress)

Keep it as a future priority:

No, the marked improvement over the last two years has resulted in new systems which are now well embedded. However, a high rate of rehabilitation attendance remain as a contractual commitment with Knowsley Primary Care Trust and as such continued monitoring remains in place and is reviewed by senior members of the Community Cardiovascular Team on a monthly basis.

Footnote:

The review by the Audit Commission highlighted concern regarding patients labelled as “not eligible” for cardiac rehabilitation. As a consequence, we carried out our own review and have now corrected the discrepancies. Therefore the chart shown above represents the amended figures. An action plan has been put in place to ensure robust systems and avoid errors in the future:

- all new staff will be made aware of the correct process of identifying “ELIGIBLE PATIENTS”
- we will introduce a robust checking system
- we will produce our reports based on numbers of eligible and not eligible patients.

Priority Five: Improve the experience of care for our patients

Category:

Patient Experience

What:

Develop 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 second year of the plan.

Who collects this data and how?

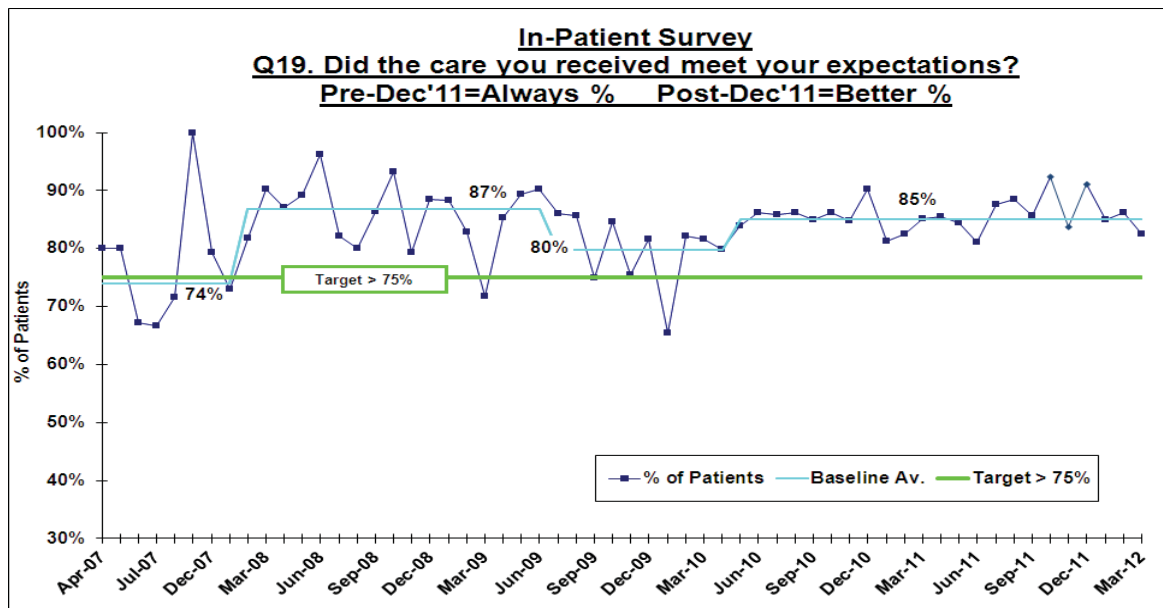
As a means of measuring impact of the plan, we track the experience of our patients against six key questions aligned to the Patient Experience Vision described in Appendix 1. This is measured from the responses to monthly and twice annual surveys from patients receiving care in our hospital. Results are summarised by clinical quality staff. Additionally, the Clinical Quality Department manage the Trust's participation in the National Inpatient and Outpatient surveys, the results of which are analysed by the Care Quality Commission. Additionally, we continue to monitor overall rates of satisfaction but have chosen to raise the bar even higher by recording the percentage of patients who report that we have **exceeded** their expectations rather than fully meeting them, which was our benchmark up to December 2011.

By when:

March 2012

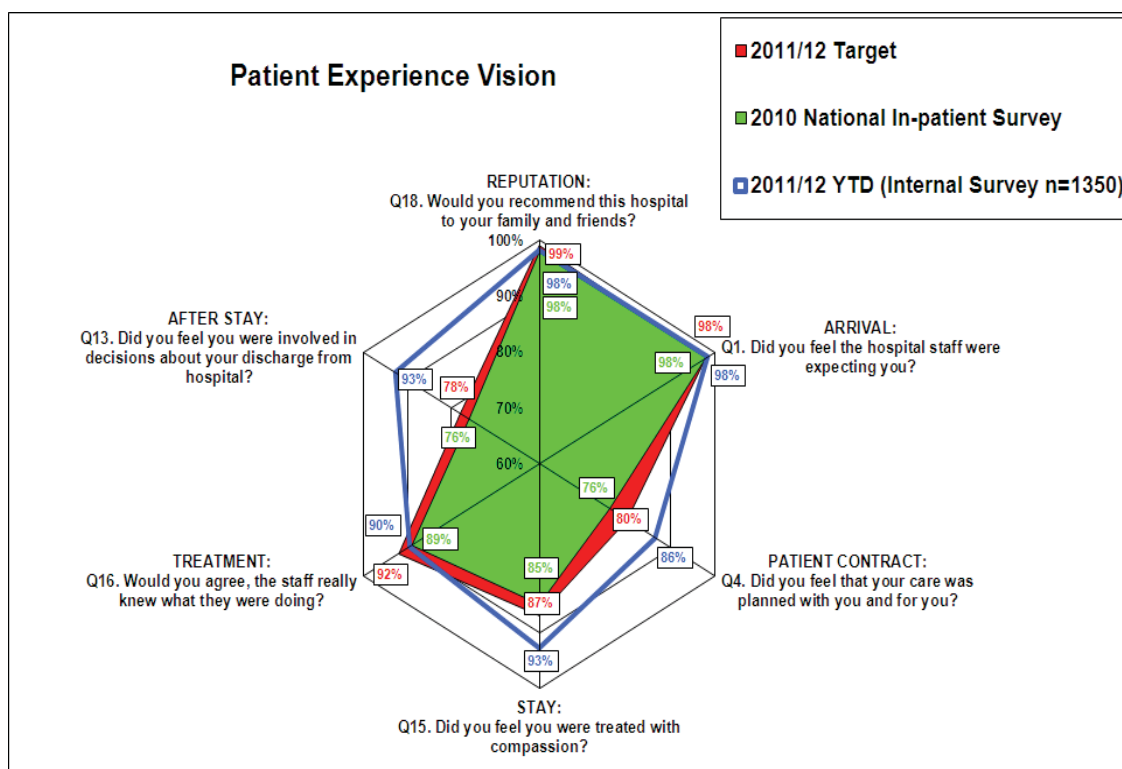
Current status:

Achieved. The percentage of patients reporting that we meet their expectations **all of the time** is now very consistent, and always well above our target. After December 2011 we have changed the possible responses to include *better than expected* and this will now be the level of satisfaction we expect to achieve.




Additionally, the six questions asked as part of our commitment to excellent patient care have been set up with the following targets:


1. The percentage of patients who are willing to recommend the Liverpool Heart and 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 Inpatient Survey which reflects the number of patients who say they were involved in the decision about their discharge from hospital (target 78%)



The blue line above demonstrates that we have achieved very high levels of performance for each and every indicator. We remain, however, 2% under target for patients agreeing staff really know what they are doing. This result has influenced the choice of priorities for next year's quality account described in the section below (see *Part 2, Priorities for 2012/13; Priority Three: Upskill our staff to deliver excellent clinical care*).

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. Liverpool Heart and Chest Hospital recognises that patients and families have experience, expertise, insights, and perspectives that can be invaluable to bringing about transformational change in health care and enhancing quality and safety. The Patient and Family Engagement Plan has been developed and presented to the Patient and Family Experience Committee and Board of Directors detailing how Liverpool Heart and Chest Hospital consults and engages with the patients and families it serves. This plan outlines the principles and structures used to ensure meaningful patient and family engagement in individual care provision and overall business of the organisation. So that we understand the true experiences of our patients and families, the Trust uses various methods such as focus groups, surveys and engagement events throughout the year to capture experiences and themes. This plan has been delivered as a series of challenging projects, which has included:

Project	Progress
Redevelopment of Oak and Day ward	<p>The Trust held engagement events to involve patients and families in the redevelopment of Oak Ward and Day Ward. This involved patients and families creating mood boards and telling us how they wanted the new wards to look and feel. A mock-up room was developed based on patients and families feedback. The redevelopment project is expected to be completed by winter 2012/2013. Below is an artist impression of the mock-up room designed by patients and families.</p> 
Review of the patient environment	<p>Engagement has been conducted via a range of methods such as patient and family events, one to one interviews, and focus groups on Amanda Unit, Elm Ward, Cedar Ward, Birch Ward and Critical Care Unit to enhance the healing environment through the experiences of patients and families. The projects are overseen by the Patient and Family Advisory Board for the Environment on a bi-monthly basis. The Trust is now progressing to implementing the improvements. These include refreshing the décor of rooms, bathrooms and bays with colours and furnishing agreed with patients and families through engagement.</p>
Introducing pagers in outpatients	<p>We have introduced pagers so that if clinics are delayed, patients feel they can leave the waiting area but be confident they will be informed when they are needed for their appointment.</p>
A revised volunteers programme	<p>The Trust has now recruited over 70 volunteers from diverse communities. The volunteers have been involved in meet and greet, patient support and surveys.</p>

Birch Ward lounge and waiting area	 <p data-bbox="635 633 1326 705">A new lounge and waiting area for patients and families has been developed following feedback.</p>
Support Nurse Role	<p data-bbox="635 712 1326 1037">The specialist support nurse role was piloted successfully with excellent feedback from patients and families. This ensures that the patient is followed by the same dedicated nurse from admission to discharge. Specialist support has now been rolled out to a number of areas including surgery and cystic fibrosis. This level of support is also available to patients with multiple needs and requiring complex care</p>
Outpatient Department review	<p data-bbox="635 1043 1326 1149">Carried out a review of the Outpatient Department, which has highlighted the following areas for improvement:</p> <ol data-bbox="683 1155 1326 1335" style="list-style-type: none"> 1. Reduction in avoidable waits 2. Refurbishment of the outpatient department 3. Increase information available to patients (electronic screens, use of pagers) <p data-bbox="635 1341 1326 1402">These changes will be part of the next year improvement plan</p>

Other improvements achieved:

- Implemented a number of changes to the environment to reduce concerns raised regarding mixed sex accommodation
- Participated in the 2011 National Inpatient Survey and action planned the results
- Introduced a new set of questions in a twice yearly inpatient survey directly aligned to the delivery of those things deemed by the Care Quality Commission as important (the 16 quality and safety outcomes).

Keep as future priority?

Yes. Even though we have achieved this priority, improving the patient experience remains the Trust's top ambition for the future. We have developed our comprehensive delivery plan yet further which will take us to 2013.

Further improvements identified:

- Embedding of the Patient and Family Engagement Plan to continue the engagement with the patients and families it serves.
- We will strengthen relationships with external partners including the LINk/HealthWatch, community groups such as GP Patient Participation Forums, voluntary organisations and other statutory organisations. These links will be constantly reviewed and improved.
- Commitment to enhance the care of some of our most vulnerable patients who normally do not attend engagement events or respond to surveys. Working in partnership with external partners will support the Trust in capturing their experiences.

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.

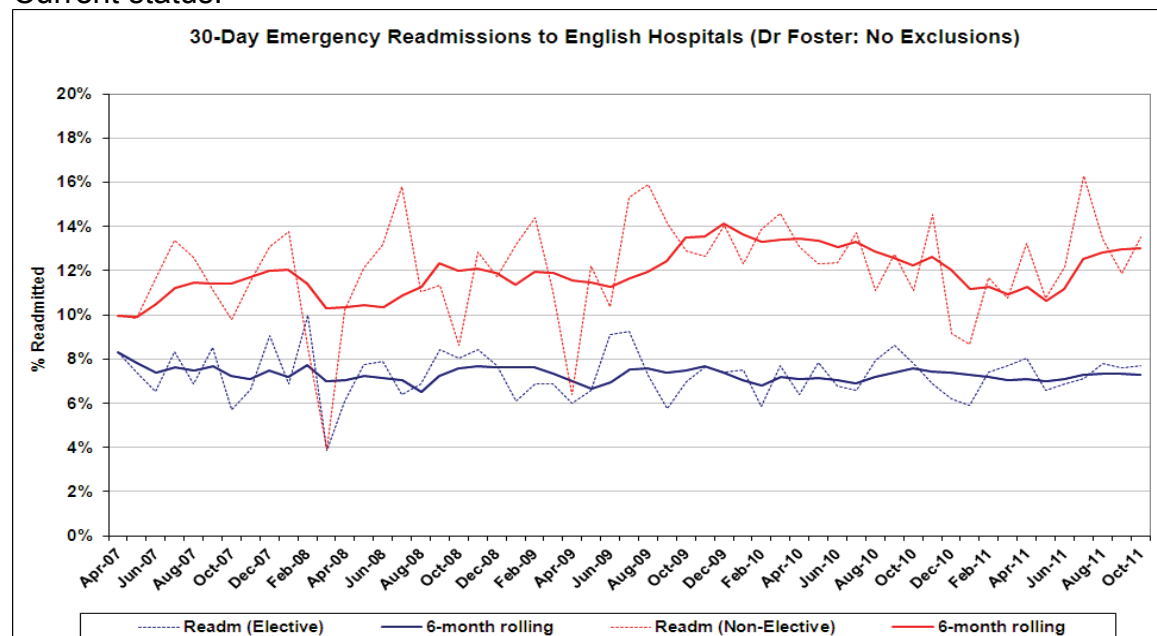
By when?

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:



Partially achieved. Despite our very best efforts, we have not fully met this priority. The readmission rate for patients originally admitted following a planned procedure has remained stubbornly flat (blue line). In patients readmitted following an unplanned procedure, however, we have reduced the rate from a high point of 14.2% to low of 10.6% (red line), a relative reduction of 25%. However, the rate has crept up again in recent months.

Improvements achieved:

- Teach back has been rolled out on all wards. This ensures that all patients have a thorough explanation of their take home medication and that their level of understanding has been checked.
- Key carer. All appropriate patients have a key carer identified who will be present when discharge information and cardiac rehabilitation discussions are held.
- High risk heart failure patients receive a telephone call shortly after discharge to ensure that they have no queries or symptoms that may cause them to readmit.
- All heart failure patients have a dedicated line to call in if they need advice
- Reviewed whether our discharge letters (which normally follow a few weeks later) were adding value above the discharge summary (that the patient receives on discharge). Patients have been asked whether they wanted to receive a discharge letter in addition to the summary; those who express that preference have received both. Tailoring the information the patient wants helps with their understanding of their condition and stops unnecessary access to the health service.

Keep as a future priority?

No. Reducing avoidable re-admissions continues to be a priority that is core to the success of this Trust. However, we now consider it to be “business as usual”, and as such the spotlight produced by the Quality Account is no longer needed. The Trust will however continue to work to reduce avoidable re-admissions by focusing on:

- Development and implementation of a dedicated Discharge Advice Line. This will be open 24/7 every day. Patients will be able to receive advice from a hospital clinician.
- Introduction of assessment beds - a patient who needs extra care following discharge can be brought back into the Trust, receive this care quickly and efficiently, and be discharged again in the same day. The provision of this type of care does not count as a readmission.
- Ward staff will identify patients at high risk of readmissions and they will receive a supportive phone call within 3 days of discharge.

Performance on these additional improvements will continue to be tracked by the Clinical Quality Committee.

Priorities for 2012/13

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

From the review of performance in 2011/12, the Trust is pledging to continue the following work:

Priority One: Improve the experience of care for our patients

We will implement the third year of the plan and continue to measure its impact from the results to the six key questions together with overall rates of satisfaction with our services.

In brief, the Trust will focus on the following areas:

1. Embedding the Patient Experience Vision to all wards and departments
2. Embedding family centred care to all directorates
3. Delivery of contracts of care for at least 75% of patients
4. Clear plans for patient and family, and public engagement process
5. Embedding the process of “shadowing” in order to identify service improvements. Shadowing involves a member of staff following the patient through a process of care and attempting to see the experience of care from the patient's perspective
6. Spread and sustain the outcomes from support nurse role
7. Implement changes to the Outpatient Department as per review reported in November 2011.

What follows are the new **additional** priorities for improvement in 2012/13.

Priority Two: Improve the coverage of outpatients receiving a blood sugar test

Category:

Effectiveness

What:

Ensure more eligible patients receive the blood glucose test when they attend as outpatients for a pre-operative consultation. This work complements the priority last year to improve referral to the Diabetes Specialist Nurse.

Why:

All patients meeting certain criteria should have a blood sugar test when they attend an outpatient consultation. We know that only approximately three quarters of these patients receive this test at the moment. This means that there could be an additional 25% of patients who are presenting with a high blood sugar that is not being measured in enough time to allow the Diabetes Specialist Nurse to intervene and correct prior to receipt of their definitive operation. Poorly controlled blood sugars increase the risk of infection, leads to poor wound healing and lengthens hospital stay.

How much:

We aim to improve the coverage of pre-operative outpatients receiving a blood sugar test to 90%.

By when:

March 2013.

Who collects these data and how?

The Clinical Quality Department match up the electronic records of those patients who attend outpatients and those who have received the test.

Current status:

During 2011, 76% of eligible patients received a blood glucose test at pre-assessment clinic.

Improvements Identified:

- Develop strict eligibility criteria for those patients who should receive the blood sugar test.
- Use checklist and reminder systems to ensure these are implemented consistently in the outpatient department.
- Ensuring that patients with existing diabetes get appropriate management pre-admission

Priority Three: Upskill our staff to deliver excellent clinical care

Category:

Safety

What:

Enable staff to be the best that they can be by producing a competency framework that sets minimum skill standards for staff and deliver the necessary developmental requirements for staff to achieve these standards.

Why:

The Trust is committed to ensuring we have a competent and capable workforce able to provide excellent, safe and compassionate care to every patient, every day.

How much:

The standards of care delivered in the Trust are already high as evidenced by the national inpatient survey results – Liverpool Heart and Chest Hospital is the highest performing hospital in providing overall patient care. However we aim to build on this success over the next year by developing clearer, more robust competency pathways to provide better assurance that our staff are equipped with the skills to do their jobs effectively. This will help us achieve the target we have set around staff appearing to know what they are doing described in the patient experience priority (see *Part 2, Review of priorities from 2011/12, Priority five: Improve the experience of care for our patients*).

By when:

March 2013

Who collects the data and how?

Data will be collected by the Learning and Development Department. Trainers will collect attendance sheets at each delivered course or seminar, and this will be sent to the Learning and Development Department to be added to the Learning Management System, from which reports can be obtained. Review on their progression will be done on a monthly basis.

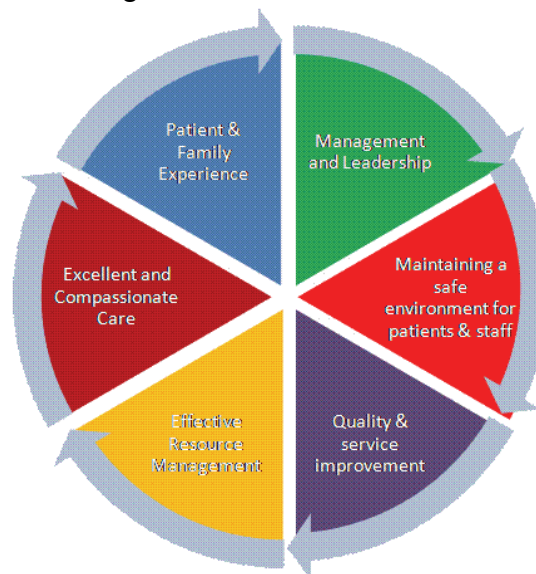
Current status:

Liverpool Heart and Chest Hospital has a well-established learning and development plan; the development of our staff is a key component in the delivery of high quality patient care. The Trust has a series of

courses covering competencies for our clinical staff, and also the post-qualification framework which allows staff to do additional courses as per their requirements. The Trust also has a robust system for monitoring staff developmental needs. Monthly checks are carried out by the Learning and Development department on the status of achieved Personal Developmental Reviews (PDR) carried out. Heads of Departments receive a monthly update and ensure all staff have their reviews done. This is one of our key performance indicators.

Improvements identified:

- To develop an effective Preceptorship Pathway (transition period for practitioners at the start of their careers which will help them begin the journey from novice to experts). This process will be trialed with newly qualified nurses starting at the Trust from September 2012 with the aim to roll out to all other Allied Health Professionals.
- A development pathway for healthcare assistants has also been developed and will run alongside the Preceptorship Pathway. The pathways will equip the new practitioner with essential skills and will have inbuilt assessment throughout the Preceptorship period.
- Development of a competency framework for all clinical staff. This will be piloted within the nursing workforce at the first stage with the aim to roll out further. The competency framework is currently at test stage and includes the sections identified in the diagram below. The framework will set key standards for care delivery and each practitioner will be assessed against the standards. Development areas will be identified by using the framework as part of each staff member's annual review. The Manager and Practitioner will set an action plan to ensure achievement of the standards. Data will be collected centrally on how well staff are achieving against the competences as part of the annual review performance ratings in use at the Trust.



Priority Four: Improve the assessment of quality of life in our heart disease patients

Category:

Effectiveness

What:

Improve the assessment of quality of life in patients receiving elective bypass surgery or stenting.

Why:

The NHS is moving towards measuring its performance in terms of the outcomes it delivers, rather than how many procedures or treatments it performs. For the patient, one of the key outcomes is how much better do they feel as a result of receiving their operation. This is measured by asking the patients to complete a quality of life questionnaire before and at some time after their operation when they have fully recovered. The difference in self-reported quality of life (also known as a patient reported outcome, or PROM) is a measure of how much better (or worse) the patient feels as a result of treatment. This type of assessment is now standard across the NHS for hip and knee replacement and varicose vein and inguinal hernia surgery. Bypass surgery and stenting are next in line, and this Hospital is leading the national pilot of this work.

How much:

We will ensure 80% of our bypass surgery and stenting patients complete the pre-operative questionnaire.

By when:

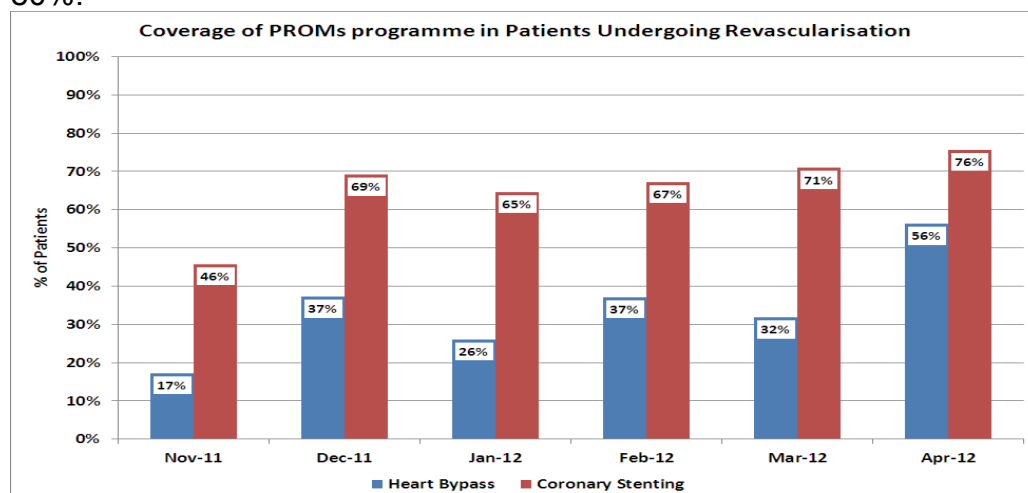
March 2012.

Who collects these data and how?

Staff in outpatients invite all bypass surgery and stenting patients to complete the questionnaire. Completed questionnaires are then sent to the Department of Health, which in turn completes the assessments by sending the patients a post-operative questionnaire. The data is then analysed by the Information Centre before being fed back to the hospitals and published on the Department of Health website.

Current status:

This work began in November 2011 and whilst we have shown improvement over time, performance is some way below the target of 80%.



Improvements Identified:

- Complete review of how bypass surgery and stenting patients get invited to the Clinical Nurse Practitioner clinic to receive their pre-operative assessment.
- Development of systems on the wards to identify and invite patients to participate who have not attended the Clinical Nurse Practitioner clinic and as such have not had the opportunity to participate.
- Feedback of results to involved staff to act as an on-going motivator to invite patients to participate.

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 2011/12 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 and 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 10,000 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 a dedicated workshop 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 Liverpool Heart and Chest Hospital and the best performance, together with number of people likely to benefit. We call this the scope for improvement. The shortlist was presented to the Trust's Clinical Quality Committee who approved the final shortlisted priorities on behalf of the Board of Directors.

This process was developed and tested last year, and has been further improved this year.

Like last year the process has resulted in one of the suggestions from stakeholders external to the Trust being accepted as priority, namely:

Priority Three. Upskill our staff to deliver excellent clinical care.

Review of services

During 2011/12 the Liverpool Heart and Chest Hospital NHS Foundation Trust provided and/or sub-contracted 12 NHS services.

Liverpool Heart and Chest Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 12 of these NHS services. The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by the Liverpool Heart and Chest Hospital NHS Foundation Trust for 2011/12.

Participation in Clinical Audits

During 2011/12, 16 national clinical audits and 1 national confidential enquiry covered NHS services that Liverpool Heart and Chest NHS Foundation Trust provides.

During 2011/12, Liverpool Heart and Chest NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest NHS Foundation Trust were eligible to participate in during 2011/12 are as listed in table 1.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest NHS Foundation Trust participated in during 2011/12 are as listed in table 1.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, 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.

Table 1

Name of audit	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
Peri-and Neo-natal		
Perinatal mortality (MBRRACE-UK)	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 (NNAP)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Children		
<ul style="list-style-type: none"> · Paediatric pneumonia (British Thoracic Society) · Paediatric asthma (British Thoracic Society) · Pain management (College of Emergency Medicine) · Childhood epilepsy (RCPH National Childhood Epilepsy Audit)* · Paediatric intensive care (PICANet)* · Diabetes (RCPH National Paediatric Diabetes Audit)* 	No	Not relevant - Paediatric services are not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
<ul style="list-style-type: none"> · Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit) 	Yes	147/147 (100%) submitted Congenital. 8/8 (100%) submitted Infective Endocarditis. 25/25 (100%) submitted ICD & Pacing. Data submission for remaining cases for 2011/12 is due 31/05/2012
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	62/62 (100%) submitted for Aug-Nov 2011 period as per study criteria
Adult community acquired pneumonia (British Thoracic Society)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Non-invasive ventilation - adults (British Thoracic Society)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Pleural procedures (British Thoracic Society)	Yes	11/11 (100%) submitted. Insufficient records to meet study criteria (Minimum 5 records for parts 2A, 2C and 2D respectively. LHCH: 2A = 3 records, 2C = 4 records and 2D = 4 records).
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Registered and participating from April 2011. 157/157 (100%) cases submitted
Severe sepsis and septic shock (College of Emergency Medicine)	No	Not relevant - Audit is applicable to Emergency departments
Adult critical care (ICNARC CMPD)	Yes	Submitted 294/294 (100%) ITU patients in 2011. Increased number of bed included in this audit from 2012. Submitted 579/579 (100%) POCCU and ITU in Qtr.4 Jan 2012 - March 2012
Potential donor audit (NHS Blood &	No	Not relevant. Data collection was revised in

Name of audit	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
Transplant)		October 2009 - collects information on patient deaths in ICUs and emergency departments but excludes cardiothoracic ICUs.
Seizure management (National Audit of Seizure Management)	No	Not relevant – audit focuses upon cases presenting to emergency departments in the UK with a seizure.
Long term conditions		
Diabetes (National Adult Diabetes Audit)*	No	LHCH did not participate as the eligibility criteria does not cover specialist Trusts
Heavy menstrual bleeding (RCOG National Audit of HMB)*	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Chronic pain (National Pain Audit)*	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 appropriate for the LHCH to participate in this audit.
Ulcerative colitis and Crohn's disease (UK IBD Audit)*	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Parkinson's disease (National Parkinson's Audit)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Adult asthma (British Thoracic Society)	No	LHCH patients are not suitable for the asthma audit as acute asthma patients get admitted to the A & E or Medical admissions unit at acute Trusts
Bronchiectasis (British Thoracic Society)	Yes	20/20 (100%) submitted for 1 October 2011 to 30 November 2011 as per study criteria
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)*	No	This procedure is not undertaken at LHCH as a specialist tertiary Trust for heart and lung disease
Elective surgery (National PROMs Programme)	No	Not relevant - The four clinical procedures (Hip, Knee, Hernia and Varicose veins) covered in this audit are not undertaken at LHCH as a specialist tertiary Trust for adult heart and lung disease
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	Not relevant - data is collected from all transplant centres in the UK and Ireland
Liver transplantation (NHSBT UK Transplant Registry)	No	Not relevant - data is collected from all transplant centres in the UK and Ireland
Coronary angioplasty (NICOR Adult cardiac interventions audit)*	Yes	A total of 2972 including coronary pressure studies and IVUS (2841 PCIs) cases for 2011 (100%) submitted.
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	No	Not relevant - procedures are not undertaken at LHCH as a specialist tertiary Trust for heart and lung disease
Carotid interventions (Carotid	No	Only undertaken concomitantly with cardiac

Name of audit	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
Intervention Audit)*		surgery and submitted as part of Adult Cardiac Surgery Audit
CABG and valvular surgery (Adult cardiac surgery audit)*	Yes	Adult cardiac surgery data submissions are undertaken every 12 weeks as required by CCAD. FY 11/12 Q1 x 439 Cases Submitted (100%) Q2 x 455 Cases Submitted (100%) Q3 x 441 Cases Submitted (100%) Q4 x Cases to be submitted by 30/06/2012
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)*	Yes	906/906 (100%) cases submitted to CCAD.
Heart failure (Heart Failure Audit)*	Yes	204/ 204 (100%) cases submitted to CCAD.
Acute stroke (SINAP)*	No	Not relevant as LHCH does not admit patients following acute stroke
Cardiac arrhythmia (Cardiac Rhythm Management Audit)*	Yes	A total of 1487 (100%) pacing and implantable cardiac defibrillators cases and 1073 (100%) EPS cases have been submitted for the reporting period Jan 11 – Dec 11
Renal disease		
Renal replacement therapy (Renal Registry)	No	Not relevant - service not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Renal transplantation (NHSBT UK Transplant Registry)	No	Not relevant - service not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Cancer		
Lung cancer (National Lung Cancer Audit)*	Yes	404/404 (100%) have been submitted having been first seen at LHCH in 2011 as per this audit's criteria. 271/271 (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 (National Bowel Cancer Audit Programme)*	No	Not relevant - procedures are not undertaken at LHCH as a specialist tertiary Trust for heart and lung disease
Head & neck cancer (DAHNO)*	No	Not relevant - procedures are not undertaken at LHCH as a specialist tertiary Trust for heart and lung disease
Oesophago-gastric cancer (National O-G Cancer Audit)*	Yes	181/181 (100%) cases submitted. Data submission for remaining cases for 2011/12 is due 1/10/2012.
Trauma		
Hip fracture (National Hip Fracture	No	Not relevant - a trauma service is not

Name of audit	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
Database)*		provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Severe trauma (Trauma Audit & Research Network)	No	Not relevant - a trauma service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
Psychological conditions		
Prescribing in mental health services (POMH)	No	Not relevant - Psychological services are not provided at LHCH as a specialist tertiary Trust for heart and lung disease
Schizophrenia (National Schizophrenia Audit)*	No	Not relevant - Psychological services are not provided at LHCH as a specialist tertiary Trust for heart and lung disease
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	23/23 (100%) submitted.
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	Audit is designed in 2 phases. Collected data Sept –Nov 2011 as per study criteria. Of which 9 cases submitted as part of Phase 1 (100%) Phase 2 commencing following instruction from NCA on cases submitted in phase 1 with a completion due by 29/06/2012
*Blood transfusion in adult cardiac surgery (National Comparative Audit of Blood Transfusion)	Yes	In addition to the above blood transfusion audits, LHCH are participating in this audit. 456/456 (100%) submitted.
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	100 cases randomly selected for data period 01/03/2011-31/03/2011, of which 20 cases selected by NHPHA for validation exercise. All data (100%) submitted by 30/11/2011 deadline as per study criteria.
End of life		
Care of dying in hospital (NCDAH)	No	As a tertiary trust our numbers are too low to meet NCDAH 3rd Round criteria. LHCH are participating in the pilot of using the Liverpool Care Pathway version 12 in ICU
Total: 51	16	

Other National Clinical audits

During 2011/12 Liverpool Heart and Chest NHS Foundation Trust participated in 2 other national clinical audits in addition to those described above

Audit Title	Participated 2011/12	% cases submitted
National Inpatient Survey	Yes	549/850 (65%) of consecutive inpatients identified in time period June/July 2011 responded and were included in the submission
National Outpatient Survey	Yes	507/850 (61%) of consecutive outpatients identified in time period April 2011 responded and were included in the submission

National Confidential Enquiries 2011-12

National Confidential Enquiries		
Study title	Eligible to participate Yes / No	If No: reason If Yes: % cases submitted
Maternal infant and perinatal	No	Not relevant –as LHCH is a specialist tertiary Trust for adult heart and lung disease
Suicide and homicide in mental health (NCISH)	No	Not relevant –as LHCH is a specialist tertiary Trust for adult heart and lung disease
Patient Outcome and Death (NCEPOD)		
Cardiac Arrest	Yes	3 cases were completed for the summary spread sheet and subsequently selected by NCEPOD for questionnaire and case note extracts. These were received and distributed to clinicians for submission by 06/05/2011. 3/3 (100%) submitted, including organisational questionnaire by Nov 2011.
Bariatric surgery	No	LHCH did not meet criteria for participation. An organisational questionnaire was completed March 2012.
Alcohol related liver disease	Yes (pilot only)	Participated: LHCH participated in the pilot study (October 2011). LHCH did not meet study criteria for the main study.

The reports of 11 national clinical audits were reviewed by the provider in 2011/12 and Liverpool Heart and Chest NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National inpatient survey

We have achieved high levels of satisfaction in our patients. However, there are two areas in which improvements have been identified:

- Need to ensure patients with an anaesthetist get a clear explanation of their procedure

- The non-availability of medicines as the main reason for delays in discharge. It was noted that improvements had been made regarding information on medicine side effects, danger signals, discharge information and intelligibility of discharge letters.

National outpatient survey

- New welcome pack developed with the aim of reducing anxiety for patients and guiding and empowering patients to question healthcare professionals during consultations
- Move from an "opt in" to an "opt out" process for copy letters regarding outpatient consultations for all services from 1st April 2012
- Work is being undertaken to review "Quality of Consultation" and issues covered include patients advised about the danger signals to look for at home, involvement in decision making and explanation regarding the side effects of medication.

Lung cancer (National Lung Cancer Audit)

- Data quality issues are a key focus for improvement. Patients that are referred to Liverpool Heart and Chest Hospital for surgery but have been diagnosed at the Royal Liverpool Hospital have been missed from our submissions, as the national database would not allow entry from the two sites. However, Liverpool Heart and Chest Hospital has highlighted this issue to the national team and has proposed that patients referred to us from the Royal Liverpool Hospital are also submitted to the database as our patients. This will result in more meaningful data for the Liverpool Lung Cancer Unit produced in future.

National Heart Failure Audit 2010/11

Recommendations for improving data completeness and for improving the quality of care and patient outcomes are being met.

Actions to further improve this have included:

- An E-referral system set-up for our heart failure service
- Use of electronic hand-held devices to support data collection
- On-going regular education / training sessions with the heart failure community nurses in relation to the heart failure pathway

The effectiveness of these changes will be audited in 2012-13 including measures against outcomes, re-admission and survival in Liverpool Heart and Chest Hospital diagnosed heart failure patients.

The National Diabetes Audit 2010

- Implementing a clinical guideline for optimising pre-operative health in patients with diabetes undergoing elective surgery

ICNARC annual report (published April 2011)

Unfortunately by only being compared to general Intensive Care Units we are not able to receive specific information on the effectiveness of our cardiac and thoracic treatment.

Emergency use of oxygen 2011 (British Thoracic Society)

According to the British Thoracic Society national audit data we are performing above the national average for oxygen prescribing and appear to be on par when monitoring saturations.

Actions for improvement:

- Induction training of clinical staff to address that only 54% of prescriptions contained a range as specified by the British Thoracic Society and as contained on the paper prescription chart, and the need of signing for oxygen as it is administered.

Bronchiectasis (British Thoracic Society)

As a tertiary centre, we see the more complex bronchiectasis patients. This impact results in a higher use of intravenous antibiotics and the incidence of difficult to manage infections such as pseudomonas.

Action for improvement:

- Referring patients with moderate and high dyspnoea score to rehabilitation
- More detailed assessment of sputum by doctors to improve index consultation
- Potential use of spirometry before and after patients are commenced on nebulised antibiotics.

2011 Re-audit of Bedside Transfusion Practice

Liverpool Heart and Chest Hospital was fully compliant with 4 out of 6 national standards. However, in two standards the level of compliance was 83% and 96%. These related both at measurement of blood pressure, pulse and temperature at 15 minutes from start of transfusion and at the end of each transfused unit, respectively.

The area for improvement is the documenting of patient observations. Patients are being continuously monitored, however the observation was not written on the clinical chart.

Action for improvement

- Audit findings were discussed with the managers of the areas concerned who agreed to do a spot check audit to ensure improvement is occurring.

National Confidential Enquiry Reports

Centre for Maternal and Child Enquiries (CMACE)

Any reports published during 2011/12 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 (NCISH)

Any reports published during 2011/12 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.

NCEPOD reports

Surgery in Children Report 'Are We There Yet'?

An organisational gap analysis is being conducted and an action plan developed. Actions identified thus far include:

- Resuscitation policy review to include reference to paediatrics
- Develop a standard operational policy for performing surgery for children

Peri-operative Care Report 'Knowing the Risk'

An organisational gap analysis is being conducted and an action plan to be developed.

The reports of 65 local clinical audits were reviewed by the provider in 2011/12 and Liverpool Heart and Chest NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Documentation:

Several audits have demonstrated that improvement in clinical documentation was needed:

- Redesigning care pathway documentation in line with developments for electronic patient records
- Continuing to raise awareness through nursing and doctor induction sessions

Nutrition:

- Continuing to implement changes in practices to improve the patient experience, using patient satisfaction survey feedback and meal observations
- The volunteer role is expanding to support mealtimes
- Pilot of meal times and if successful to be implemented
- Embedding the nasogastric tube management policy and care pathway with further training and competency assessment.

Stroke care:

- Continuing to improve care and rehabilitation for patients who have stroke whilst an inpatient at Liverpool Heart and Chest Hospital, modifying the stroke pathway and re-audit using appropriate key indicators of best practice.

Venous ThromboEmbolism (VTE) prevention:

- Embedding the use of the graduated compression stocking care plan and the VTE risk assessment and prophylaxis algorithm

Delirium:

- Delirium task and finish group was established to review NICE Clinical guidelines, resulting in a delirium policy being written and this is to be fully implemented

- Training / education underway on recognising and managing delirium
- Introduction of tools to assess and diagnose delirium

Radiology services:

A patient satisfaction survey was undertaken to ensure the quality of the radiology services is maintained throughout the department.

- Improve signage within the department
- Improve staff explanation of procedure and staff introduction
- Improve patients' information - "How to obtain results"
- Achieve 100% clear patient Identification.

The intention is to undertake a re-audit in 2013

Anaesthetic and pain control processes in cardiology

- Written information has been amended
- Sedation practices are being reviewed

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Liverpool Heart and Chest Hospital NHS Foundation Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 1,408.

Compared to 2010/11, 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 and 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 and Chest Hospital NHS Foundation Trust was involved in conducting 15 clinical research studies in the cardiovascular specialty, 8 clinical research studies in the cancer speciality, 2 clinical research studies in the critical care specialty, 5 clinical research studies in the respiratory specialty and 4 clinical research studies in quality of life / outcomes during 2011/12.

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

There were 49 clinical staff participating in research approved by a research ethics committee at Liverpool Heart and Chest Hospital NHS Foundation Trust during 2011/12. These staff participated in research covering 5 medical specialties.

In the last three years, a total of 109 peer-reviewed publications have resulted from general research activity; 27 of those have resulted from our involvement in NIHR research. Our engagement with clinical research also demonstrates Liverpool Heart and 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 **UK Lung Cancer Screening Trial (UKLS)**. Lung cancer is a major health problem nationwide, and particularly in the Northwest. Lung cancer often develops slowly. It is thought that cells first become abnormal at least five years before the cancer can be detected. By the time lung cancer is diagnosed, it has often spread outside the lung. If this happens, the cancer can only rarely be cured. Lung cancer screening uses an advanced x-ray technique, called computed tomography (CT) scanning, in order to find lung cancer before symptoms develop so that early treatment can remove the cancer and deaths from lung cancer may be prevented. If the results of our trial show that CT scanning of the lungs in healthy people is worthwhile then, in the future, CT scanning may be used throughout the country for lung cancer screening. This would be similar to the breast, cervical and bowel cancer screening programmes used today.
- A Pilot **Randomised Control Trial, in Intensive Care Patients, Comparing Seven Days Versus Two Days Treatment With Empirical Antibiotics to Treat Hospital Acquired Infection of Unknown Origin (READ-ICU)**. Patients in intensive care units are at higher risk of hospital acquired infections compared with those in non-critical care areas. Despite the major advances in intensive care management, hospital acquired infection remains the leading cause of death in intensive care units. Many patients die of complications associated with the infection. Patients in the intensive care unit suspected of having an infection are usually given courses of antibiotics of variable duration to reduce the risk of complications and this may take 7 days or more. This is also the case in patients with no evidence of infection. At present some doctors believe that extended antibiotic treatment for this category of patients may be harmful. By reducing the duration of antibiotic treatment for patients with unconfirmed infection it is thought that this has the potential to reduce the spread of antibiotic resistant strains of bacteria such as MRSA and to decrease the incidence of the serious secondary infections with *Clostridium difficile*. However, there is no firm evidence to guide doctors as to which is the best treatment strategy. This study compares the progress of patients suspected of having an infection treated with a shortened course of broad spectrum antibiotics (2 days) as compared to the usual 7 days or more. The outcomes of this trial are expected to benefit both the patient and the NHS, as there is a significant cost saving linked to the potential change of practice.

- **Patient Reported Outcome Measures (PROMs)** in bypass surgery and stenting. Patient reported outcomes measure how much better the NHS is making patients as a consequence of the treatment it delivers. Quality of life questionnaires are completed by eligible patients before and six months after their operation. The difference between the quality of life scores is an indication of how much better (or worse) the *patient* feels as a consequence of their treatment. When these differences are added up across many patients, it tells us how well the *service* is performing in terms of achieving relief of symptoms, improving the patients' emotional outlook and restoring their ability to go about their activities of daily living. This hospital is leading the national pilot of this work for the Department of Health. The results will determine if patient reported outcomes become standard across the NHS for all patients receiving bypass surgery and stenting. Moreover, the results will provide a fascinating insight into how effective our bypass surgery and stenting services are in doing what they set out to do.

Those research 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 in 2011/12 on a similar project to offer a community based chronic obstructive pulmonary disease (COPD) service to those residents in Knowsley. The success of cardiovascular disease community service was rewarded by receiving the National Health Services Journal Innovation Award in 2011.

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 Minimal Invasive Valve Surgery. Surgery to the valves in the heart carries a long recovery period, as the patient's chest is usually cut open. The Minimal Invasive approach enters the heart through a small incision along the ribs, reducing the required recovery period from 3 months to 6 weeks. This also results in better outcomes and reduced costs of care, and better patient experience.

Goals Agreed with Commissioners

A proportion of Liverpool Heart and Chest Hospital NHS Foundation Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between Liverpool Heart and 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 and Chest Hospital NHS Foundation Trust in 2011/12 were to:

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

£1,047,421 was conditional upon achieving the above quality improvement and innovation goals. Liverpool Heart and Chest Hospital NHS Foundation Trust achieved most goals with an underachievement of discharge planning and smoking cessation which resulted in a 2.8% penalty on full payment (to be confirmed by commissioning Primary Care Trust).

The CQUIN indicators for Liverpool Heart and Chest Hospital NHS Foundation Trust in 2012/13 are to:

1. Improve responsiveness to the personal needs of patients
2. Venous thromboembolism assessment and treatment
3. NHS Safety thermometer
4. Dementia assessment and referral
5. Improve the outcomes and experience of care in heart attack, heart failure and bypass grafting patients (Advancing Quality)
6. Seven day-urgent transfer for cardiac surgery
7. Seven day-urgent transfer for cardiac intervention
8. Cardiovascular disease and cystic fibrosis data dashboards
9. Communication: timely discharge summaries and letters
10. Medicines management
11. Implement “Energise for Excellence” (includes pressure ulcers, falls, nutrition, care of dying pathway, the dignity of care)

Further details of the agreed goals for 2011/12 and for the following 12 month period are available from: [2011/12 CQUIN schemes in North West - NHS Institute for Innovation and Improvement](#) or upon request from Dr Margarita Pérez-Casal, Head of Clinical Quality (e-mail margarita.perez-casal@lhch.nhs.uk or telephone 0151 600 1467).

What others say about the Provider

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

The Care Quality Commission has not taken enforcement action against Liverpool Heart and Chest Hospital NHS Foundation Trust during 2011/12.

Liverpool Heart and Chest Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period 2011/12.

However, the Trust has participated in an unannounced review by the Care Quality Commission on the 21st February 2012. Five standards were reviewed on this occasion:

- Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
- Outcome 4: People should get safe and appropriate care that meets their needs and support their rights.
- Outcome 7: People should be protected from abuse and staff should respect their human rights.
- Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills.
- Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.

The Care Quality Commission found the Trust to be compliant in all the reviewed standards with no major or minor concerns expressed.

Data quality

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

- Continuation of embedding the Trust's data quality strategy that is aimed at improving the collection, storage, analysis, reporting and validation of information.
- Continuation of the Trust's Data Quality Committee which meets on a monthly basis to identify and discuss potential data quality issues which need to be addressed and actioned accordingly. The Committee tackles issues identified through external (e.g. SUS Data Quality Dashboard and the Care Quality Commissions Quality and Risk Profile) and internal sources (e.g. Critical Information Reporting Reviews or adhoc issues raised by staff).
- Continuation of highlighting key topics each month to identify and resolve by:

- Using „message of the day“ on key systems
- Producing monthly Hot Topics e.g. Ward attenders/referral processes
- Implementation and development of a Trust Data Quality Tool available to key staff across the organisation which identifies errors recorded on Trust systems and assigns principal owners. This ensures clarity over which staff groups are responsible for tackling data quality issues. Data quality errors identified within the tool will be monitored by the Data Quality Committee in the form of a Data Quality Dashboard.
- Further development of a program of education and awareness raising in data quality which comprises:
 - 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.

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.

NHS Number and General Medical Practice Code Validity

Liverpool Heart and Chest Hospital NHS Foundation Trust submitted records during 2011/2012 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 outpatient care
Valid NHS number was:	99.9%	99.7%
Valid General Medical Practice Code was:	100%	99.9%

Note: Liverpool Heart and 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 and Chest Hospital NHS Foundation Trust's Information Governance Toolkit assessment for 2011/12 was submitted with an overall score of 74% "green-satisfactory" achieving level 2 or above for all requirements. The Trust also received independent assurance from the Mersey Internal Audit Agency in March 2012 obtaining a "significant" assurance opinion.

Clinical coding error rate

Liverpool Heart and Chest Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission. It was noted that the Trust continues to maintain its high level of coding accuracy.

The error rates reported in the latest published audit for Cardiology diagnoses and treatment coding (clinical coding) were:

Primary diagnoses incorrect – 1.0%
Secondary diagnoses incorrect – 0.3%
Primary procedures incorrect – 0%
Secondary procedures incorrect – 0%

The error rates reported in the latest published audit for a random sample of diagnoses and treatment coding (clinical coding) were:

Primary diagnoses incorrect – 1.0%
Secondary diagnoses incorrect – 0.5%
Primary procedures incorrect – 1.0%
Secondary procedures incorrect – 1.1%

The Clinical Coding department have the following programme of improvement work in place during 2012:

- Continuation of an internal audit plan to assess coding accuracy
- Closer working with clinicians to gain better understanding between clinical terminology / documentation and clinical coding practices
- Utilisation of information from Dr Foster Intelligence to identify any potential scope for improvements in clinical coding i.e depth of coding
- Enhancement of the use of clinical coding to better describe patient harm/safety events across the Trust.

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 2011/12. 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 and 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.

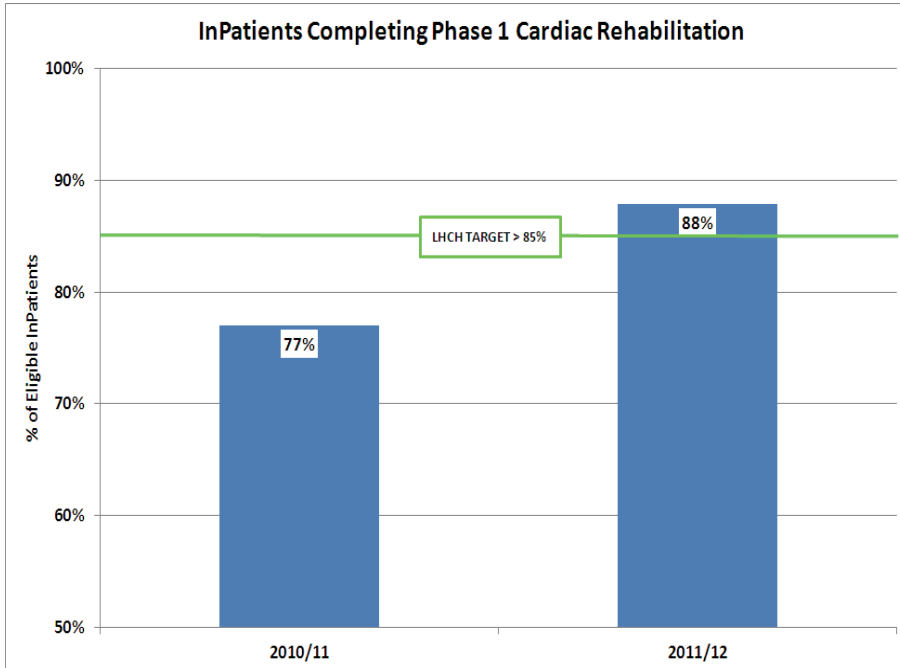
Quantitative Metrics

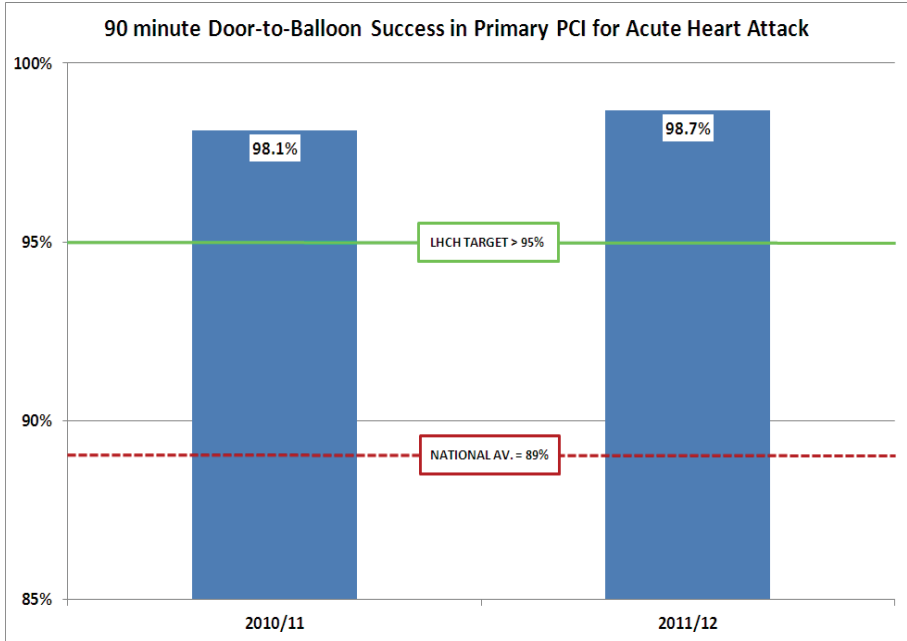
Safety													
Metric	Pressure ulcer incidence	Organisation Wide or Service Specific	Organisation Wide	<div><p>Pressure Ulcer Incidence Rate at End of Year</p><table><caption>Pressure Ulcer Incidence Rate at End of Year</caption><thead><tr><th>Grade</th><th>2010/11</th><th>2011/12</th></tr></thead><tbody><tr><td>Grade 2</td><td>0.97%</td><td>0.60%</td></tr><tr><td>Grade 3 & 4</td><td>0.31%</td><td>0.23%</td></tr></tbody></table></div>	Grade	2010/11	2011/12	Grade 2	0.97%	0.60%	Grade 3 & 4	0.31%	0.23%
Grade	2010/11	2011/12											
Grade 2	0.97%	0.60%											
Grade 3 & 4	0.31%	0.23%											
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 Trust's risk management processes	Improvements planned	1.Continued staff education 2.Developing the role of the tissue viability link nurse 3.Implement a Pressure Ulcer Bundle with a focus on pressure ulcer prevention										
LHCH Performance 2011/12	Grade 2 = 0.60% (< 4 per month) Grade 3+ = 0.23% (1.5 per month)	LHCH Performance 2010/11	Grade 2 = 0.97% (> 6 per month) Grade 3+ = 0.31% (2 per month)										
Interpretation of Results	The number of patients suffering with pressure ulcers has decreased this year. Patients treated as inpatients at the Trust can be reassured that our average number of pressure ulcer incidents per month is lower than last year. The Trust has managed to further improve from last year.												

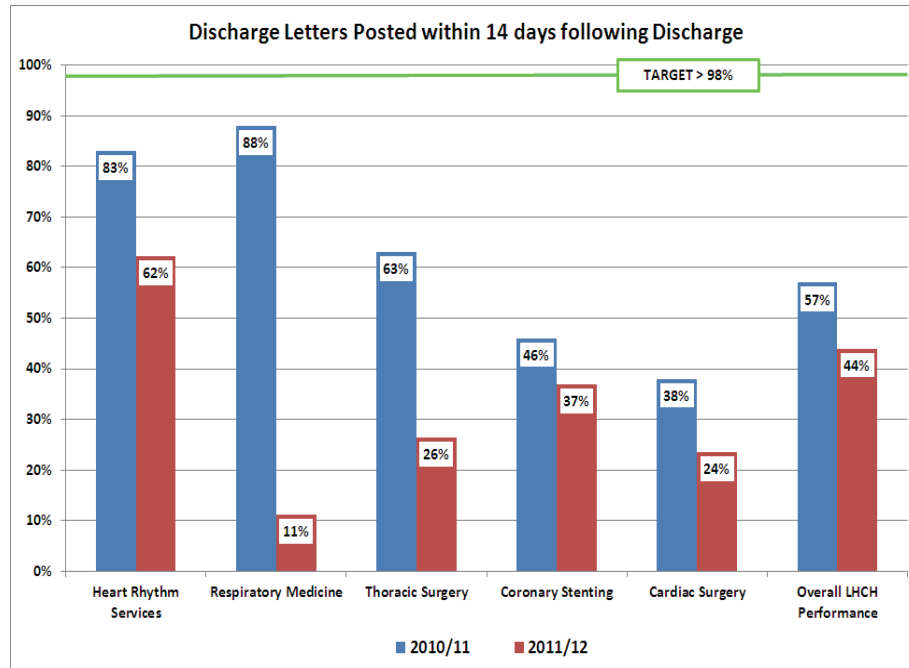
Safety										
Metric	No. patient falls	Organisation Wide or Service Specific	Organisation wide	<div>Falls Incidents in Admitted Patients</div> <table><thead><tr><th>Year</th><th>% All Admitted Patients</th></tr></thead><tbody><tr><td>2010/11</td><td>0.90%</td></tr><tr><td>2011/12</td><td>0.71%</td></tr></tbody></table>	Year	% All Admitted Patients	2010/11	0.90%	2011/12	0.71%
Year	% All Admitted Patients									
2010/11	0.90%									
2011/12	0.71%									
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 Trust's risk management processes	Improvements planned	Embedding of Comfort Checks in wards							
LHCH Performance 2011/12	0.71% (93 falls in 13,163 admissions)	LHCH Performance 2010/11	0.90% (116 falls in 12,847 admissions)							
Interpretation of Results	The number of falls has been reduced this year. This is good for our patients, as they can feel assured that the care provided is of the highest quality. We have improved over the last year, and we plan to continue the good work into 2012/13.									

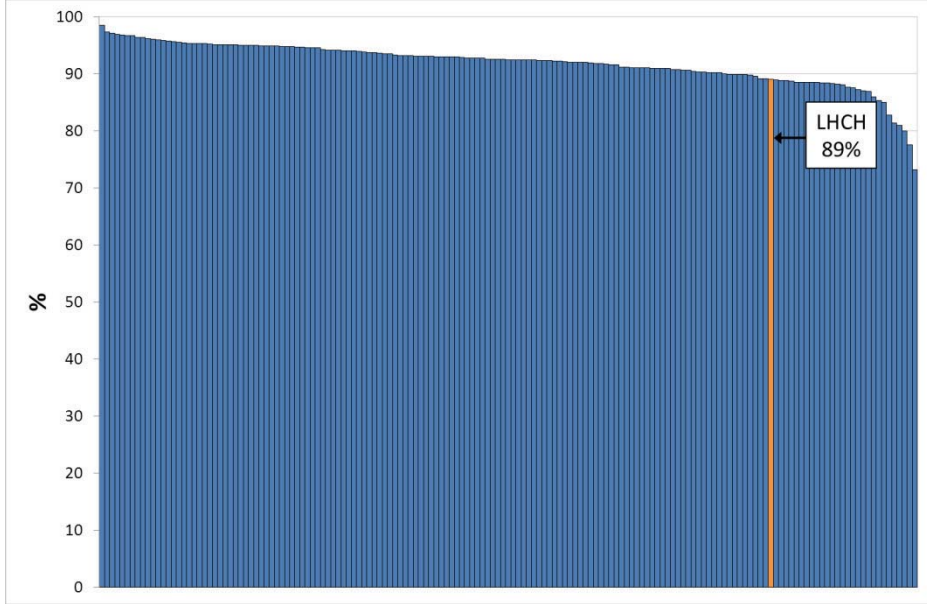
Safety																						
Metric	Number of patients acquiring MRSA bacteraemia whilst in hospital	Organisation Wide or Service Specific	Organisation wide	<div><p>InPatients with LHCH-Acquired MRSA Bacteraemia</p><table><caption>InPatients with LHCH-Acquired MRSA Bacteraemia</caption><thead><tr><th>Financial Year</th><th>Number of Patients</th></tr></thead><tbody><tr><td>2004-05</td><td>9</td></tr><tr><td>2005-06</td><td>5</td></tr><tr><td>2006-07</td><td>8</td></tr><tr><td>2007-08</td><td>7</td></tr><tr><td>2008-09</td><td>0</td></tr><tr><td>2009-10</td><td>1</td></tr><tr><td>2010-11</td><td>2</td></tr><tr><td>2011-12</td><td>4</td></tr></tbody></table></div>	Financial Year	Number of Patients	2004-05	9	2005-06	5	2006-07	8	2007-08	7	2008-09	0	2009-10	1	2010-11	2	2011-12	4
Financial Year	Number of Patients																					
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2009-10	1																					
2010-11	2																					
2011-12	4																					
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	1.Surgical site infection – action plan in place 2.Intravascular lines – Care bundles to be completed and overseen by ward managers 3.MRSA screening – audits performed monthly on number of screens done and timing of screens and decolonisation regimes																			
LHCH Performance 2011/12	4 patients	LHCH Performance 2010/11	2 patients																			
Interpretation of Results	We have seen the number of MRSA bloodstream infections increase to four patients this year. These cases occurred in separate wards and at different times; all of them 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).																					

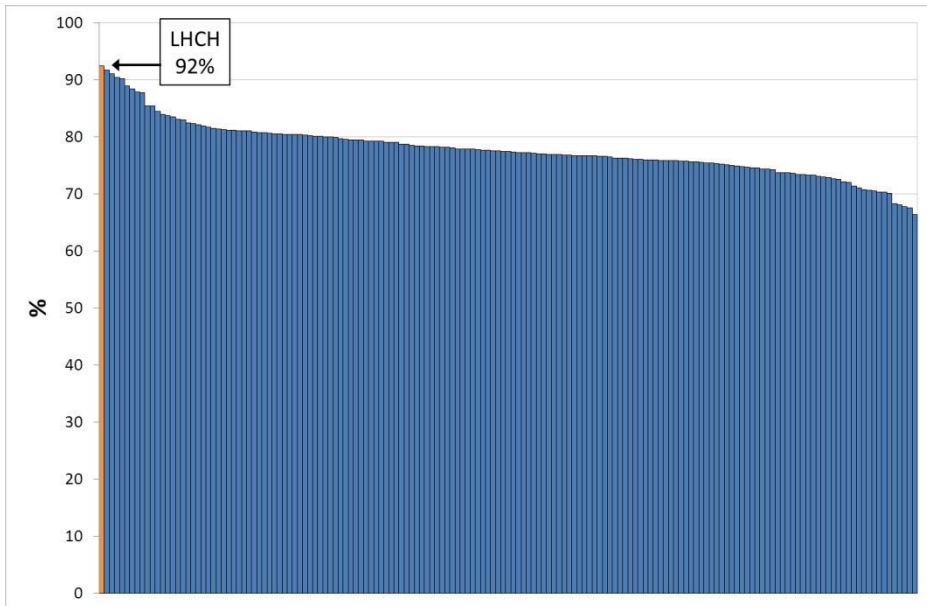
Effectiveness																																																																					
Metric	Percentage of patients receiving smoking cessation advice (brief intervention)	Organisation Wide or Service Specific	Organisation wide	<div><p>Brief Intervention for Current Smokers</p><table border="1"><thead><tr><th>Month</th><th>BI (n)</th><th>Not Done (n)</th><th>BI (%)</th><th>Not Done (%)</th></tr></thead><tbody><tr><td>2011-05</td><td>118</td><td>48</td><td>71</td><td>29</td></tr><tr><td>2011-06</td><td>116</td><td>77</td><td>60</td><td>39</td></tr><tr><td>2011-07</td><td>99</td><td>80</td><td>55</td><td>45</td></tr><tr><td>2011-08</td><td>133</td><td>68</td><td>66</td><td>34</td></tr><tr><td>2011-09</td><td>120</td><td>79</td><td>60</td><td>40</td></tr><tr><td>2011-10</td><td>119</td><td>74</td><td>62</td><td>38</td></tr><tr><td>2011-11</td><td>109</td><td>87</td><td>55</td><td>45</td></tr><tr><td>2011-12</td><td>134</td><td>59</td><td>69</td><td>31</td></tr><tr><td>2012-01</td><td>122</td><td>94</td><td>57</td><td>43</td></tr><tr><td>2012-02</td><td>145</td><td>41</td><td>78</td><td>22</td></tr><tr><td>2012-03</td><td>168</td><td>66</td><td>72</td><td>28</td></tr><tr><td>Grand Total</td><td>1383</td><td>773</td><td>64</td><td>36</td></tr></tbody></table></div>	Month	BI (n)	Not Done (n)	BI (%)	Not Done (%)	2011-05	118	48	71	29	2011-06	116	77	60	39	2011-07	99	80	55	45	2011-08	133	68	66	34	2011-09	120	79	60	40	2011-10	119	74	62	38	2011-11	109	87	55	45	2011-12	134	59	69	31	2012-01	122	94	57	43	2012-02	145	41	78	22	2012-03	168	66	72	28	Grand Total	1383	773	64	36
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Grand Total	1383	773	64	36																																																																	
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. Local CQUIN indicator																																																																		
How is data collected	When staff have identified a current smoker they should deliver advice and record this on the Trust's e-referral system	Improvements planned	Introduction of Health risk assessment as part of normal practice looking at weight, diet, alcohol, etc																																																																		
LHCH Performance 2011/12	64%	LHCH Performance 2010/11	68%																																																																		
Interpretation of Results	We have not met the target set; we will continue to improve work on this indicator next year. We will continue the training for staff in how to take brief interventions forward with our patients and are introducing a health risk assessment which will be taken forward through to our Electronic Patient Records system in due course.																																																																				

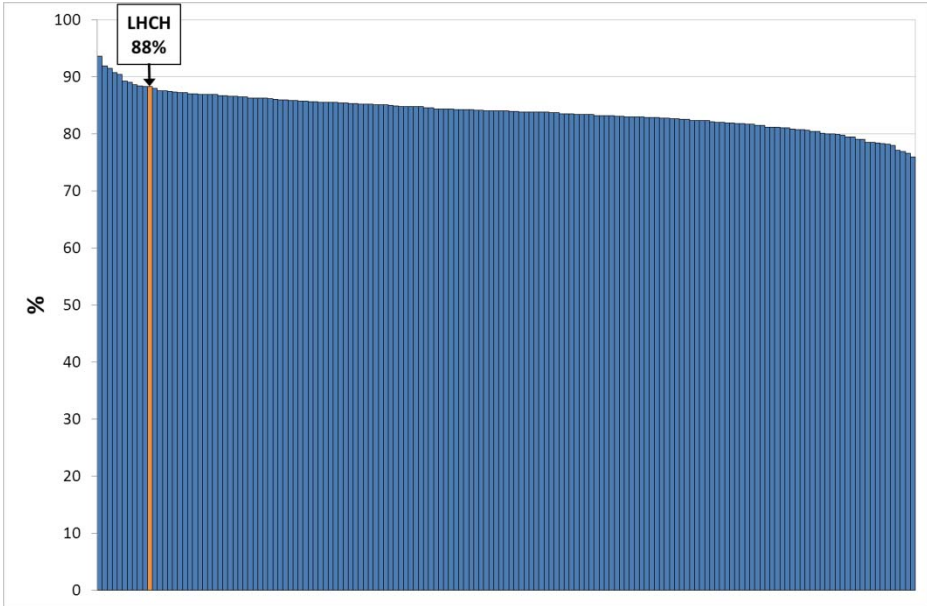
Effectiveness										
Metric	% patients completing phase one Cardiac rehabilitation	Organisation Wide or Service Specific	Organisation wide – phase 1;	<div><p>InPatients Completing Phase 1 Cardiac Rehabilitation</p><table><caption>InPatients Completing Phase 1 Cardiac Rehabilitation</caption><thead><tr><th>Year</th><th>% of Eligible InPatients</th></tr></thead><tbody><tr><td>2010/11</td><td>77%</td></tr><tr><td>2011/12</td><td>88%</td></tr></tbody></table></div>	Year	% of Eligible InPatients	2010/11	77%	2011/12	88%
Year	% of Eligible InPatients									
2010/11	77%									
2011/12	88%									
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	We plan to extend our service to the appropriate aneurysm patients. To maintain the quality of the service and the level of uptake.							
LHCH Performance 2011/12	88%	LHCH Performance 2010/11	77%							
Interpretation of Results	We have achieved the 2011/12 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 further improvements. This will be taken forward over 2012/13.									

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	 <p>90 minute Door-to-Balloon Success in Primary PCI for Acute Heart Attack</p> <table><thead><tr><th>Year</th><th>Success Rate (%)</th></tr></thead><tbody><tr><td>2010/11</td><td>98.1%</td></tr><tr><td>2011/12</td><td>98.7%</td></tr></tbody></table> <p>LHCH TARGET > 95%</p> <p>NATIONAL AV. = 89%</p>	Year	Success Rate (%)	2010/11	98.1%	2011/12	98.7%
Year	Success Rate (%)									
2010/11	98.1%									
2011/12	98.7%									
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 Performance 2011/12	98.7 %	LHCH Performance 2010/11	98.1 %							
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 in 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	 <table><caption>Discharge Letters Posted within 14 days following Discharge</caption><thead><tr><th>Service</th><th>2010/11 (%)</th><th>2011/12 (%)</th></tr></thead><tbody><tr><td>Heart Rhythm Services</td><td>83%</td><td>62%</td></tr><tr><td>Respiratory Medicine</td><td>88%</td><td>11%</td></tr><tr><td>Thoracic Surgery</td><td>63%</td><td>26%</td></tr><tr><td>Coronary Stenting</td><td>46%</td><td>37%</td></tr><tr><td>Cardiac Surgery</td><td>38%</td><td>24%</td></tr><tr><td>Overall LHCH Performance</td><td>57%</td><td>44%</td></tr></tbody></table>	Service	2010/11 (%)	2011/12 (%)	Heart Rhythm Services	83%	62%	Respiratory Medicine	88%	11%	Thoracic Surgery	63%	26%	Coronary Stenting	46%	37%	Cardiac Surgery	38%	24%	Overall LHCH Performance	57%	44%
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Cardiac Surgery	38%	24%																							
Overall LHCH Performance	57%	44%																							
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	Embed electronic dictation for all Doctors Feedback on performance																						
LHCH Performance 2011/12 Q4	44%	LHCH Performance 2010/11 Q4	57%																						
Interpretation of Results	We have not achieved the target set for this indicator. This continues to be an important issue, and further work will be carried out to improve this. Use of electronic dictation will be further embedded.																								

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 inpatient stay. Results are benchmarked with other Trusts in England.	Improvements planned	Capital project in place for the re-development of two ward areas.	
LHCH 2011/12	89.1%	LHCH 2010/11	94.3%	
Interpretation of Results	These results are based on patients" perceptions. Although the results indicate a slight drop, our monthly returns to the Strategic Health Authority continue to show complete compliance with regards to patients not sharing mixed sex sleeping and bathing areas. We are confident that our patients do not share sleeping areas.			

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	Capital project in place for the re-development of two ward areas. Implementing the Patient and Family engagement plan	
LHCH Performance 2011/12	92.4%	LHCH Performance 2010/11	92.1%	
Interpretation of Results	Our inpatients have voted us top in the country for the sixth year running on this overall quality of care question. Our patient experience vision maintains the focus on this overall question, and we hope that we can maintain this position again next year.			

Patient Experience				
Metric	% patients reporting good or excellent overall quality of care– Outpatients	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 outpatient appointment. Results are benchmarked with other Trusts in England.	Improvements planned	1.Invite and encourage patients to take notes during their outpatient appointment 2.Use models and drawings to better explain treatments 3.Staff to use teach-back by asking patients to explain what they have been told	
LHCH Performance 2011/12	88.2%	LHCH Performance 2009/10	88.9%	
Interpretation of Results	The service we provide in our outpatient department is of high quality; our patients have voted us among the top 10% in the country. We have plans to further improve this in 2012/13.			

Patient Experience																									
Metric	Responsiveness to patients needs	Organisation Wide or Service Specific	Organisation wide	<div>Responsiveness to Patients' Needs</div> <div>(Composite Score based on the 5 agreed questions from the National InPatient Survey)</div> <table><caption>Responsiveness to Patients' Needs Data</caption><thead><tr><th>Year</th><th>Composite Indicator (%)</th><th>Target (%)</th></tr></thead><tbody><tr><td>2006</td><td>74.4%</td><td>-</td></tr><tr><td>2007</td><td>76.4%</td><td>76.4%</td></tr><tr><td>2008</td><td>76.4%</td><td>78.0%</td></tr><tr><td>2009</td><td>73.6%</td><td>79.6%</td></tr><tr><td>2010</td><td>77.4%</td><td>81.2%</td></tr><tr><td>2011</td><td>79.5%</td><td>82.8%</td></tr></tbody></table>	Year	Composite Indicator (%)	Target (%)	2006	74.4%	-	2007	76.4%	76.4%	2008	76.4%	78.0%	2009	73.6%	79.6%	2010	77.4%	81.2%	2011	79.5%	82.8%
Year	Composite Indicator (%)	Target (%)																							
2006	74.4%	-																							
2007	76.4%	76.4%																							
2008	76.4%	78.0%																							
2009	73.6%	79.6%																							
2010	77.4%	81.2%																							
2011	79.5%	82.8%																							
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	Embedding Teach back, to make sure patients know exactly what their discharge summary means, and what to expect from their medication																						
LHCH Performance 2011/12	79.5%	LHCH Performance 2010/11	77.4%																						
Interpretation of Results	The Trust continues to meet the 2% improvement target set by our commissioners. Improvements were most obvious again in the way we prepare the patients for discharge with respect to their medication. Teach back was introduced last year with excellent feedback from our patients; it will be further embedded this year.																								

Qualitative Findings

The themes below have been derived from feedback received from patients and families who have participated in engagement events across the Trust. These events used an evidence-based tool which asked the participants to choose those words that best reflected their experience at each stage of their patient journey. Overall, feedback indicates that patients and families continue to use very positive words to describe the care they received as highlighted below. The size of the word corresponds to the how often patients mentioned it.



Aspects of our service that require improvement

However, there are certain areas in which our patients and families have told us that they would like to see further improvements; words that have come up at the focus group were:



These are the improvements planned to address the above issues:

- Improving waiting times and delays in Outpatients
- Taking into consideration comorbidities when planning care
- Providing appropriate information to patients and families on discharge
- Improving directions to and within the Trust. Patients have said that the signage on its own does not facilitate their visit to Liverpool Heart and Chest Hospital.
- Improving patient and family support post discharge

Themes in Common with our Priorities Arising from Complaints

In 2011/12 the Trust received a total of 58 complaints, this is a 32% decrease compared to 2010/11. 15 complaints required corrective action and action plans were implemented.

Of these, 8 were associated with the priorities set for improvement this year. These were:

- Diabetes management (1)
- Patient experience (7)

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 2011/12	2011/12	Target 2010/11	2010/11
Clostridium Difficile – meeting the Clostridium Difficile objective	<=7	8	<=18	5
MRSA – meeting the MRSA objective	<=6	4	<=6	2
Maximum waiting time of 31 days for subsequent treatments for all cancers	>=94%	100%	>=94%	95.4%
Maximum waiting time of 62 days for first treatment for all cancers	>=79%	85.7%	>=85%	85.6%
Referral to treatment times – admitted (95 th percentile)	<23 weeks	19.5 weeks	<23 weeks	19 weeks
Referral to treatment times – non-admitted (95 th percentile)	<18.3 weeks	16.0 weeks	<18.3 weeks	17.1 weeks
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	>=96%	99.3%	>=96%	96.6%
Maximum waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspected cancer referrals	>=93%	99.4%	>=93%	98.8%
Screening all elective inpatients for MRSA	>=100%	108.1%	>=100%	147.8%

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

Statement from the Commissioning Primary Care Trust

As Director for Service Improvement and Executive Nurse for NHS Merseyside I believe that the account represents a fair and balanced view of the 2011/12 progress that Liverpool Heart and Chest NHS Foundation Trust has made against the identified quality standards. The Trust has complied with its contractual obligations and has made good progress over the last year with evidence of improvements in key quality & safety measures.

In line with the NHS (Quality Accounts) Regulations 2011, NHS Merseyside can confirm that we have reviewed the information contained within the account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. We have reviewed the content of the account and can confirm that this complies with the prescribed information, form and content as set out by the Department of Health.

Liverpool Heart and 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. NHS Merseyside has an excellent relationship with the Trust and recognises their commitment to working closely with Clinical Commissioning Group to ensure the ongoing delivery of high quality services.

Overall NHS Merseyside welcomes the vision described within the Quality Accounts, agrees on the priority areas and will continue to work with Trust to improve the quality of services provided to patients. NHS Merseyside is supportive of the process Liverpool Heart and Chest NHS Foundation Trust has taken to engage with patients, staff and stakeholders in developing a set of quality priorities and measures for 2011/12 and applaud their continued commitment to improvement.



Trish Bennett
Director of Service Improvement & Executive Nurse
NHS Merseyside

Liverpool Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group welcomes the opportunity to receive and comment on Liverpool Heart and Chest NHS Foundation Trust Quality Accounts for 2011/12.

In preparation for the formal establishment of the CCG in April 2013, NHS Liverpool have led the contractual arrangements over the past year and this account is consistent with reports received and development of priorities for 2012/13.

It is clear to the CCG that Liverpool Heart and Chest NHS Foundation Trust has a clear commitment to quality improvement and engagement with patients and staff. Clear progress has been made through the year.

We have established excellent working arrangements between the CCG and the Trust and look forward to developing our relationship further over the coming years as we collaboratively seek to improve health outcomes for the population of Liverpool.

Signed

Dr. Nadim Fazlani,
Chair Liverpool Central Locality,
NHS Liverpool Clinical Commissioning Group

Dr. Simon Bowers,
Chair Liverpool Matchworks Locality,
NHS Liverpool Clinical Commissioning Group

Ray Guy,
Chair, Liverpool North Locality,
NHS Liverpool Clinical Commissioning Group

Liverpool LINK - Liverpool Heart & Chest Hospital NHS Foundation Trust - Quality Account Commentary 2011/12

Liverpool LINK once again welcomes the opportunity to comment on Liverpool Heart & Chest Hospital NHS Foundation Trust's Quality Account.

We would like to congratulate the Trust on its achievements during 2011/12 and are particularly pleased to note that the Trust has been rated top performing Trust in the country for the past six years for the quality of overall patient care.

The Quality Account document is reasonably easy to read and understand, however some of the graphs could benefit from a little more explanatory text to make them more accessible to the public who are not all used to reading graphs. This would also help to compensate for the fact that some of the text on some of the graphs is rather small and hard to read. During our engagement with the Trust regarding this Quality Account, Liverpool LINK asked that the public be explicitly referred to as well as patients in terms of engagement. This suggestion was welcomed by Officers from the Trust and should be reflected in the completed document.

We are pleased to note that the Trust has met 5 of the priorities that it chose last year. Our attention was also drawn to Priority 5: Improving the experience of care for patients. It is clear that the Trust achieved very high levels of performance for each and every indicator but were 2% under target for patients agreeing staff really know what they are doing. The fact that this feedback has influenced the choice of priorities for next year's quality account is commendable as it demonstrates the use of the patient feedback data in informing future plans (see Part 2, Priorities for 2012/13; Priority Three: Upskill our staff to deliver excellent clinical care). We are also reassured that remedial action for the 6th priority "Reducing Rates of readmission" will take place, and we look forward to the Trust making more progress regarding the 6th priority in the coming year.

Liverpool LINK is also pleased to note that only one of this year's priorities is also supported by a Commissioning for Quality and Innovation (CQUIN) target. As CQUINs are already incentivised by commissioners, therefore Liverpool LINK views non-CQUIN Quality Account Priorities as adding yet further value to the Trust's activities.

Liverpool LINK has two members designated to engage with Liverpool Heart & Chest Hospital NHS Foundation Trust on an ongoing basis. These LINK members have engaged closely with the Trust to inform this commentary and they will be interested to monitor progress against the quality priorities chosen for 2012/13.

We also hope to continue to be involved in patient and public engagement and consultation activities, particularly around quality priorities.

Dr. Eric Toke and John Roberts, Liverpool LINK

Footnote: As a consequence of this feedback the Trust has modified its quality accounts by including:

- More detailed explanation on the mortality graphs and details of actual figures
- Reference to the public as one of the target audiences for the patient experience engagement plan

Statement from the Host Overview & Scrutiny Committee

The Adult Social Care and Health Select Committee noted the quality accounts without specific comments. This will be recorded in the minutes of the Select Committee when it meets on 12th June.

Peter Seddon, Legal Services, Liverpool City Council

Statement from the Trust's Council of Governors Quality Account Task and Finish Group

The Quality Account Task and Finish Group have continued to meet throughout the year with our members and the public. We have reviewed the Quality Accounts 2011/12 for the Trust and are confident they are an accurate representation of the Trust performance in 2011/12.

We had a very well attended public meeting to discuss the work of the hospital which included clinicians, stakeholders, staff, patients and their families, together with members of the public from North Wales and the Isle of Man.

It was also from this meeting that the programme of work was chosen for consideration for the coming year. I am sure the whole organisation will respond to the challenges presented to them by the cuts and demands of Government and the patients, in the future. As a group, we are confident that the targets and aspirations will be achieved in the coming months.

Ken Blasbery, Chair.

Enabling Quality Management Systems

The delivery of high quality care depends as much on the workforce, leadership and information management and technology as it does upon the systems and processes that lead to the delivery of direct patient 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 a capable and competent workforce, maximising the potential of all staff to deliver excellent, compassionate and safe patient care every day. Our values and behaviours are an integral part of our mission and play an important part in the recruitment of new staff and our appraisal and personal development processes.

Staff Engagement

Research demonstrated that staff engagement has an influence on patient outcomes and the delivery of high quality care. For us, this means our staff "going the extra mile" for our patients. During 2011 we developed our Staff Experience Vision to describe what staff can expect from the trust and what is expected from them. The vision has 5 pillars which are

- Reputation and Pride
- Commitment and Attitude
- Support and Wellbeing
- Training and Learning
- Achievement and Recognition

Staff understanding the contribution they make is an important part of staff engagement. To support this we have revised our Appraisal and Personal Development Review process to encompass both the patient and staff experience visions. In addition to managers formally reviewing individual performance, our process encourages staff to think for themselves how they can best use their skills to support delivery of the Trust's objectives. Together staff and their managers work together to agree a personal development plan to support our ethos of continuous improvement.

The national NHS Staff Survey provides good evidence of our continuous improvements over recent years. As well as improving our responses year on year, our staff engagement scores have moved from below average to above average when compared to other specialist Trusts.

Year	2007	2008	2009	2010	2011
Response Rate	38%	63%	64%	63%	62%
% of staff having an appraisal	49%	56%	79%	84%	87%

% of staff agreeing appraisal helped them to do job better	46%	57%	61%	63%	69%
% of staff agreeing they feel satisfied with quality of work and patient care they are able to deliver	72%	84%	85%	83%	85%
% of staff who would be happy for a friend or relative to be treated at LHCH	Not asked	Not asked	89%	88%	91%
Staff agreeing they are satisfied with their job (maximum score = 5)	3.33	3.54	3.55	3.56	3.55
% of staff who would recommend LHCH as a place to work	Not asked	51%	64%	59%	62%
Overall Staff Engagement Score (out of 5)	Not asked	Not asked	3.78	3.80	3.85

	2010/11		2011/12		
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	Trust Improvement/Deterioration
KF8. Percentage of staff working extra hours (lower score is better)	59%	65%	57%	67%	Improved 2%
KF14. Percentage of staff appraised with personal development plans in last 12 months	79%	68%	79%	70%	No change
KF18. Percentage of staff suffering work-related stress in last 12 months (lower score is better)	25%	26%	21%	27%	Improved 4%
KF28. Impact of	1.53	1.57	1.47	1.55	Improved 0.06

	2010/11		2011/12		
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	Trust Improvement/Deterioration
health and well-being on ability to perform work or daily activities (lower score is better)					

	2010/11		2011/12		Trust Improvement/Deterioration
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
KF21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	96%	93%	96%	Deteriorated 2%
KF23. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (lower score is better)	5%	3%	7%	3%	Deteriorated 2%
KF29. Percentage of staff feeling pressure in last 3 months to attend work when feeling Unwell (lower score is better)	29%	23%	28 %	22%	Improved 1%
KF9. Percentage of staff using flexible working options	51%	65%	60%	65%	Improved 9%

The published results of the survey are based only on a sample of the workforce. However, the Trust undertakes a survey of all staff to give everybody an opportunity to comment on issues which affect them at work. As a result of this approach, every ward and department receives their own results from which they can identify key actions for improvement.

A key element of staff engagement is empowerment or staff's ability to become involved and influence improvements in service delivery. The Trust has built on the success of the service improvement work started during 2010. Whilst each formal service improvement programme has a designated executive sponsor and project manager, it is the work undertaken by the multidisciplinary team using Plan, Do, Study, Act improvement methodology that has led to the success of a number of service improvements.

- The Readmissions project for 2011/12 had over 78 members of staff within the project teams from all disciplines across the Trust. Engagement was very high from all staff involved.
- The transparency pilot has involved all ward areas, tissue viability, Public Relations and Communications. This involved working alongside 8 other Trusts. We are now also mentoring some of the new Trusts who are about to embark upon the project.
- We have further trained 40 members of senior staff in improvement methodology and project planning across the Trust. Each of them has now undertaken their own project with support from the Service Improvement Team.

In addition to formal service improvement projects, staff have been empowered to make small scale changes to improve patient and family experience which we call "majoring on the minor". This includes the introduction of morning visiting on Oak Ward, improvements to the waiting area environment in theatres and our volunteers escorting patients to and from the outpatient departments. Small changes that make a big difference to our patient experience.

The Trust has a series of formal mechanisms for consultation with staff and accredited trade union representatives. These include Partnership Forum, Local Negotiation Committee, Policy Review Group and Health and Wellbeing Group (formerly the Staff Forum). Elected staff representatives also form part of the Trust's Council of Governors.

Staff Health and Wellbeing

In July 2011 the Trust conducted an internal staff survey which included some questions from the national staff survey as well as specific questions related to health and wellbeing. In September 2011 the Trust implemented a Health and Wellbeing Strategy. Our aim is to support staff to improve physical and emotional wellbeing. A range of initiatives were developed in response to feedback received from the survey and executive roadshows. This includes a staff physiotherapy service, a running club, weight management support and an Employee Assistance Programme. The Trust continues to provide smoking cessation services for staff together with health assessments and flu vaccinations.

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

Staff Survey Questions	2008	2009	2010	2011
Overall health (over the last four weeks) was excellent, very good or good	question not asked	76%	79%	82%
In general my job is good for my health	question not asked	44%	43%	49%
My immediate manager takes a positive interest in my health and well being	question not asked	49%	50%	53%

The Trust has been recognised by the World Health Organisation as a Health Promoting Hospital. We will work closely with managers and staff to improve staff wellbeing and reduce sickness absence rates to achieve our target of 3.6% for 2012/13.

Planning and Developing the Workforce

Each year the Directorate Management teams work with senior members of the Finance and Human Resources teams to develop workforce plans to deliver existing services and reflect any known or planned changes. Examples of this are the planned changes to service delivery for upper gastrointestinal and thoracic surgery patients and the development of our Knowsley community Chronic Obstructive Pulmonary Disease services. These plans are used to inform each Directorate's Annual Plan and overall Trust plans to ensure that we have the right workforce with the right skills at the right time. There is an increasing requirement for staff to work more flexibly both in terms of duties undertaken and working hours.

Workforce planning is not an annual event but an ongoing and continuous consideration for the Trust. An example of this is the review of our nursing workforce using a combination of the Association of United Kingdom University Hospitals (AUKUH) and the Professional Judgement models. The review involves three separate assessments undertaken over a 12 month period before final conclusions are drawn. Two assessments were completed during 2011/12 both of which demonstrated adequate staffing levels at that time. A final report will be presented to the Workforce Committee in October 2012.

The Trust uses every opportunity it can to identify talented staff and offer opportunities to develop skills to extend existing roles or transfer across professions. We are particularly proud of our success in developing staff in Bands 1-4 through our

use of apprentice programmes. Three out of five case studies used by NHS Northwest to launch the apprentice promise are staff from this Trust.

The Trust has a Learning Needs Analysis which outlines the mandatory training requirements for all staff. This is based on National Health Service Litigation Authority standards to minimise risk to patients and staff in addition to trust identified training requirements. Mandatory training compliance is reported to managers by the Learning and Development team. The Trust has streamlined mandatory training to ensure that staff receive appropriate and relevant training in a timely fashion to reduce the impact of staff away from the workplace. Where appropriate the Trust has made greater use of e-learning to assess staff competence.

There are specific training requirements for doctors in training. The Trust has experienced some difficulties recruiting junior medical staff and as a consequence has strengthened its approach to training junior doctors and medical students. This has resulted in a more focussed approach and has further developed the Trust's reputation as a training centre.

During 2011 the Trust commenced work to develop a competency framework which will ensure that our staff have the skills and competencies to deliver the specialised care that our patients need. This links to one of the priorities chosen for 2012/13, the up-skilling of our staff.

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

Turnover is comfortably within our target of 10%. Mandatory training and appraisal are slightly below our target of 85%. Disappointingly sickness absence deteriorated further against our challenging target of 3.6%.

Metric	2008/9	2009/10	2010/11	2011/12
Sickness Absence %	5.6%	3.9%	4.2%	4.5%
Turnover %	11.4%	9.6%	6.7%	7.4%
Mandatory Training %	85%	82%	83%	84%
Appraisal Coverage %	85%	62%	82%	79%
Temporary Staff Spend	£1,445,323	£1,359,012	£1,317,657	£1,869,892

Leadership

Leadership is a key component of a successful organisation. The Trust has recognised this and during 2011 has further developed the Excellence in Management and Leadership programme. Over 100 staff have participated; early

evaluation has demonstrated the impact that the programme has had on individual delegates and their teams. The Patient Experience Vision, Values and Behaviours and more recently the Staff Experience Vision have been incorporated into the programme to emphasise their importance and the role that our leaders play in embedding these principles across the Trust. Importantly the programme is not a "one size fits all" and delegates identify their development needs based on a bespoke 360 degree appraisal designed for the Trust. The programme was adapted early in 2011 for delivery to senior medical staff and was extremely well received.

The Trust Senior Management Team was formed during the latter part of 2010. The team consists of General Managers and Deputy Directors/Heads of Service from nursing and corporate teams. During 2011 the team received external coaching support from a leading management consultant to support their personal and professional development in delivering Trust operational services.

Membership and Volunteers

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 Trust's 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 and 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.

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 review for 2011/12 took place in February 2012, and we are still waiting for the results of the inspection.

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

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 patient’s 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 and verification processes in place to ensure the data from the systems that is used to supporting decision making is accurate and reliable. In 2011/12, the Trust continued 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. Continuing to use a data quality grading system that evaluates the quality of the data upon which important decisions about the Trust’s business are made

3. Continuing to evaluate internal data quality issues through a 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.
4. Establishing an internal Critical Reporting Systems Review process which assesses the accuracy and validity of key reporting across the Trust, such as 18-weeks and cancer waiting times data.

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 Trust's Board of Directors, 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 are much more useful.
- Subscribes to Dr Foster, a commercial benchmarking solution which allows Trusts to identify others that are similar. This improves the meaning and utility of benchmarks compared.

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 2012/13 through the Trust and beyond through:

- Clinical Standardisation – to date, cost improvement plans have been achieved largely by our ability to negotiate cheaper prices for the goods that we use. We are reaching the limits of how successful this strategy can be in the future as profit margins for companies are now exceptionally small. Through 2012/13 and beyond, we will begin a programme of transformation in the delivery of clinical care that will call for much more standardisation in how things are done. That is, clinical teams using the same treatment plans and as such resources, to treat patients receiving the same procedure. This will not signal a reduction in the quality of care, rather quality of care should improve as treatment plans will be based on the best available evidence of what works. We anticipate costs will fall from stripping out from the treatment plans things that add little value to the care of the patient.
- The Electronic Patient Record – fundamental to the delivery of standardised treatment plans is the Electronic Patient Record. Over the next two years, the Trust will implement the computerisation of the totality of information systems that

record treatment data about patients. This offers up the opportunity to use the power of computers to:

1. Remind clinicians of the need to perform care tasks for patients so nothing ever gets forgotten such as reminders about the delivery of key information to the patient in preparing for discharge
2. Check that all treatments are compatible with one another, and do not put the patient at risk of harm, such as adverse drug reactions which might occur if two incompatible drugs are prescribed together.
3. Allow access of the patient to their own health record, so that they can become part of the decision making surrounding their care, and check that the details we hold about them are correct.

The Electronic Patient Record offers a step change opportunity to improve the quality and safety of patient care in our hospital.

- Integrated Care – we have developed a proven model for the integration of care for patients receiving cardiovascular and chronic obstructive pulmonary treatments for the residents of Knowsley. We are keen to have this model adopted by other neighbouring Primary Care Trusts who reside within our catchment. We will be taking forward opportunities with those Primary Care Trusts who have expressed interest in being partners in this type of care model during 2012/13.
- Research – Our research activity is growing rapidly. This is affording the opportunity for more and more patients to be enrolled in our research trials of the future. It is a well-established fact that patients who participate in trials enjoy two primary benefits:
 1. A number of the patients (typically half) will receive the new research agent being tested, be that a new drug, new device, or new model of care. These patients have the potential to benefit directly from the better results the new agent may bring
 2. All patients who participate in research tend to receive better care as the research plans staff work to in delivering the care demand very close scrutiny and a high attention to detail. As such, the care is more standardised and systematic leading to better overall care.

Taken together, these four new initiatives as well as the successes reported in last year's 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 and Chest Hospital NHS Foundation Trust can play its part as a key member of the local health economy. Work done in 2011/12 in the reduction of delayed discharges with our colleagues in community care is an excellent example of this work in action.

Acknowledgements

The Board of Directors of the Liverpool Heart and 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 and Chest Hospital NHS Foundation Trust
- Liverpool Primary Care Trust Quality staff
 - Leigh Thompson-Greatrex - Head of Clinical Quality Improvement, Liverpool Primary Care Trust
 - Trish Bennett - Director of Service Improvement and Executive Nurse, Liverpool Primary Care Trust
 - Peter Groggins, NHS Merseyside
- The Council of Members Quality, Safety and Patient Experience Subgroup:
 - Ken Blasbery
 - Michael Dibben
 - Pat Firby (Non-Executive Director)
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 - John Roberts
 - Tony Roberts
 - Roy Stott
 - Ron Thompson
 - Judy Wright
 - Menna Wyn-Harland
- Attendees at the Quality Account priorities focus group (drawn from the Trust's membership):
 - Dawn Clarke , NIB Northwest
 - Charles Cuckson, Patient
 - Roy Griffiths, Council of Governors, North Wales
 - Claire James, Northwest Specialist Commissioning Team
 - Helen Lockett , Liverpool Community Health
 - Joan Mansel-Edwards, Patient
 - Robert Mansel-Edwards, Patient
 - Arthur Newby, Volunteer, member of SURE group
 - Wendy O Connor , Cheshire & Merseyside Clinical Networks
 - Paula Pattullo, Council of Governors, Merseyside
 - Frieda Rimmer, Heart Support Wirral
 - Stephen Roberts, Patient
 - Tony Roberts, Council of Governors, Rest of England and Wales
 - Ann Thornber, Council of Governors
 - Sandra Vaughan, Patient

- Dr David Webster, General Physician, South Liverpool Clinical Commissioning Group
- Julie Williams, University of Chester
- Keith Wilson, Patient and Chairman SURE group
- 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
 - Claire Stevens, Network Development Officer, Liverpool LiNK
- Host Overview and Scrutiny Committee:
 - Peter Seddon, Legal Services, Liverpool City Council
- 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 and 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 Margarita Perez-Casal, Head of Clinical Quality,
 (E-mail margarita.perez-casal@lhch.nhs.uk or telephone 0151 600 1647).

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 knowledgeable 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.”

6. Staff

As at 31st March 2012, the Trust employed 1417 staff totalling 1290.41 whole time equivalent.

Our staff continue to deliver outstanding levels of patient care during a challenging time for the NHS. We have progressed our Patient and Family Experience Vision with all wards and departments considering how best they can improve services for our patients and families. Being rated top for overall patient care in the national inpatient survey for the 5th year running is testament to the dedication and commitment of our staff.

Our vision for staff

During 2011, we continued the ethos of continuous improvement. Managers and staff have worked together to make small changes which we call "majoring on the minor" to enable us to achieve our mission to provide **Excellent, Compassionate and Safe care for every patient every day.**

During Spring and Summer 2011, over 400 staff were consulted in the development of our Staff Experience Vision. This is a vision which describes what staff can expect from the Trust in return for high performance and is underpinned by our values and behaviours.

The five pillars of our **Staff Experience Vision**

Liverpool Heart and Chest Hospital **NHS**
NHS Foundation Trust

Why work anywhere else?

- Reputation & pride**
I am proud to work for LHCH
- Commitment & attitude**
I know what is expected of me and what I can expect in return
- Support & wellbeing**
I am supported in my working life
- Training & learning**
I am equipped with the skills to do a great job
- Achievement & recognition**
I have a rewarding and fulfilling role

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

The patient and family experience vision, values and behaviours and staff experience vision have all been incorporated into our appraisal system to ensure that they are at the heart of all that we do. Our recruitment and appraisal processes are now linked in with our values and behaviours.

As part of our staff experience vision we developed our Health and Wellbeing Strategy. We have offered staff a range of healthy lifestyle initiatives such as yoga,

weight management classes and a running club as well as providing an Employee Assistance Programme for help and advice on a range of issues including counselling and financial management. We have also implemented a car lease scheme, home computing scheme and continue to offer a cycle to work scheme.

A number of staff completed the Liverpool Marathon in October and inspired by last year's success a team of over 70 staff, friends and family members entered the Liverpool Half Marathon.

We also recognised national days of celebration such as Nurses Day and Adult Learners Week.

Recognising our talented staff

The second "Our Team's got Talent" Team of the Year Awards were held in July 2011. Once again the event was a great success and recognised the truly fantastic work of all of our teams. From many nominations there were 5 awards. These were:

- The Outstanding Innovation in Practice Award won by Knowsley CVD Project
- The Outstanding Example of the Patient Vision in Action Award won by the Theatre Team
- The Going Above and Beyond Award won by the Clinical Audit Team
- The Outstanding Teamwork to Improve Patient Care Award won by the Cardiac Physiology Team
- The Chairman's award won by the Porters.

In January 2012, we relaunched and renamed our employee of the month scheme to the Purple Stars Award extending the nomination process to patients, families and carers.

Learning and Development

In May 2011 during Learning at Work Week, we celebrated the success of our apprenticeship programme with over 40 staff receiving awards for their achievements. A number of staff have used their learning to support career progression whilst others have grown more confident in their existing roles.

The Excellence in Management and Leadership programme is now well established with over 100 managers enrolled in the programme. As well as supporting individual development, the programme has generated a number of service improvement projects which have supported delivery of the Patient Experience Vision.

A revised appraisal process was piloted before full roll-out across the Trust in September 2011. This has enabled staff to better understand their contribution and consider their development needs as we strive for continuous improvement.

Staff Satisfaction

As in previous years we participated in the National Staff Survey. Again we achieved a 63% response rate which was higher than the national average.

	2010		2011		Trust improvement / deterioration
Response rate	Trust	National average	Trust	National average	
	63%	55%	62%	54%	-1%

The top and bottom four ranking scores for the 2011 survey are shown below:

	2010		2011		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	79%	68%	79%	70%	No change – top score when compared with other specialist trusts
KF 8: % of staff working extra hours**	59%	60%	57%	67%	2% improvement
KF 18: % of staff suffering work related stress in last 12 months**	25%	26%	21%	27%	4 % improvement
KF28 Impact of health and well being on ability to perform work or daily activities**	1.53	1.57	1.47	1.55	No change

** the lower the score the better

	2010		2011		Trust improvement / deterioration
Bottom four ranking scores	Trust	National average	Trust	National average	
KF 9: % of staff using flexible working options	52%	65%	60%	65%	8% improvement
KF 21: % of staff reporting errors, near misses or incidents witnessed in last month	92%	96%	93%	96%	1% improvement
KF 23: % of staff experiencing physical violence from patients, relatives or public in last 12 months**	5%	3%	7%	3%	2% deterioration
KF29: % of staff feeling	28%	23%	28%	22%	No change

pressure in last 3 months to attend work when feeling unwell**					
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** the lower the score the better

Staff satisfaction and motivation at work are rated as above average (compared to average in 2010). The areas of most improvement are support received from immediate managers and staff accessing flexible working options.

During 2012/13 the trust will focus on continuing to work to improve staff engagement and support staff health and well being initiatives.

Through our Partnership and Staff Forums the Trust has worked with trade unions, professional bodies and staff to develop policies and practices to manage and support staff in the workplace. On a more informal basis the Board of Directors has regularly visited wards and departments to talk to staff and patients about their experiences and listen to ideas to improve services for patients and support staff at work. In addition, staff have been involved in patient experience events and there have been a number of roadshow events aimed specifically at staff.

Trust managers receive routine updates on the financial position through team brief and local directorate meetings. The Operational Cost Improvement Group meets on a monthly basis to identify opportunities for improving efficiency. In addition the Staff Suggestion Scheme provides staff with the opportunity to generate ideas that will either improve services, generate income or save money.

Workforce Key Performance Indicators

Sickness absence performance has deteriorated in 2011/12 and is above the target of 3.6%. We will continue to work with staff to develop health and wellbeing initiatives and support our managers to engage more effectively with their staff as teams and individuals.

Appraisal and mandatory training performance is slightly below target at the end of the year but we anticipate that this target will be achieved and sustained during 2012/13.

Turnover is well within target. Whilst this reflects a general reduction across the health economy, we have also seen improvements in the national staff survey for staff engagement and the number of staff who would recommend the Trust as an employer.

No. of Staff	Sickness Absence 2011/12	Appraisal Coverage	Mandatory Training	Turnover
	4.45%	79%	83%	7.4%
Target	3.6%	85%	85%	10%

Equality, Diversity and Human Rights

During 2011 the Trust updated its Single Equality Scheme and Action Plan to reflect changes to legislation through The Equality Act 2010 and to build on good practice. The revised scheme was widely consulted on with staff, patients, members and local community groups. We also have a Non-Executive Director champion for equality, diversity and human rights. Our commitment is to ensure that no individual or group is disadvantaged or discriminated against. This commitment applies equally to staff as it does to patients, families, carers and other stakeholders.

The Trust has undertaken significant work around the Care Quality Commission's (CQC) Essential Standards of Quality and Safety (ESQS), assessing the processes and outcomes of the care delivered to patients. Elements include safety, quality, efficiency and experience. Our work has focused on translating the standards into user friendly audits which integrate the equality, diversity and human rights considerations of each of the outcomes. This in turn has helped our staff to embed EDHR principles and considerations in day to day activities.

We have received positive feedback on our Equality Delivery System submission which was described by LINKs as “ *a strong submission with clear plans to progress forward*”.

Our employment policies provide provision to support staff who develop a disability to remain in employment. This includes offering a phased return from long term absence, rehabilitation support and making reasonable adjustments including reduction of hours or change to working arrangements. Redeployment is also considered in the event of any employee being unable to continue in their current role.

During 2011 our Occupational Health Service (provided by Aintree Hospital) supported the Trust to develop a range of health and wellbeing initiatives including on-site staff physiotherapy services and an Employee Assistance Programme. The number of staff receiving the flu vaccination increased from 51% in 2010 to 64% in 2011 which was in the top 25% of trusts nationally.

Demographic Workforce Profile

	2010/11	%	2011/12	%
Age Band				
16 - 20	12	0.87	8	0.56
21 - 25	102	7.40	116	8.19
26 - 30	142	10.30	151	10.66
31 - 35	196	14.21	189	13.35
36 - 40	204	14.79	190	13.42
41 - 45	216	15.66	221	15.61
46 - 50	220	15.95	231	16.24
51 - 55	153	11.09	179	12.64
56 - 60	77	5.58	79	5.58
61 - 65	45	3.26	43	3.04
66 - 70	10	0.73	10	0.71

71 & above	2	0.15	0	0.00
Ethnicity				
White	1210	87.74	1247	88.10
Mixed	14	1.02	12	0.85
Asian or Asian British	118	8.56	116	8.19
Black or Black British	13	0.94	17	1.20
Other	24	1.74	16	1.13
Not Stated	0	0	9	0.56
Gender				
Male	357	25.89	365	25.78
Female	1022	74.11	1052	74.22
Transgender	0	0.00	0	0.00
Recorded Disability	38	2.76	43	3.03
Sexual Orientation				
Bisexual			5	0.34
Gay			5	0.34
Heterosexual			836	57.22
Lesbian			3	0.20
Not stated			568	28.80
Religion or Belief				
Athiesm			69	4.87
Buddhism			3	0.21
Christianity			704	49.72
Hinduism			13	0.92
Islam			10	0.71
Jainism			1	0.07
Judaism			2	0.14
Other			44	3.11
Sikhism			1	0.07
Not stated			570	40.18
Total	1,379		1417	

Corporate Social Responsibility

During 2011 the Trust continued to work with local secondary schools on health promotion, careers advice and applied science in healthcare.

The first Introduction to Medicine programme was implemented for prospective medical students. The programme provides a fantastic opportunity for students from local schools to gain access to clinical observations and receive mentoring support from consultant medical staff.

In continuing our commitment to supporting young people from our local area the trust recruited 6 young people to a cadet scheme providing structured work experience and training in preparation for permanent employment.

7. Statement as to disclosure to auditors

In accordance with the requirements of the Companies (Audit, Investigations and Community Enterprise) Act 2004 the Trust confirms that, for each individual who was a director at the time that the director's report was approved that:

- So far as each director is aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware: and
- That 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.

For the purposes of this declaration:

- Relevant audit information means information needed by the NHS foundation trust's auditor in connection with preparing their report and that:
- Each director has made such enquiries of his/her fellow directors and taken such other steps (if any) for that purpose, as are required by his /her duty as a director of the trust to exercise reasonable care, skill and diligence.

8. Annual Governance Statement

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 2012 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. 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 and Governance.

A new Risk Management Strategy was introduced in 2011/12 and provides a framework for managing risks across the organisation. Its aim is to enhance and reinforce a culture of openness and safety whilst encouraging creativity and innovation in which risks are proactively identified and managed.

The Strategy sets out the specific roles of the Board and Standing Committees together with the individual responsibilities of the Chief Executive, Executive Directors, managers and all staff in managing risk.

The Corporate Readiness Committee, Clinical Quality Committee, Finance Committee, Workforce Committee and Patient and Family Experience Committee along with their sub committees provide the mechanism for managing and monitoring risk throughout the Trust and there are clear processes for reporting of major risks through to the Board.

This structure is supported by robust governance processes within Directorates. General Managers ensure that reporting and review of all risk registers within their Directorates occurs at least twice a year. Directorate Risk Registers are also reviewed at least twice a year. Corporate risk registers are reviewed by the Corporate Governance Committee twice yearly.

The Corporate Readiness Committee provides oversight of the Trust's risk management processes, incorporating health and safety and business continuity and emergency planning. The Corporate Readiness assurance committee reviews a risk register chosen at random for the purpose of encouraging learning for the members.

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. This includes the risks arising from the assessment of Essential Standards of Quality and Safety which are performed at least annually in each ward and department to ensure continued compliance with the Outcomes set by the Care Quality Commission.

The risks are then analysed in order to determine their relative importance using a level of concern matrix. Minor concern risks are managed locally by the area in which they are found while moderate / major concern risks are escalated to the appropriate manager for consideration and inclusion in the Directorate or Executive Team Risk register.

In the case of a major concern being identified from either the review of departmental risk registers or the business of the Trust, then the risk will be escalated to the Executive Team for moderation and assignment to the appropriate assurance committee. The Board of Directors is notified at its next meeting through receipt of a "BAF Key Issues Report" from each Assurance Committee.

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 the risk may be transferred to others such as NHS Insurance Schemes or sharing the risk in the contracts drawn up with others.

The system of internal control relating to Information Governance is managed through the Board of Directors Assurance Framework which includes Executive Accountability and a clear performance monitoring and management processes.

Information Governance Toolkit Attainment Levels

The Trust's Information Governance Toolkit assessment for 2011/12 was submitted with an overall score of 74% "Green Satisfactory" achieving level 2 or above for all requirements. The Trust also received independent audit assurance in March 2012 obtaining a "significant" assurance opinion.

The Risk and Control Framework

The system of internal control relating to Information Governance is managed through the Trust's Board Assurance Framework which includes Executive Accountability and a clear performance monitoring and management processes. Identified risks are reported via the Information Governance Committee to the Corporate Readiness Committee, with any risks triggering the escalation threshold reported to the Board of Directors.

Serious Untoward Incidents

The Trust has had no reported serious untoward incidents involving personal data i.e. incidents classified as severity rating 3-5.

Summary of Other Personal Data Related Incidents

The Trust has had one incident involving personal data during 2011-12 which was classified at a severity rating of 2. A full investigation was undertaken with remedial actions agreed and implemented.

SUMMARY OF PERSONAL DATA RELATED INCIDENTS IN 2011-12		
Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	1
II	Loss of Inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	0

Data quality risks are managed through the Information Governance risk register, which is reviewed by Corporate Governance Committee twice a year. In addition, independent assurance is provided by the Audit Commission's PbR (Payment by Results) Data Assurance Framework review and the Information Governance Toolkit self- assessment review by internal audit.

Risks to delivery of the Trust's Quality Account indicators are managed through the Clinical Quality Committee. 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 CQC essential standards of quality and safety. The CQC made an unannounced inspection in March 2012, and confirmed compliance with outcomes 01, 04, 07, 14 and 16.

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 the 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 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 risk assessed for deliverability and potential impact on patient safety through an Executive led review process. The outcome of this assessment is reported to Finance Committee and Board of Directors as part of the sign off of annual plans.

The Finance Committee and Board of Directors also receive a report on a quarterly basis that examines the trading position forecast for the next two years allowing the Board to identify any issues in respect of the Trust being maintained as a going concern.

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" into the operations of directorates and departments and the external auditor provides an annual value for money opinion.

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 2011/12 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 frontline 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. the Outcomes Framework, Commissioning for Quality & Innovation (CQUIN) and Advancing Quality)
3. Our Quality Account Task and Finish Council of Governors sub-group, who are continuously identifying priorities from the Trust's 10,000 public 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 North Merseyside 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 a dedicated workshop, identified a range of improvements they would like to see implemented which would improve relationships with the Trust.

Priorities were shortlisted by the Executive Team based upon the gap in performance between the hospital and the best performance, together with the 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 approved the policies on behalf of the Board of Directors.

This process is now mature after three years of being used and successively refined.

The Trust has as annual external audit of the Quality Account, which attracted significant assurance in being reported as a balanced view of the Trust's performance on quality. Past recommendations have been largely centred on improvements in data quality process and policy; significant improvements have been made in this regard across the last two years 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. This is supported by dashboards at Directorate and Ward level which helps staff maintain focus on the Trust's overall priorities for quality and safety.

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 who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report included in 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, Corporate Readiness Committee and Clinical Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board has reviewed its assurance processes and introduced a new Board Assurance Framework in 2011/12 that provides me with an overview of the internal control environment and evidence of the effectiveness of the controls that manage the risks to the organisation achieving its principal objectives. This is reviewed at every Board meeting. The Board undertook a comprehensive review of these new arrangements, including changes to the Assurance Committee structure in November 2011 and concluded that the new processes are effective and have added value to the way in which the Board operates.

The Audit Committee reviews the effectiveness of internal control through delivery of the internal audit plan and by undertaking a rolling programme of reviews of the Board's Assurance Committees, including the Clinical Quality and Corporate Readiness Committees.

The Chair of the Audit Committee has provided me with an annual report of the work of the Audit Committee that supports my opinion that there are effective processes in place for maintaining and reviewing the effectiveness of internal control.

The head of internal audit has also provided me with significant assurance on the effectiveness of the systems of internal control. The opinion is based on a review of the Board Assurance Framework, outcomes of risk based reviews and follow up of previous recommendations.

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, Corporate Readiness 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 through key issues reports from Standing Committees
- Audit Committee scrutiny of controls in place
- Review of serious incidents and learning by the standing committees,
- 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 2011/12, however the following issue remains a risk and is being monitored and managed closely:

- Infection prevention – C-Difficile target – the Trust believes that it has reached the minimum levels of preventable infection for the type, complexity and safety needs of the patients it treats and has sought external assurance in 2011/12 that confirmed its procedures and practices for preventing and controlling infection are robust. The Trust has breached its annual target for 2011/12 with 8 cases against a target of 7, although 2 cases have been appealed. The Trust has taken appropriate measures to liaise with Monitor regarding the possible impact upon the Trust's governance rating and has received confirmation that it will remain at amber/green. The Trust has reviewed control measures and deems them to be as robust as possible. The Infection Prevention Committee will continue to monitor all infections on a case by case basis and take immediate action if required to ensure the safety of patients.



Chief Executive

30th May 2012

9. Other disclosures in the public interest

Health and Safety

The Health and Safety Committee is an established committee within the Trust. The committee reviewed its terms of reference in July 2011 and achievements made against the terms of reference show positive improvements. Awareness-raising about health and safety has continued with an ongoing inspection regime developed to highlight any areas of weakness in clinical and non clinical areas that the Trust will concentrate on.

Consultations

There have been no public consultations during 2011/12 and none are planned for the forthcoming year.

Limited assurance report to the Council of Governors of Liverpool Heart and Chest Hospital NHS Foundation Trust

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 Liverpool Heart and Chest Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium difficile; and
- Maximum waiting times of 62 days from urgent GP referral to first treatment for all cancers.

I refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

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 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 Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports

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

I read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2011 to April 2012;
- Papers relating to quality reported to the Board over the period April 2011 to April 2012;
- Feedback from the Commissioners dated 28/05/2012;
- Feedback from LINKs dated 28/05/2012;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16/05/2012;
- The national patient survey dated March 2012;

- The national and local staff survey dated July 2012;
- The results of the unannounced Care Quality Commission inspection and risk profiles dated 21/02/2012; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated 10/04/2012.

I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). My responsibilities do not extend to any other information.

I am in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. My team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Liverpool Heart & Chest Hospital NHS Foundation Trust as a body. The purpose of the report is to assist the Council of Governors in reporting the Liverpool Heart & 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 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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 & 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:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents listed above.

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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

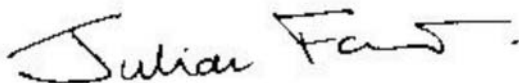
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Liverpool Heart & Chest Hospital NHS Foundation Trust.

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 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports. .

Julian Farmer – Officer of the Audit Commission



Audit Commission, 2nd Floor, Aspinall House Close, Middlebrook, Horwich, Bolton, BL6 6QQ

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 2012 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 Accounting Policies (page 6 of the accounts) of the Trust in line with International Financial Reporting Standards.

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

- *the table of salaries and allowances of senior managers [and related narrative notes] on page 18;*
- *the table of pension benefits of senior managers [and related narrative notes] on page 19; and*
- *the disclosure of the median remuneration of the reporting entity's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director.*

This report is made solely to the Board of Governors of [Name] 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 Board 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. In addition, I read all the financial and non-financial 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 [Name] NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the [year/period] 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 [*subject to audit*]¹ 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 2011/12 for which the financial statements are prepared is consistent with the financial statements.

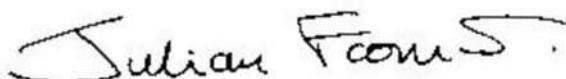
Matters on which I report by exception

I report to you if, in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

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 (ARM).

Julian Farmer - Officer of the Audit Commission



Audit Commission, 2nd Floor, Aspinall House, Aspinall Close, Middlebrook, Horwich, Bolton, BL6 6QQ

30 May 2012

For the attention of the NAO auditors of the Consolidated NHS Foundation Trusts account; the Department of Health Group; and Whole of Government Accounts consolidation schedules

This report is intended solely for the use of the National Audit Office (NAO) in connection with the audit of the Consolidated NHS Foundation Trusts Accounts; the Department of Health (DH) Group Accounts; and for the use of the NAO with respect to its audit of the Whole of Government Accounts, and should not be used for any other purpose.

As auditor of the annual accounts of Liverpool Heart and Chest Hospital NHS Foundation Trust

I confirm:

- compliance with the Group Audit Instructions issued by the NAO;
- the related party transactions reported in both the financial statements and FTC Consolidation schedules are materially accurate;
- intra-group elimination data included in the FTC Consolidation Schedules with respect to balances as at 1 April 2010, 31 March 2011 and 31 March 2012; and transactions for both the 2010-11 and 2011-12 financial years, is free from material misstatement for the purposes of the Consolidated NHS Foundation Trust Accounts; and the DH Group Accounts;
- intra-government data included in the FTC Consolidation Schedules with respect to balances as at 1 April 2010, 31 March 2011 and 31 March 2012; and transactions for both the 2010-11 and 2011-12 financial years, is free from material misstatement for the purposes of the Whole of Government Accounts;
- the additional information provided in the consolidation schedule ('Alignment Additional Info' worksheet) for the purposes of inclusion in the DH Group Accounts is not materially inconsistent with the final audited accounts or relevant underlying records;
- I have considered the need to for any referrals to be made to Monitor in accordance with the requirements of paragraph 6 of Schedule 10 of the National Health Service Act 2010 for the year, and that no such referrals have been made.
- there have been no indicators of management bias;
- there have been no significant deficiencies in internal control identified other than those reported in the Annual Governance Statement or ISA (UK & Ireland) 260 Report;
- disclosures included in the Annual Governance Statement are consistent with the audited financial statements and with the results of the audit;
- there are no other significant matters which have been reported to those charged with governance, including fraud or suspected fraud;
- the audit has been carried out in accordance with the Audit Code for NHS Foundation Trusts issued by Monitor; and
- through the provision of the documents set out below, that all audit findings and matters relevant to the conclusion of the Group auditors, as laid out in ISA (UK & Ireland) 600, have been communicated:
 - copy of the 'Report to the Those Charged with Governance' issued under ISA (UK & Ireland) 260;
 - audit certificate and opinion;

- o signed audited financial statements;
- o final FT consolidation schedule; and
- o signed auditors' report on consolidation schedule.

I have not found out any exceptions to the above representations which exceed the clearly trivial level.

The materiality I have applied in conducting my audit is £1054k and the performance materiality I have applied in conducting my audit is £941k.

Signature:

Name:

Position:

Audit Supplier:

Date:

Julian Farmer

Julian Farmer

Engagement Lead

Audit Practice of the Audit Commission
 Audit Commission, 2nd Floor, Aspinall House,
 Aspinall Close, Middlebrook, Horwich,
 Bolton, BL6 6QQ

30 May 2012

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

Summarisation schedules numbers FTC01 to FTC40 for 2011/12 are attached.

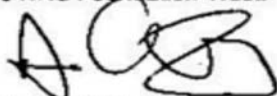
Finance Director Certificate

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 2011/12* 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.

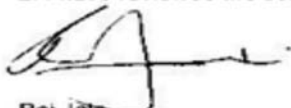


Aaron Cummins
Finance Director
30th May 2012

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 Jatin
Chief Executive
30th May 2012

Data entered below will be used throughout the workbook:

Trust name:	Liverpool Heart and Chest Hospital NHS Foundation Trust
This year	31st March 2012
Last year	31st March 2011
This year ended	31st March 2012
Last year ended	31st March 2011
This year commencing:	1st April 2011

Liverpool Heart and Chest Hospital NHS Foundation Trust - Accounts 31st March 2012

Foreword

The accounts for the year ended 31st March 2012 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

Date 29th May 2012

**STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED
31st March 2012**

		2011/12	2010/11
			Restated
	NOTE	£000	£000
Revenue			
Operating Income	7	102,545	101,323
Other operating revenue	8	4,254	4,836
Operating expenses	11	(104,598)	(103,645)
Operating surplus (deficit)		2,201	2,514
Finance costs:			
Investment Revenue	17	150	118
Other gains and (losses)	18	0	0
Finance costs	19	(36)	(42)
Surplus/(Deficit) for the financial period		2,315	2,590
Public dividend capital dividends payable		(1,727)	(1,730)
Retained surplus/(deficit) for the period		588	860
Other comprehensive income			
Revaluation gains/(losses) and impairment losses on property, plant and equipment		819	1,045
Total comprehensive income for the period		1,407	1,905

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

The notes on pages 142 to 172 form part of these accounts.

**STATEMENT OF FINANCIAL POSITION AS AT
31st March 2012**

		31st March 2012	31st March 2011	4 months to 31st March 2010
	NOTE	£000	(restated) £000	(restated) £000
Non-current assets				
Property, plant and equipment	21	61,590	58,386	56,619
Intangible assets	22	995	183	44
Total non-current assets		62,585	58,569	56,663
Current assets				
Inventories	28	2,899	4,026	2,803
Trade and other receivables	29	3,655	2,606	3,282
Cash and cash equivalents	32	17,479	17,264	13,708
		24,033	23,896	19,793
Non-current assets held for sale	33	0	0	0
Total current assets		24,033	23,896	19,793
Total assets		86,618	82,465	76,456
Current liabilities				
Trade and other payables	34	(14,427)	(12,675)	(8,123)
Borrowings	35	(287)	(220)	(352)
Provisions	41	(917)	(670)	(720)
Other liabilities	42	(1,622)	(1,570)	(1,632)
Net current assets/(liabilities)		6,780	8,761	8,966
Total assets less current liabilities		69,365	67,330	65,629
Non-current liabilities				
Borrowings	35	(798)	(170)	(374)
Provisions	41	0	0	0
Other liabilities	42	0	0	0
Total assets employed		68,567	67,160	65,255
Financed by taxpayers' equity:				
Public dividend capital		62,799	62,799	62,799
Retained earnings		(4,039)	(5,056)	(5,933)
Revaluation reserve		9,807	9,417	8,389
Total Taxpayers' Equity		68,567	67,160	65,255

The financial statements and notes on pages 138 to 172 were approved by the Board on and signed on its behalf by:

Signed 

Chief Executive

Date: 30th May 2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Balance at 1 April 2011	62,799	(5,056)	9,417	67,160
Prior period adjustments	0	0	0	0
Adjustments for Transforming Community Services transactions	0	0	0	0
Restated balance at 1 April 2011	62,799	(5,056)	9,417	67,160

Changes in taxpayers' equity for 2011-12

Total Comprehensive Income for the period:				
Retained surplus/(deficit) for the period.	0	588	0	588
Net gain on revaluation of property, plant and equipment	0	0	86	86
Net gain on revaluation of intangible assets	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0
Impairments and reversals	0	0	733	733
Asset disposals	0	0	0	0
Movements on other reserves	0	0	0	0
Transfer between reserves	0	429	(429)	0
Balance at 31st March 2012	62,799	(4,039)	9,807	68,567

Changes in taxpayers' equity for 2010-11

Balance at 1 April 2010	62,799	(6,909)	7,999	63,889
Prior period adjustment	0	976	390	1,366
Total Comprehensive Income for the period:				
Retained surplus/(deficit) for the period.	0	860	0	860
Net gain on revaluation of property, plant and equipment	0	0	264	264
Net gain on revaluation of intangible assets	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0
Impairments and reversals	0	0	781	781
Asset disposals	0	73	(73)	0
Movements on other reserves	0	(56)	56	0
Transfer between reserves	0	0	0	0
Balance at 31st March 2011	62,799	(5,056)	9,417	67,160

**STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31st March 2012**

		for period ended 31st March 2012	for period ended 31st March 2011
	NOTE	£000	£000
Cash flows from operating activities			
Operating surplus/(deficit)		2,201	2,514
Depreciation and amortisation		4,467	5,153
Impairments		39	671
Reversal of impairments		(96)	(988)
Transfer from donated asset reserve		0	14
Dividends accrued and not paid or received		0	
(Increase)/decrease in trade and other receivables		(1,032)	561
(Increase)/decrease in inventories		1,127	(1,223)
Increase/(decrease) in trade and other payables		1,914	3,310
Increase/(decrease) in other current liabilities		52	524
Increase/(decrease) in provisions	41	247	(50)
Tax (paid)/received		0	0
Net cash inflow/(outflow) from operating activities		8,919	10,486
Cash flows from investing activities			
Interest received		150	118
Purchase of Intangible assets		(870)	
(Payments) for property, plant and equipment	21	(6,899)	(5,055)
Net cash inflow/(outflow) from investing activities		(7,619)	(4,937)
Net cash inflow/(outflow) before financing		1,300	5,549
Cash flows from financing activities			
Capital element of finance leases		695	(336)
Interest element of finance lease		(36)	(42)
PDC dividend paid		(1,744)	(1,615)
Net cash inflow/(outflow) from financing		(1,085)	(1,993)
Net increase/(decrease) in cash and cash equivalents		215	3,556
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		17,264	13,708
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	32	17,479	17,264

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 FT ARM which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2011/12 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

There has been a national exercise to restate 2010/11 final accounts for the impact of the removal of the Donated asset reserve and the Government grant reserve. Prior year comparatives have been amended to reflect the impact of this restatement.

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 2011/12 Foundation Trust Annual Reporting Manual (FTARM). The Accounting Policies contained in the FT ARM 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 Payment by Results (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.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Asset Valuation - The Foundation Trust appointed an independent valuer to value its land and buildings at March 31st 2012. This was mainly a "good housekeeping" exercise with the exception of the detailed valuation of the 10 bedded extension to Cedar ward. The valuation has been undertaken 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 2011/12 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 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 with the 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 operating expenses at the time the Foundation Trust commits itself to the retirement, regardless of the method or timing 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 Foundation Trust;
- 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, 31st March 2011 and 31st March 2012 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 depreciation 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 Foundation Trust 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

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

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

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, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the 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 before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

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

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.17 Government Grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a Government grant reserve is no longer maintained. The value of assets received by means of a Government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition. The Trust does not currently have any Government grants.

1.18 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 as 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.

1.19 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.

1.20 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

1.21 Inventories

Inventories are valued at the lower of cost and net realisable value using the First In, First Out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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.

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

1.23 Provisions

The 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 3% (2010/11: 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

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

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

1.24 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. The contribution is charged to expenditure. 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 41 but is not recognised in the NHS Foundation Trust's accounts.

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.

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

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 with sufficient reliability. 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; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial Assets at 'Fair Value Through Income & Expenditure'

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 assets at fair value through Income & Expenditure. They are held at fair value, with any resultant gain or loss recognised in calculating the Foundation Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

The Foundation Trust does not hold any of this class of assets.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The Foundation Trust does not hold any of this class of assets.

Available for sale financial assets

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.]

The Foundation Trust does not hold any of this class of assets.

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

1.28 Financial Assets (continued)

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 transactions 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 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 2012;
- 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 NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

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 (including lottery funded assets), (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (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.

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

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 NHS trusts 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 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 Foundation 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'.

Until 31 March 2013, 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 Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation

IAS 12 - Income Taxes (amendment) - subject to consultation

IAS 19 Post-employment benefits (pensions) - subject to consultation

IAS 27 Separate Financial Statements - subject to consultation

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

IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13

IFRS 9 Financial Instruments - subject to consultation - subject to consultation

IFRS 10 Consolidated Financial Statements - subject to consultation

IFRS 11 Joint Arrangements - subject to consultation

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

IFRS 13 Fair Value Measurement - subject to consultation

IPSAS 32 - Service Concession Arrangement - subject to consultation

2 Operating Segments

The Foundation Trust has one segment for the provision of healthcare which generated income of £106.79m

	2011/12	2010/11
	£000	£000
The main sources of income received were:-		
North West Specialist Commissioning Team	73,830	70,386
Health Commission Wales	14,987	17,191

	Healthcare Segment	
	2011/12	2010/11
	£000	£000
Income	106,799	106,159
Surplus/(Deficit)	588	860
Net Assets:	68,567	67,160

3 Income generation activities

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

4 Operating Income analysed by classification	2011/12	2010/11
	£000	£000
Elective income	48,485	49,261
Non elective income	29,746	30,222
Outpatient Income	12,359	8,888
Other NHS clinical income*	7,721	8,656
Private patient income	2,990	2,993
Other non-protected clinical income	1,244	1,303
Total Income from activities	102,545	101,323
Research & Development	730	566
Education & Training	2,737	2,756
Charitable & other contributions to expenditure	65	0
Non-patient care services to other bodies	75	
Transfer from Donated Asset reserve in respect of depreciation on donated assets	0	0
Reversal of impairments of Property, plant & equipment	96	988
Other Income	551	526
Total other operating income	4,254	4,836
Total Operating income	106,799	106,159

*Other NHS Clinical Income is analysed in note 5 below

5 Analysis of Other NHS Clinical Income	2011/12	2010/11
	£000	£000
Drugs and Devices - Non Contracted	342	881
NHS Trust Income - SLA's	1,436	1,521
PCT Income - Non Contracted	1,586	1,753
Cystic Fibrosis Inpatients	3,896	3,789
Non recurrent Winter Pressures/Performance	461	600
Patient transport service	0	112
	7,721	8,656

6 Private Patient Income	2011/12	2010/11	Base Year 2002/03
			£000
Private Patient Income	2,990	2,994	2,876
Total Clinical Income	99,555	96,444	54,831
Proportion of private patient income as a percentage of Clinical Income	3.0%	3.1%	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 Revenue from patient care activities

	Year ended 31st March 2012	Year ended 31st March 2011
	£000	£000
NHS Foundation Trusts	299	286
NHS Trusts	1,733	1,930
Strategic Health Authorities	0	0
Department of Health	4	
Primary Care Trusts	82,315	78,719
NHS Other	8	11
Local authorities	1	4
Non NHS:		
- Private patients	2,990	2,994
- Overseas patients (non reciprocal)	0	7
- NHS Injury Scheme	1	0
- Other*	15,194	17,372
	102,545	101,323

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

8 Other Operating Revenue

	Year ended 31st March 2012	Year ended 31st March 2011
	£000	£000
Research & Development	730	566
Education and training	2,737	2,756
Charitable and other contributions to expenditure	65	0
Non-patient care services to other bodies	75	
Transfer from donated asset reserve in respect of depreciation on donated assets	0	0
Reversal of impairments of property, plant and equipment	96	988
Other income*	551	526
	4,254	4,836

*Other Operating revenue Income is analysed in Note 9 below

9 Analysis of Other Operating Revenue - Other income

	Year ended 31st March 2012	Year ended 31st March 2011
	£000	£000
Estates recharges	0	0
Pharmacy sales	15	18
Staff accommodation rentals	0	0
Clinical tests	0	0
Clinical excellence awards	489	500
Other	47	8
	551	526

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

	Year ended 31st March 2012	Year ended 31st March 2011
	£000	£000
Income from Activities - Mandatory Services	94,158	93,753
Income from Activities - Non-Mandatory Services	8,386	7,570
	102,544	101,323

10 Revenue

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

	Year ended 31st March 2012	Year ended 31st March 2011
	£000	£000
11 Operating Expenses		
Services from NHS Foundation Trusts	183	271
Services from NHS Trusts	4,440	4,253
Services from Primary Care Trusts	165	134
Services from other NHS bodies	2	0
Employee Expenses - Executive directors	422	238
Employee Expenses - Non-executive directors	71	74
Employee Expenses - Staff	57,179	55,527
Drugs costs	4,174	4,181
Supplies and services - clinical (excluding drug costs)	26,102	27,006
Supplies and services - general	1,566	1,388
Establishment	917	828
Research and Development	0	10
Transport	73	67
Premises	2,742	1,876
Increase/(decrease) in provision for impairment of receivables	320	140
Depreciation on property, plant and equipment	4,409	5,126
Amortisation on intangible assets	58	27
Impairments of property, plant and equipment	39	671
Audit fees	60	65
Other auditor's remuneration	0	20
Clinical negligence	354	429
Legal fees	156	109
Consultancy costs	296	139
Training courses and conferences	172	314
Patient travel	12	123
Car parking and Security	285	248
Redundancy	51	0
Insurance	102	102
Other services, eg external payroll	81	0
Losses, ex gratia & special payments	88	71
Other	79	208
	104,598	103,645

	Year ended 31st March 2012	Year ended 31st March 2011
	£000	£000
12 Audit Fees and Other Remuneration		
Statutory Audit	60	65
Other Auditors remuneration		
Financial reporting evaluation	0	20
	<u>60</u>	<u>85</u>

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 which were under 5 year agreements. Where the 5 year lease term has expired the Trust has agreed to extend leases but there is no ongoing contractual commitment.

13.1 As lessee

	Year ended 31st March 2012	Year ended 31st March 2011
	£000	£000
Payments recognised as an expense		
Minimum lease payments	49	37
Contingent rents	0	0
	<u>49</u>	<u>37</u>

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

	Year ended 31st March 2012	Year ended 31st March 2011
	£000	£000
Total future minimum lease payments		
Payable:		
Not later than one year	6	26
Between one and five years	11	24
After 5 years	0	0
Total	<u>17</u>	<u>50</u>

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 benefits and staff numbers

14.1 Employee expenses

	Year ended 31st March 2012			Year ended 31st March 2011		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Salaries and wages	48,042	46,532	1,510	46,526	45,874	652
Social Security Costs	3,716	3,506	210	3,415	3,324	91
Employer contributions to NHS Pension scheme	4,809	4,809	0	4,668	4,668	0
Pension costs - other contributions	0	0	0	0	0	0
Other post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0
Agency and contract staff	1,254	0	1,254	1,324	0	1,324
Total gross employee benefits	57,821	54,847	2,974	55,933	53,866	2,067
less income in respect of Salaries and wages where netted off expenditure	(138)	(138)	0	(139)	(139)	0
less income in respect of Social security costs where netted off expenditure	(13)	(13)	0	(13)	(13)	0
less income in respect of Pension cost where netted off expenditure - defined contribution plans	(18)	(18)	0	(15)	(15)	0
Employers contributions to NHS Pensions	0	0	0	0	0	0
less income in respect of Pension cost where netted off expenditure- other contributions	0	0	0	0	0	0
less income in respect of Other post employment benefits where netted off expenditure	0	0	0	0	0	0
less income in respect of Other employment benefits where netted off expenditure	0	0	0	0	0	0
less income in respect of Termination benefits where netted off expenditure	0	0	0	0	0	0
less income in respect of Agency/contract staff where netted off expenditure	0	0	0	0	0	0
Total net employee benefits	57,652	54,678	2,974	55,766	53,699	2,067
Employee benefits capitalised as part of assets	0	0	0	0	0	0
Total net employee benefits excluding capitalised costs	57,652	54,678	2,974	55,766	53,699	2,067

14.2 Average number of people employed

	Year ended 31st March 2012			Year ended 31st March 2011		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	141	132	9	140	130	10
Administration and estates	283	269	14	271	263	8
Healthcare assistants and other support staff	217	211	6	217	214	3
Nursing, midwifery and health visiting staff	522	505	17	510	495	15
Scientific, therapeutic and technical staff	222	212	10	209	200	9
Social care staff	0	0	0	6	3	3
Other	0	0	0	2	1	1
Total	1,386	1,329	57	1,355	1,306	49
Of the above - staff engaged on capital projects	0	0	0	0	0	0

14.3 Management and Administration Costs

	Year ended 31st March 2012	Year ended 31st March 2011
	£m	£m
Management costs	5.694	5.399
Income	106.799	106.320
Percentage of Management Costs to Income	5.33%	5.08%

14.4 Staff Sickness Absence

	Year ended 31st March 2012	Year ended 31st March 2011
Days Lost (Long Term)	15,949	13,382
Days Lost (Short Term)	7,308	8,222
Total Days Lost	23,257	21,604
Total Staff Years	1,281	1,306
Average working days lost	18.2	16.5
Total Staff Employed in Period (Headcount)	1,580	1,540
Total Staff Employed in Period with no absence (Headcount)	731	660
Percentage Staff with no Sick Leave	46.27%	42.86%

14.5 Exit Packages agreed in 2011-12

	31st March 2012			31st March 2011		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number
Less than £10,000	0	2	2	0	0	0
£10,001-£25,000	1	0	1	0	3	3
£25,001-£50,000	1	0	1	0	2	2
£50,001-£100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	1	1	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	2	3	5	0	5	5
Total resource cost (£000s)	51	215	266	0	114	114

Exit costs include payments made during the year and a provision for an Exit package in respect of a Senior officer which has been agreed by the Board which will be paid in 2012/13.

Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. During the year there were no early retirements.

Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year.

An outline of these follows:-

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

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

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

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

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

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

The valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2012 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

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

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

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

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

16 Retirements due to ill-health

For the year ended 31st March 2012 there was 1 early retirement at a cost of £150k from The NHS Foundation Trust agreed on the grounds of ill-health. (31st March 2011 nil)

	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000
17 Investment Revenue		
Interest revenue:		
Bank accounts	150	118
Total	<u>150</u>	<u>118</u>

18 Other Gains and Losses

There are no other gains or losses

	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000
19 Finance Costs		
Interest on obligations under finance leases	36	42
Total	<u>36</u>	<u>42</u>

20 Better Payment Practice Code

20.1 Better Payment Practice Code - measure of compliance

	Year Ended 31st March 2012 Number	£000s	Year ended 31st March 2011 Number	£000s
Total Non-NHS trade invoices paid in the period	31,464	46,531	33,571	44,582
Total Non NHS trade invoices paid within target	30,046	45,102	32,169	43,522
Percentage of Non-NHS trade invoices paid within target	95.5%	96.9%	95.8%	97.6%
Total NHS trade invoices paid in the period	928	12,659	999	13,369
Total NHS trade invoices paid within target	848	12,518	880	10,470
Percentage of NHS trade invoices paid within target	91.4%	98.9%	88.1%	78.3%

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 2012 £000	Year ended 31st March 2011 £000
Amounts included within other interest payable arising from claims made under this legislation.	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	<u>0</u>	<u>0</u>

21 Property, plant and equipment

	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
2011/12:								
Cost or valuation at 1st April 2011	3,235	44,116	529	1,155	19,833	4,076	2,114	75,058
Prior period adjustment	0	(963)	(27)	0	(32)	0	0	(1,022)
Additions purchased	0	1,468	0	2,542	1,821	881	0	6,712
Additions donated	0	0	0	0	25	0	0	25
Reclassifications	0	958	0	(1,059)	0	101	0	0
Revaluations	0	(571)	8	0	86	0	0	(477)
Impairments	0	(25)	0	0	0	0	0	(25)
Disposals	0	0	0	0	(1,885)	(352)	0	(2,237)
At 31st March 2012	3,235	44,983	510	2,638	19,848	4,706	2,114	78,034
Depreciation at 1st April 2011	0	963	27	0	11,259	2,992	1,431	16,672
Prior period adjustment	0	(963)	(27)	0	(32)	0	0	(1,022)
Charged during the year	0	1,358	20	0	2,459	387	185	4,409
Impairments	0	39	0	0	0	0	0	39
Reversal of impairments	0	(96)	0	0	0	0	0	(96)
Cumulative depreciation adjustment following revaluation	0	(1,301)	(20)	0	0	0	0	(1,321)
Reclassifications	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(1,885)	(352)	0	(2,237)
Depreciation at 31st March 2012	0	0	0	0	11,801	3,027	1,616	16,444
Net book value								
Purchased	3,235	44,590	208	2,638	6,585	1,679	498	59,433
Finance Leased	0	0	0	0	1,038	0	0	1,038
Donated	0	393	302	0	424	0	0	1,119
Total at 31st March 2012	3,235	44,983	510	2,638	8,047	1,679	498	61,590

The Prior period adjustment relates to an amendment to the opening balances to Gross Book Value and accumulated depreciation to reflect the impact of the District Valuer's revaluation effective from 31st March 2011.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings excluding dwellings	Dwellings	Plant and machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 31 March 2011	1,903	5,998	192	1,150	0	174	9,417
Prior period adjustments	0	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0	0
At 1 April 2011 restated	1,903	5,998	192	1,150	0	174	9,417
Movement in year	0	705	28	(319)	0	(24)	390
At 31 March 2012	1,903	6,703	220	831	0	150	9,807

21.1 Analysis of Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Information technology	Furniture & fittings	Total
Net Book Value								
NBV - Protected Assets at 31st March 2012	3,235	41,185	0	0	0	0	0	44,420
NBV - Unprotected Assets at 31st March 2012	0	3,798	510	2,638	8,047	1,679	498	17,170
Total at 31st March 2012	3,235	44,983	510	2,638	8,047	1,679	498	61,590

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

	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
2010/11:								
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	771	10	0	0	0	0	781
Disposals	0	(12)	0	0	(5,450)	0	0	(5,462)
At 31st March 2011	3,235	44,116	529	1,155	19,833	4,076	2,114	75,058
Depreciation at 1st April 2010	0	0	0	0	13,543	2,538	1,242	17,323
Charged during the year	0	1,292	27	0	3,164	454	189	5,126
Impairments	0	671	0	0	0	0	0	671
Reversal of impairments	0	(988)	0	0	0	0	0	(988)
Disposals	0	(12)	0	0	(5,448)	0	0	(5,460)
Depreciation at 31st March 2011	0	963	27	0	11,259	2,992	1,431	16,672
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

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Plant and	Information	Furniture &	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1st April 2010 (restated)	1,903	5,416	9	886	0	174	8,388
Movement in year	0	582	183	264	0	0	1,029
At 31 March 2011	1,903	5,998	192	1,150	0	174	9,417

21.3 Analysis of Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Information technology	Furniture & fittings	Total
Net Book Value								
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

21.4 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 2012.

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	37
Assets under Construction & POA	3	25
Plant & Machinery	0	10
Information Technology	0	5
Furniture and Fittings	0	9

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 holds temporarily idle assets but these are considered to be of immaterial value.

22 Intangible assets

	Computer software - purchased	Assets under Construction	Total
2011/12:			
	£000	£000	£000
Gross cost at 1st April 2011	370	0	370
Additions	101	769	870
Gross cost at 31st March 2012	471	769	1,240
Amortisation at 1st April 2011	187	0	187
Charged during the year	58	0	58
Amortisation at 31st March 2012	245	0	245
Net book value			
Purchased	226	769	995
Donated	0	0	0
Total at 31st March 2012	226	769	995
2010/11:			
	£000	£000	£000
Gross cost at 1st April 2010	219	0	219
Prior period adjustment	(15)	0	(15)
Gross cost at 1st April 2010 restated	204	0	204
Additions	166	0	166
Gross cost at 31st March 2011	370	0	370
Amortisation at 1st April 2010	175	0	175
Prior period adjustment	(15)	0	(15)
Gross cost at 1st April 2010 restated	160	0	160
Charged during the year	27	0	27
Amortisation at 31st March 2011	187	0	187
Net book value			
Purchased	183	0	183
Donated	0	0	0
Total at 31st March 2011	183	0	183

Assets under construction relates to licenses associated with the Electronic Patient record capital scheme.

These assets have useful economic lives of no more than 5 years.

Intangible fixed assets held for 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 2012. There has been an overall upward revaluation by £790k,

Within this sum there has been :-

- reversal of prior year impairments of £96k which have been credited to income..
- negative impairments of £39k charged to expenditure.
- upward revaluations of (not previously impaired) purchased buildings of £758k credited to the revaluation reserve.
- Negative impairments charged to the revaluation reserve of £25k.

24 Analysis of impairments and reversals recognised in 2011-12

31st March 2012

**Total
£000**

Property, Plant and Equipment impairments and reversals taken to SoCI

Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0

Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	(57)
Changes in market price	0
Total charged to Annually Managed Expenditure	(57)

Property, Plant and Equipment impairments and reversals charged to the Revaluation Reserve

Loss or damage resulting from normal operations	0
Over Specification of Assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	(733)
Changes in market price	0
Total impairments for PPE charged to reserves	(733)

Total Impairments of Property, Plant and Equipment	(790)
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Total Impairments charged to Revaluation Reserve	(733)
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	(57)
Overall Total Impairments	(790)

25 Investment Property

The Trust does not have Investment Property

26 Commitments

26.1 Capital commitments

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

	31st March 2012	31st March 2011
	£000	£000
Property, plant and equipment	4,674	881
Intangible assets	0	0
Total	4,674	881

26.2 Other financial commitments

The trust has not entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements) as defined within IFRIC 12

27 Intra-Government and other balances

	Receivables		Payables	
	Current	Non-current	Current	Non-current
	£000s	£000s	£000s	£000s
Balances with other Central Government Bodies	496	0	1,825	0
Balances with Local Authorities	0	0	62	0
Balances with NHS Trusts and Foundation Trusts	322	0	1,825	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,687	0	2,471	0
At 31st March 2012	2,505	0	6,183	0
prior period:				
Balances with other Central Government Bodies	144	0	1,718	0
Balances with Local Authorities	1	0	0	0
Balances with NHS Trusts and Foundation Trusts	490	0	1,786	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	936	0	3,066	0
At 31st March 2011	1,571	0	6,570	0

28 Inventories	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000
Balance at 1 April 2011	555	3,471	0	0	0	0	4,026
Prior period adjustment	0	0	0	0	0	0	0
Merger adjustment	0	0	0	0	0	0	0
Restated at 1 April 2011	555	3,471	0	0	0	0	4,026
Additions	9,748	19,123	0	0	0	0	28,871
Inventories recognised as an expense in the period	(9,853)	(20,145)	0	0	0	0	(29,998)
Write-down of inventories (including losses)	0	0	0	0	0	0	0
Reversal of write-down previously taken to SoCI	0	0	0	0	0	0	0
Transfers (to)/from other bodies	0	0	0	0	0	0	0
Transfers (to) Foundation Trusts	0	0	0	0	0	0	0
Balance at 31 March 2012	450	2,449	0	0	0	0	2,899

Inventories	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000
Balance at 1 April 2010	537	2,265	0	0	0	0	2,802
Prior period adjustment	0	0	0	0	0	0	0
Merger adjustment	0	0	0	0	0	0	0
Restated at 1 April 2010	537	2,265	0	0	0	0	2,802
Additions	7,895	29,292	0	0	0	0	37,187
Inventories recognised as an expense in the period	(7,877)	(28,086)	0	0	0	0	(35,963)
Write-down of inventories (including losses)	0	0	0	0	0	0	0
Reversal of write-down previously taken to SoCNI	0	0	0	0	0	0	0
Transfers (to)/from other bodies	0	0	0	0	0	0	0
Transfers (to) Foundation Trusts	0	0	0	0	0	0	0
Balance at 31 March 2011	555	3,471	0	0	0	0	4,026

29 Trade and other receivables

29.1 Trade and other receivables	Current		Non current	
	31st March 2012 £000	31st March 2011 £000	31st March 2012 £000	31st March 2011 £000
NHS receivables	1,409	1,141	0	0
Other receivables with related parties	1,629	865	0	0
Provision for impaired receivables	(560)	(240)	0	0
VAT	382	143	0	0
Prepayments	529	349	0	0
Accrued income	94	275	0	0
PDC receivable	68	51	0	0
Other receivables	104	22	0	0
Total	3,655	2,606	0	0

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 renegotiated 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.

29.2 Provision for impairment of receivables	31st March 2012	31st March 2011
	£000	£000
Balance at 1 April 2011	240	109
Adjustments	0	0
Restated balance at 1 April 2011	240	109
Amount written off during the year	0	(9)
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	320	140
Balance at 31 March	560	240

29.3 Impaired receivables past their due date	31st March 2012	31st March 2011
	£000	£000
By up to 30 days	143	118
By 30 to 60 days	0	0
By 60 to 90 days	0	0
By 90 to 180 days	0	0
By over 180 days	417	122
Total	560	240

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

29.4 Receivables past their due date but not impaired	31st March 2012	31st March 2011
	£000	£000
By up to 30 days	843	378
By 30 to 60 days	87	276
By 60 to 90 days	756	58
By 90 to 180 days	72	177
By over 180 days	13	99
Total	1,771	988

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

30 Other financial assets

The Foundation Trust has no other Financial Assets

31 Other current assets

The Foundation Trust has no other Current Assets

32 Cash and Cash Equivalents	31st March 2012	31st March 2011
	£000	£000
Balance at start of period	17,264	13,708
Net change in year	215	3,556
Balance at end of period	17,479	17,264
Made Up Of		
Cash at commercial banks and in hand	58	14
Cash with the Government Banking Service	17,421	17,250
Other current investments	0	0
Cash and Cash Equivalents as in Statement of Financial Position	17,479	17,264
Bank overdraft	0	0
Cash and Cash Equivalents as in Statement of Cash Flows	17,479	17,264

33 Non-Current Assets Held for Sale

There are no Non Current Assets held for sale.

34 Trade and other payables	Current	
	31st March 2012	31st March 2011
	£000	£000
Receipts in Advance	21	(2)
NHS payables - revenue	2,854	2,029
NHS payables - capital	0	0
Other trade payables - revenue	2,924	2,208
Other trade payables - capital	837	999
Taxes payable	1,281	1,132
NHS Pension Scheme Liability	606	586
Other payables	311	858
Accruals	5,593	4,865
Total	14,427	12,675

35 Borrowings	Current		Non-current	
	31st March 2012 £000	31st March 2011 £000	31st March 2012 £000	31st March 2011 £000
Finance lease liabilities	287	220	798	170
Total	287	220	798	170

36 Finance lease obligations

The Foundation Trust has entered into lease arrangements for medical equipment associated with the 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. Upon expiry of the original lease term the leased equipment has been either returned to the lessor, purchased outright within the Capital Programme or been the subject of a new lease agreement

The difference between the future minimum lease payments and their present value is the interest rate implicit in the lease which is £196k at 31st March 2012.

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease payments	
	31st March 2012 £000	31st March 2011 £000	31st March 2012 £000	31st March 2011 £000
Within one year	343	242	288	220
Between one and five years	821	173	682	170
After five years	117	0	115	0
Less future finance charges	(196)	(25)	0	0
Present value of minimum lease payments	1,085	390	1,085	390
Included in:				
Current borrowings	(287)	220	(287)	220
Non-current borrowings	(798)	170	(798)	170
	(1,085)	390	(1,085)	390

The Foundation Trust does not have sublease arrangements.

37 Finance lease receivables (i.e. as lessor)

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

38 Finance Lease Commitments

The Trust does not have any Finance lease commitments at 31st March 2012 as all lease agreements are recognised within Finance lease obligations note 36.

39 Other Financial Liabilities

The Trust does not have any other Financial Liabilities

40 Deferred Income	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Opening balance at 01/04/11	1570	1092	0	0
Deferred income addition	1656	1654	0	0
Release to SOCI	(1,604)	(1,176)	0	0
Current deferred Income at 31 March 2012	1,622	1,570	0	0
Total other liabilities (current and non-current)	1,622	1,570		

41 Provisions	Current		Non-current	
	31st March 2012 £000	31st March 2011 £000	31st March 2012 £000	31st March 2011 £000
Legal claims	20	30	0	0
Equal pay	556	576	0	0
Other	341	64	0	0
Total	917	670	0	0

	Legal claims £000	Equal pay £000	Other £000	Total £000
At 1st April 2011	30	576	64	670
Arising during the year	20	0	300	320
Used during the year	(25)	(19)	(24)	(68)
Reversed unused	(5)	0	0	(5)
At 31st March 2012	20	557	340	917

Expected timing of cash flows:

Not later than one year	20	557	340
later than one year and not later than five years	0	0	0
later than five years	0	0	0

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

£m	
As at 31st March 2012	1,962
As at 31st March 2011	1,567

41 Provisions (continued)

The Foundation Trust has total provisions at 31st March 2012 of £917k. Within this total the largest provision is for £556k 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 process is ongoing.

Other provisions includes a provision of £200k for an Exit package for a Senior Officer and £100k for the residual value of fixed assets in respect of PACS

The Foundation Trust has a provision for Liability to Third Parties legal claims of £20k 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.

The remainder of provisions of £41k relates mainly to an onerous contract.

42 Other Liabilities

	Current	
	31st March 2012	31st March 2011
	£000	£000
Deferred grants income	38	369
Other deferred income	1,584	1,201
	<u>1,622</u>	<u>1,570</u>

43 Contingencies

43.1 Contingent Liabilities

	31st March 2012	31st March 2011
Other contingent liabilities	(10)	(14)
Total	<u>(10)</u>	<u>(14)</u>

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

43.2 Contingent Assets

The Foundation Trust does not have any contingent assets .

44 Financial Instruments

44.1 Financial assets

	At fair value through Income & Expenditure	Loans and receivables	Total
	£000	£000	£000
Receivables - NHS excluding non financial assets		1,017	1,017
Receivables - Non NHS excluding non financial assets	0	2,186	2,186
Other investments	0	0	0
Other financial assets	0	0	0
Cash and cash equivalents	0	17,479	17,479
Total at 31st March 2012	<u>0</u>	<u>20,682</u>	<u>20,682</u>

Receivables - NHS excluding non financial assets	0	1,149	1,149
Receivables - Non NHS excluding non financial assets	0	1,261	1,261
Other investments	0	0	0
Other financial assets	0	0	0
Cash at bank and in hand	0	17,265	17,265
Total at 31st March 2011	<u>0</u>	<u>19,675</u>	<u>19,675</u>

44.2 Financial liabilities

	At fair value through Income & Expenditure	Other financial liabilities	Total
	£000	£000	£000
Obligations under finance leases		1085	1,085
NHS payables excluding non financial assets	0	5,856	5,856
Non-NHS payables excluding non financial assets	0	6,337	6,337
Provisions under contract	0	1,121	1,121
Total at 31st March 2012	<u>0</u>	<u>14,399</u>	<u>14,399</u>
Obligations under finance leases	0	390	390
NHS payables excluding non financial assets	0	3,061	3,061
Non-NHS payables excluding non financial assets	0	7,674	7,674
Provisions under contract	0	670	670
Total at 31st March 2011	<u>0</u>	<u>11,795</u>	<u>11,795</u>

Provisions under contract are held at book value

44.3 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 2012 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.

44.4 Maturity of Financial Liabilities

The Foundation Trust has no Financial Liabilities.

45 Events After the Reporting Period

The Foundation Trust has had no material events after the end of the reporting period.



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