Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Annual Report and Accounts **2012/13**

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

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

Contents

Chair and Chief Executive's Foreword

Firstly, we must pay tribute to the ongoing commitment and dedication of all staff and volunteers who always put patients at the centre of everything we do.

As a result of living up to our mission of 'Excellent, Compassionate and Safe care for every patient, every day', our focus on delivering patient and family centred care saw us win the HSJ Hospital of the Year Award in 2012.

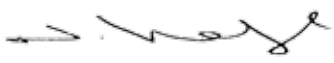
Our new cardiac ward, Oak Ward, opened in February providing modern, hotel style accommodation for patients and family members. We have developed a new model of care, which we believe will be a first in the UK and in much of the rest of the western world. The model replaces a recovery inpatient model with a rehabilitation inpatient model. This is a really exciting innovation, designed to improve outcomes, patient experience and reduce costs.

Through our Staff Experience Vision, we have developed leadership in all areas throughout the organisation and focussed on staff well-being. In the recent staff survey results, the Trust was in the top 5 in the UK for staff confirming they would recommend the hospital.

As a large research Trust, we opened a new Research Unit during the year, as part of our aim to expand our research activities. Our partnership with the Royal Brompton & Harefield NHS Foundation Trust and Imperial College London has made good progress and we have embarked upon some innovative research trials, including a First in Man Study.

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.

Both the Governors and the wider membership have continued to give their time freely to support the hospital and its work and for that we are very grateful.



Neil Large
Chairman

Raj Jain
Chief Executive

Key achievements of 2012/13

- Voted best hospital provider of the year by the Health Service Journal for 2012
- Full roll out across the hospital of the Patient Experience Vision and the Staff Experience Vision
- 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 August 2012. The Trust was inspected on 5 standards, and found to be fully compliant in all of them.
- All minimum standards of care met or exceeded as defined by the Department of Health.
- Achievement of all cancer waiting time targets
- The lowest mortality rate in the country for aortic surgery, 10% versus the average national of 22.8%.
- Delivery of the best heart attack and coronary bypass grafting services in the region.
- 96% of our patients confirmed they would "definitely recommend" Liverpool Heart and Chest Hospital to their family and friends and 86% said the care we provided exceeded their expectations
- Embedding and expanding our volunteers scheme
- Main site (one of only two) as a national pilot 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
- Second year of the Institute of Cardiovascular Medicine and Science, in collaboration with Royal Brompton and Harefield NHS Foundation Trust and Imperial College London; significant progress made on collaborative research, education and service development as a consequence of this venture

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

Liverpool Heart and Chest Hospital is one of the largest specialist heart and chest hospitals in the UK, providing specialist services in cardiothoracic surgery, cardiology, respiratory medicine including adult cystic fibrosis and diagnostic imaging. In 2012/13 the Trust was rated as the top performing hospital for "overall patient care" in the Care Quality Commission's National Inpatient Survey for the sixth year running and won the HSJ Hospital of the Year Award.

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 in 2012/13 was £112.0m, an increase of 4.9% from 2011/12 reflecting continuous growth in the demand for services in recent years. The total income was derived from a number of key contracts; £69.4m from North West Specialist Commissioning Team for Tertiary Care activity (including £2.6m for activity from the Isle of Man), £14.7m from the Welsh Health Specialised Services Committee, £9m from North West PCTs for Secondary Care activity, £3.1m from Community contracts, £2.9m from Private Patient work, £2.6m for Clinical Education and Training and £0.57m in support of Research and Development activities.

The table below demonstrates the movement in patient activity numbers since 2009/10:

	2009/10	2010/11	2011/12	2012/13	3 Year Growth %
Surgery inpatients	3,572	3,604	3,356	3,636	1.8%
Cardiology inpatients	8,555	8,858	9,186	8,888	3.9%
Outpatients	59,257	62,794	64,226	63,968	7.9%

Whilst elements of growth had been planned with commissioners and continue to reflect the Trust's success in securing additional contracts to deliver end to end care in the community for local patients suffering with Chronic Obstructive Pulmonary Disease (COPD) and the management of Cardiovascular Disease (CVD) services, the Trust has experienced material levels of unplanned additional activity in 2012/13.

Throughout 2012/13, the Trust has continued to achieve success with regards to its ambitions to deliver the Patient Experience Vision finishing first in the country for "overall patient care" in the national inpatient survey for the sixth year running plus winning the Health Service Journal, Provider of the Year 2012 award. The Trust achieved most of its quality and safety measures and continued to invest in its estate and facilities opening a new Research and Development department as well as the new, state of the art Oak Ward.

Analysis of 2012/13 Financial Performance

The Trust's financial plans for 2012/13 required the delivery of a surplus of £1.1m (after the achievement of a £4m cost improvement programme). The Trust achieved a normalised surplus of £1.24m as summarised in the table below:

	2012/13 Plan £'000	2012/13 Actual £'000	Variance £'000
Income	107,592	112,036	4,444
Costs			
Pay	(59,219)	(60,014)	(795)
Direct Non-Pay	(34,891)	(37,243)	(2,352)
Overheads	(6,222)	(7,389)	(1,168)
EBITDA	**7,260**	**7,390**	**130**
Net Finance Costs	(6,181)	*(9,873)	(3,692)
Surplus	**1,079**	**(2,483)**	**(3,562)**
Add back Exceptional Costs	**N/A**	**3,725**	**3,725**
Normalised Surplus	**1,079**	**1,242**	**163**

* Net Finance Costs include an impairment £3.5m

Income is above plan for 2012/13 by £4.4m (4.3%). This has been driven by a number of factors:

The North West Specialist Commissioning and secondary care contracts combined, over performed by £2.7m. The key areas of over performance included Upper Gastrointestinal Surgery (25%), Thoracic Surgery (19%), Electrophysiological Studies (15%), Endobronchial Ultrasound (13%), Critical Care (8%) and Outpatient appointments (2.4%).

The Welsh Contract over performed by £0.2m predominantly based on over performance in Thoracic Surgery (27.5%) and Catheterisation procedures (49%). Overall the activity was 0.3% below plan but the case mix resulted in a financial over performance.

Activity from the Isle Man and non-contracted areas over performed by £0.2m and £0.3m respectively whilst income recovered for the cost of high cost devices and drugs excluded from tariff, over recovered by £0.6m.

Private patient income under performed by £0.67m. This is driven by below plan activity which has been mitigated in part by a pricing increase, following a review of prices in year.

Other income over performed by £1m and included various sources of income including Grant/Commercial Trials and Research and £0.5m from donated income towards the cost of the new Research and Development Department.

Costs and Cost Improvement Programme

The Trust's costs in 2012/13 were above plan by £4.3m (4%) reflecting additional costs incurred in delivering higher than anticipated levels of activity. Inpatient activity was 4% above plan, Critical Care activity 7% above plan and Outpatient activity 2.2% above plan.

Pay costs were £0.8m (1.3%) above plan and include a provision for restructuring costs of £0.3m. The over spend reflects increased activity and ward occupancy levels. Additional costs were incurred to ensure adequate levels of staff were present to ensure continued patient safety and to maintain the high standard of care that patients can expect from the Trust. Additional and temporary increases in staff came at a premium rate but were essential during periods of high occupancy.

Direct non pay costs were above plan by £2.4m (6.7%) mainly in relation to Clinical supplies reflecting the high levels of activity.

The Trust also delivered a Cost Improvement Programme (CIP) of £4.3m or 4% of its operating expenditure over the period. The savings can be categorised as follows:

YTD Performance by Category	Plan £'000	Actual £'000	Variance £'000
Income	1,190	596	-594
Pay	957	1,290	333
Non Pay	2,024	2,395	371
Total	**4,171**	**4,281**	**110**

Key enabling strategies that produced 2012/13 cost savings included procurement practices, skill mix reviews, additional revenue generation and Service Line Reporting reviews that led to standardisation of products and practices.

CIP schemes are identified by Directorates and are subject to review via the Trust Senior Management Team and Executive Team but also through appropriate Assurance Committees (Workforce, Finance, Clinical Quality, and Patient and Family Experience) to ensure they will not have a detrimental effect upon patient safety or quality of care.

Capital Investments and Cash flow

During the 2012/13 financial year, the total capital investment in improving the hospital facilities was £10.5m. The main investments included £2.1m to build a new state of the art ward to replace Oak Ward. The project included the relocation of the Executive offices into modular accommodation to vacate the area within the main hospital building required for the build.

The Trust's main project in year was the development of an Electronic Patient Record with £3.6m invested to date. The project is due to go live in June 2013 and will mean the replacement of all paper health records with an electronic system that has added functionality in excess of traditional recording of information.

A new Research and Development Unit was built at a cost of £0.8m supported by £0.5m from donated funds and work started on a new Day Ward due to open in December 2013.

Replacement medical equipment costs were £1.0m and £1.2m was invested in improving Information Technology and IT resilience. The Picture Archiving and Communication System in the Radiology Department was also replaced at a cost of £0.5m.

2012/13 Capital Programme Summary	£'m
Electronic Patient Record	3.6
New Build Wards and Departments	3.5
Information Technology	1.7
Medical Equipment	1.0
Backlog Maintenance and Other	0.7
Total Investment	**10.5**

After funding the capital programme outlined above, the Trust has a closing cash balance of £14.8m as at 31st March 2013. This was £6.5m ahead of plan and reflects slippage in the original Capital Expenditure Programme of £2.3m and movements in working capital. This cash will be carried forward to fund the capital investment rolled forward into next year together with further investment in future years.

Financing

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

	Limit £m	Utilised £m
Prudential Borrowing Limit (PBL)	20.5	1.0
Working Capital Facility (WCF)	7.6	0.0
Total Borrowing Limit	**28.1**	**1.0**

The Trust has had no call to use the WCF over the period and some £1m of lease costs were charged against the PBL.

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. During the year cash investments accrued £74k of interest.

Monitor Key Financial Indicators

Financial Risk Ratings	Plan	Actual
Underlying Performance – EBITDA Margin	3	3
Achievement of Plan – EBITDA Achieved	5	4
Financial Efficiency – Return after financing	3	3
Financial Efficiency – Net Surplus Margin	2	3
Liquidity	3	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 overall FRR of 3.35 (rounded to level 3) in 2012/13 which was marginally ahead of 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 with patient activity levels exceeding plan, the Trust has successfully delivered its financial plan including the delivery of £4.3m of efficiency and savings. Plans for 2013/14 have been set and aim to build upon this year's strong performance, with further investment in the Trust's Estate and the introduction of the Electronic Patient Record, 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.

The Trust has 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.

The Trust is also implementing an environmental management system and policy incorporating carbon management, travel and procurement.

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 its 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 on-going improvement against relevant quality and safety indicators, chosen from their relevance to the objectives set either in the annual plan, key strategies or CQUIN and quality account priorities.

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

Capacity to Delivery 2012/13 CQUIN Targets – this risk has centred on:

- The ability to transfer patients requiring urgent cardiac surgery within seven days of referral and acceptance for transfer. The Trust has had to develop new processes for receipt, documentation and internal management of referrals together with the creation of additional non-elective theatre capacity. These initiatives have been successful in allowing the Trust to hit its targets up to Q3 of 2012/13. However, the change in theatre utilisation is putting additional pressure on the cardiac surgery service line to hit the elective (18 week) referral to treatment target.

- Delivery of timely communications to general practitioners. Work has been underway to develop internal systems within the Trust capable of interfacing with CCG provided "Mersey Information Gateway". This is the equivalent of an electronic sorting office which can ensure the accurate and timely delivery of electronic communications addressed to GPs. After some technical delays, the system is now under test with a plan to roll out to all GPs in 2013/14 if successful.

In addition, the Trust has actively managed the number of patients with hospital acquired Clostridium Difficile through excellent infection prevention practices. End of year performance was, however, 8 cases, 4 above the target set by commissioners but 4 below the de-minimus set by Monitor.

The Board of Directors is continuously reviewing and improving its assurance systems. A new electronic integrated performance report has been introduced that brings the monitoring of all Trust targets, both internal and external, into one repository. The system has built in benchmarking and time trend analysis.

The Trust also received a report from its internal auditors which reported significant assurance against its Quality Governance Framework. A number of small enhancements were recommended which are in the process of being implemented. A future audit will provide the assurance that these enhancements are working.

Further detail on quality governance and quality is described in the Quality Report section of this document.

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 second unplanned visit in August 2012.

Performance against the Commissioning for Quality and Innovation (CQUIN) schemes:

- Responsiveness to Patients' Needs – partial payment
- Venous Thromboembolism – full payment
- Safety Thermometer – full payment
- Dementia – full payment
- Advancing Quality care bundles – partial payment
- General Practitioner Communication – partial payment
- Medicines Management – full payment
- Pressure Ulcers – full payment
- Patient Falls – full payment
- Patient Dietetics – full payment
- Care of the Dying Pathway – full payment
- Health and Wellbeing Strategy – full payment
- Nurse Led Discharge – full payment
- Urinary Tract Infection – partial payment
- Implementation of Clinical Dashboards – full payment
- Urgent referrals treated within seven days – partial payment

	Annual Plan 2011/12	Q1	Q2	Q3	Q4
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Green	Green	Amber-green	Amber-green

	Annual Plan 2012/13	Q1	Q2	Q3	Q4
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Amber-green	Green	Amber-green	Green

Overall the Trust expects to recover 88.5% of its full CQUIN allocation. However, a final decision on CQUIN payments is yet to be agreed with commissioners.

Performance against Quality Account priorities:

- Improve the experience of care for patients – improvements fully delivered
- Improve the coverage of outpatients receiving a blood sugar test – improvements partially delivered
- Upskill staff to deliver excellent clinical care – improvements fully delivered
- Improve the assessment of quality of life in heart disease patients – improvements fully delivered

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

1.3 Any new or significantly revised services

During 2013, we opened the newly refurbished Oak Ward as mentioned in the Chair and Chief Executive's foreword. This is based on a new model of care which explores the concept of identifying a care partner for the patient when they are admitted to hospital and seeing what elements of care that care partner would like to be involved in. This will be somebody who knows the person well and will help staff to better understand the person behind the patient. The contract of care, which also forms part of this service improvement work, is also being considered. The aim of this contract is that it will contain an understanding of the needs/preferences of the patient and family so that staff can better meet their needs. Work for the Oak Ward model of care and design of the ward has been completed with full patient and family engagement. The Risk assessment booklet has been further developed to identify patients with comorbidities.

1.4 Working with our Patients and Visitors

The Trust has continued to run engagement events to capture feedback from patients and families on their experience of the hospital, either as an outpatient or inpatient. The engagement time was also used to explore the mission statement and how this has been achieved in the delivery of excellent, compassionate and safe care for every patient, every day.

Feedback was sought from patients and their families on the key components of excellence, compassion and safety. The aim was to understand their perspectives to enable us to highlight any improvements and provide an opportunity to embed these into service improvement initiatives where applicable. The events have been supported by representation from the Executive Team, Non-Executive Directors, Governors, Liverpool LINk and clinical staff.

Quotations from patients and families attending the events:

'I arrived at 9am and was back home post procedure at 5.30pm. Amazed at the quickness of stay and being home so fast.'

'I had not heard of the Heart and Chest hospital, so I was a bit worried. Felt very safe and supported by staff once I was there.'

'The heart failure team were in regular contact – very good. Felt someone was always available if concerned.'

'On arrival I felt safe and confident, that the treatment would be of the best available throughout the whole country.'

Key actions:

- The Trust has developed a network of staff champions to energise patient and family centred care which will support the key elements of delivering compassionate care. Training has been delivered at staff induction and during preceptorship to embed the principles of delivering compassionate care. The staff champions will continue to meet monthly to monitor progress and further training sessions are planned for 2013.

- The Learning and Development Department has developed and piloted a new induction and preceptorship programme for all newly recruited qualified nursing staff. The programme is focused strongly on the Patient Experience Vision with an emphasis on delivering compassionate care to patients and families. Evaluation of the programme was very positive and it has been rolled out to all new starters within the organisation in March 2013.

- The Trust has involved patients in assessing the care environment through the Patient Led Assessment of Care Environment (PLACE) initiatives. This has enabled the Trust to embed the feedback from patients and demonstrate actions such as ensuring availability of hand gels and cleanliness. The Senior Nurse team has a programme of walkabouts to monitor standards of professionalism and maintain the confidence of patients and families.

- Directions – Through the Enhancing the Healing Environment project, the Trust is developing the signage to support patients with directions in hospital. External signage has been improved in the hospital grounds, however further exploration is being carried out to try and improve the internal signage.

Critical Care Rooms

Work has been undertaken by previous patients and families who spent time in the critical care areas and identified what they wanted the critical care family rooms to look and feel like, alongside the multi-disciplinary team. These discussions allowed plans to be drawn up and this project has now been sent to tender.

Cancer event

A cancer engagement event was held in April to determine what the experience was of patients and their families against the six steps of the Patient Experience Vision. Feedback from this event will be actioned when further work is undertaken in relation to the cancer strategy. This will be presented to Patient and Family Experience Committee in 2013.

Support groups

"Little and Often" group
Regular engagement is held with the Little and Often group, with meetings being held monthly. Discussion and support is offered and speakers are provided at the request of the group.

Marfans /Aortic services
The aortic support group meets on a bi-monthly basis. The Aortic Team also hold quarterly patient educational events and the agenda is patient and family led. Previous sessions have focussed on information about aortic and Marfans services, the new Oak Ward, patient and family centred care, as well as a tour of the mock up room for Oak Ward and the theatre department. The support group enabled patients and families (both new and existing patients / families) to provide feedback about their experiences.

Critical Care – Family engagement group
The patient support group (follow-up after Critical Care) runs monthly and is advertised in the "steps" booklet that is provided to families and is promoted both within ITU and by the Outreach Service. The support group is led by the outreach nurses in conjunction with an Intensivist with the aim to support patients and families with any problems they may have had following discharge. The forum enables patients and families to discuss their experiences with other patients or on a one to one basis if necessary. Improvement work is undertaken when issues are identified

Patient and family shadowing

Patient and family shadowing is a method to capture in real time the care experience of patients and families at LHCH. A committed and empathic shadower follows a patient and/or the patient's family throughout a selected care episode. All disciplines of staff both clinical and non-clinical have the opportunity to engage with a patient and/or their family through shadowing to understand how care is delivered at LHCH as seen through the eyes of the patient.

This work is aligned to the Trust's Patient and Family Experience Vision. The project has been underway for almost a year and to date, over 70 patient and family shadows have been achieved.

Shadowing has demonstrated care delivered with compassion and many examples of exemplar care but has also shown potential for improvement where patients' preferences could be better reflected. For example, in the outpatients department visual teaching aids are now used and patients are encouraged to write down pertinent information during the consultation.

Shadowing has also demonstrated how willing patients are to participate in feedback techniques and patients have often reported how much they enjoyed the shadowing process. Staff have also embraced the opportunity to engage with patients and their families to understand, and gain insight into, the care experience. Staff have described an increased sense of empathy and how they now understand the needs of their patients and families better following shadowing.

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. The Trust continued to work closely with the LINk/HealthWatch. Further information is detailed in the Quality Account.

Improvements in patient/carer information

During the year, all the written patient information for families and carers has been reviewed in line with comments made from patients and additional information has been included in our booklets. During the year, a further 21 new booklets were produced and other areas have been identified where more written information is required, for example, for new procedures or surgical techniques. Good progress has been made in this area.

Discharge information has also been reviewed and is available in large print. There are information fact sheets available for family members in the Critical Care Unit. These provide families with information regarding procedures that their relative may have during their time on the Unit.

In addition, many of the patient information leaflets are available in audio format for the most frequently performed procedures including cardiac surgery, cardiac rehabilitation, lung surgery and insertion of a permanent pacemaker and many more. Information is also available in different formats/languages on request.

Information on complaints handling

The Trust aims to deliver care and services to the highest standards but recognises that if expectations are not met that we will receive complaints. The Trust recognises that it can learn from the complaints received and thereby improve the quality of services. It strives to assist people in presenting their concerns and complaints about services and care and in achieving a satisfactory resolution and outcome to complaints. The importance of properly managing complaints in the NHS is recognised at the highest level and this is reflected the 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 70 complaints from 1st April 2012 to 31st March 2013. 100% of complaints were acknowledged within the Department of Health timeframe of three days and 100% responded to within the negotiated timeframe.

The above figures demonstrate that the Trust has 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. The Trust not only uses complaints for information, but also maps this against other sources of patient feedback and experience such as monthly inpatient satisfaction surveys to provide real time patient feedback to help provide the best possible care for 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.

There is a quarterly Complaints Review Panel headed by Non-Executive Directors. This panel provides assurance to the Trust Board that complaints are being managed appropriately, learnt from, shared widely and embedded within the organisation.

Stakeholder relations

The Trust has continued to work in partnership with Knowsley PCT and Council on providing its community CVD and COPD services to residents in Knowsley.

2. Remuneration Report

Year ended 31st March 2013			
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		3,247
G Russell - Medical Director	25-30	165-170	
D Jago - Director of Finance*	50-55		634
A Cummins – Previous Director of Finance*	15-20		678
M Greatrex – Deputy Director of Finance*	20-25		
S Pemberton - Director of Nursing *	85-90		
H Holmes – Previous Director of Nursing*	5-10		351
M Jackson - Director of Research & Informatics	80-85		
P N Large - Chair	40-45		
P Firby - Non Executive Director	10-15		
R Toomey - Non Executive Director	10-15		
B Leek - Non Executive Director	10-15		
G Appleton - Non Executive Director	10-15		
D Bricknell - Non Executive Director	10-15		

** D Jago commenced as Director of Finance on 24th September 2012*
** S Pemberton commenced as Director of Nursing on 7th May 2013*
** M Greatrex commenced as Deputy Director of Finance on 16th April 2012. During the financial year M Greatrex was acting Director of Finance from 4th June 2012 to 23rd September 2012*
** Aaron Cummins left the Trust on 4th June 2012*
**Hazel Holmes left the Trust on 7th May 2012*

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	5,749
G Russell - Medical Director	25-30	165-170	0
A Cummins - Director of Finance	90-95	0-5	3,009
H Holmes - Director of Nursing	95-100	0-5	4,008
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 2013*

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 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31st March 2013 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31st March 2013 £000	Cash Equivalent Transfer Value at 31st March 2012 £000	Real Increase /(decrease) in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
R Jain - Chief Executive	-2.5-5	-12.5-15	30-35	100-105	614	677	-63	0
G Russell - Medical Director	0-2.5	0-2.5	50-55	160-165	1097	1086	11	0
D Jago - Director of Finance	-0-2.5	-0-2.5	30-35	95-100	556	550	6	0
S Pemberton - Director of Nursing	5-7.5	17.5-20	25-30	75-80	404	293	111	0
Research and Informatics	0-2.5	5-7.5	25-30	75-80	493	442	51	0
Director of Finance	2.5-5	7.5-10	15-20	45-50	214	171	43	0
Director of Finance	5-7.5	17.5-20	15-20	45-50	204	124	80	0
Director of Nursing	2.5-5	12.5-15	30-35	95-100	455	376	79	0

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 2012/13 was £197k (2011/12, £195k). This was 8 times (2012/13) the median remuneration of the workforce, which was £25k, (2011/12 £24k).

The median remuneration of the workforce has increased by £1k for 2012/13 compared to 2011/12. The increase can be attributed to incremental drift and the public sector pay award (2012-13), which has awarded employees earning a full time equivalent of £21,000 or less a pay increase of £250.

In 2012/13, nil (2011/12, 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.

Reporting related to the Review of Tax Arrangements of Public Sector Appointees

In relation to off payroll engagements at a cost of over £58,000 per annum, there have been 3 in place from 31 January 2012 to 31 March 2012.

Raj Jain
Chief Executive
Date: 28th May 2013

3. Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of Liverpool Heart and Chest 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 Monitor.

Under the NHS Act 2006, Monitor has directed Liverpool Heart and Chest 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 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 to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Raj Jain
Chief Executive
Date: 28th May 2013

4. NHS Foundation Trust Code of Governances

The Board of Directors and the Council of Governors are committed to continuing to operate according to the highest standards of corporate governance.

The Trust is compliant with the principles and provisions of the NHS Foundation Trust Code of Governance.

The Board of Directors meets formally seven times each year in order to effectively discharge its duties.

As well as developing strategy, the Board regularly reviews performance against all regulatory and contractual obligations and has established effective governance structures to secure compliance with Care Quality Commission outcomes, NHS Litigation Authority standards and to ensure effective risk management processes.

All Directors have responsibility to constructively challenge the decisions of the Board. 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 Board Assurance Framework in place which is adding value to the Board and robust performance management processes in which Governors undertake the annual appraisal of the Chair led by the Senior Independent Director. In 2012/13, 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. During 2012/13, the policy on the composition of the Non-Executive Directors was updated and approved by the Council of Governors to reflect the skills and competencies required to inform the recruitment process for three new Non-Executive Directors.

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. 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 reviews 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 the bi-annual member newsletters and use of online surveys. During 2012/13, this has been further strengthened following the joint Council of Governors and Board of Directors away day, where it was agreed to set up Governor interest groups. These met from March 2013 before the formal Council meeting and provide an informal opportunity for Governors to consider items on the agenda and network informally with the Non-Executive Directors.

The Council of Governors meets formally on a quarterly basis and has nominated a Senior Governor. In 2012/13 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 2012/13, the Chair had no other significant commitments that conflicted or impacted 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 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 the 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.

The 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 the Rest of England and Wales (1 seat)
- 6 are elected by staff from 4 defined classes – registered and non-registered nurses (2 seats), Non Clinical (2 seats), Allied Healthcare Professionals, Technical and Scientific (1 seat) and Registered Medical Practitioners (1 seat)
- 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 Council of Governors at its joint development day on 13th November 2012, considered the representation of appointed Governors, balancing the time difficulties that appointed Governors can potentially experience with the need for effective engagement and eliminating any potential conflicts of interest.

At its March 2013 meeting, the Council of Governors approved the recommendation to remove the following appointed Governor seats:

- Liverpool PCT (required by the Health and Social Care Act 2012)
- The North West Specialist Services Commissioning Team
- Betsi Cadwaladr University Health Board.

To ensure representation from North Wales, the Council approved the recommendation to include the Association of Voluntary Organisations in Wrexham (AVOW).

This change will come into effect from 1st April 2013, and will bringing the total number of Governors on the Council from 27 to 25. This ensures the Trust remains in line with the Constitution which requires that the number of Public Governors is more than half of the total number of Governors. Previously the number of appointed and staff Governors numbered 13, compared to 14 public Governors.

The names of those who have served as Governor in 2012/13 are listed in the attendance report at the end of this section.

The initial Governors served 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 the Trust (staff Governors) or are no longer supported in office by the organisation that they represent (nominated Governors).

Elections were held for 12 seats (8 public Governors and 4 staff Governors) on the Council of Governors in 2012. Nine seats were uncontested and an election was held for the three Governor seats in the public Merseyside constituency, in accordance with the model election rules.

Governor Development:

The Trust provides many opportunities for Governors to be actively involved and this work makes a real difference to patients and the wider community:

- Governors are involved in reviewing, updating and delivering the membership strategy, recruiting new members and ensuring that member communications are 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 interest groups have been set up, where Governors meet informally before the formal Council of Governors meeting. This provides a further way of Governors interacting and discussing items on the agenda, as well as networking with Non-Executive Directors
- 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 the Staff Experience Vision (including short listing of nominations for annual staff awards); and the 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. The first set of amends under the 2012 Health and Social Care Act came into force on 1st October 2012. These were approved at the Annual Members' Meeting in 2012 and subsequently approved by Monitor. Governors have been involved in considering the remainder of the changes which are expected to come into force during 2013/14.

In addition to the above, the Trust has encouraged development through the provision of training and support including induction for new Governors, attendance at external Governor development events, working groups/ seminar such as financial and quality reporting, individual discussions with the Chair and Trust Secretary and tours of new facilities. 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. At the joint development day, Governors evaluated the performance of the Council of Governors and identified actions and objectives for the next 12 months. They also considered the forthcoming changes in legislation and the differences this will bring to their roles.

Elections

The Board of Directors can confirm that elections for public and staff governors held in 2012/13 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	Vera Hornby Brian Roberts Saad Al-Shukri
Cheshire (Election Uncontested)	2	Ken Blasbery David Hicks
North Wales (Election Uncontested)	2	Michael Bowyer Roy Griffiths
Rest of England and Wales (Election Uncontested)	1	Tony Roberts
Staff		
Non Clinical (Election uncontested)	1	Tony Grimes
Qualified and Unqualified Nurses (Election uncontested)	1	Peter Hannaford
Registered Medical Practitioners (Election uncontested)	1	Dr Mike Desmond
Allied Health Professionals, Technical and Scientific (Election uncontested)	1	Doreen Russell

The above Governors were elected/ re-elected for 3 years and their tenures will complete at the end of the 2015 Annual Members Meeting.

In November 2012, Dave Foulkes (staff constituency Registered and Non-registered Nurses) and Caroline Jackson (public constituency North Wales) resigned from their seats. Both seats were filled by the next highest polling candidates in the respective elections, Neville Rumsby, for the staff constituency seat and Denis Bennett for the public constituency seat. Both took up their posts from December 2012 and will hold office until the end of the 2014 Annual Members' Meeting. In addition, Saad Al-Shukri resigned from his public constituency seat for Merseyside in January 2013. The seat was filled by the next highest polling candidate, Neil Marks, who will also hold office until the end of the 2014 Annual Members' Meeting.

Governor Attendance at Council of Governor Meetings 2012/13

Governor Name	Council of Governor Meeting Dates 2012/13			
	11th June 2012	24th September 2012	3rd December 2012	4th March 2013
Public Constituency				
Merseyside				
Ken Halligan	X	X		
Vera Hornby	√	√	√	√
Mandy Jones	X	X		
Debbie Mawson	√	X	√	√
Paula Pattullo	√	√	√	√
Roy Stott	√	√	√	√
Brian Roberts			√	√
Saad Al-Shukri			X	
Neil Marks				√
Cheshire				
Kenneth Blasbery	√	√	√	√
Michael Brereton	√	√	√	√
David Hicks	√	√	√	√
Judith Wright	X	X	√	√
North Wales				
Roy Griffiths	√	√	√	√
Caroline Jackson	X	X		
Michael Bowyer	√	X	X	√
Denis Bennett			X	√
Rest of England and Wales				
John (Tony) Roberts	√	X	√	√
Staff Constituency				
Registered Nurses and Non-Registered Nurses				
Peter Hannaford	√	√	√	√
David Foulkes	X	X		
Neville Rumsby			√	√
Non Clinical				
Christine Bell	X	√	√	√
Anthony Grimes	X	√	√	√
Allied Health Professionals, Technical and Scientific				
Bashir Matata	X	√		
Doreen Russell			√	√

Governor Name	Council of Governor Meeting Dates 2012/13			
	11th June 2012	24th September 2012	3rd December 2012	4th March 2013
Staff Constituency (continued)				
Registered Medical Practitioners				
Johan Waktare	X	X		
Michael Desmond			√	√
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	X
Menna Harland (Liverpool John Moores University)	√	√	√	X
Jake Morrison (Liverpool City Council)	√	√	√	X
Vacant (Cystic Fibrosis Trust)	X	X	X	X
Vacant (Betsi Cadwaladr University Health Board)	X	X	X	X

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.

During 2012/13, two new Executive Directors (Nursing and Finance) and an Associate Director (Service Improvement) took up post.

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 participates 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 and the review of competencies and skills to inform the recruitment of three new Non-Executive Directors, ahead of three current Non-Executive tenures enduring 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. During 2012/13, the Board had agreed to develop a new 'lite' Integrated Business Plan and associated Board development plan, in order to meet the challenges of the changing NHS landscape. This piece of work will be completed for the Board away day in December 2013.

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 new Non-Executive Directors join.

The Board and Audit Committee have evaluated the effectiveness of Board Committees in accordance with the 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 2012/13 were as follows:

Name	Position	Date appointed	Expiry of current term of office
Neil Large *Qualified accountant and diverse NHS career spanning 40 years*	Chairman	1st December 2009 *	13th October 2013
Patricia Firby *Registered nurse with 25 years' experience in nurse education, MSc in Social Research Methods*	Senior Independent Director and Deputy Chair	1st December 2009 *	31st May 2013
Robert Toomey *Qualified accountant and doctorate in economic history with experience of board level roles in a number of private sector organisations*	Non-Executive Director and Chair of Audit Committee	1st December 2009 *	30th April 2013
Bridget Leek *BSC in Mathematics and Fellow of Institute of Actuaries with 10 years senior level experience in the financial industry.*	Non-Executive Director	1st December 2009 *	31st May 2013
David Bricknell *Master in Research and PhD in strategic decision making with a career in the legal industry.*	Non-Executive Director	2nd March 2010 Term extended from 1st March 2013	28th February 2016
Geoffrey Appleton *LLB (Hons) and MA in Criminology with extensive experience in legal and personnel roles.*	Non-Executive Director	2nd March 2010 Term extended from 1st March 2013	28th February 2016

* 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. Following successful performance appraisals, the Council of Governors approved the re-appointment of both David Bricknell and Geoffrey Appleton for further three year terms each, effective from 1st March 2013. In addition, in light of current Non-Executive Director tenures ending during 2013, Pat Firby stepped down from the Deputy Chair and Senior Independent Director roles. The Council of Governors approved the appointed of Geoffrey Appleton as Deputy Chair and David Bricknell as Senior

Independent Director and identified Non-Executive Director for whistleblowing. Both of these appointments were effective from 1st January 2013.

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 2012/13 were as follows:

Name	Position
Raj Jain *BA (Hons) with previous NHS Board level experience as Executive Director for Workforce and Service Improvement and FT Project Director at Salford Royal NHS FT.*	Chief Executive
Glenn Russell *Consultant Anaesthetist (Member of Liverpool Society of Anaesthetists) with extensive experience in cardiac anaesthesia both in the UK and overseas.*	Medical Director and Deputy Chief Executive
Hazel Holmes (until 7th May 2012) *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.*	Director of Nursing
Aaron Cummins (until 3rd June 2012) *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.*	Director of Finance
Mark Jackson *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.*	Director of Research and Informatics
Sue Pemberton (w.e.f. 8th May 2012) *BSc (Hons), Diploma in Professional Nursing Practice. Previous roles have included Deputy Director of Nursing and Governance at LHCH, Assistant Director of Nursing and Lead Nurse, both at Salford Royal NHSFT.*	Director of Nursing
David Jago (w.e.f. 24th September 2012) *BA (Hons), Member of Chartered Institute of Public Finance and Accounting. Previous roles have included Director of Finance, Procurement and IM&T at Tameside Hospital NHS Foundation Trust, Deputy Director of Finance at University Hospital South Manchester and Deputy Director of Finance at Conwy and Denbighshire NHS Trust.*	Director of Finance

Attendance at Board of Directors Meetings 2012/13

Director	24th April 2012	30th May 2012	24th July 2012	30th October 2012	27th November 2012	29th January 2013	26th March 2013
Neil Large (Chair)	√	√	√	√	√	√	√
Raj Jain	√	√	√	√	X	√	√
Patricia Firby	√	√	√	√	√	√	√
Robert Toomey	√	√	√	√	√	√	√
Bridget Leek	√	√	√	√	√	√	√
David Bricknell	√	√	√	√	√	X	√
Geoffrey Appleton	√	√	√	√	√	√	√
Glenn Russell		√	√	√	√	√	√
Hazel Holmes	X						
Sue Pemberton		X	√	√	√	√	√
Aaron Cummins	√	√					
Mark Greatrex (Acting DoF)			√				
David Jago				√	√	√	√
Mark Jackson	√	√	√	√	√	√	√

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 2012/13.

Attendance at Audit Committee meetings 2012/13

Member	16th April 2012	30th May 2012	17th September 2012	15th October 2012	19th November 2012	14th January 2013	18th March 2013
Robert Toomey (Chair)	√	√	√	√	X	√	√
Patricia Firby	√	√	X	√	√	√	√
Bridget Leek	√	√	√	√	√	√	√
David Bricknell	√	√	√	√	√	√	√
Geoffrey Appleton	√	√	√	√	√	√	√

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 2012/13 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 were involved in the selection process for the new external audit contract, which was approved by the Council of Governors on 24th September 2012.

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 2012/13, 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).

The Committee oversaw the recruitment process during 2012/13 of three new Non-Executive Directors. This involved reviewing the skill mix needed to complement existing Board skills, updating the policy on the composition of the Non-Executive Directors, agreeing the advertising process and job specifications, shortlisting the candidates and interviewing candidates. Adverts were placed by the Trust for the three Non-Executive Directors. Three public Governors were on the interview panel and the Committee recommended the appointment of three candidates to the Council of Governors at the meeting on 4th March 2013. During this financial year, the committee met on 5 occasions in addition to interviewing the candidates.

Nominations & Remuneration Committee (Executive)

Membership: Chaired by Neil Large with all other Non-Executive Directors as members. The Chief Executive was in attendance for all matters, apart from those relating to the Chief Executive.

The Committee met on two occasions in 2012/13.

Attendance at Nominations and Remuneration Committee (Executive) in 2012/13:

Member	24th April 2012	24th July 2012
Neil Large (Chair)	√	√
Patricia Firby	√	√
Robert Toomey	√	√
Bridget Leek	√	√
David Bricknell	√	√
Geoffrey Appleton	√	√

During 2012/13 two new Executive Directors (Nursing and Finance) and an Associate Director (Service Improvement) took up post. The work of the committee ensured that the new directors had appropriate induction and development plans that would support them in becoming successful members of the team.

The committee heard from the Chief Executive on his plans to develop the new team so that it could reach the high performance of the previous team. A structured development process was agreed. This includes development at individual and team level.

The committee reviewed a succession plan that covered all directors and their reports. This plan included the development of existing staff and the identification of individuals elsewhere in the health economy of the North West.

The performance of each member of the Executive Team was reviewed, including the Chief Executive. The committee noted the contribution made by Executives to the exceptional performance of the Trust.

The committee determined that given the financial challenges faced by the Trust and staff, that it was not appropriate to award an increase to pay scales.

4.5 Membership

The Trust is committed to ensuring that 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.

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. The Trust operates an 'opt out' basis. The staff constituency is divided into four classes to reflect the 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

The Trust believes that its membership makes a real contribution to improving the health of the local communities and our emphasis is on encouraging an active and engaged membership.

The 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 contributes to and supports 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, the Membership Strategy was reviewed and updated. The membership plans are to:

- Continue to grow a membership that is representative of the patient population rather than increasing membership size.
- Continually increase the quality of engagement and participation through involving members in all sectors of the communities served - 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.

The target for public membership was to reach and maintain 10,100 members by 31st March 2013 which we are delighted to have achieved.

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 continued to organise a series of highly successful 'Medicine for Members' events at which clinical specialists have hosted talks and discussion in local community settings. This year, we also held our first Members' Health Day which offered members the opportunity to tour the hospital facilities, receive health checks and lifestyle advice as well as listen to a talk on heart health. This event was introduced in response to feedback in the last bi-annual members' survey when members stated they would like more health events such as this. The events also provide Governors with an opportunity to meet with members.

In order to recruit new members to manage our churn rate and to improve representation of younger members (17-21 age bracket), we have attended a number of recruitment events e.g. community health events and University freshers' fairs.

Membership profile

Constituency			
Public Constituency	As at 1st April 2012	As at 31st March 2013	Increase/ Decrease (%)
Cheshire	2,305	2,358	+2.3%
Merseyside	5,005	4,994	-0.2%
North Wales	1,867	2,035	+9%
Rest of England and Wales	700	763	+9%
Total – Public Constituency	**10,065**	**10,150**	**+0.84%**
Staff Constituency	1,320	1,384	+4.8%

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

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 2012/13, 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

This year we have been awarded the very prestigious Acute Provider of the Year Award by the Health Services Journal. Additionally our theatre team has received the Nursing Times Award for "enhancing patient dignity", and two of our services have also received recognition from NHS Merseyside for "Innovation and Wellbeing" and for "Patients' Choice". 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 2012/13, we opened a state of the art research unit housing all our clinical quality, research and informatics staff; this excellent facility acts as a central knowledge hub in the Trust, offering the critical mass necessary for the development and implementation of new ideas for improvement of patient care.

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 three of the four priorities we set ourselves last year. These were:
1. Improving the experience of care for our patients
2. Upskill our staff to deliver excellent clinical care
3. Improve the assessment of quality of life in our heart disease patients

We have just fallen short of meeting our target for:
4. Improve the coverage of outpatients receiving a blood sugar test

but have made an improvement nonetheless. 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 Clinical Commissioning Groups, Local Involvement Networks / Healthwatch, 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 fourth 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 2012/13

We have developed and upheld these values throughout 2012/13 which has resulted in another year of considerable achievement, which included:

- Voted best Hospital Provider of the year by the Health Service Journal for 2012
- Full roll out across the hospital of the Patient Experience Vision and the Staff Experience Vision
- 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 August 2012. The Trust was inspected on 5 standards, and found to be fully compliant in all of them.
- All minimum standards of care met or exceeded as defined by the Department of Health.
- Achievement of all cancer waiting time targets
- The lowest mortality rate in the country for aortic surgery, 10% versus the average national of 22.8%.
- Delivery of the best heart attack and coronary bypass grafting services in the region.
- 96% of our patients confirmed they would "definitely recommend" Liverpool Heart and Chest Hospital to their family and friends and 86% said the care we provided exceeded their expectations
- Embedding and expanding our volunteers scheme
- Main site (one of only two) as a national pilot 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
- Second year of the Institute of Cardiovascular Medicine and Science, in collaboration with Royal Brompton and Harefield NHS Foundation Trust and Imperial College London; significant progress made on collaborative research, education and service development as a consequence of this venture.

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: 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 third 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.

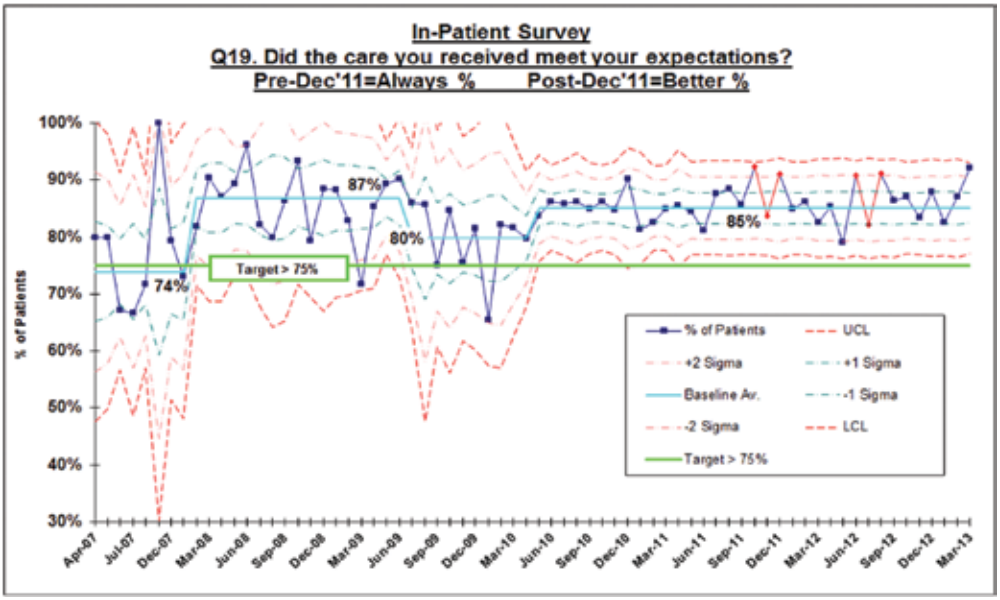
Additionally, we continue to monitor overall rates of satisfaction but have chosen to raise the bar even higher by recording the percentage of patients who report that we have **exceeded** their expectations rather than fully meeting them, which was our benchmark up to December 2011.

By when:

March 2013

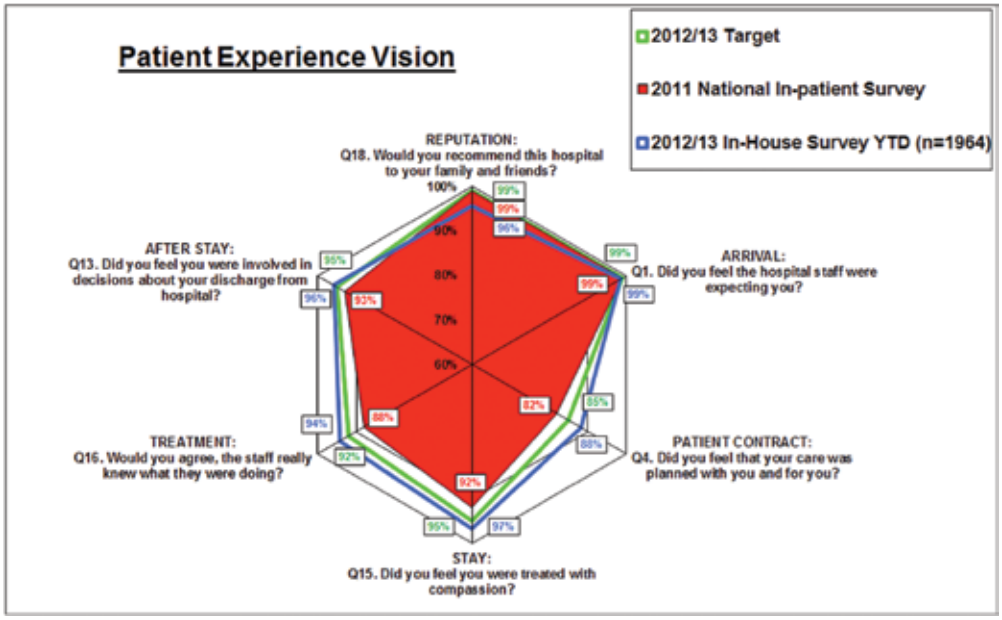
Current status:

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 it has been since the level of satisfaction we expect to achieve.



Additionally, the 6 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 99%)
3. The percentage of patients who felt their care was fully planned with them and for them (target 85%)
4. The percentage of patients who report that the hospital staff were compassionate (target 95%)
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 95%)



The blue line above demonstrates that we have achieved very high levels of performance for each and every indicator. We have exceeded our targets in four of the six areas (contract, stay, treatment and after stay) and have met our target on arrival. However we have dropped 3% for patients recomending this hospital to their family and friends. This result has influenced the choice of priorities for next year's quality account described in the section below (see Part 2, *Priorities for 2013/14; Priority One: Improve Recommendation of our Hospital to Friends and Family).*

We continue to 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	The new Oak Ward opened to patients in January 2013. It has a very fresh feel and all patients and families really like it. We have included the introduction of sleeping facilities for relatives should they prefer to stay with the patient. The redevelopment of Day Ward is currently ongoing and will be ready in 2013/14.
Implementing pagers in outpatients	We have this year implemented the use of 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.
A revised volunteers programme	The Trust has now recruited over 70 volunteers from diverse communities. The volunteers have been involved in meet and greet, patient support and surveys. They have become an essential part of the Trust and they greatly contribute to patient and family wellbeing.
Support Nurse Role	The specialist support nurse role has now been implemented following last year's pilot. 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

Other improvements achieved:

- Implemented a number of changes to the environment to reduce concerns raised regarding mixed sex accommodation
- Participated in the 2012 National Inpatient survey and action planned the results

Keep as future priority?
No. We continue to monitor patient experience as part of business as usual. Our first priority for this year is around patient experience, and we are introducing the Patient and Family Centred Care vision this year as part of our overall strategy.

Further improvements identified:

- Introduction of Patient and Family Centred Care programme this year; launched in April 2013.
- We will further strengthen relationships with external partners including the Healthwatch, community groups such as GP Patient Participation Forums, voluntary

organisations and other statutory organisations. These links will be constantly reviewed and improved.

- We continue our 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 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 were receiving this test last year. This means that there could be an additional 25% of patients who are presenting with a high blood sugar which was 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 aimed to improve the coverage of pre-operative outpatients receiving a blood sugar test to 90%.

By when:

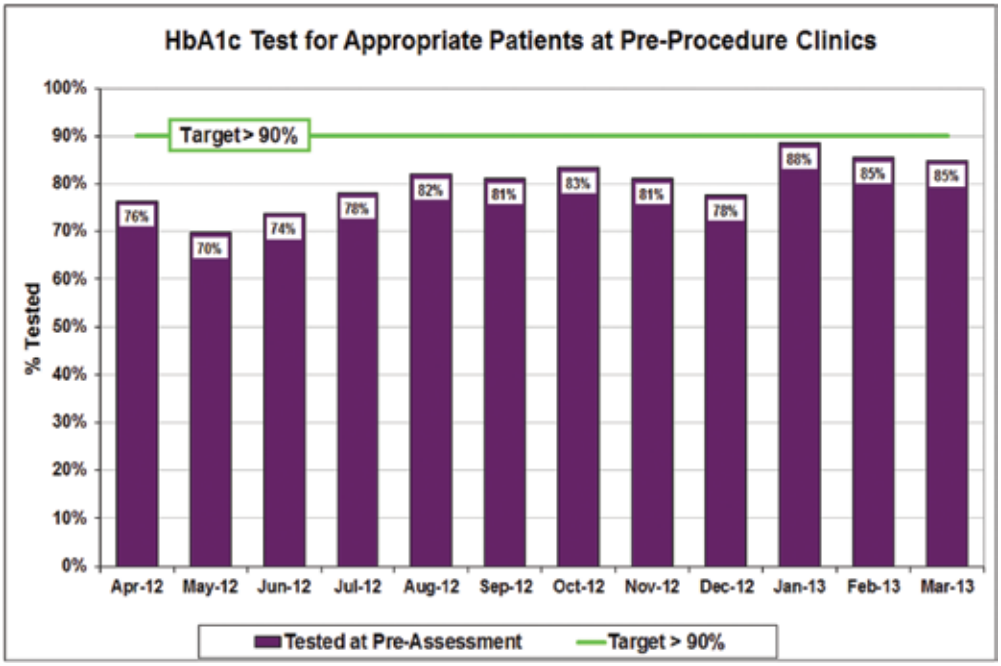
March 2013.

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:

Not achieved, but improved. In the first quarter of the year we developed strict eligibility criteria for those patients who should receive a blood sugar test. The baseline of 76% of patients receiving a blood sugar test at pre-assessment remained low in the first quarter of the year while we devised a pathway for the identification and implementation of the test; we saw a small improvement in quarters 2 and 3, reaching 80% of patients. The target set was to reach 90% of the patients fitting the criteria by the end of the year; we saw a marked improvement in January 2013 reaching 88% of appropriate patients, with an overall of 86% for quarter 4, only a 4% below the target set for end of year.



Improvements achieved:

- Development of the eligibility criteria for patients receiving the blood sugar test
- Introduction of a checklist and reminder system for implementation in the outpatient department

Keep as a future priority?

No. Although we have not reached our set target, we are not keeping this as a priority for next year. We recognise however that the correct management of diabetes and blood sugar in perioperative patients is essential for the reduction of infection and other complications. Therefore, we will continue to work on the implementation of the checklist and the uptake of the test in the eligible patients.

Improvements Identified:

- Further embedment of the checklist and reminder systems to maximise their implementation consistently in the outpatient department
- Involvement of the hospital coordinators to ensure that patients transferred into the Trust for emergency revascularisation are also managed appropriately regarding their blood sugar level
- 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 this year we have aimed to build on this success 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 *(Priority one: Improve the experience of care for our patients).*

By when:

March 2013

Who collects the data and how?

Data is collected by the Learning and Development Department. Trainers collect attendance sheets at each delivered course or seminar, and this is 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 is done on a monthly basis.

Current status:

Achieved. During 2012/13 work has commenced on development of clear LHCH specific staff profiles and, alongside this, development of competency pathways that are aligned to and follow the patient journey.

An example of a staff profile is the LHCH staff nurse development pathway for newly qualified staff nurses. This profile is divided into three stages:

Stage 1 - Preceptorship period 0-6 months
Stage 2 – Consolidation of learning 6-12 months
Stage 3a – Proficiency 12 months -2.5 years
Stage 3b - Developing Leadership potential

A further example is the LHCH Health Care Assistant staff profile which is actioned through the Development Pathway.

Improvements achieved:

- The LHCH Preceptorship Pathway for newly qualified nurses commenced in September 2012. This pathway supports practitioners at the start of their careers and helps them begin the journey from novice to experts. The programme has been designed to support, assist and encourage staff to develop the knowledge

and skills in all areas of practice so that they can contribute to our Patient and Family Experience Vision of providing Excellent, Compassionate and Safe Care to every patient, every day. The programme runs twice per year with the intention to roll out to all other Allied Health Professionals in future programmes. Twenty newly qualified nurses attended the first programme in September 2012. At the end of this year 22 attendees were enrolled to commence the next programme in March 2013.

- LHCH Healthcare Assistant (HCA) Development Pathway: the need for Trusts to review processes for Healthcare Assistant (HCA) development has been raised by the Francis Report (Francis, 2013) with further recommendations supported by the Willis Commission (2012). Nationally, HCAs are not regulated by professional bodies nor have a guaranteed standard of training. LHCH has responded to this challenge by developing a HCA Development Pathway focussing on quality and patient safety. The LHCH pathway programme commenced in November 2012 and is aimed at all HCA staff employed at LHCH, both newly employed and existing staff. Plans are in place to ensure every HCA employed at LHCH will have attended a development programme by April 2014.

  One of the main recommendations of the Willis Commission is that *"all staff at Agenda for Change bands 3-4 (and their equivalent outside the NHS) who deliver care should be trained to NVQ level 3 as a minimum UK standard"*. (Willis Commission 2012). The LHCH HCA Pathway supports, assists and encourages each HCA to develop their knowledge and skills so they can contribute to the Trust's Vision of personalised Patient and Family Centred Care. The three day accelerated pathway includes workshops, interactive group learning, clinical practice focus and self-directed learning sessions, each focused on clear competences delivered in a blended learning approach and dictated by the HCA role. Evaluation shows that HCAs are equipped with the basic skills, knowledge and attitude required of all LHCH staff. On completion the Trust supports all HCAs in undertaking an Apprenticeship in Health at a minimum of level 2. Overall, the LHCH HCA Pathway has provided a foundation in the minimal requirements of all LHCH HCA staff and in turn will uphold the nationally recognised values in delivering high quality compassionate care to all. Evaluation of the September 2012 programme was very positive with one attendee stating:

  > *"It was really good to attend this course. It makes you realise how important your job role is and how important it is to make sure patients feel valued and respected. Also, it was nice to meet other healthcare workers. It was very nice to feel the job we do is much appreciated".*

  Additionally, the development of a competency framework for all clinical staff is something that we will continue. The LHCH competency framework aims to set key standards for care delivery where 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. Initial work has commenced on a competency framework for nursing staff bands 5-7 and also Allied Health professionals.

Keep as a future priority?

No. The Trust is committed to continue the upskilling of staff as business as usual. This is part of the Learning and Development plans for the next year.

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 coronary artery bypass surgery (CABG) or stenting (PCI).

Why:

The NHS is moving towards measuring its performance in terms of the outcomes it delivers (the Outcomes Framework), 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 has led the national pilot of this work.

How much will we improve:

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

By when:

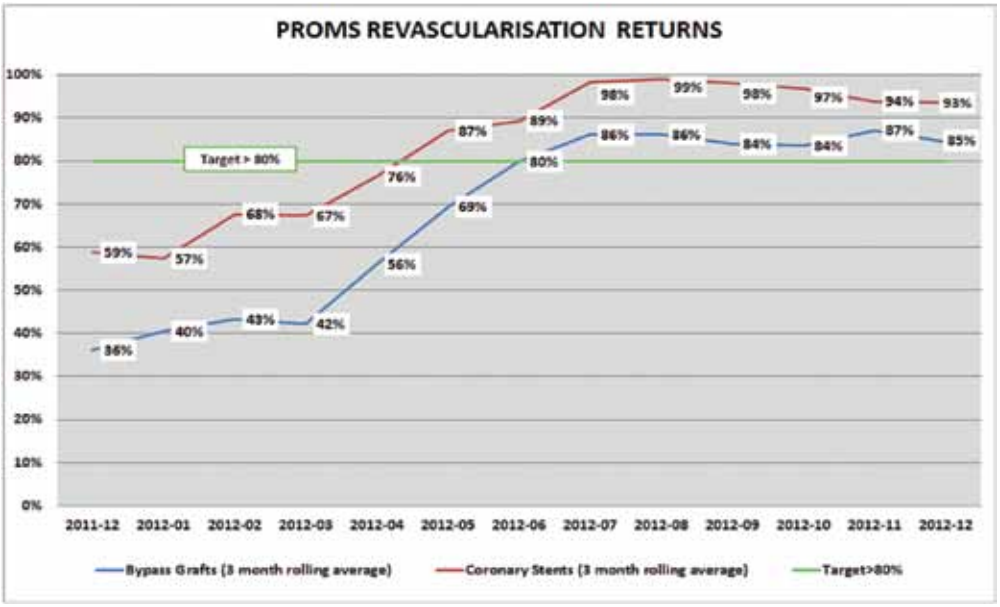
Recruitment closed in December 2012 and will be reported in March 2013.

Who collects these data and how:

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

Current status:

Achieved. We have achieved and exceeded our target. Completion of the quality of life assessments was undertaken by 85% of elective bypass surgery and 93% of elective stenting patients by the end of the pilot project.



Improvements achieved:

- Providing advance warning to potential patients from inclusion of a letter in their outpatient appointment pack. This information asks patients to please bring their glasses to the appointment so that they may read the questionnaires unaided
- Allocation of responsibility for participation to relevant service line managers in our hospital
- Weekly reporting of participation, including analysis of where non-participation was occurring
- Introduction of a second opportunity for participation in patients who either refused or were missed during recruitment in the outpatients department
- The introduction of some dedicated audit support that assisted the local lead for PROMS with the administration of the programme

Keep as future priority?

No. Even though we have achieved this priority, this work was only ever a pilot project conducted for the Department of Health, and recruitment to the project has now ceased. As the lead organisation for the pilot, we have the responsibility of analysing the data and making a recommendation to the Department of Health whether this work would be valuable if adopted into the national PROMS programme. This work is expected to conclude in early 2014.

Priorities for 2013/14

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

The Trust is committed to improve the following areas in 2013/14:

Priority One: Improve Recommendation of our Hospital to Friends and Family

Category:

Patient experience

What:

Every health care provider is now expected to ask their patients the following question after receiving their services:
"How likely are you to recommend our ward to friends and family if they needed similar care or treatment?" This *Friends and Family test* is to be used as a key measure of patient experience across the NHS.

Why:

Our Trust has a great track record in improving the patient experience evidenced from our focus on the Patient Experience Vision over the past three quality accounts. We wish to continue this work over the coming three years and broaden its appeal to families also. Results from the Friends and Family test will provide a comparable measure of patient experience between all healthcare facilities. We believe our work will place us high compared to our peers making us the natural choice for patients and families when seeking cardiothoracic health care.

How much:

Achieve a Net Promoter Score (see below) of 90%. This is an exceptionally high target, given most industries achieve scores of 20% to 40%.

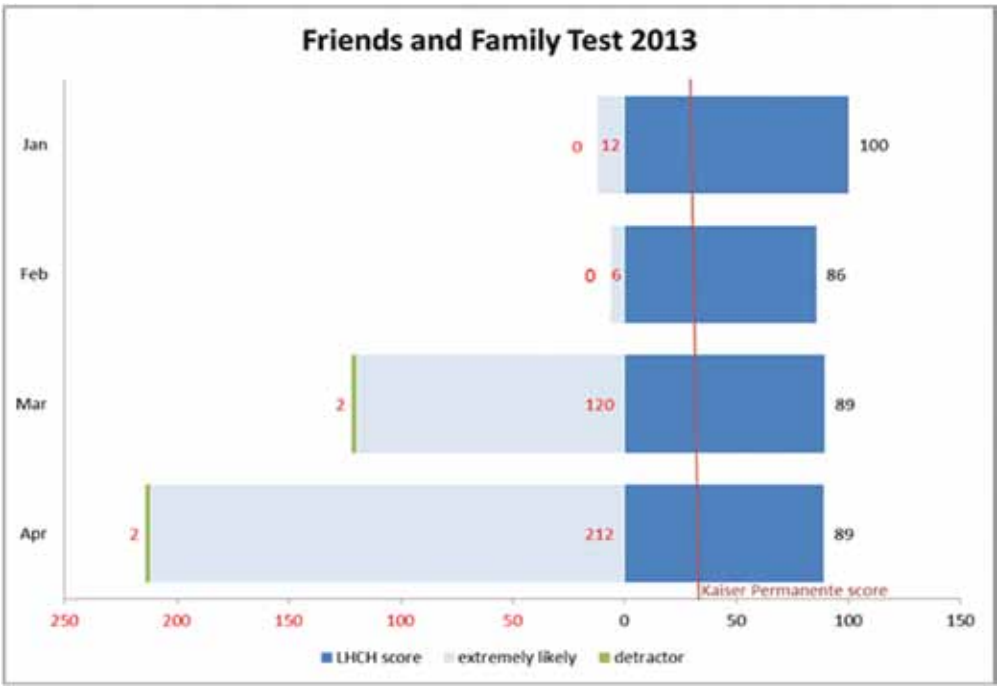
By when:

March 2014

Who collects the data and how:

The Clinical Quality Department collates the monthly data. Inpatients are approached on their day of discharge from the hospital by Trust staff and asked to complete the family and friends test on an iPad. For those that prefer to complete it following discharge, they are given an electronic link to the web-based questionnaire for completion at home. The responses are completely anonymous and patients are encouraged to give their honest response. The questionnaire's results are collated and analysed by Clinical Quality staff. In addition to the question, comments may be left that are also shared with staff. A Net Promoter Score is calculated from the responses which is the percentage of patients who are very unlikely, unlikely and neither likely nor unlikely (together called the "detractors") to recommend us to friends and family subtracted from those that are extremely likely (the "promoters"). Those that are likely to recommend us (the "passives") are deemed satisfied but unenthusiastic, and therefore do not lend any weight to either group.

Current status:



We started asking this question of our patients in January 2013 and started to get a good number of responses from March. The above graph shows our results over our first four months experience. To date, we have had 348 patients expressing an extremely likely opinion on recommending us to family and friends. Only four patients report that they were either very unlikely, unlikely and neither likely nor unlikely to recommend us. Even with these very good results, our overall Net Promoter Score is running in the high 80s, as the balance of patient opinion is made up of those who are satisfied but unenthusiastic. We are using the well-established and renowned Kaiser Permanente score as our benchmark

Improvements identified:

- Recognise families as important members of the heath care, this will involve patients and families in all aspects of planning, delivery and evaluation of care at LHCH by roll out of the care partner programme.
- Patient and family focused handovers of care
- Development of a Patient Family centred nursing care model
- Provide easy and accessible opportunities for patients and families to ask questions.
- Patient and family centred care ward rounds
- Identification of areas for improvement from patients' feedback
- Action patients' recommendations

Priority Two: Improve the Timeliness of our Communications to General Practitioners at the Point of Discharge

Category:

Effectiveness

What:

Improve the timeliness of communications to General Practitioners at the point of discharge.

Why:

General Practitioners perform a really important role in continuing the care of patients following contact with the hospital specialists. As such, it is really important for them to receive information about a patient's treatment as soon after this contact as possible. This ensures that all management and preventative measures associated with the patient's care are implemented in a timely way, minimising the patient's chances of becoming unwell and even perhaps needing to be admitted to hospital. At present, the patients generally receive two sets of communications: A discharge summary which should be issued following an inpatient stay on the day of discharge, and a formal discharge letter that follows attendance as an outpatient, ideally within two weeks.

How much:

Our aim is to ensure 95% of inpatients have their discharge summary electronically transmitted to their GP within 24 hours of discharge and for 95% outpatients to have a discharge letter electronically transmitted to the GP within two weeks of their outpatient attendance.

By when:

March 2014

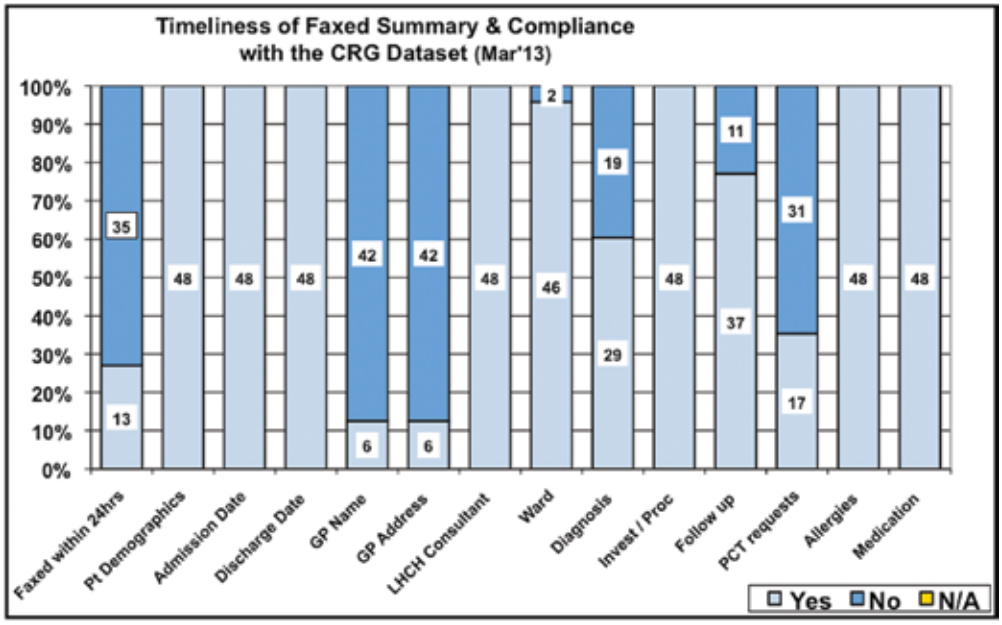
Who collects the data and how:

At present, we rely on faxed discharge summaries for inpatient discharges and typed and posted letters for outpatient attendances. In June 2013, the Trust will cross over to an electronic patient record, which will provide the functionality to both electronically transmit and then track the timeliness of all patient correspondence. Staff in the Information Department will have the responsibility of compiling performance reports to share with management and clinical staff which will demonstrate performance against these two targets.

Current status:

The Trust has successfully established a pilot electronic discharge summary scheme in 2012/13 with a number of neighbouring GP practices. This year we need to roll out the system to all practices working with the Trust. As yet, no work has commenced on electronic outpatient correspondence as this is tied up with the electronic patient record project due to "go-live" in June.

However, the Trust has undertaken an audit to assess the status of this priority. When looking at the timeliness and completeness of the minimum dataset for discharge summaries, only 27% of the letters were sent within 24 hours; in the majority, GP details were missing, and only 60% of the letters included details on diagnosis.



Improvements identified:

- The e-discharge pilot has commenced on all wards at LHCH and we are able to transmit a TTO electronically within 24 hours of discharge for those who live in Liverpool / Sefton and their GPs are set up and ready to receive them. We are awaiting full roll-out of this to all GPs across Liverpool and Sefton.
- With regard to the timeliness of our communications we are working with Consultants, SpRs and admin teams to improve this for our discharge letters. These need to be sent to the GP within 14 days of the patient being discharged. We are measuring this via our G2 digital dictation system. Working groups have commenced within the Trust to ensure improvements are effective.

Priority Three: Development and Implementation of a Health Economy Wide Discharge Checklist

Category:

Effectiveness

What:

Develop and implement a Health economy wide discharge checklist. A checklist provides a step by step guide for staff throughout the process of discharge, ensuring nothing gets forgotten.

Why:

Timely information and communications are essential to ensure that patients are discharged effectively and as scheduled. Lack of clarity and omissions in the provision of information to patients and families about information related to the immediate period following discharge from staff can impact on patient experience at the time of discharge, resulting in delays and poor patient post discharge experience. This can lead to patients being unclear in how to care for themselves at best or becoming unwell and readmitting back to hospital at worst, if the discharge has not been conducted in a systematic and effective way.

How much:

The Trust will work with other hospitals in Merseyside to devise a discharge checklist that suits all patients being discharged from hospital, irrespective of which hospital or following which procedure.

Following design of the discharge checklist, the Trust will ensure that a minimum of 90% of its patients have their discharges supported by the discharge checklist.

By when:

March 2014

Who collects the data and how:

Design phase: The Trust will come together with other Trusts in Merseyside to establish best practice for safe and effective discharges. This will be run as a project by Liverpool Clinical Commissioning Group.

Once established, the checklist will be made available to all staff who have a role in discharging patients from our wards. Through our new electronic patients record, we will make the checklist available as an electronic template which staff will be asked to complete in the days and hours running up to a patient being discharged. Information staff will be able to collate how often the checklist is following and the extent to which all the steps are completed. These reports will be made fed back to clinical teams allowing them to identify areas for improvement.

Current status:

We have no hard and fast data on the percentage of patients whose discharge is supported by a discharge checklist, but we estimate this to be around 70%.

Improvements identified:

- Establish best practice for discharge.
- Build template that turns best practice into short actionable steps for staff into our electronic patient record.
- Develop reporting methodology.
- Feedback discharge checklist compliance results to staff via ward dashboards.

Priority Four: Reduce Pressure Sores Across the Health Economy

Category:

Safety

What:

In our desire to see care for patients become more integrated, we will work with other health care facilities who refer us patients and those to whom we refer to reduce the number of pressure sores that occur in patients receiving our care.

Why:

Pressure sores are painful, provide a site for infection, prolong hospital stay and increase healthcare costs. Moreover, with appropriate care, are largely preventable. Our Trust has done great work over the past two years in reducing the number of pressure sores in our patients by 75%. Other health care facilities we believe may not have had the same focus on improving pressures sores as us. As such, we want to share our expertise with other organisations so that their care improves, and in so doing the number of patients referred to us who have a pre-existing pressure sore is reduced.

How much:

We want to reduce the percentage of patients who have had a pressure sore, either in the Trust that referred them to us, or as a consequence of the care we provide by 25%.

By when:

March 2014

Who collects the data and how:

For one day each month, every patient in the Trust is examined to determine if they have any pressure sores, and if so, was that pressure sore present on admission (i.e. they acquired the sore either at home or in another health care facility) or did they develop it whilst receiving care from us. This "census" is called the Safety Thermometer and happens in every hospital in the NHS. The information is reported to the Department of Health who produce reports about the quality and safety of all NHS hospitals.

Current status:

Since the Safety Thermometer data collection started in 2012, up to the end of March 2013, 1444 LHCH inpatients were examined. Of these, 35 patients were found to have a pressure ulcer (2.4%). Nationally, during 2012/13, 5.7% of the 1.9 million audited patients had a pressure ulcer.

Improvements identified:

This work will only be successful if there is willingness amongst other health care providers to come together to address this important topic and if Liverpool Clinical Commissioning Group help us in setting up a forum to discuss best practice and improvements. On the proviso these two important enablers are put in place, we will:

- Define best practice
- Devise some terms of reference for this health economy wide group to come together
- Share the number of pressure sores occurring in each organisation and reasons why they occurred
- Explore preventative measures that can be taken for future patients
- Monitor the number of patients getting new pressure sores to ensure the effectiveness of our efforts

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 2012/13 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)/ Healthwatch, who have attended our stakeholders' event for Quality Accounts prioritisation.
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 2011/12, and fully implemented in 2012/13.

Like previous years this process has resulted in at least one of the suggestions from stakeholders external to the Trust being accepted as priority. This year, two of the suggested priorities have been influenced by our stakeholders, namely:

Priority Two: Improve the Timeliness of our Communications to General Practitioners at the Point of Discharge,

and

Priority Three: Development and Implementation of a Health Economy Wide Discharge Checklist

Review of services

During 2012/13 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 it on the quality of care in all 12 of these NHS services.

The income generated by the NHS services reviewed in 2012/13 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 2012/13.

Participation in Clinical Audits

During 2012/13, 14 national clinical audits and 1 national confidential enquiry covered NHS services that Liverpool Heart and Chest Hospital NHS Foundation Trust provides.

During 2012/13, Liverpool Heart and Chest Hospital NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital NHS Foundation Trust were eligible to participate in during 2012/13 are as listed in table 1.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital NHS Foundation Trust participated in during 2012/13 are as listed in table 1.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2012/13, 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: 2012/13

	Name of audit by category	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
	Acute		
1	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
2	Adult critical care (ICNARC CMP)	Yes	Data is submitted on a quarterly basis; For quarters 1-3 (April 2012 – December 2012), Critical Care (ITU and POCCU) submitted 1596 /1596 (100%) patients to ICNARC which is all admissions during this timeframe. Quarter 4: 390 admissions since the start of January 2013 yet to be submitted. The deadline for sending the data relating to the patients admitted in quarter 4 of 2012-13 is not until the end of April.
3	Emergency use of oxygen (British Thoracic Society)	Yes	71/71 (100%) submitted for Oct 2012 period as per study criteria
4	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) During 2012/13 hospitals were eligible to enter data into 4 NCEPOD studies: - *Cardiac arrest - *Bariatric surgery - Alcohol Related Liver Disease - Subarachnoid Haemorrhage	*Yes	The following studies are not relevant to LHCH - Alcohol Related Liver Disease - Subarachnoid Haemorrhage LHCH participated in: Cardiac arrest- submitted 3/3 (100%) cases and completed all questionnaires and case note returns for this study (100%) Bariatric surgery - only the organisational questionnaire was appropriate to complete No cases were included for the main study.
5	Hip, knee and ankle replacements (National Joint Registry)	No	These procedures are not undertaken at LHCH as a specialist tertiary Trust for Heart and Lung disease
6	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
7	Renal colic (College of Emergency Medicine)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
8	Severe trauma (Trauma Audit and Research Network, TARN)	No	Not relevant -a trauma service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
	Blood and transplant		
9	Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	Not relevant - data is collected from all transplant centres in the UK and Ireland
10	National Comparative Audit of Blood Transfusion programme	Yes	LHCH contributed 5 cases to the 2012 National Comparative Audit of Blood Sample Collection and Labelling. This was 100% of the sample required.

	Name of audit by category	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
	Blood and transplant (continued)		
11	Potential donor audit (NHS Blood and Transplant)	No	Not relevant. Data collection was revised in October 2009 -collects information on patient deaths in ICUs and emergency departments but excludes cardiothoracic ICUs.
	Cancer		
12	Bowel cancer (NBOCAP) (Subscription funded from April 2012)	No	Not relevant - procedures are not undertaken at LHCH as a specialist tertiary Trust for Heart and Lung disease
13	Head and neck cancer (DAHNO) (Subscription funded from April 2012)	No	Not relevant - procedures are not undertaken at LHCH as a specialist tertiary Trust for Heart and Lung disease
14	Hip, knee and ankle replacements (National Joint Registry)	Yes	430/430 (100%) have been submitted having been first seen at LHCH in 2012 as per this audit's criteria. 313/436 (72%) 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. Work is on-going to validate cases before upload
15	Oesophago-gastric cancer (NAOGC) (Subscription funded from April 2012)	Yes	0/294 (0%) cases submitted. Data submission for cases seen between April 2012 and March 2013 is due 1/10/2013.
	Heart		
16	Acute coronary syndrome or Acute myocardial infarction (MINAP) (subscription funded from April 2012)	Yes	98/998 (100%) cases submitted to CCAD (Time period April 12 – Jan 13).
17	Adult cardiac surgery audit (ACS)	Yes	Adult cardiac surgery data submissions are undertaken every 12 weeks as required by CCAD. FY 12/13 Q1 x 430 Cases Submitted (100%) Q2 x 439 Cases Submitted (100%) Q3 x 424 Cases to be submitted by 31/03/2013 (100%) Q4 x approximately 459 cases to be submitted by 30/06/2013

	Name of audit by category	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
	Heart (continued)		
18	Cardiac arrhythmia (HRM)	Yes	A total of 1496 (100%) pacing and implantable cardiac defibrillators cases and 1091 (100%) EPS cases have been submitted for the reporting period Jan 12 – Dec 12
19	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	149/149 (100%) submitted Congenital. 0/0 (0%) submitted Infective Endocarditis. 32/32 (100%) submitted ICD & Pacing. (Time period April 12 – March 13).
20	Coronary angioplasty (subscription funded from April 2012)	Yes	A total of 2991 including coronary pressure studies and IVUS (2860 PCI's) cases for 2012 (100%) submitted.
21	Heart failure (HF) (subscription funded from April 2012)	Yes	158/ 158 (100%) cases submitted to CCAD (Time period April 12 – Jan 13) Participation requirement is 20 cases per month.
22	National Cardiac Arrest Audit (NCAA)	Yes	April – December 2012. 96/96 (100%) cases submitted. Q4 data to be submitted April 2013 .
23	National Vascular Registry (elements will include CIA, National Vascular Database, AAA, 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
24	Pulmonary hypertension (Pulmonary Hypertension Audit)	No	Not relevant – LHCH patients are referred to Sheffield Specialised Services.
	Long term conditions		
25	Adult asthma (British Thoracic Society)	No	LHCH patients are not suitable for the asthma audit as acute asthma patients get admitted to the A and E or Medical admissions unit at acute trusts
26	Bronchiectasis (British Thoracic Society)	Yes	20/20 (100%) submitted for 1 October 2012 to 30 November 2012 as per study criteria
27	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	No	LHCH did not participate as the eligibility criteria does not cover specialist Trusts
28	Diabetes (Paediatric) (NPDA)	No	Not relevant - Paediatric services are not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
29	Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services (previously listed separately on 2010/11 quality accounts list)	No	Not relevant - service not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease

	Name of audit by category	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
	Long term conditions (continued)		
30	National Review of Asthma Deaths (NRAD)	No	Not applicable - asthma deaths tend to occur in those hospitals that have acute admissions for asthma, which does not apply to the LHCH.
31	Pain database	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.
32	Renal replacement therapy (Renal Registry)	No	Not relevant - service not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
33	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
	Mental Health		
34	Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No	Not relevant –as LHCH is a specialist tertiary Trust for adult heart and lung disease
35	National audit of psychological therapies (NAPT)	No	Not relevant –as LHCH is a specialist tertiary Trust for adult heart and lung disease
36	Prescribing Observatory for Mental Health (POMH) (Prescribing in mental health services)	No	Not relevant - Psychological services are not provided at LHCH as a specialist tertiary Trust for Heart and Lung disease
	Older people		
37	Carotid interventions audit (CIA) (subscription funded from April 2012)	No	Only undertaken concomitantly with cardiac surgery and submitted as part of Adult Cardiac Surgery Audit
38	Fractured neck of femur	No	Not relevant -a trauma service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
39	Hip fracture database (NHFD)	No	Not relevant -a trauma service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
40	National audit of dementia (NAD)	No	Not applicable - this audit focused on the care of people with dementia in general hospitals. LHCH is a specialist tertiary trust for adult heart and lung disease
41	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

	Name of audit by category	Eligible to participate? Yes / No	If No: reason If Yes and not participating : reason If Yes and participating % cases submitted
	Older people (continued)		
42	Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13)	No	Not relevant as LHCH does not admit patients following acute stroke as a specialist tertiary Trust for adult heart and lung disease
	Other		
43	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
	Women's and Children's Health		
44	Child health programme (CHR-UK)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
45	Epilepsy 12 audit (Childhood Epilepsy)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
46	Maternal, infant and new born programme (MBRRACE-UK)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
47	Neonatal intensive and special care (NNAP) (subscription funded from April 2012)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
48	Paediatric asthma (British Thoracic Society)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
49	Paediatric fever (College of Emergency Medicine)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary Trust for adult heart and lung disease
50	Paediatric intensive care (PICANet)	No	Not relevant -This service is not provided at LHCH as a specialist tertiary trust for adult heart and lung disease
51	Paediatric 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
	Total: 51	**YES =14**	

Other National Clinical audits

During 2012/13 Liverpool Heart and Chest Hospital NHS Foundation Trust participated in 1 other national clinical audit in addition to those described above

Audit Title	Participated 2012/13	% cases submitted
National Inpatient Survey	Yes	563/850 (67%) of consecutive inpatients identified in time period June/July 2012 responded and were included in the submission

The reports of 18 national clinical audits were reviewed by the provider in 2012/13 and Liverpool Heart and Chest Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Acute

Adult critical care (Case Mix Programme – ICNARC CMP)

We have not received a report for 2012/13 although we are due to receive one soon. As our case mix shows, a large number of patients are received from other Trusts for treatment and then returned to those Trusts for rehabilitation care and we are reliant on them for providing ultimate hospital outcomes. The final hospital outcomes for patients admitted to LHCH in quarter 1 of 2012-13 has only just been received.

As such the last report received from ICNARC for patients admitted to Critical Care relates to admissions in quarter 4 of 2011-12. This report indicated that the units SMR (Standardised Mortality Ratio – the number of observed deaths compared to expected deaths using mortality predictors), using the ICNARC model, is significantly lower than prediction. When the APACHE II model is used (this does not analyse all the Cardiac patients) the SMR, although not as good, is still significantly lower than the prediction.

Hopefully the next report from ICNARC will be circulated prior to the next Critical Care Delivery Group in March. Sadly ICNARC have to yet to receive enough members to form a dedicated Cardiac sub-group so we are compared to all general units. It is hoped that further cardiac units will join the CMP in coming months so that proper analysis of Cardiac and Thoracic work in Intensive Care Units can be undertaken.

Emergency use of oxygen 2012 (British Thoracic Society) Published December 2012

Overall there has been an improvement in prescribing from 74% in 2011 to 79% in 2012. Compared with the national average LHCH is better at prescribing oxygen but falls behind when identifying ranges.

Lack of signatures for oxygen prescribing are marginally worse than the national average but all practice in this area both locally and nationally is poor and requires more attention.

With regards to target ranges, on the whole LHCH is better at maintaining saturations within ranges that are identified

Actions for improvement:

- Increase awareness of need to identify the range during induction sessions Respiratory Nurses to perform random checks and to identify and advise of incorrect prescriptions

- Pilot a train the trainer scheme on one ward to increase awareness around the BTS guidance for emergency oxygen and correct prescribing techniques including stopping the prescription when oxygen no longer required.

Bronchiectasis (British Thoracic Society)
Published March 2013
The findings are similar to last year for the 2012 bronchiectasis audit:

- LHCH appears to see a more unwell group of bronchiectasis patients than the national average, 75% of LHCH patients had 3 or more infections/year versus 41.7% of the national average. Further confirmed by:
  - 50% of LHCH patients have pseudomonas versus 27% national average
  - 15% of LHCH patients have ABPA versus 6.9% national average
  - LHCH has more patients using nebulised antibiotics 25% versus 10.2% national average
  - LHCH patients appear to be affected by SOB more than the national average, LHCH 75% versus 53.5% national average.

- *On a par with sending the above patient group to rehab 33.3% versus 32.1% national average, but when broken down we are better as only 10% were not referred versus 42% national average the remaining 40% of patients refused,10% unsuitable and 40% on waiting list.
- On a par/ better with use of CT scan to diagnose bronchiectasis 100% LHCH versus 91.4% and 100% of our patients have been taught chest clearance versus 77.7% national average
- Better than national average at sending sputum at start of exacerbation 70% LHCH versus 53.5%
- *But below average at sending sputum for routine bacterial culture when clinically stable 55% versus 61.7% national average
- On a par with patients requiring IV antibiotic therapy 15% versus 18.4 % national average. 100% of these patients had objective evaluation at beginning and end of their IV treatment versus 78.4% national average.
- 90-95% of LHCH patients investigated for causes of bronchiectasis e.g. immunodeficiency, aspergillosis versus 68.3%
- *Better than national average for provision of self -management plans LHCH 80% versus 32.8%

***Action required**

- Respiratory Nurse Specialists (RNS) will ensure pulmonary rehabilitation referral forms are available to consultants during clinic to ensure we refer all patients who are suitable and agree to rehab.

- Doctors to refer all bronchiectasis patients they see in clinic into RNS to ensure all patients have provision of a self- management plan; RNS can also request routine sputum samples if patient is able to produce any at the time as not always possible.

National Comparative Audit of Blood Transfusion

Audit of blood sampling and labelling Published December 2012
A local audit of samples rejected by the Laboratory for LHCH from the data submitted to this National Comparative Audit was undertaken. Staff requesting and taking transfusion samples are required to follow the Hospital Transfusion Policy. Laboratory staff processing transfusion samples are required to follow the same policies.

There were no incidents in the Trust of wrong blood in the wrong tube over this audit period.

The results of this audit show a continuing improvement in compliance with the transfusion policy from the previous audits and a reduction in the numbers of samples rejected.

There was no further action advised as these were no harm incidents and the incidents are on the decrease year on year according to our previous audits. The training sessions provided by the Laboratory will continue.

Cancer

Lung cancer (National Lung Cancer Audit)
Published December 2012
There are two points of learning from this national audit. One related to the recording and documenting of clinical data and the second to the involvement of specialist nurses at diagnosis. As the audit report is the result of a triangulation of services which covers three Trusts, it proves difficult to ensure that data quality at each Trust is at the highest level.

Oesophago-gastric cancer (NAOGC)
Published July 2012
Recommendations within the report are already being met at LHCH. The only minor action required is as follows:

LHCH undertakes a readmission audit within directorates. Whilst the specialty under which the patient was discharged/re-admitted is easily extracted, further work is required to identify which are palliative care patients.

Heart

Acute coronary syndrome or Acute myocardial infarction (MINAP)
Published November 2012

All patients admitted to Liverpool Heart and Chest Hospital that are clinically diagnosed with ST-Elevation Myocardial Infarction (STEMI) are uploaded to NICOR as part of the MINAP audit programme. The results from the recently published report in comparable to LHCH is as follows:

Criteria	National 2011-12 %	LHCH %
DTB	92	98
CTB 150 overall	83	82
CTB 150 directs	89	98
CTB 150 transfers	51	50
CTB 120 overall	62	66
Direct admission to LHCH	79	55

Actions required:
Up to this year, LHCH has been excluded from submitting out NSTEMI/ ACS patients to the national audit. However, from April 2013 we will be required to also submit data on these cases.

Adult cardiac surgery audit (ACS)
Published June 2012

This audit collects information on activity, trends and outcomes in adult cardiac surgery in GB and Ireland. LHCH uses this information to benchmark local performance against national agreed standards.
We are above or on par with national averages
- No consultant outliers

Cardiac arrhythmia (HRM) Published January 2013

Our clinical lead, Dr D J Wright, scrutinises the Device Survey in great detail each year.

The implant rates confirm that LHCH is:
1. above national average and national target for implanting CRT devices
2. above national average and almost at national target for ICD devices
3. below national average and national target for pacemakers

LHCH is the sole implanter of CRT and ICD devices so we are performing well.

Surrounding hospitals implant the majority of pacemakers so we are under performing. This will be raised at the network wide Device Leads meeting which is chaired by our clinical lead.

There is very little quality data in the survey. However, Dr Wright and Dr Todd have been part of a national working group who are mandating the inclusion of complication data as part of the survey for future years. This work is almost complete. LHCH is already collecting all the required data and we are presenting our 3 year complications for 2008-9-10. We aim to publish this later in the year. This will not only provide us with a benchmark but hope it will be adopted as the national benchmark.

Congenital heart disease (Paediatric cardiac surgery) (CHD)
Every year, a NICOR Data Auditor and one external consultant in adult congenital cardiology visit LHCH and audit a sample of our data submissions. In addition they visit our catheter labs and review theatre books as a cross-reference for their validation process. In July 2012 a Trust level report was produced by NICOR (time period of care addressed 2010-11).
On the whole, the data was accurate and well documented in the theatre and cath lab log books. The Data Quality Indicator has increased by almost 10% which is excellent.

Action plan addressed following recommendations for the 2012 report.

- A congenital stamp to be used in both cath lab and theatre log books to identify clearly whether or not a procedure is for congenital heart disease. This has now been implemented: Feb 2013

Coronary angioplasty
Published January 2013

The audit provides information on the:
- The structure of the provision of PCI services across the UK
- Clinical care and treatment provided by each hospital, measured against national aggregated data and agreed national standards
- The process of care e.g. delays in receiving treatments such as primary PCI
- The outcome for patients such as complications, adverse cardiac events and death

At local level, we use this information to benchmark our hospital and consultant performance.
- High success rates and low MACE (Major Adverse Coronary Events)
  - No consultant outliers

Further improvement work
- Impact of PPCI
  - Need to consider risk adjustment
- Data entry remains open to interpretation
  - Independent monitoring

Heart failure (HF) Published November 2012
National Heart Failure Audit 2011/12 recommendations for improving the quality of care and patient outcomes are being met.

Actions to further improve this have included:

- Network roll-out of prognostic indicator tool in heart failure. This will assess appropriate patients for relevant palliative care in timely manner.
- 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 2013/14 including measures against outcomes, re-admission and survival in Liverpool Heart and Chest Hospital diagnosed heart failure patients.

National Cardiac Arrest Audit (NCAA)

The audit monitors and reports on the incidence of, and outcomes from, in-hospital cardiac arrests in order to inform practice and policy. It aims to identify and foster improvements in the prevention, care delivery and outcomes from cardiac arrest.
The current scope of data collection is: all individuals (excluding newborns) receiving chest compressions and/or defibrillation and attended by the hospital-based resuscitation team (or equivalent) in response to the 2222 call.
The Liverpool Heart and Chest Hospital joined on the 1st April 2011 and from this date has collected and entered data of all 2222 confirmed cardiac arrest calls. Consequently since this date we have been provided with NCAA Reports which provide grouped comparisons for example, presenting rhythm, age, etc. against all NCAA data (for the reporting period), an analysis of activity at the hospital, and an overview of the completeness of data submitted. NCAA Reports are quarterly (based on a financial year, i.e. April to March), cumulative (i.e. Q1, Q1+2, Q1+2+3, Q1+2+3+4), and provided on validated data only.
As a sufficient number of records for team visits accumulate, models predicting outcomes following a team visit are being developed, to ensure that comparisons between hospitals are fair, and will be included in proposed NCAA Comparative Reports.

National inpatient survey
Published April 2013

Two areas for improvement

- The explanation for patients from the anaesthetist

- Pre-discharge information on medicine side effects and how that impacts upon delayed discharges overall

National Health Promotion in Hospital Audit
Acute and specialist Trusts final report 2012

The following areas for improvement have been identified:

Training

Health Promotion (HP) team to reinstate training with staff –if not able to do formal then informal sessions.

- Opportunity to have the Electronic training 'every Contact Counts 'within NLMS
- Re-evaluate smoking champions role and provide some updated training
- Assess the compliance of the Healthy Living Assessment (HLA) within the Primary PCI and PCI pathway
- Completion of HLA and outcomes should be monitored within the Trust with consequences for poor compliance

All Trusts incorporate a validated alcohol assessment tool such as AUDIT or CAGE into their care pathways for inpatient care.
This tool has been reviewed by HP team –not suitable to use within a tertiary setting more suited to use in alcohol services therefore questions on HLA formatted to obtain as much information as possible to ascertain patients' alcohol consumption, pattern and obtain category- e.g. Binge drinking

All Trusts ensure that a commitment to delivering health promotion to patients, staff and visitors, is explicitly incorporated into their stated aims and mission
Not explicitly incorporated into the aims and mission or Personal Development Reviews - needs more emphasis and consequence for poor compliance.

National Confidential Enquiry Reports

Maternal, infant and new born programme (MBRRACE-UK)
Any reports published during 2012/13 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.
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)
Any reports published during 2012/13 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

Bariatric Surgery: Too Lean a Service? (2012)
Published October 2012
The report was initially sent to the medical director for information as learning from the report findings for this type of specialist surgery could possibly be transferable to practices at LHCH. The report was discussed at the Clinical Audit and Effectiveness Group in November 2012. At LHCH we do not undertake bariatric surgery; however those recommendations that are transferable to our specialist surgery practices are being met. At LHCH patients for elective surgery are seen at pre-assessment clinics, with opportunity for consent to be undertaken prior to admission and re-confirmed on admission. As a specialist tertiary Trust we have access to multi-disciplinary teams (MDT), have processes in place for MDT meetings. We already participate in national heart disease and relevant national cancer audits.

Cardiac Arrest Procedures: Time to Intervene? (2012)
Published June 2012
The review of this report was led by the Trust's resuscitation officer in consultation with the Resuscitation Committee and with each Directorate. Having completed the review the following actions were agreed to improve current practices:

- Two consultants will lead on exploring whether ceiling of care documentation could be introduced and if so to develop such a document within the electronic patient record
- Whether a patient should have had a DNACPR decision in place will be added to the assessment tool that the reviewing consultant completes when reporting to the Mortality Review Group
- An audit of clerking and examination will be incorporated into the 'clinical record keeping audit'.

Peri-operative Care: Knowing the Risk (2011)
Published December 2011
The review of this report was led by the Trust's Clinical lead for anaesthesia. Having completed the review the following actions were agreed to improve current practices:

- Formalise an MDT programme for cardiac surgical cases
- Introduce pre-operative anaesthetic assessment service for thoracic surgery

The reports of 41 local clinical audits were reviewed by the provider in 2012/13 and Liverpool Heart and Chest NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Fasting audit

- Trust wide education regarding the Preoperative Fasting of Adults Policy to ensure patients are not fasted unnecessarily
- Trust wide education to ensure adherence to recommended fasting times for food and fluids pre procedure
- Anaesthetists to ensure light early breakfast and fluids prescribed on EPMA
- Education at ward level to ensure patients are given fluids and food as prescribed on EPMA

Mesothelioma Audit:
This was undertaken by Dr M Ledson on behalf of the Merseyside and Cheshire Cancer Network. The audit has been presented both to the Lung Network group and at our Liverpool Lung Cancer Unit annual meeting.
The Audit identified our number of cases and that in terms of Thoracoscopy, Surgery, Chemotherapy, Radiotherapy, Chemo/Rad and survival we outperformed the Network as a whole. Going forward:

- Set up an on-going mesothelioma clinical database for network use. This data set can be used by clinical teams to identify areas where treatment rates can be improved

Continuous Glucose Monitoring (CGM) For Cystic Fibrosis Related Diabetes (CFRD)

- CGM is a useful tool in both the diagnosis and management of CFRD
- Can detect CFRD even when HBA1C normal
- Now incorporated into our CF Annual Screen
- Food and exercise diary useful in both management and diagnosis groups

Re-Audit of Secondary Prevention Following Primary PCI (PPCI)

- Need to increase education or awareness of the PPCI prescribing protocol and the 'gold standard' of discharge summaries. This is to be included into new doctor induction training
- Prescribing system should provide more prompts regarding the titration of medications and documentation be changed to provide better guidance along the patient pathway to prescribing an aldosterone antagonist, a drug used to treat high blood pressure and heart failure by getting rid of more fluid in the body, by increasing urine output.

An audit of delays in aortic surgery referrals caused by failure to send imaging

- Secretaries now have a password to our imaging system to check that relevant images are on the system when referrals are received. Following discussions with the PACs office we learn that the system is due for a major upgrade in the spring which should facilitate faster image linking between hospitals.

- We plan to introduce an e-referral system for Aortic referrals and we hope to be able to link this to the introduction of the EPR system and other e-referral systems in the hospital.

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 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 3,436.

Compared to 2011/12, we have more than doubled 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, 9 clinical research studies in the cancer speciality, 9 clinical research studies in the surgery / critical care specialty, 10 clinical research studies in the respiratory specialty and 4 clinical research studies in quality of life / outcomes during 2012/13.

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 55 clinical staff participating in research approved by a research ethics committee at Liverpool Heart and Chest Hospital NHS Foundation Trust during 2012/13. These staff participated in research covering 5 medical specialties.

In the last three years, a total of 115 peer-reviewed publications have resulted from general research activity; 25 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 L**ung Cancer **S**creening 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.

- **H**ow **E**ffective are **A**ntithrombotic **T**herapies in **P**rimary **PCI** (**HEAT-PPCI**). During a heart attack, often an artery is blocked and the blood supply to parts of the heart is completely interrupted. The preferred treatment option is called Primary Percutaneous Coronary Intervention (PPCI) or primary angioplasty. This is an urgent treatment to restore blood flow to the heart by opening the blocked artery using small balloons and stents. During PPCI in every case we use drugs to prevent blood clotting at the treatment site. Two anticlotting drugs, Heparin and Bivalirudin, are in widespread and routine use worldwide as well as in our hospital. Both agents have been studied and are known to be safe and effective. Currently we do not know for sure if one drug may have some slight advantage over the other in the setting of PPCI. Hence, we are comparing Heparin and Bivalirudin to see if there is any difference in the treatment of heart attacks and reducing complications of treatment such as bleeding. This will help us choose the better medication for patients requiring PPCI in the future. We will recruit approximately 1800 patients undergoing PPCI at Liverpool Heart and Chest Hospital over a period

of 28 months. These patients will be randomly allocated into one of the two groups either receiving Heparin or Bivalirudin. All other treatments will be the same for both groups according to standard PPCI treatments. Both groups of patients will have a blood sample taken during the procedure to assess tests of platelets and blood clotting. Platelets play a major role in blood clotting and our study will compare the effects of Heparin and Bivalirudin on platelet function. Patients will be followed up for 28 days to look for any difference between the two groups for heart attacks, additional angioplasty procedures, stroke and death.

- **N**eural **C**ardiac **T**herapy for **H**eart **F**ailure (**NECTAR-HF**). Heart failure (HF) is one of the leading causes of death and hospitalization in European countries. There have been many advances in the treatment of heart failure including new drugs and new uses for implantable devices like pacemakers, but these are not appropriate for all patients, and sometimes are not effective is some patients. New therapies are needed to improve patient health. Studies with animals, and a recent first-in-human study, have demonstrated that influencing the nervous system by electrical stimulation of a particular nerve in the neck (called the vagus nerve) may be a promising therapeutic approach to slow the progression of heart failure. The purpose of this study is to evaluate the effects of electrical stimulation of the vagus nerve to determine if this new investigational therapy can safely improve heart failure. The vagus nerve transmits signals to and from the brain and various organs in the body, including the heart. There is evidence that stimulating this nerve may help heart failure patients.
  One of the patients participating in this trial at the Trust has been the subject of a BBC television report.

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. The Trust has seen the consolidation of the cardiovascular and chronic obstructive pulmonary disease (COPD) community services in Knowsley, started in 2010/11 and 2011/12 respectively.

The adoption of innovative practice is governed by the Trust's Clinical Audit and Effectiveness Committee which 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 alcohol ablation to treat cardiomyopathy. The procedure uses the property of a very small dose of alcohol to kill heart muscle in the area of the heart causing the pathology. A very small probe is used to deliver the dose to the site through the coronary vessels, with the aid of angiography and a contrast dye. The cardiologist is able to localise the precise area that needs repairing, by delivering a small dose of alcohol, the muscle is killed, producing a controlled heart attack, and the heart then goes back to the healthy state. Patients are given excellent outcomes without the

need for major surgery, or even the need for a general anaesthetic. This also results in 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 2012/13 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 2012/13 were 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)

£1,809,000 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 on communication and seven day transfer for cardiac surgery. However, this did not result in any penalty on full payment (to be confirmed by main Clinical Commissioning Group).

The CQUIN indicators for Liverpool Heart and Chest Hospital NHS Foundation Trust in 2013/14 are to:

1. Improve the experience of patients and measure success through the Friends and Family test
2. NHS Safety Thermometer
3. Dementia assessment, referral and carer support
4. Venous thromboembolism assessment and treatment
5. Improve the outcomes and experience of care in heart attack, heart failure and bypass grafting patients (Advancing Quality)
6. Ensure patient quality and safety across the health care system

7. Communication: timely discharge summaries and letters
8. Improve performance against the 62 day cancer waiting times standard from urgent suspected cancer referral to first definitive treatment
9. Develop an effective discharge planning protocol and to monitor its usage and implementation

Further details of the agreed goals for 2012/13 and for the following 12 month period are available 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 2012/13.

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 2012/13.

However, the Trust has participated in an unannounced review by the Care Quality Commission on the 23rd August 2012. Five standards were reviewed on this occasion:

- Outcome 1: Respecting and involving people who use services
- Outcome 5: Meeting nutritional needs
- Outcome 7: Safeguarding people who use services from abuse
- Outcome 21: Records
- Outcome 13: Staffing

The inspectors spent the whole day at the Trust as part of their rigorous assessment on two of our wards, Oak and Elm. The Care Quality Commission found the Trust to be compliant in all the reviewed standards with no major or minor concerns expressed.

In particular, they highlighted how staff are 'exceptional' and were impressed with the quality of the whole multi-disciplinary team, the way in which staff go the extra mile for patients and their families, and address the individual needs of every patient.

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 programme 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 2012/2013 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:	99.8%	99.4%
Valid General Medical Practice Code was:	100%	100%

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 2012/13 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 2013 obtaining a 'significant' assurance opinion.

Clinical coding error rate

Liverpool Heart and Chest Hospital NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2012/13 by the Audit Commission. The Trust received for the third year running in 2013 the CHKS Data Quality Award for Specialist Trusts which is based on the quality of clinical coding data.

However, the last audit undertaken in 2011/12 noted that the Trust continues to maintain its high level of coding accuracy with the following error rates identified:

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 has the following programme of improvement work in place during 2013:

- continuation of an internal audit plan to assess coding accuracy
- continuation of closer working with clinicians to gain better understanding between clinical terminology / documentation and clinical coding practices
- continuation of utilising information from Dr Foster Intelligence to identify any potential scope for improvements in clinical coding i.e. depth of coding
- continuation of enhancements 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 2012/13.

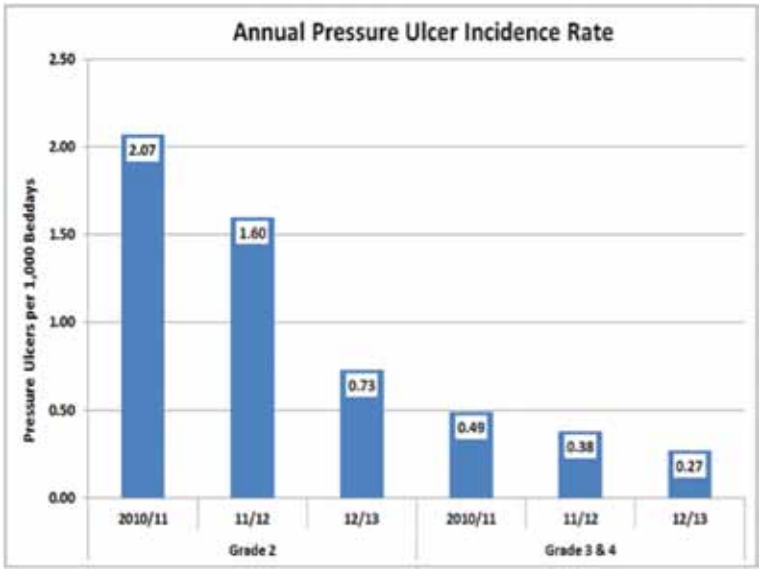
Presented are:

- 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 Clinical Commissioning Group.

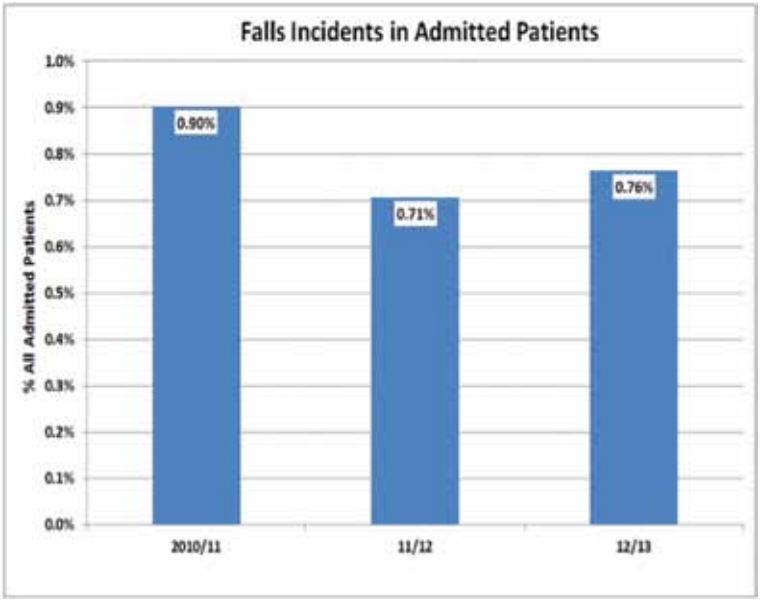
- Qualitative findings, that is, themes emerging from comments provided by patients who have used our services.

Quantitative Metrics

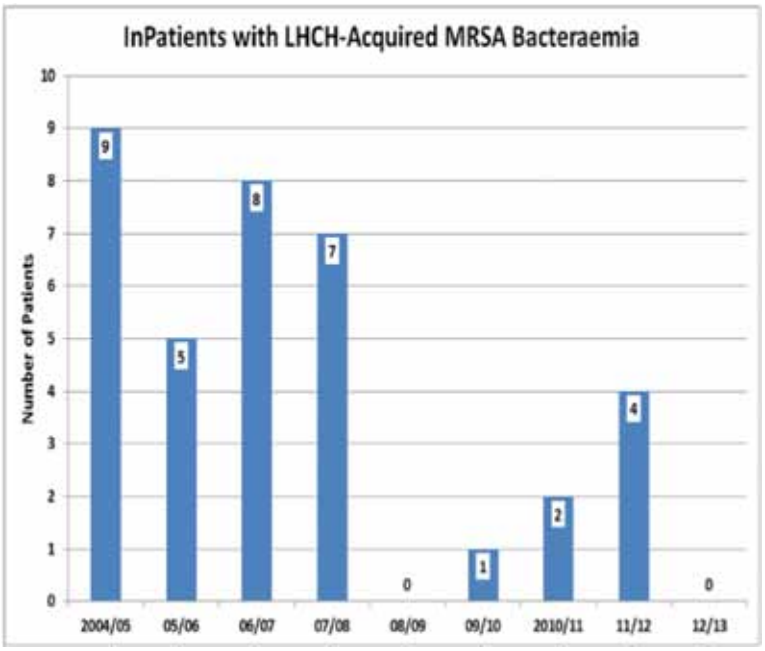
Safety			
Metric	Pressure ulcer incidence	**Organisation Wide or Service Specific**	Organisation Wide
Derived From	Referrals to the Tissue Viability Specialist Nurse	**Why metric chosen**	Pressure ulcers are painful for patients and contribute to a negative patient experience. Nursing high impact action; local CQUIN indicator
How is data collected	Staff who observe a pressure ulcer report this to the Trust's Tissue Viability Service for treatment	**Improvements planned**	1.Continued staff education 2.Establishment of the Pressure Ulcer Bundle with a focus on pressure ulcer prevention
LHCH Performance 2012/13	Grade 2 = 0.73 (~4 ulcers per month) Grade 3+ = 0.27 (1.3 ulcers per month)	**LHCH Performance 2011/12**	Grade 2 = 1.60 (~7 ulcers per month) Grade 3+ = 0.38 (1.7 ulcers per month)
Interpretation of Results	In previous years pressure ulcers were reported in terms of the number of patients with pressure ulcers. To come in line with common practice, now we are reporting the actual number of pressure ulcers. However, whichever way used for measuring this indicator, the occurrence of pressure ulcers at LHCH is becoming rarer and the impact to patients reducing. 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 and the year before.		



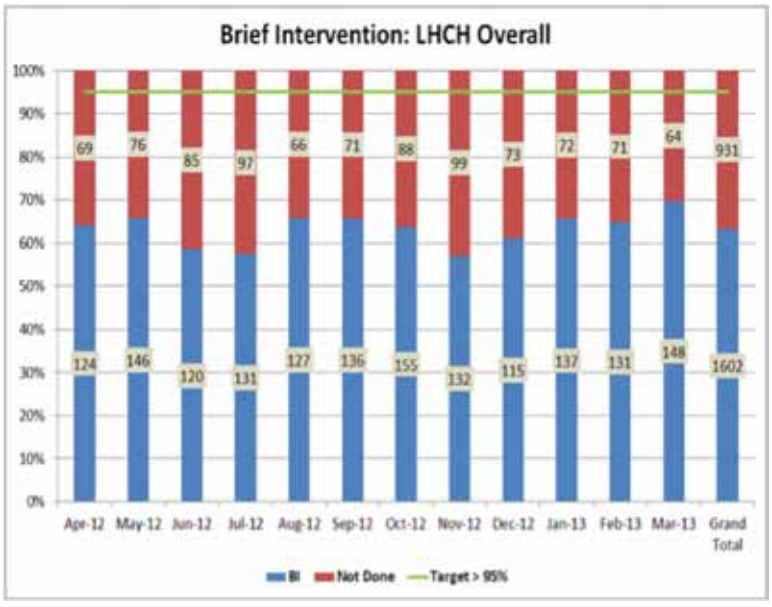
Safety			
Metric	No. patient falls	**Organisation Wide or Service Specific**	Organisation Wide
Derived From	Incident reporting	**Why metric chosen**	Falls have the potential to cause significant harm. Nursing high impact action; local CQUIN indicator
How is data collected	Staff who witness or become aware of a fall report this via the Trust's risk management processes	**Improvements planned**	Embedding of Comfort Checks in wards
LHCH Performance 2012/13	0.76% (104 falls in 13,619 admissions)	**LHCH Performance 2011/12**	0.71% (93 falls in 13,163 admissions)
Interpretation of Results	The number of falls in 2012/13 was slightly higher than last year. However, with the corresponding rise in overall activity, the falls incident rate has not changed significantly. The risk profile of our inpatients has become more challenging recently. However, falls rates still remain lower than they were 2 years ago. We will continue to strive to reduce the number of falls our patients experience.		



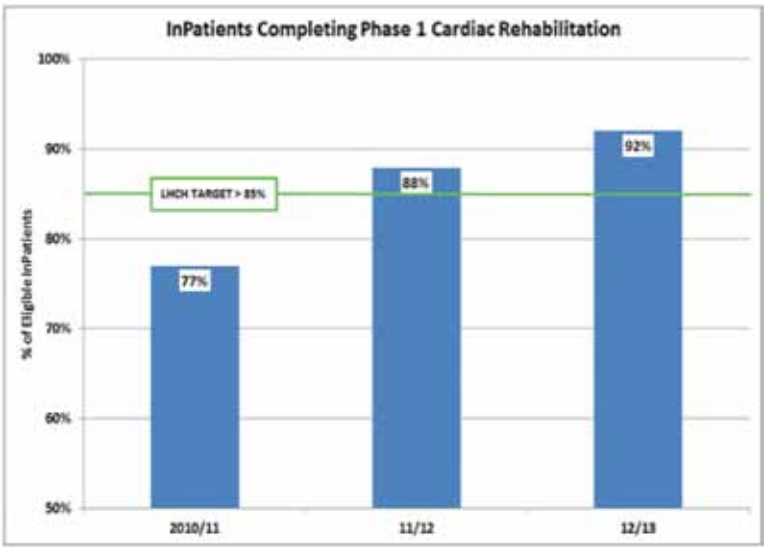
Safety			
Metric	Number of patients acquiring MRSA bacteraemia whilst in hospital	**Organisation Wide or Service Specific**	Organisation Wide
Derived From	Infection prevention team	**Why metric chosen**	Major concern of patients; Department of Health priority
How is data collected	Monthly surveillance reported to health protection agency. National definitions of bacteraemia applied.	**Improvements planned**	We'll continue with the processes put in place last year: 1. Surgical site infection check 2. MRSA screening audits 3. Central lines bundle
LHCH Performance 2012/13	0 patients	**LHCH Performance 2011/12**	4 patients
Interpretation of Results	There were no cases of MRSA bloodstream infections at our Trust this year. The trend over the last 10 years has been steeply downward. Infection control continues to be one of our top priorities.		



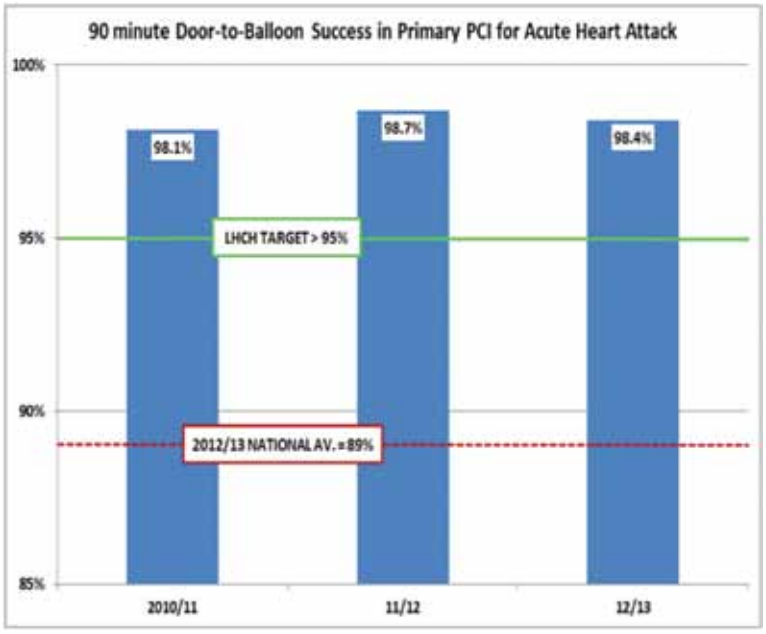
Effectiveness			
Metric	Percentage of patients receiving smoking cessation advice (brief intervention)	**Organisation Wide or Service Specific**	Organisation Wide
Derived From	Internal electronic referrals tool	**Why metric chosen**	Continuing to smoke after treatment greatly raises long term risks of death, heart attack and stroke. Local CQUIN indicator
How is data collected	When staff have identified a current smoker they should deliver advice and record this on the Trusts e-referral system	**Improvements planned**	Introduction of Health risk assessment as part of normal practice looking at weight, diet, alcohol, etc
LHCH Performance 2012/13	63%	**LHCH Performance 2011/12**	64%
Interpretation of Results	We have remained below target yet again; although we have introduced systems to ensure the advice is given, it is the documentation of this that reflects badly on us. We are confident that with the introduction of Electronic Patient Records this year, we will see an improvement.		



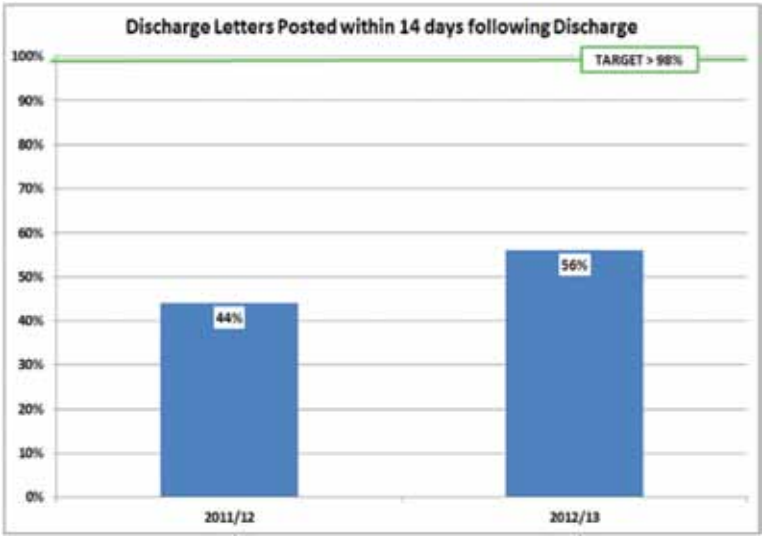
Effectiveness			
Metric	% patients completing phase one cardiac rehabilitation	**Organisation Wide or Service Specific**	Organisation wide – phase 1;
Derived From	Local audit figures	**Why metric chosen**	Promotes lifestyle change and reduces future risk of cardiac events such as heart attacks
How is data collected	When in hospital, patients receiving heart treatments receive a comprehensive educational session about lifestyle and its importance in promoting future wellness. This data is sent to the Clinical Quality Department for analysis.	**Improvements planned**	To maintain the quality of the service and the level of uptake by nominating a cardiac rehabilitation trainer at each ward and increase training of ward staff for the delivery of cardiac rehabilitation.
LHCH Performance 2012/13	92%	**LHCH Performance 2011/12**	88%
Interpretation of Results	We have exceeded the 2012/13 target set for this indicator, which is a great improvement from last year. We will continue the excellent service provided by having ward specific cardiac rehabilitation trainers.		



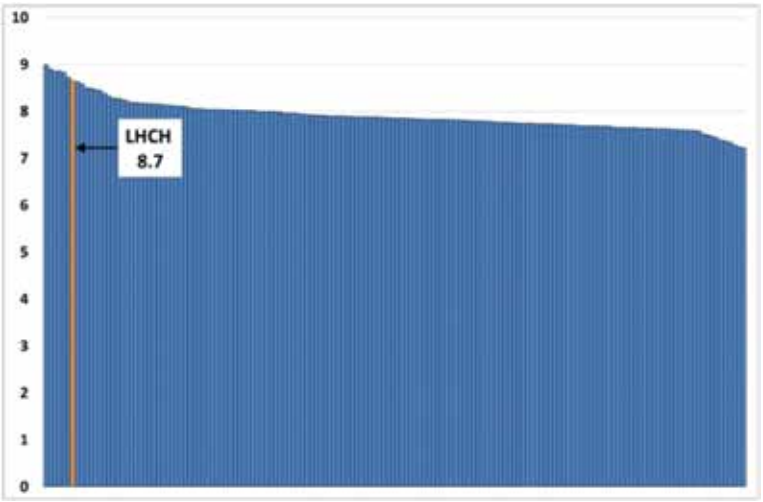
Effectiveness			
Metric	% patients with heart attack receiving treatment within 90 minutes of arrival (door to balloon time)	**Organisation Wide or Service Specific**	Service specific - Cardiology
Derived From	Local audit figures	**Why metric chosen**	Service has expanded this year, so need to ensure good quality care has been maintained
How is data collected	LHCH contribution to myocardial infarct national audit project (MINAP) collected into in house electronic database. National definition of performance measures used from MINAP.	**Improvements planned**	Performance is excellent so we aim to learn from each of the times performance is not perfect.
LHCH Performance 2012/13	98.4%	**LHCH Performance 2011/12**	98.7 %
Interpretation of Results	The high standard set in previous years has been maintained this year. Our patients continue to benefit from this extremely efficient, gold-standard service.		



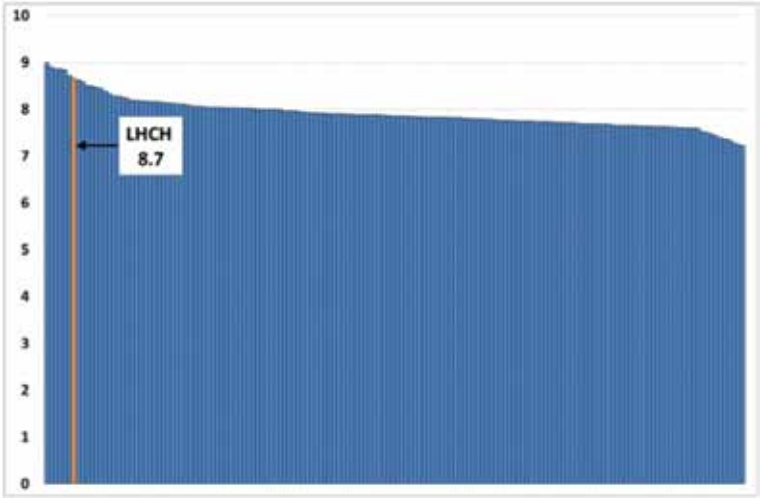
Effectiveness			
Metric	% patients discharge letters written, typed and sent within 14 days of discharge	**Organisation Wide or Service Specific**	Service specific – Support Services
Derived From	Local audit figures	**Why metric chosen**	Timely communication to other health care professionals is essential to ensure continuity of care
How is data collected	Medical secretaries record the date of discharge, date dictation is completed and date typed and dispatched for discharge letters.	**Improvements planned**	Implementation of the Electronic Patient Record (EPR) system will include a module for generating patient correspondence. Development of standard documentation across the health economy as part of our CQUIN and priority for 2013/14.
LHCH Performance 2012/13	56%	**LHCH Performance 2011/12**	44%
Interpretation of Results	We have not achieved the target set for this indicator. Implementation of the EPR will improve the timeliness of patient correspondence. We are emphasizing the importance of discharge documentation by making this one of our priorities for 2013/14.		



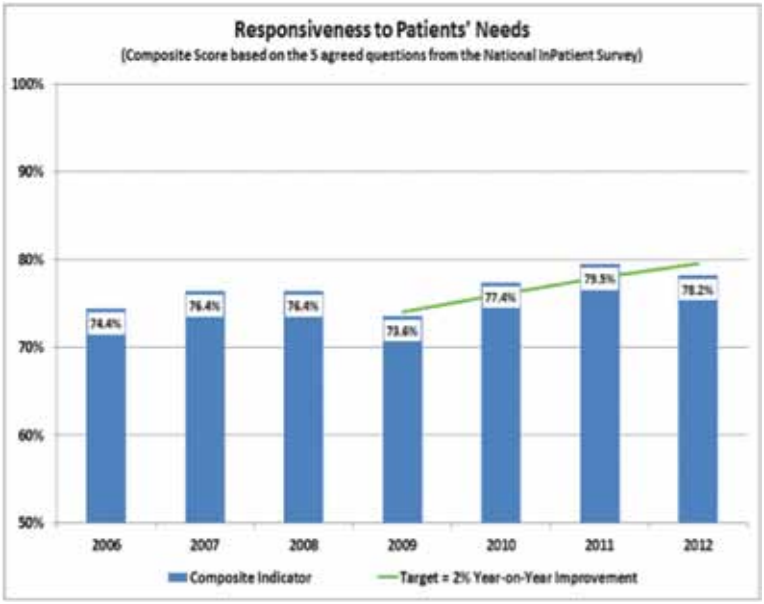
Patient Experience			
Metric	% patients who perceived they did not share a sleeping area with patients of the opposite sex.	**Organisation Wide or Service Specific**	Organisation wide
Derived From	National patient survey results	**Why metric chosen**	Sharing sleeping areas threatens patients' dignity. 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**	Day ward being re-developed as part of the Capital Project of improvement in the Trust
LHCH Performance 2012/13	9.1 (91%)	**LHCH Performance 2011/12**	89.1%
Interpretation of Results	These results are based on patients' perceptions. The results this year indicate a level of improvement from last year. We have developed a new surgical ward in which areas are clearly delimited following single sex guidelines. 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 inpatient stay. Results are benchmarked with other Trusts in England.	**Improvements planned**	Capital project in place for the re-development of one ward area. Implementing the Patient and Family centred care plan
LHCH Performance 2012/13	8.7 (87%)	**LHCH Performance 2011/12**	92.4%
Interpretation of Results	We have had a slight drop in our overall performance rates. The format of the question in the national survey has been changed to give a score from very poor to a very good experience, making difficult to compare this year's figures with previous years. However, as the score ranges from 0 to 10, a rate of 8.7 is still in the top quartile. The experience of our patients is paramount to the Trust, and we keep this as one of our major Trust objectives.		



Patient Experience			
Metric	Responsiveness to patients needs	**Organisation Wide or Service Specific**	Organisation wide
Derived From	Average of 5 key questions drawn from the national patient survey results	**Why metric chosen**	Summary of overall experience of care. National CQUIN indicator
How is data collected	850 LHCH patients are invited to complete a questionnaire about their inpatient 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 Embed a generic discharge summary with clear instructions and information
LHCH Performance 2012/13	78.2%	**LHCH Performance 2011/12**	79.5%
Interpretation of Results	We have seen a small drop in our performance this year. This is mainly due to imperfections in our discharge process, which we are making a priority in this year's quality account.		



Qualitative Findings

The Trust has facilitated four corporate engagement events in the past year which were designed to capture feedback on patient and family experience of the hospital either as an outpatient or an experience during a stay in hospital. The engagement time was also used to explore the Trust's mission statement and how we had met this in the delivery of excellent, compassionate and safe care for every patient, every day. Feedback was sought from patients and their families on the key components of excellence, compassion and safety, with the aim to understanding their perspectives to enable us to better embed these into service improvement initiatives. The events have been supported by representation from the Executive Team, Non-Executives, Governors, Local Involvement Networks (LINks)/ Healthwatch, Trust Volunteers and clinical staff. They focus on patient and family centred care so we can better understand how our patients and families would like services to improve with a focus on family centred care and how this would improve their experience.

General quotations from the events from patients and families:

'I arrived at 9am and was back home post procedure at 5.30pm. Amazed at the quickness of stay and being home so fast.'

'I had not heard of Heart and Chest hospital, so I was a bit worried. Felt very safe and supported by staff once I was there.'

'The Heart failure team were in regular contact – very good. Felt someone was always available if concerned.'

'On arrival I felt safe and confident, that the treatment would be of the best available throughout the whole country.'

Key themes drawn from feedback on compassionate care:-

Key actions taken:

The Trust has developed a network of staff champions to energise patient and family centred care which will support the key elements of delivering compassionate care. Training has been delivered at staff induction and during preceptorship to embed the perceptive of patients in delivering compassionate care. The staff champions will continue to meet monthly to monitor progress and further training sessions are planned for 2013.

The Learning and Development Department has developed and piloted a new induction and preceptorship programme for all newly recruited qualified nursing staff. The programme is focused strongly on the Patient Experience Vision with an emphasis on delivering compassionate care to patients and families. Evaluation of the programme was very positive and it will be rolled out to all new starters within the organisation.

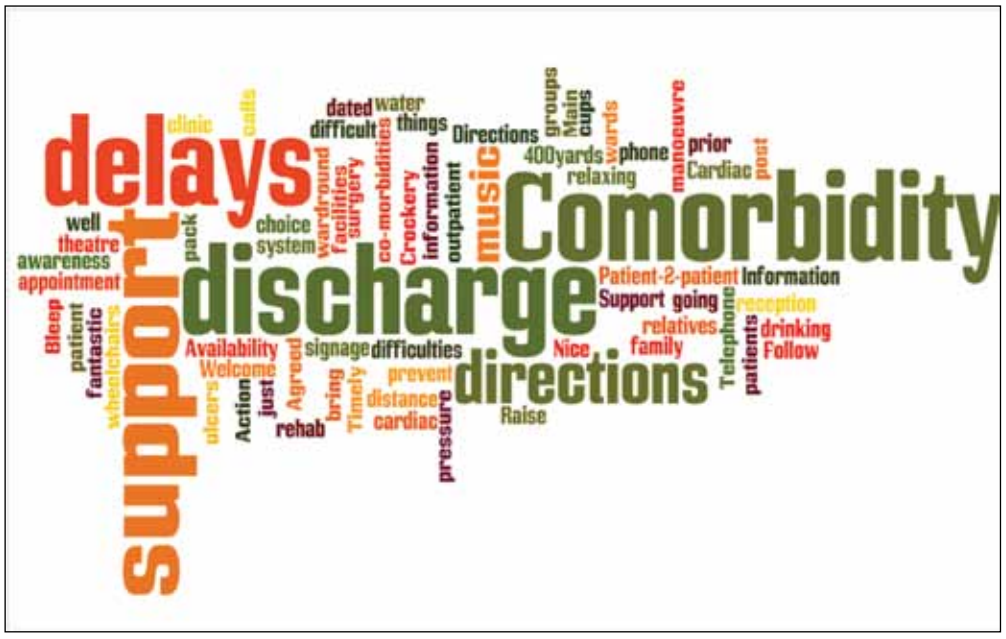
Key themes on patient safety:

- High standards of cleanliness
- High level of professionalism
- Friends and family received positive information that patient was comfortable
- Not picking up hospital acquired infection
- Hand hygiene for patients, visitors and staff
- Staff inspiring confidence in the way that they deliver care
- Keeping patients comfortable, regular checks, mannerisms and having confidence in what they do
- Reassurance from staff throughout stay
- Risks clearly explained
- Witnessing staff using hand gels and adhering to infection prevention policies
- Swift response to buzzers

Key actions taken:
The Trust has involved patients in assessing the care environment through the Patient Led Assessment of Care Environment (PLACE) initiatives. This has enabled the Trust to embed the feedback from patients and demonstrate actions such as ensuring availability of hand gel and cleanliness. The Senior Nurses team has a programme of walkabout to monitor standards of professionalism and maintain the confidence of patients and families. The nursing staff facilitate comfort checks to ensure that patients are safe at all times.

The Management Congress focused on harm and what this meant to staff and this was followed by patient safety roadshows which were delivered to all areas to discuss the issues of safety and reducing harm with staff across the organisation. Staff feedback from these events has been used to inform further work across the organisation to develop a patient safety strategy. This was launched as the "Safe from Harm" vision in April 2013 (see appendix 2).

Key themes on excellence



Four key themes for improvement were identified:

Comorbidity - The risk assessment booklet has been further developed to identify patients with comorbidities. The Model of Care Service Improvement Project led by the surgical directorate has incorporated this theme. This explores the concept of identifying a care partner on admission to hospital and what elements of care they would like to be involved in. This will be somebody who knows the patient well and will help staff to better understand the person behind the patient. The contract of care which also forms part of this service improvement work is being considered presently. The aim of this contract is that it will contain an understanding of the needs/preferences of the patient and family so that staff can better meet their needs.

Discharge / Delays – To support the improvement work carried out around discharge further. Work focusing on discharge planning is currently being examined through the patient flow project. This will incorporate the recommendations from a multi-professional task and finish group that was established to review delays in discharge when waiting for medications at discharge.

Directions – Through the Enhancing the Healing Environment project, the Trust is developing the signage to support patients with directions in hospital. External signage has been improved in the hospital grounds, however further exploration is being carried out to try and improve the external signage to the Trust.

Key themes Patient and Family Centred Care (PFCC)

- Supporting families to feel more confident to look after loved ones when they return home
- Involving and communicating effectively with families can reduce unnecessary phone calls to the ward
- Open visiting can spread the visitors' arrival over the day rather than concentrated in short hours
- Open visiting can support carers to continue with their usual routine at home
- Families sometimes travel a long journey for just short hours of visiting and it is positive if it's open hours
- Provision of volunteer support for lone patients

Patient and Family Quotes

- *"Everything was explained before, during and after procedure"*
- *"I was worried about going on holiday but the doctor reassured me that it was okay"*
- *"My wife was worried about me but she felt I was in safe hands and well supported"*
- *"The treatment failed the first time but worked on the second attempt and my quality of life has improved after my treatment"*
- *"The nurses were fantastic and protecting my privacy and dignity at all times during my stay"*
- *"My family was kept informed about my care and my wife stayed in Robert Owen House"*
- *"I wish I could have stayed a few more days longer for peace of mind"*

Key Actions

The organisation has introduced open visiting times for relatives. This has been welcomed by most patients and the Trust is planning to evaluate the success of the initiative. A network of PFCC champions have been introduced in wards and departments.

Patient Stories

Patient stories have been presented to the Board of Directors since December 2008 and provide a valuable insight into the patient experience. Patient stories are evolving to include the patient and family experience. In order to involve as many staff as possible in the collection of stories, Patient and Family Experience Champions from the clinical areas in the Trust have received training recently in gathering stories and have been tasked with providing a patient/family story monthly. The Trust has recently engaged volunteers in capturing stories. It was felt that this may enhance the experience for the volunteer as well as offering patients and families an opportunity to share their experience. Those volunteers who expressed an interest were given training in collecting stories and tasked with undertaking the collection of a story.

Shadowing

Patient and family shadowing is a method to capture in real time the care experience of patient and families at LHCH. A committed and empathic shadower follows a patient and/or the patient's family throughout a selected care episode. All disciplines of staff both clinical and non-clinical have the opportunity to engage with a patient and or their family through shadowing to understand how care is delivered at LHCH as seen through the eyes of the patient. This work is aligned to the Trust's Patient and Family Experience strategy.

This project has been underway for almost a year and to date over 70 patient and family shadows have been achieved.

Shadowing has demonstrated care delivered with compassion and many examples of exemplar care but has also shown potential for improvement where patients' preferences could be better reflected. For example in the outpatients department we now use visual teaching aids and encourage patients to write down pertinent information during the consultation.

Shadowing has also demonstrated how willing patients are to participate in feedback techniques and often report how much they enjoy the shadowing process. Staff have also embraced the opportunity to engage with patients and their families to understand the care experience and gain insight into the care experience. Staff also describe an increased sense of empathy and how they now understand the needs of their patients and families better following shadowing.

Volunteers

LHCH recognises the value of volunteering in improving the health and wellbeing of patients and relatives who use its services and, in order to achieve this, LHCH is strongly committed to ensuring the necessary support structures are in place. A volunteering strategy has been developed and outlines the vision of the organisation.

Our vision is to have an exciting, challenging, vital, vibrant volunteering community, with shared staff and volunteer expertise across systems to enhance patient and family experience by 2015.

This vision will be achieved by:

- Attracting and retaining volunteers who are aligned to our organisational values and behaviours
- A shift in culture by developing a workforce that acknowledges the importance of volunteers
- Fostering excellent relationships between staff and volunteers

The Trust has so far recruited 90 volunteers contributing approximately 950 hours per month and 24% of volunteers commit to more than one slot per week. Volunteering is planned as slots such as:

- 9am-1pm
- 1pm-5pm
- 5pm-9pm

These slots are the same for weekends. Around 5% of volunteers have committed to out-of-hours volunteering.

Volunteers carry out activities such as:

- Meet and greet
- Mealtime assistance
- Shop run
- Tea bar assistant
- General ward support
- Patient engagement activities support

Volunteers receive bespoke induction and training to ensure that they are effective in their roles.

Themes in Common with our Priorities Arising from Complaints

The Trust received 70 complaints from 1st April 2012 to 31st March 2013. .

This is an increase of 19% of complaints received in comparison to the 59 received the previous year. In line with this the Trust has seen an increase in outpatient activity of 10%, elective admissions of 3% and emergency admissions of 5%.

100% of complaints were acknowledged within the DoH timeframe of 3 days and 100% responded to within the negotiated timeframe with improvements tailored to the circumstances of the complainant's experience

19 of the 67 closed complaints were considered to have valid issues and to be well founded requiring action and improvements made. All action plans were presented and actions monitored until complete through relevant Directorate Governance Committees. 13 complaints still remain open and may require corrective action and be considered upheld.

Metrics against Department of Health Quality Indicators

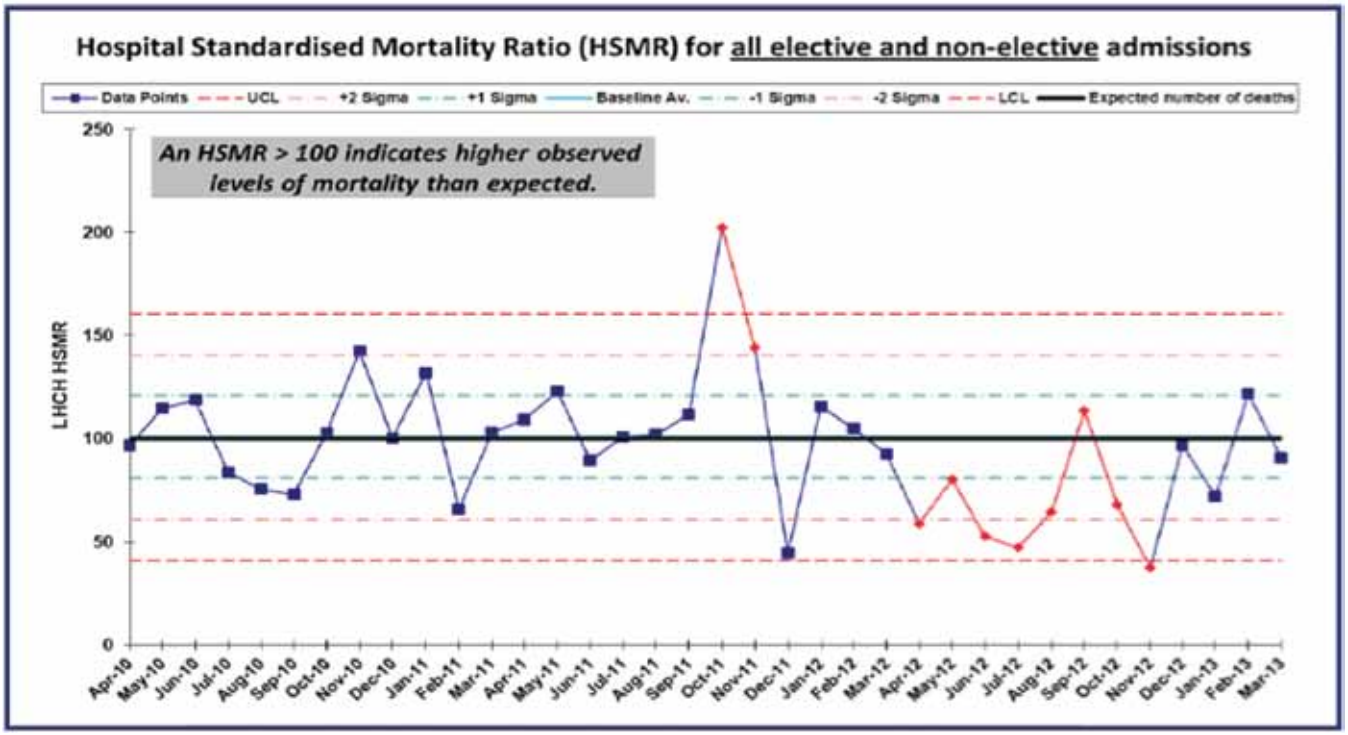
Hospital-level mortality

The Liverpool Heart and Chest Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

Specialist acute Trusts do not calculate their mortality rates using the summary hospital-level mortality indicator (SHMI); instead acute specialist Trusts use the hospital standardised mortality ratio from the Strategic Health Authority dashboard, which is used in the table below.

	Target 11/12	Performance 11/12	Target 12/13	Performance 12/13
Hospital Standardised Mortality Ratio (Dr Foster) – from SHA Dashboard	<100	68.9	<100	90.2
Percentage of patient deaths with palliative care coded at either diagnosis or specialty level	None	10.5%	None	18.8%

In addition, because of the specialist nature of its services, Liverpool Heart and Chest Hospital has devised its own Hospital Standardised Mortality ratio that is updated each month as part of its performance management arrangements and reported to the Trust's Clinical Quality Committee.



The chart compares the Trust actual performance against that of our expected. If the ratio is below 100 (black line on chart) we are doing better than expected. Points above the black line indicate poorer performance. In October 2011 mortality was significantly higher than expected.

The Liverpool Heart and Chest Hospital NHS Foundation Trust intends to take the following actions to improve this rate and so the quality of its services by:

- Reintroduce the Patient Safety Group as the body with overall responsibility for safety in the Trust
- Broaden the remit of the mortality review group to morbidity, often an important prequel to subsequent death

Readmission within 28 days of discharge

The Liverpool Heart and Chest Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

The percentage of readmissions refers to those coming back to our Trust. We have seen a reduction from last year, although our rates are overall very low.

	Target 11/12	Performance 11/12	Target 12/13	Performance 12/13
Trust's responsiveness to the personal needs of its patients	78%	79.5%	79.5%	78.2%

The Liverpool Heart and Chest Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- Ensuring the systematic training of teach back to all new personnel appointed to a role that involves discharging patients.

Staff recommending the Trust to family and friends

The Liverpool Heart and Chest Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

The percentage of staff either extremely likely or likely happy to recommend the Trust has remained at the same level over the last two years, and high at 92%.

	Target 11/12	Performance 11/12	Target 12/13	Performance 12/13
Percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	None	92%	None	92%

Venous thromboembolism (VTE) assessment

The Liverpool Heart and Chest Hospital NHS Foundation Trust considers that this data is as described for the following reasons:
Our rate of assessment of patients at admission is consistently high, we have a well-established monitoring system in place. Additionally, VTE risk assessment is one of our CQUIN priorities.

	Target 11/12	Performance 11/12	Target 12/13	Performance 12/13
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism	90%	96.05%	90%	96.17%

The Liverpool Heart and Chest Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- Establishment of a VTE steering group which ensures compliance with the CQUIN requirement and the high quality care of our admitted patients
- Learning from each and every VTE through root cause analysis and feedback of lessons learned.

C.difficile infection

The Liverpool Heart and Chest Hospital NHS Foundation Trust considers that this data is as described for the following reasons:
Our infection rates are consistently low; the number of C.difficile cases remained at 8 the same as last year; although the SHA target was lower than our performance at 4, the target set by our regulator, below, Monitor for 2012/13 was 12, and therefore our performance is bettered.

	Target 11/12	Performance 11/12	Target 12/13	Performance 12/13
Rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over	None [<=7]	15.2 per 100,000 bed days [8]	None [<=4]	13.5 per 100,000 bed days [8]

Actual numbers shown in [ ]. SHA targets shown. Monitor targets were 7 and 12 for respective years.

The Liverpool Heart and Chest Hospital NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services by:

- Screening patients for C.difficile when infection is suspected
- Isolation of infected patients to avoid risk of spread

Patient safety incidents

The Liverpool Heart and Chest Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

	Target 11/12	Performance 11/12	Target 12/13	Performance 12/13
Number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	None	1118 incidents 8.8 per 100 admissions (12650 admissions) 3 (0.3%) resulted in server harm or death	None	1064 incidents 8.2 per 100 admissions (12978 admissions) 3 (0.3%) resulted in server harm or death

The Liverpool Heart and Chest Hospital NHS Foundation Trust intends to take the following actions to improve this number and so the quality of its services by:

- Implementation of the Trust's new vision for safety – Safe from Harm *(see Appendix 2 for details of vision)*

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

Statement for the Liverpool Clinical Commissioning Group

Nil return

Statements from Local Involvement Networks (LINks)/ Healthwatch

This commentary addresses the Quality Account but also draws on the sustained and positive engagement that was established between Liverpool LINk and Liverpool Heart and Chest Hospital NHS Foundation Trust. The engagement was maintained seamlessly throughout the LINk transition into Healthwatch Liverpool thus forming the basis for this informed commentary by Healthwatch Liverpool.

The comments made here pertain to a draft Quality Account document that was made available to Healthwatch Liverpool prior to Quality Account publication.

By attending a number of relevant engagement/consultation events Healthwatch Liverpool has satisfied itself that the Trust has effectively consulted with, informed and involved service users, staff and other stakeholders in the choice of its Quality Accounts priorities and on the implementation of resulting action plans.

The Quality Account contains far too much information to comment on in detail here, but there are a few key points that Healthwatch Liverpool would like to highlight. Healthwatch Liverpool is pleased to note that the Trust has been awarded HSJ Provider of the Year after, and amongst other achievements, delivered improved quality with less money for the 3rd year. Also, Healthwatch Liverpool is very pleased to observe that the Trust has given such a high priority to improving the care of patients in this Quality Account. This is of fundamental importance and linking this with priorities around upskilling of staff and the priority around Improving Recommendation of the Trust to Friends and Family in 2013/14 signals an appropriate level of commitment regarding the care of patients. Also, the patient experience vision and survey results are quite impressive.

The document sets out the relevant quality performance data clearly so it is easy to see where the Trust is performing well, as is generally the case, and it is also clear where things are not going as well e.g. where at times there has been higher levels of mortality than expected.

As has been the case with previous quality accounts produced by LHCH, this Quality Account is exemplary in the both the level of information given and the clarity with which it is presented.

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

Andrew Lynch
Development Officer
Healthwatch Liverpool Scrutiny

St Helens Local Involvement Network (LINk)

The hospital seems to have a good reputation with patients and professionals and the accounts reflect this in the awards it has received, the comments made by patients within the document and the people I am in contact with.

Like many Quality Accounts it contains language that the lay-people cannot understand and tables requiring a degree in statistics to comprehend. As a blind person reading this document, it did however meet my access needs and is quite a good attempt in meeting the needs of others. Having the tables and text in 'Word' format was useful; however it would be better to maintain one format throughout the document.

I am aware of the positive impact technology has in our everyday lives. Greater use can cause exclusion for disabled people, employees who are disabled, people who cannot afford computers or people with print & intellectual impairments. If introducing technology to improve systems or include patients, this needs to be given serious thought.

I attended the Quality Accounts presentation so I know the issue using jargon was raised. The tables could be attached at the end of the document. An easy-read version and other formats of the document need to be made available upon request; it does not state you offer this.

The conversational nature of the account is refreshing and enables understanding of where the hospital was at, what it had done and where it is going next. The mix of qualitative, quantitative and patient input is useful and interesting.

The priorities chosen were clear and if not met, there was a good explanation as to why.

Individuals are, or will be, involved at all levels in the hospital's future and it was good to see that attempts are being made to involve patients, staff and the wider community in having their say.

I was concerned that little or no reference was made to equality issues, even though I am aware of the hospital's approach through the Equality Delivery System and Equality and Diversity training for staff.

A reference was made to bringing along your glasses to complete questionnaires - this assumes that the patient can read. What about blind, print impaired or people whose first language is not English?

A commitment has been made to 'vulnerable patients'. Who are they and why may they have difficulty in engaging with, attending events or having their needs met? What is the Trust's approach in addressing the needs of 'vulnerable patients'?

It is a positive move and will be supported by patients and the wider community, if a more integrated approach is adopted with more joined up thinking that involves health partners and Adult Social Care to produce a person-centred approach.

My hope is that the hospital will work with Healthwatch to keep up the good work, taking their suggestions on board.

John Perry
Board member St. Helens LINk;
Liverpool LINk Core Group

Statement from the Host Overview & Scrutiny Committee
Nil return

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

This Group of Governors has continued to meet throughout the year having our members and the public attending.

We have reviewed the Quality Accounts for 2012/13 for the Trust and are confident they represent a true account of the Trust performance based on the audited figures presented.

Our Public Meeting was very well attended, to discuss the work of the Hospital. Clinicians, Stakeholders, Staff, Patients and Family members, as well as members of the Public attended from Merseyside, Cheshire, North Wales and the Isle of Man.

We also had Presentations from our Nursing Staff working in the community of Knowsley.

At this meeting, a selection of work to be considered by the Clinical Directorate was chosen for the coming year.

Concerns were raised regarding cuts to Finance and other practices.

We, as a group, are confident that this Hospital will respond, as it always has, in a very positive way, to the problems of the year ahead, but we are assured that at present there is no impact to the quality of care for patients.

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 2012 we have continued to refine our Staff Experience Vision which describes 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. Following the revision of our Appraisal and Personal Development Review process in 2011 to encompass both the patient and staff experience visions we have continued to engage and consult with managers and staff to ensure that the skills and experience that they possess are fully utilised to support delivery of the Trust's objectives.

As mentioned earlier we believe that staff engagement is paramount to the delivery of high quality care and our commitment to this ethos was clearly demonstrated when we were awarded the best provider of healthcare in the country after winning the 2012 Provider Trust of the Year Award at the HSJ Awards. We were described as "An outstanding performer with impressive research and an impressive broad network of committed care in the community".
In addition the judges felt that we were "really reinventing the role of the hospital in the community for the NHS".

We have also continued to work with staff to refine staff engagement and this has been reflected in the results of the NHS Staff Survey for 2012 which saw our engagement score rise from 3.85 to 3.92 placing LHCH 6th out of all the Acute Specialist Trusts who

took part in the survey and 12th out of 250 overall participants. The survey also provides good evidence of our continuous improvements over recent years and we are delighted that we had the highest score of all specialist acute Trusts in the following key areas;
Key Finding 9. Support from immediate managers
Key Finding 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (lowest %)
Key Finding 21. Percentage of staff reporting good communication between senior management and staff.

Year	2007	2008	2009	2010	2011	2012
Response Rate	38%	63%	64%	63%	62%	55%
% of staff having an appraisal	49%	56%	79%	84%	84%	89%
% of staff agreeing appraisal helped them to do job better	46%	57%	61%	63%	69%	70%
% of staff agreeing they feel satisfied with quality of work and patient care they are able to deliver	72%	84%	85%	83%	85%	86%
% of staff who would be happy for a friend or relative to be treated at LHCH	Not asked	Not asked	89%	88%	91% *4.04	*4.20 (not as %)
Staff agreeing they are satisfied with their job (maximum score = 5)	3.33	3.54	3.55	3.56	3.55	3.76
% of staff who would recommend LHCH as a place to work	Not asked	51%	64%	59%	62% *4.08	*4.20 (not as %)
Overall Staff Engagement Score (out of 5)	Not asked	Not asked	3.78	3.80	3.85	3.98

*In 2012 the results are expressed as a score up to a maximum of 5.

	2011/12		2012/13		
Top 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	**Trust Improvement/ Deterioration**
KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. (lower score is better)	11%	14%	15%	23%	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible.
KF9. Support from immediate managers. (higher score is better)	3.74	3.64	3.85	3.69	Improved 0.11
KF18. Percentage of staff experiencing harassment, bullying, or abuse from patients, relatives or the public in last 12 months (lower score is better)	7%	3%	14%	21%	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible.
KF21. Percentage of staff reporting good communication between senior management and staff	40%	35%	41%	33%	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible.

	2011/12		2012/13		
Bottom 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	**Trust Improvement/ Deterioration**
KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	93%	96%	87%	92%	Deteriorated 6%
KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (lower score is better)	7%	3%	8%	6%	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible.
KF20. Percentage of staff feeling pressure in last 3 months to attend work when feeling Unwell (lower score is better)	28 %	22%	25%	23%	Improved 3%
KF26. Percentage of staff having equality and diversity training in the last 12 months	44%	50%	55%	61%	Improved 11%

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.

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 September 2011, the Trust implemented a Health and Wellbeing Strategy with the aim of supporting staff to improve physical and emotional wellbeing. We have now developed a Health and Wellbeing Action plan for 2013/14 and the following are examples of a number of initiatives that we will continue to run for our staff.

Long Service Award Ceremonies – to recognise the hard work and achievement that our committed staff provide to our patients, a number of long service award ceremonies will be held where awards will be presented to staff by our Executive Team.

Flu Campaign - The Trust launched a flu campaign to help protect our staff and patients against the risks associated with flu and this is currently an on-going initiative. The response to this campaign has been a positive one whereby the last figures submitted were that over 60% of staff had been vaccinated so far.

Salary sacrifice schemes – The Trust runs a number of salary sacrifice schemes to help staff make tax efficient savings on the following:

- Nursery fees for an on-site nursery
- Car lease scheme
- Cycle to work scheme

These schemes have been hugely successful with the car lease scheme being particularly well-received following Trust wide consultation with staff around the staff experience vision.

Employee Assistant Programme – The employee assistance programme is an advice helpline (and website) aimed at supporting staff with difficulties that they may encounter in their lives- for example financial difficulties or bereavement. This programme can also support staff who require counselling as the service offers one to one counselling sessions in addition to telephone advice which is available 24 hours a day, 7 days a week.

Physical activity – The Trust introduced a number of physical activity initiatives such as the running club which takes place each Wednesday evening and Zumba and Yoga classes which took place on a weekly basis. There is also a free on-site gym which staff may access and if needed, advice is available regarding healthy eating plans and training plans to help with weight loss programmes and fitness regimes.

Staff Physiotherapy service – This is a free service to help those staff with musculo-skeletal health problems access physiotherapy rapidly to help them maintain their attendance at work and improve their general well-being. The number of instances of musculo- skeletal problems has decreased over the last 12 months as a direct consequence of the introduction of this initiative

Workplace Wellbeing Charter – Last year the Trust achieved the highest accolade with regards to the health and well-being initiatives they provided for staff and we were awarded the 'green standard'. We will continue to adopt the framework of the charter when developing and implementing our health and wellbeing initiatives over the next 12 months.

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

Staff Survey Questions	2009	2010	2011	2012
In general my job is good for my health	44%	43%	49%	46%
My immediate manager takes a positive interest in my health and well being	49%	50%	53%	64%
My organisation takes positive action on health and wellbeing	n/a	n/a	n/a	59% against an average of 44%

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 2013/14.

We have also become a Responsibility Deal Partner via the Department of Health initiative the "Public Health Responsibility Deal" and signed up to a number of pledge delivery plans, laying out how we intend to meet each of the pledges we have signed up to including Chronic Conditions Guides, Smoking Cessation / Respiratory Health and Mental Health Workplace Adjustments

Planning and Developing the Workforce

Each year the Finance, Learning and Development and Human Resources teams work with senior members of the Directorate Management teams to develop workforce plans to deliver existing services and prepare for known or planned future redesign. 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. Findings are reported via the Workforce Committee.

Development of staff in Bands 1 to 4

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. Our apprenticeship scheme is seen as a key factor in training the full range of clinical, non-clinical and ancillary staff so that they are supported in developing the key skills and attributes required for their roles.

LHCH Healthcare Assistant Development Pathway

The need for Trusts to review processes for Healthcare Assistant (HCA) development has been raised by the Francis Report (Francis, 2013) with further recommendations supported by the Willis Commission (2012). An integral part of the Staff Experience Vision at Liverpool Heart and Chest Foundation Trust is commitment to encouraging and supporting all Health Care Assistants in developing and succeeding in their professional career.

Based on the factors identified in the literature, and on the Trust commitment and ambition to encouraging and supporting all health care assistants to develop and succeed in their professional career, Liverpool Heart and Chest NHS Foundation Trust took the decision that every health care assistant employed at the Trust should have the opportunity to attend a bespoke development pathway either on commencement in post, or for those staff already in post, by March 2014.

The first LHCH Healthcare Assistant Development Pathway ran in September 2012. Plans are in place for a full series of programmes during 2013-2014 to cover all healthcare assistants currently employed in the Trust (Band 2 upwards). Following this initial roll-out, the programme will run at least twice per year and is being updated with each cohort depending on the changing healthcare priorities and the needs of the staff.

The LHCH Health Care Assistant Pathway has been designed to support, assist and encourage each HCA to develop their knowledge and skills so that they can contribute to the Trust's 'Patient and Family Centred Care' strategy of providing personalised Excellent, Compassionate and Safe care to every patient, every day. Overall, the LHCH HCA Pathway has provided a foundation in the minimal requirements of all LHCH HCA staff and in turn will uphold the nationally recognised values in delivering high quality compassionate care to all.

The Trust has a Learning Needs Analysis which outlines the statutory and 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. This contributes to the Trust's 'Safe from Harm' vision. Mandatory training compliance is reported to managers on a monthly basis by the Learning and Development team. During the past year, the Learning and Development team have worked proactively with local managers in all areas to support them in achieving compliance with required training. The existing mandatory training workbook for non-clinical staff has been revised and re-launched in August 2012. In addition, new medical and clinical workbook have been developed and introduced alongside on-line assessment. All topics are mapped to the Northwest Core Skills Programme. All on-line assessments now require 80% pass rate providing assurance. LHCH is currently fourth in the National League Table for e-learning use via OLM.

During the year the Trust has continued 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. The competency framework is currently being piloted with the nursing workforce with plans agreed to roll this out to other professions during 2013-2014. Following the successful introduction of a Preceptorship Pathway for newly qualified nurses was introduced in September 2012 with a second programme commenced in March 2013. Plans are in place to roll this initiative out to all newly qualified clinical professional staff during 2013-2014.

Turnover is above our target of 10%. Mandatory training and appraisal are slightly below our target of 85%. However, we saw a small improvement in our sickness absence albeit still below our challenging target of 3.6%.

Metric	2008/9	2009/10	2010/11	2011/12	2012/13
Sickness Absence %	5.6%	3.9%	4.2%	4.5%	4.2%
Turnover %	11.4%	9.6%	6.7%	7.4%	13%
Mandatory Training %	85%	82%	83%	84%	80%
Appraisal Coverage %	85%	62%	82%	79%	76%
Spend	£1,445,323	£1,359,012	£1,317,657	£1,869,892	

Links between Quality and Resources

Information Resources – Quality in Measurement

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

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

1. The Patient Administration System (PAS)
2. Clinical databases, populated by the clinicians at the point of delivery of clinical care which capture detailed data about a patients disease and treatment
3. The Data Warehouse, which integrates a number of clinical and financial information systems with the PAS
4. Service Line Reporting, which brings together administrative, clinical and financial information so that productivity as well as quality can be assessed.

Each system has a number of internal and external audit and verification processes in place to ensure the data from the systems that is used to supporting decision making is accurate and reliable. In 2012/13, 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 2013/14 through the Trust and beyond through:

- Clinical Standardisation – Through 2013/14 and beyond, we will continue 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 2013/14.

- 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.

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  - Kath Griffiths, Council of Governors, North Wales
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  - Karen Prior, Voluntary and Community Action Wirral
  - Barbara Quinn, member of SURE
  - Thelma Riddell, member of SURE
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  - Peter Seddon, Legal Services, Liverpool City Council
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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

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

"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.

"They were expecting me"

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".

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."

Appendix 2 Safe from Harm Vision

Step	*Safe from Harm* - what our Trust will look like in three years' time
Reputation *Everyone knows we are safe*	My patients and my colleagues feel sufficiently assured to recommend care in my organisation for themselves, their family or friends. My Trust is recognised as being number one in the country for patient safety. *KPI's:* *Patient: How likely are you to recommend our ward to friends and family if they needed similar care or treatment? (96% agree - target 99%)* *Staff: If a friend or relative needed treatment I would be happy with the standard of care provided by this Organisation. (92% agree - target 95%)*
Commitment *I actively contribute to making care safer*	I constantly challenge myself to do all that I can possibly do to prevent, minimise or reduce harm to the patients in my charge. Progress against our commitment to Safe from Harm is visible for all to see, and we have achieved the ambitions we set for ourselves for the first three years. *KPI: I think we should NOT accept that harm happens (68% agree - target 90%)*
Culture *Patient safety is our first priority*	Patient safety is my Trust's first priority. My colleagues and I have embraced the pursuit of *Safe from Harm* as a long term aspiration. There is strong leadership for safety all levels, and responsibility for safety amongst clinical and non-clinical colleagues is visible and transparent. I see excellence in teamworking and communication on a daily basis. My patients comment on our attention to detail where their safety is concerned. My Trust invests in quality to improve safety and reduce costs. We have high rates of incident reporting with the majority being near misses. There are excellent feedback and communication systems in place to let us know how we are performing. We feel empowered to raise concerns about safety in good faith without fear of retribution. All our Trust strategies are harmonised to maximise the impact on harm reduction. *KPI's:* *Leaders in the organisation drive patient safety (80% agree – target 90%)* *The staff in this area of work take responsibility for patient safety (81% agree – target 90%)*
Knowledge and Learning *We know how to reduce harm*	My Trust has made training available to meet our increased demands for education in patient safety and we effectively learn from all harm that occurs in our organisation. We review the literature to identify improvement opportunities to attack harms that are proving resistant to reduction. Where the evidence base does not exist, our Trust commissions new programmes of work to solve these problems. We actively audit changes made to our systems and processes to ensure that previous improvements are being sustained. *Is your knowledge of how to reduce harm better now than it was a year ago? (74% agree – target 90%)*

Step	***Safe from Harm* - what our Trust will look like in three years' time**
Action *We deliver on plans to reduce harm*	We use recognised improvement methodologies to trial initiatives to reduce direct or potential harm. Proven improvements become business as usual. We deliver reliable care that protects patients against potential recognised harms using our comprehensive suite of safety alerts, order sets, care pathways, policies and protocols, and we react quickly and appropriately to harm when it occurs. Our plans for improving competency are in place and delivering. Patients and families work with us as partners to identify opportunities to make our care safer. *KPI: Changes in my area of work have been made as a result of improvements to patient safety we have identified and acted upon (74% agree - target > 90%)*
Outcomes *Our care is getting safer and safer*	We have tried and tested methods that accurately record all the harm in the organisation, and excellent feedback systems are in place at every level and across all sections of the organisation. Our outcomes are displayed widely and openly for all to see, be they patients, families, staff or others. Primary ● Patient care is getting safer and safer (KPI: integrated safety measure – 79% harm free – target 95%) Primary ● Patient care is getting safer and safer (KPI: integrated safety measure – 79% harm free – target 95%) Secondary ● Our safety culture is the envy of others (year on year improvements on safety culture survey) ● Patients and families feel safe in our environment (add question to Friends and Family test) ● Staff engagement gets stronger and stronger (year on year improvement in scores) ● Costs of care are falling (as a consequence of standardisation and reduced defects; reducing average cost per case)

6. Staff

As of March 2013, the Trust employed 1446 staff totalling 1308.96 whole time equivalents.

Staff continue to deliver outstanding levels of patient care during a challenging time for the NHS. We have been awarded the best provider of healthcare in the country after winning the 2012 Provider Trust of the Year Award at the HSJ Awards.

Our vision for staff

During 2012, the ethos of continuous improvement has continued. Managers and staff have worked together to make small changes which are called 'majoring on the minor' to enable us to achieve our mission to provide Excellent, Compassionate and Safe care for every patient every day.

Health and wellbeing initiatives

Over the last 12 months, the Trust carried out a number of health and wellbeing initiatives which have been well received by staff. Such initiatives will continue to be developed through the Trust's health and wellbeing group over the coming 12 months. These have included:

Long service award ceremonies

To recognise the hard work and achievement that committed staff provide to patients, a number of long service award ceremonies were held whereby awards were presented to staff by the Executive Team.

Flu campaign

The Trust launched a flu campaign to help protect staff and patients against the risks associated with flu and this is currently an ongoing initiative. The response to this campaign has been positive. The last figures submitted showed that over 60% of staff had been vaccinated.

Salary sacrifice schemes

The Trust runs a number of salary sacrifice schemes to help staff save money on the following:

- Nursery fees for the on-site nursery
- Car lease scheme
- Cycle to work scheme

These schemes have been hugely successful with the car lease scheme being particularly well-received following Trust-wide consultation with staff around the staff experience vision.

Employee assistant programme
The employee assistance programme is an advice helpline (and website) aimed at supporting staff with difficulties that they may encounter in their lives, for example, financial difficulties or bereavement. This programme can also support staff who require counselling as the service offers one to one counselling sessions in addition to telephone advice which is available 24 hours a day, 7 days a week.

Physical activity
The Trust introduced a number of physical activity initiatives such as the running club which takes place each Wednesday evening and Zumba and Yoga classes which took place on a weekly basis. There is also a free on-site gym which staff may access and if needed, advice is available regarding healthy eating plans and training plans to help with weight loss programmes and fitness regimes.

Staff physiotherapy service
This is a free service to help those staff with musculo-skeletal health problems access physiotherapy rapidly to help them maintain their attendance at work and improve their general well-being.

Workplace wellbeing charter
Last year, the Trust achieved the highest accolade with regards to the health and wellbeing initiatives provided for staff by being awarded the 'green standard' which we hope to maintain over the coming year.

Recognising our talented staff
Our third annual awards evening for 'Our Team's Got Talent' was held on Friday 29th June at Aintree Racecourse. The event was a great success and a perfect opportunity for staff to celebrate team successes together.

Our winners for the awards were as follows:
- **Outstanding Innovation in Practice Award** to the Critical Care and Learning and Development Team
- **Outstanding Example of the Patient Vision in Action Award** to the Coronary Care Team
- **Going Above and Beyond Award** to the Clinical Coding and Estates teams
- **Outstanding Teamwork to Improve Patient Care Award** to Knowsley Community COPD Service
- **Governors' Award** to the Cardiac Rehabilitation Team
- **Chairman's Award** to the Customer Care Team

Birch Ward, Critical Care and the Multi Professional Team, Mini Mitral Team, Physiotherapy Surgical Team and Research were all Highly Commended.

Learning and Development

In May 2011 during Learning at Work Week, the Trust celebrated the success of the 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

The Trust also continued to work with staff to refine staff engagement and this has been reflected in the results of the NHS Staff Survey for 2012 which saw the Trust's engagement score rise from 3.85 to 3.92 placing LHCH 6th out of all the Acute Specialist Trusts who took part in the survey and 12th out of 250 overall participants. The survey also provides good evidence of our continuous improvements over recent years and we are delighted that we had the highest score of all specialist acute Trusts in the following key areas;

Key Finding 9. Support from immediate managers

Key Finding 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (lowest %)

Key Finding 21. Percentage of staff reporting good communication between senior management and staff.

The tables below evidences our continuous improvement over the last 5 years based on our staff survey results

Year	2008	2009	2010	2011	2012
Response Rate	63%	64%	63%	62%	55%
% of staff having an appraisal	56%	79%	84%	87%	89%
% of staff agreeing appraisal helped them to do job better	57%	61%	63%	69%	70%
% of staff agreeing they feel satisfied with quality of work and patient care they are able to deliver	84%	85%	83%	85%	85%

Year	2008	2009	2010	2011	2012
% of staff who would be happy for a friend or relative to be treated at LHCH	Not asked	89%	88%	91%	92%
Staff agreeing they are satisfied with their job (maximum score = 5)	3.54	3.55	84%	87%	89%
% of staff who would recommend LHCH as a place to work	51%	64%	59%	62%	72%
Overall Staff Engagement Score (out of 5)	Not asked	3.78	3.80	3.85	3.92

	2011/12		2012/13		
Top 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	**Trust Improvement/ Deterioration**
KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. (lower score is better)	11%	14%	15%	23%	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible.
KF9. Support from immediate managers. (higher score is better)	3.74	3.64	3.85	3.69	Improved 0.11
KF18. Percentage of staff experiencing harassment, bullying, or abuse from patients, relatives or the public in last 12 months (lower score is better)	7%	3%	14%	21%	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible.
KF21. Percentage of staff reporting good communication between senior management and staff	40%	35%	41%	33%	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible.

	2011/12		2012/13		
Bottom 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	**Trust Improvement/ Deterioration**
KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	93%	96%	87%	92%	Deteriorated 6%
KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (lower score is better)	7%	3%	8%	6%	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible.
KF20. Percentage of staff feeling pressure in last 3 months to attend work when feeling Unwell (lower score is better)	28 %	22%	25%	23%	Improved 3%
KF26. Percentage of staff having equality and diversity training in the last 12 months	44%	50%	55%	61%	Improved 11%

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 in previous years, the results of the staff survey will be disseminated and communicated through the organisation to all staff. Following on from this all departments will develop a plan that identifies key actions for improvement. We will continue to monitor staff engagement throughout the year by undertaking a number of specific internal surveys, including Health and Wellbeing.

Workforce key performance indicators

Sickness absence performance has deteriorated in 2012/13 and is above the target of 3.6%. The Trust will continue to work with staff to develop health and wellbeing initiatives and support managers to engage more effectively with their staff as teams and individuals. We are currently exploring a targeted MOT health check for staff to assist them in being proactive towards their health and wellbeing.

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	Turnover
1436	4.20%	12.77%
Target	3.6%	9%

Corporate social responsibility

During 2012/13, 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 the local area, the Trust recruited 6 young people to a cadet scheme providing structured work experience and training in preparation for permanent employment.

Equality, diversity and human rights

The Trust has experience of working with patients with diverse needs. Services are accessible to those with language needs and interpreting services are available for those patients who need it, including a telephone interpreting service 24/7 and face-to-face interpreting.

Chaplaincy services are available for patients' religious needs. Different menu choices are available such as halal, Kosher, Caribbean or therapeutic diets. Other examples include a shuttle bus service for patients with mobility difficulties, hospital passport for vulnerable patients, hospital communication book for patients with hearing loss and visual impairment accessible to all staff and a red tray system for dementia or learning disabilities patients who need support with feeding. The Trust adheres to the single sex accommodation policy as being in mixed-sex hospital accommodation can be difficult for some patients for a variety of personal and cultural reasons.

Patient demographics and information on protected characteristics is used to develop alert cards for patients such as hard of hearing or blind patients. This enables staff to make reasonable adjustments when caring for patients. We provide information in other different languages and/or in large print, easy read, audio, Braille or other formats.

The Trust pays due regard to the general equality duty and has an Equality, Diversity and Human Rights policy which applies to all services it provides. This ensures that the working culture is positive and free from discrimination. The Trust's Single Equality Scheme ensures that equality and diversity considerations are embedded in the way it operates. The Trust requires the completion of equality impact assessments for new services and this ensures equal opportunities in accessibility of services. The Equality Delivery System is an integral part of the service development within the organisation. The Trust, through the Equality, Diversity and Human Rights Committee and engagement with local commissioners and the Local Involvement Network (LINk), has agreed four objectives for development in 2013. These are clearly aligned to the Patient and Family Experience Vision and Staff Experience Vision and are taken from the Equality Delivery Systems (EDS) outcomes framework; and relate to goal two (Improved patient access and experience) and goal three (Empowered, engaged and well supported staff). Development of the objectives will be monitored by the committee and local HealthWatch England.

The four objectives identified by the EDHR steering group are:

- Patients, carers and communities can readily access services and should not be denied access on unreasonable grounds
- Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected in how their privacy and dignity is respected
- Staff are free from abuse, harassment and bullying violence from patients their relatives and colleagues, with redress being open and fair to all
- The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population.

Demographic Workforce Profile

	2011/12	%	2012/13	%
Age Band				
16 - 20	8	0.56%	6	0.42%
21 - 25	117	8.26%	116	8.08%
26 - 30	151	10.66%	149	10.38%
31 - 35	190	13.42%	174	12.12%
36 - 40	190	13.42%	210	14.62%
41 - 45	222	15.68%	206	14.35%
46 - 50	229	16.17%	233	16.23%
51 - 55	180	12.71%	195	13.58%
56 - 60	76	5.37%	88	6.13%
61 - 65	43	3.04%	43	2.99%
66 - 70	9	0.64%	15	1.04%
71 & above	1	0.07%	1	0.07%
Gender				
Male	368	25.99%	384	26.74%
Female	1,048	74.01%	1,052	73.26%
Transgender				
Recorded Disability				
	42	2.97%	40	2.79%
Sexual Orientation				
Bisexual	5	0.35%	5	0.35%
Gay	5	0.35%	6	0.42%
Heterosexual	844	59.60%	892	62.12%
I do not wish to disclose	162	11.44%	148	10.31%
Lesbian	3	0.21%	3	0.21%
Undefined	397	28.04%	382	26.60%
Bisexual	5	0.35%	5	0.35%

Demographic Workforce Profile (continued)

	2011/12	%	2012/13	%
Religion or Belief				
Athiesm	70	4.94%	81	5.64%
Buddhism	4	0.28%	5	0.35%
Christianity	710	50.14%	738	51.39%
Hinduism	13	0.92%	12	0.84%
I do not wish to disclose	160	11.30%	144	10.03%
Islam	10	0.71%	13	0.91%
Jainism	1	0.07%	1	0.07%
Judaism	2	0.14%	2	0.14%
Other	48	3.39%	57	3.97%
Sikhism	1	0.07%	1	0.07%
Ethnic Origin				
White - British	1,199	84.68%	1,217	84.75%
White - Irish	18	1.27%	22	1.53%
White - Any other White background	30	2.12%	30	2.09%
Mixed - White & Black Caribbean	1	0.07%	1	0.07%
Mixed - White & Black African	3	0.21%	2	0.14%
Mixed - White & Asian	3	0.21%	3	0.21%
Mixed - Any other mixed background	5	0.35%	3	0.21%
Asian or Asian British - Indian	101	7.13%	98	6.82%
Asian or Asian British - Pakistani	6	0.42%	7	0.49%
Asian or Asian British - Bangladeshi	2	0.14%	0	0.00%
Asian or Asian British - Any other Asian background	7	0.49%	9	0.63%
Black or Black British - Caribbean	3	0.21%	2	0.14%
Black or Black British - African	12	0.85%	13	0.91%
Black or Black British - Any other Black background	2	0.14%	2	0.14%
Chinese	8	0.56%	6	0.42%
Any Other Ethnic Group	6	0.42%	8	0.56%
Undefined	2	0.14%	5	0.35%
Not Stated	8	0.56%	8	0.56%
Total	**1,416**		**1,416**	

The Trust facilitates focus groups, engagement events and support groups which encourage patients from diverse populations to interact and integrate. These groups are also attended by staff members from the Trust to support their learning and development. This fosters good relations including providing an opportunity to tackle prejudice and promoting understanding between people from different groups. We facilitate engagement events and views are sought from people who are seldom heard. We recognise that hard to reach groups do not often respond to surveys and we use a variety of methods to capture views. This includes one-to-one interviews, patient stories and shadowing. The insights captured are used in planning and development of services. Surveys can also be made available in other formats or languages. We have developed partnerships with the Local Involvement Network (LINk) to capture views from hard to reach groups. LINk members are part of the Trust's Equality and Diversity Committee which oversee Equality and Diversity across the Trust.

A volunteering scheme has been operational since 2010. We encourage patients and members of the public with different needs and certain protected characteristics to volunteer with the Trust. Our volunteering scheme provides the appropriate support for people to take on opportunities to participate in public life.

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 2013 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.

The 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 attention 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 which provides the Board of Directors with assurances on the operation of controls for all major risks.

The purpose of the Trust's risk review process is to track how the risk profile is changing over time, evaluate the progress of actions to treat key risks, ensure controls are aligned to the risk, risk is managed in accordance with the Board's appetite, resources are reprioritised where necessary and risk is escalated appropriately.

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 v10 assessment for 2012/13 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 obtaining a 'significant' assurance opinion.

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 2012/13. A full investigation was undertaken with remedial actions agreed and implemented.

Summary of other 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	0
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	1
V	Other	0

Data quality risks are managed through the Data Quality Committee which reports to the Information Governance Committee. Its risk register is part of the Information Services risk register. Information governance risks are reported directly to the Information Governance Committee via 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 August 2012, and confirmed compliance with five outcomes: safeguarding, nutrition, dignity, documentation and staffing.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

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 (as amended) 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 2012/13 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 "Medicine for Members" engagement events 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 priorities 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 of risk management and internal control

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 the Board Assurance Framework 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 has concluded again this year, 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 2012/13, however the following issues remain a risk and are being monitored and managed closely:

- Infection prevention – C-Difficile target – the Trust has breached the annual target set by commissioners for 2012/13 with 8 cases against a target of 4. The Trust remains within the Monitor threshold and has taken appropriate measures to liaise with Monitor regarding the possible impact upon the Trust's governance rating. The Trust, and external advisors, are assured that the most effective and safe infection control processes are being deployed to minimise c-difficile infection in patients. However, the medical condition and effective treatment of some of our patients results in a high risk of c-difficile presentation. There have been no cases of cross infection from one patient to another. The control of all infections remains a high priority for the Trust.
- 18 weeks admitted pathway target – the Trust failed the 18 weeks admitted pathway target in one month due to capacity and emergency planning reasons. The Trust was able to deliver the required standard in the following quarter. The Trust is working with commissioners and partners to minimise the disruption caused by emergency plans in future years.

Raj Jain
Chief Executive

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 2012 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 2012/13 and none are planned for the forthcoming year.

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 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*.

Raj Jain
Chief Executive
28th May 2013

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

Summarisation schedules numbers FTC01 to FTC41 and accompanying WGA sheets for 2012/13 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 2012/13* issued by Monitor.

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.

David Jago
Finance Director
28th May 2013

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.

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

Raj Jain
Chief Executive
28th May 2013

Data entered below will be used throughout the workbook:

Trust name:	Liverpool Heart and Chest Hospital NHS Foundation Trust
This year	31st March 2013
Last year	31st March 2012
This year ended	31st March 2013
Last year ended	31st March 2012
This year commencing:	1st April 2012

Foreword

The accounts for the year ended 31st March 2013 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

Raj Jain
Chief Executive
28th May 2013

Statement of Comprehensive Income for the period ended 31st March 2013

	NOTE	**2012/13 £000**	2011/12 £000
Revenue			
Operating Income	7	**105,432**	102,545
Other operating revenue	8	**6,604**	4,254
Operating expenses	11	**(112,788)**	(104,598)
Operating surplus (deficit)		**(752)**	2,201
Finance costs:			
Investment Revenue	17	**74**	150
Other gains and (losses)	18	**0**	0
Finance costs	19	**(57)**	(36)
Surplus/(Deficit) for the financial period		**(735)**	2,315
Public dividend capital dividends payable		**(1,747)**	(1,727)
Retained surplus/(deficit) for the period		**(2,482)**	588
Other comprehensive income			
Revaluation gains/(losses) and impairment losses on property, plant and equipment		**(266)**	819
Total comprehensive income for the period		**(2,748)**	1,407

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

The notes on pages 152 to 203 form part of these accounts.

The Trust has revalued its Estate at 31st March 2013, as a consequence:

Operating income includes a reversal of previous impaiments of £84k.

Operating expenses includes an impairment of (£3.489m).

Further the Trust has provided for restructuring costs of £319k.

The normalised surplus position after these movements reported to Monitor the independent regulator of NHS Foundation Trusts is £1.242m

Statement of Financial Position as at 31st March 2013

	NOTE	2012/13 £000	2011/12 £000
Non-current assets			
Property, plant and equipment	21	**63,739**	61,590
Intangible assets	22	**992**	995
Total non-current assets		**64,731**	62,585
Current assets			
Inventories	28	**2,557**	2,899
Trade and other receivables	29	**3,916**	3,655
Cash and cash equivalents	32	**14,790**	17,479
		21,263	24,033
Non-current assets held for sale	33	**0**	0
Total current assets		**21,263**	24,033
Total assets		**85,994**	86,618
Current liabilities			
Trade and other payables	34	**(16,145)**	(14,427)
Borrowings	35	**(219)**	(287)
Provisions	41	**(1,157)**	(917)
Other liabilities	42	**(788)**	(1,622)
Net current assets/(liabilities)		**2,954**	6,780
Total assets less current liabilities		**67,685**	69,365
Non-current liabilities			
Borrowings	35	**(732)**	(798)
Provisions	41	**(396)**	0
Other liabilities	42	**(738)**	0
Total assets employed		**65,819**	68,567
Financed by taxpayers' equity:			
Public dividend capital		**62,799**	62,799
Retained earnings		**(6,379)**	(4,039)
Revaluation reserve		**9,399**	9,807
Total Taxpayers' Equity		**65,819**	68,567

The financial statements and notes on pages 145 to 203 were approved by the Board on 28th May 2013 and signed on its behalf by:

Raj Jain
Chief Executive
28th May 2013

Statement of Changes in Taxpayers' Equity

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Total £000
Changes in taxpayers' equity for 2012-13				
Balance at 1 April 2012	**62,799**	**(4,039)**	**9,807**	**68,567**
Total Comprehensive Income for the period:				
Retained surplus/(deficit) for the period.	**0**	**(2,482)**	**0**	**(2,482)**
Net gain on revaluation of property, plant and equipment	**0**	**0**	**0**	**0**
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**	**(266)**	**(266)**
Transfer to retained earnings on disposal of assets	**0**	**37**	**(37)**	**0**
Movements on other reserves	**0**	**0**	**0**	**0**
Transfer between reserves	**0**	**105**	**(105)**	**0**
Balance at 31st March 2013	**62,799**	**(6,379)**	**9,399**	**65,819**

Changes in taxpayers' equity for 2011-12				
Balance at 1 April 2011	**62,799**	**(5,056)**	**9,417**	**67,160**
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**
Transfer to retained earnings on disposal of assets	**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**

Statement of Cash Flows for the year ended 31st March 2013

	NOTE	for period ended 31st March 2013 £000	for period ended 31st March 2012 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**(752)**	2,201
Depreciation and amortisation		**4,654**	4,467
Impairments		**3,489**	39
Reversal of impairments		**(84)**	(96)
Non Cash donations/grants credited to income		**0**	0
(Increase)/decrease in trade and other receivables		**(192)**	(1,032)
(Increase)/decrease in inventories		**342**	1,127
Increase/(decrease) in trade and other payables		**(28)**	1,914
Increase/(decrease) in other current liabilities		**(96)**	52
Increase/(decrease) in provisions	41	**636**	247
Tax (paid)/received		**0**	0
Net cash inflow/(outflow) from operating activities		**7,969**	8,919
Cash flows from investing activities			
Interest received		**74**	150
Purchase of Intangible assets		**(61)**	(870)
(Payments) for property, plant and equipment	21	**(8,489)**	(6,899)
Net cash inflow/(outflow) from investing activities		**(8,476)**	(7,619)
Net cash inflow/(outflow) before financing		**(507)**	1,300
Cash flows from financing activities			
Capital element of finance leases		**(309)**	695
Interest element of finance lease		**(57)**	(36)
PDC dividend paid		**(1,816)**	(1,744)
Net cash inflow/(outflow) from financing		**(2,182)**	(1,085)
Net increase/(decrease) in cash and cash equivalents		**(2,689)**	215
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**17,479**	17,264
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	32	**14,790**	17,479

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 2012/13 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 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.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision 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 2012/13 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 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 2013. This was mainly a "good housekeeping" exercise .The valuation has been undertaken in accordance with the requirements of IAS16 Property, Plant and Equipment. These values are reflected in the accounts.

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 2012/13 which is based on a sample of circa 200 staff which has confirmed that the original holiday pay accrual should be increased from £243k to £275k.

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.

Notes to the Accounts

1. Accounting Policies (continued)

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 with the exception of overtime and additional hours which are paid a month in arrears. 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.

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 a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Notes to the Accounts

1. Accounting Policies (continued)

1.9 Property, Plant and Equipment (continued)

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

The Trust appointed the District Valuation Service to undertake a desktop valuation of the Trust's capital property assets at 31st March 2013.

Since 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.

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

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

Notes to the Accounts

1. Accounting Policies (continued)

1.10 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.

1.12 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).

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 are not depreciated until the asset is brought into use.

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.

Notes to the Accounts

1. Accounting Policies (continued)

1.13 Impairments (continued)
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 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.

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

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

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

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create,produce and prepare the asset to the point that it is capable of operating in the manner intended by management.
Subsequently intangible assets are masured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property,Plant & Equipment.

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

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

1.16 Borrowing Costs
Borrowing costs are recognised as expenses as they are incurred

Notes to the Accounts

1. Accounting Policies (continued)

1.17 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.

1.18 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.

1.19 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.

1.20 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.

1.21 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

1.22 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.

Notes to the Accounts

1. Accounting Policies (continued)

1.23 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.

The trust has not utilised the Working capital facility

1.24 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, (2.8% for employee early departure obligations).The Trust has provided for a Permanent injury award made by the NHS Injury Benefits Scheme. This provision has been discounted at 2.35% which is the appropriate discount rate for Post employment benefits per HM Treasury's PES 16.

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 arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.25 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.

1.26 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.

Notes to the Accounts

1. Accounting Policies (continued)

1.26 Non-Clinical Risk Pooling (continued)

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

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

1.27 EU Emissions Trading Scheme

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

1.28 Contingencies

A contingent asset (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed unless the probabilty of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

The Trust is advised by the NHS Litigation Authority of amounts which should be disclosed in respect of contingent liabilities relating to employer liability claims

1.29 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.

Notes to the Accounts

1. Accounting Policies (continued)

1.29 Financial Assets (continued)

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 non-derivative financial assets that are designated as available for sale or that do not fall within any of the three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/(deficit) on de-recognition.

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

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

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

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

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

Notes to the Accounts

1. Accounting Policies (continued)

1.29 Financial Assets (continued)

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

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

1.30 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)

1.31 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.

1.32 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.

1.33 Foreign Exchange

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

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

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

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

1.34 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.

Notes to the Accounts

1. Accounting Policies (continued)

1.35 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.

1.36 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).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.37 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.

Notes to the Accounts

1. Accounting Policies (continued)

1.38 Joint Ventures

Joint ventures are separate entities over which the trust has joint control with one or more parties. The meaning of control is the same as that for subsidiaries.
Since November 2011, the Trust has participated in a joint venture with Royal Brompton & Harefield NHS Foundation Trust. The joint venture as established by the partners as a company limited by guarantee "The Institute of Cardiovascular Medicine & Science Ltd" (ICMS), to which the partners each contributed £50,000. Accounts of the company have not yet been prepared for the year ended 31st March 2013; thus the value of the contribution has been fully expensed in these Accounts. The Company did not trade in the financial year ended 31st March 2012.

Joint ventures which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'

1.39 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 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation
"IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation"

Notes to the Accounts

2. Operating Segments

The Foundation Trust has one segment for the provision of healthcare which generated income of £112.04m

	2012/13	2011/12
	£000	£000
The main sources of income received were:-		
North West Specialist Commissioning Team	**69,386**	73,830
Health Commission Wales	**14,711**	14,987
North West Secondary Contract	**9,053**	850

The North West Specialist Commissioning Team contract adopted a minimum take algorithm in 2012/13 based on nationally defined services. The impact has resulted in a split of the contract into secondary and tertiary elements reflected in the 2012/13 figures above.

	Healthcare Segment	
	2012/13	2011/12
	£000	£000
Income	**112,036**	106,799
Surplus/(Deficit)	**(2,482)**	588
Net Assets:	**65,819**	68,567

3. Income generation activities

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

Notes to the Accounts

4. Operating Income analysed by classification

	2012/13	2011/12
	£000	£000
Elective income	**50,577**	48,485
Non elective income	**31,738**	29,746
Outpatient Income	**12,558**	12,359
Other NHS clinical income*	**5,302**	7,721
Private patient income	**2,886**	2,990
Other non-protected clinical income	**2,371**	1,244
Total Income from activities	**105,432**	102,545
Research & Development	**1,213**	730
Education & Training	**2,694**	2,737
Received from NHS charities: Receipt of grants/donations for capital acquisitions - Grant	**595**	0
Charitable & other contributions to expenditure	**13**	0
Receipt of donations for capital acquisitions	**0**	65
Non-patient care services to other bodies	**197**	75
Reversal of impairments of Property, plant & equipment	**84**	96
Other Income	**1,808**	551
Total other operating income	**6,604**	4,254
Total Operating income	**112,036**	106,799

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

5. Analysis of Other NHS Clinical Income

	2012/13	2011/12
	£000	£000
Drugs and Devices - Non Contracted	**115**	342
NHS Trust Income - SLA's	**0**	1,436
PCT Income - Non Contracted	**1,052**	1,586
Cystic Fibrosis Inpatients	**4,135**	3,896
Non recurent Winter Pressures/Performance	**0**	461
Patient transport service	**0**	0
	5,302	7,721

Notes to the Accounts

6. Private Patient Income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

7. Revenue from patient care activities

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
NHS Foundation Trusts	**200**	299
NHS Trusts	**1,431**	1,733
Strategic Health Authorities	**1**	0
Department of Health	**57**	4
Primary Care Trusts	**85,876**	82,315
NHS Other	**8**	8
Local authorities	**-1**	1
Non NHS:		
- Private patients	**2,886**	2,990
- Overseas patients (non reciprocal)	**0**	0
- NHS Injury Scheme	**0**	1
- Other*	**14,974**	15,194
	105,432	102,545

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

Notes to the Accounts

8. Other Operating Revenue

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Research & Development	**1,213**	730
Education and training	**2,694**	2,737
Received from NHS charities: Receipt of grants/donations for capital acquisitions - Grant	**595**	
Charitable and other contributions to expenditure	**13**	0
Receipt of donations for capital acquisitions	**0**	65
Non-patient care services to other bodies	**197**	75
Reversal of impairments of property, plant and equipment	84	96
Other income*	**1,808**	551
	6,604	4,254

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

9. Analysis of Other Operating Revenue - Other income

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Estates recharges	**0**	0
Pharmacy sales	**5**	15
Staff accommodation rentals	**0**	0
Clinical tests	**0**	0
Clinical excellence awards	**418**	489
Other	**1,385**	47
	1,808	551

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

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Income from Activities - Mandatory Services	**98,250**	94,158
Income from Activities - Non-Mandatory Services	**10,218**	8,386
	108,468	102,544

Notes to the Accounts

10. Revenue

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

11. Operating expenses

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Services from NHS Foundation Trusts	**178**	183
Services from NHS Trusts	**4,000**	4,440
Services from Primary Care Trusts	**245**	165
Services from other NHS bodies	**0**	2
Employee Expenses - Executive directors	**429**	422
Employee Expenses - Non-executive directors	**70**	71
Employee Expenses - Staff	**58,706**	57,179
Supplies and services - clinical (excluding drug costs)	**26,245**	26,102
Supplies and services - general	**2,231**	1,566
Establishment	**1,486**	917
Research and Development- not included in employee expense)	**0**	0
Research and Development- (included in employee expense)	**789**	0
Transport	**98**	73
Premises	**3,246**	2,742
Increase/(decrease) in provision for impairment of receivables	**(38)**	320
Increase in other provisions	**0**	0
Inventories consumed (excluding drugs)	**0**	0
Drugs inventories consumed	**4,321**	4,174
Rentals under Operating leases - Minimum lease payments	**39**	0
Depreciation on property, plant and equipment	**4,590**	4,409
Amortisation on intangible assets	**64**	58
Impairments of property, plant and equipment	**3,489**	39
Audit fees- Statutory audit	**58**	60
Other auditor's remuneration	**0**	0
Clinical negligence	**481**	354
Legal fees	**89**	156
Consultancy costs	**193**	296
Training courses and conferences	**237**	172
Patient travel	**12**	12
Car parking and Security	**12**	285
Redundancy (Not included in employee expenses)	**0**	51
Redundancy (included in employee expenses)	**21**	0
Insurance	**112**	102
Other services, eg external payroll	**0**	81
Losses, ex gratia & special payments (Not included in employee expenses)	**1,120**	0
Losses, ex gratia & special payments (Included in employee expenses)	**0**	88
Other	**265**	79
	112,788	104,598

Notes to the Accounts

12. Audit Fees and Other Remuneration

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Statutory Audit	**58**	60
Other Auditors remuneration		
Financial reporting evaluation	**0**	0
	58	60

The liability agreement in place with the external auditors (Grant Thornton UK LLP) is unlimited.

13. Operating leases

The Foundation Trust has leases on 2 cars covering 3 year agreements commencing from March 2012 and June 2012 respectively. The Foundation Trust also has a lease on a van which is not subject to a long term contractual commitment. In addition the Foundation Trust has photocopiers which 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

Payments recognised as an expense	**Year ended 31st March 2013 £000**	Year ended 31st March 2012 £000
Minimum lease payments	**39**	49
Contingent rents	**0**	0
	39	49

Total future minimum lease payments	**31st March 2013 £000**	31st March 2012 £000
Payable:		
Not later than one year	**15**	6
Between one and five years	**13**	11
After 5 years	**0**	0
Total	**28**	17

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.

Notes to the Accounts

14. Employee benefits and staff numbers

14.1. Employee expenses

	Year ended 31st March 2013			Year ended 31st March 2012		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
Salaries and wages	**50,338**	**48,019**	**2,319**	48,042	46,532	1,510
Social Security Costs	**4,063**	**3,765**	**298**	3,716	3,506	210
Employer contributions to NHS Pension scheme	**4,951**	**4,951**	**0**	4,809	4,809	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	**21**	**21**	**0**	0	0	0
Agency and contract staff	**1,670**	**0**	**1,670**	1,254	0	1,254
Total gross employee benefits	**61,043**	**56,756**	**4,287**	57,821	54,847	2,974
less income in respect of Salaries and wages where netted off expenditure	(119)	(119)	0	(138)	(138)	0
less income in respect of Social security costs where netted off expenditure	(19)	(19)	0	(13)	(13)	0
less income in respect of Pension cost where netted off expenditure - defined contribution plans						
Employers contributions to NHS Pensions	(15)	(15)	0	(18)	(18)	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	**60,890**	**56,603**	**4,287**	57,652	54,678	2,974
Employee benefits capitalised as part of assets	945	392	553	0	0	0

Notes to the Accounts

14. Employee benefits and staff numbers

14.1. Employee expenses (continued)

Analysed Operating expenditure	**Year ended 31st March 2013**			Year ended 31st March 2012		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
Employee Expenses - Staff	**58,706**	**54,972**	**3,734**	57,179	54,205	2,974
Employee Expenses - Executive directors	**429**	**429**	**0**	422	422	0
Research & development	**789**	**789**	**0**	0	0	0
Redundancy	**21**	**21**	**0**	51	51	0
Total Employee benefits excl. capitalised costs	**59,945**	**56,211**	**3,734**	57,652	54,678	2,974

14.2. Average number of people employed

	Year ended 31st March 2013			Year ended 31st March 2012		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**138**	**131**	**7**	141	132	9
Administration and estates	**281**	**256**	**25**	283	269	14
Healthcare assistants and other support staff	**231**	**218**	**13**	217	211	6
Nursing, midwifery and health visiting staff	**538**	**515**	**23**	522	505	17
Scientific, therapeutic and technical staff	**217**	**206**	**11**	222	212	10
Social care staff	**3**	**0**	**3**	0	0	0
Bank & agency staff	**0**	**0**	**0**			
Other	**1**	**0**	**1**	0	0	0
Total	**1,409**	**1,326**	**83**	1,386	1,329	57
Of the above - staff engaged on capital projects	**22**	**10**	**12**	0	0	0

14.3. Management and Administration Costs

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Management costs	5.550	5.694
Income	112.036	106.799
Percentage of Management Costs to Income	4.95%	5.33%

Notes to the Accounts

14.4. Staff Sickness Absence

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Days Lost (Long Term)	**14,784**	15,949
Days Lost (Short Term)	**7,201**	7,308
Total Days Lost	**21,985**	23,257
Total Staff Years	**1,323**	1,281
Average working days lost	**16.6**	18.2
Total Staff Employed in Period (Headcount)	**1,610**	1,580
Total Staff Employed in Period with no absence (Headcount)	**748**	731
Percentage Staff with no Sick Leave	**46.46%**	46.27%

14.5. Exit Packages agreed in 2012-13

	31st March 2013			31st March 2012		
Exit packages 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**	**1**	**1**	0	2	2
£10,001-£25,000	**0**	**1**	**1**	1	0	1
£25,001-£50,000	**0**	**0**	**0**	1	0	1
£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**	**0**	**0**	0	1	1
>£200,000	**0**	**0**	**0**	0	0	0
Total number of exit packages by type (total cost)	**0**	**2**	**2**	2	3	5
Total resource cost (£000s)	**0**	**20**	**20**	51	215	266

Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme.

Notes to the Accounts

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.

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

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

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

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

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

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

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

Notes to the Accounts

15. Pension costs (continued)

c) Scheme provisions

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

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

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

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

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

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

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

16. Retirements due to ill-health

For the year ended 31st March 2013 there was 2 early retirements at a cost of £55k from The NHS Foundation Trust agreed on the grounds of ill-health. (31st March 2011 1 at a cost of £150k)

17. Investment Revenue

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Interest revenue:		
Bank accounts	**74**	150
Total	**74**	150

Notes to the Accounts

18. Other Gains and Losses

There are no other gains or losses

19. Finance Costs

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Interest on obligations under finance leases	**57**	36
Total	**57**	36

20. Better Payment Practice Code

20.1. Better Payment Practice Code - measure of compliance

	Year ended 31st March 2013		Year ended 31st March 2012	
	Number	**£000s**	Number	£000s
Total Non-NHS trade invoices paid in the period	**30,517**	**47,937**	31,464	46,531
Total Non NHS trade invoices paid within target	**29,392**	**44,204**	30,046	45,102
Percentage of Non-NHS trade invoices paid within target	**96.3%**	**92.2%**	95.5%	96.9%
Total NHS trade invoices paid in the period	**778**	**13,265**	928	12,659
Total NHS trade invoices paid within target	**648**	**11,037**	848	12,518
Percentage of NHS trade invoices paid within target	**83.3%**	**83.2%**	91.4%	98.9%

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 2013 £000	Year ended 31st March 2012 £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	**0**	0

Notes to the Accounts

21. Property, plant and equipment

2012/13:	Land	Buildings excluding dwellings	Dwellings	Assets under construct & poa	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1st April 2012	3,235	44,983	510	2,638	19,848	4,706	2,114	78,034
Prior period adjustment	0	0	0	0	0	0	0	0
Additions purchased	0	2,414	0	5,092	1,559	435	140	9,640
Additions leased	0	0	0	0	175	0	0	175
Additions donated	0	500	0	0	89	0	6	595
Reclassifications	0	1,333	0	(2,377)	1,044	0	0	0
Revaluations	0	(4,820)	(14)	0	0	0	0	(4,834)
Impairments	0	(280)	(9)	0	0	0	0	(289)
Reversal of Impairments	0	20	3					23
Disposals	0	0	0	0	(965)	0	0	(965)
At 31st March 2013	**3,235**	**44,150**	**490**	**5,353**	**21,750**	**5,141**	**2,260**	**82,379**
Depreciation at 1st April 2012	0	0	0	0	11,801	3,027	1,616	16,444
Prior period adjustment	0	0	0		0		0	0
Charged during the year	0	1,415	14	0	2,454	557	150	4,590
Impairments	0	3,489	0	0	0	0	0	3,489
Reversal of impairments	0	(84)	0	0	0	0		(84)
Cumulative depreciation adjustment following revaluation	0	(4,820)	(14)	0	0	0	0	(4,834)
Reclassifications	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(965)	0	0	(965)
Depreciation at 31st March 2013	**0**	**0**	**0**	**0**	**13,290**	**3,584**	**1,766**	**18,640**
Net book value								
Purchased	3,235	43,701	203	5,353	7,089	1,557	488	61,626
Finance Leased	0	0	0	0	982	0	0	982
Donated	0	449	287	0	389	0	6	1,131
Total at 31st March 2013	**3,235**	**44,150**	**490**	**5,353**	**8,460**	**1,557**	**494**	**63,739**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings excluding dwellings	Dwellings	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2012	**1,903**	**6,703**	**220**	**831**	**0**	**150**	**9,807**
Movement in year	0	(260)	(6)	(124)	0	(18)	(408)
At 31 March 2013	**1,903**	**6,443**	**214**	**707**	**0**	**132**	**9,399**

Notes to the Accounts

21.1. Analysis of Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construct & poa	Plant and machinery	Information technology	Furniture & fittings	Total
Net Book Value								
NBV - Protected Assets at 31st March 2013	3,235	40,538	0	0	0	0	0	43,773
NBV - Unprotected Assets at 31st March 2013	0	3,612	490	5,353	8,460	1,557	494	19,966
Total at 31st March 2013	**3,235**	**44,150**	**490**	**5,353**	**8,460**	**1,557**	**494**	**63,739**

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

2011/12:	Land	Buildings excluding dwellings	Dwellings	Assets under construct & poa	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
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**

Notes to the Accounts

21.2. Property, plant and equipment (continued)

2011/12:	Land	Buildings excluding dwellings	Dwellings	Assets under construct & poa	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
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	£000	£000	£000	£000	£000	£000
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 2013	**1,903**	**6,703**	**220**	**831**	**0**	**150**	**9,807**

21.3. Analysis of Property, plant and equipment

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

Notes to the Accounts

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 2013.

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	2	55
Dwellings	21	36
Assets under Construction & POA	1	1
Plant & Machinery	0	10
Information Technology	0	5
Furniture and Fittings	0	8

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

2012/13	Computer software - purchased £000	Assets under construction £000	Total £000
Gross cost at 1st April 2012	471	769	1,240
Additions	61	0	61
Gross cost at 31st March 2013	**532**	**769**	**1,301**
Amortisation at 1st April 2012	245	0	245
Charged during the year	64	0	64
Amortisation at 31st March 2013	**309**	**0**	**309**
Net book value			
Purchased	223	769	992
Donated	0	0	0
Total at 31st March 2013	**223**	**769**	**992**

Notes to the Accounts

22. Intangible assets (continued)

2011/12:	Computer software - purchased £000	Assets under construction £000	Total £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

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 2013. There has been an overall impairment of £3.671m as a result of this revaluation,

Within this sum there has been ;-

- Negative impairment charged to expenditure of £3.489m
- Negative impairment charged to the revaluation reserve of £289k
- Positive revaluation movement due to reversal of impairments of £84k to income
- Positive revaluation movement to revaluation reserve of £23k

In addition there has been a transfer from the revaluation reserve to retained earnings for equipment disposals of £37k and an excess depreciation adjustment of £105k.

Notes to the Accounts

24. Analysis of impairments and reversals recognised in 2012-13

	31st March 2013 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Loss as a result of catastrophe	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Over specification of assets	0
Other	3,405
Changes in market price	0
Total charged to Annually Managed Expenditure	3,405
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	266
Changes in market price	0
Total impairments for PPE charged to reserves	266
Total Impairments of Property, Plant and Equipment	3,671
Total Impairments charged to Revaluation Reserve	266
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	3,405
Overall Total Impairments	3,671

Notes to the Accounts

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 2013	31st March 2012
	£000	£000
Property, plant and equipment	**2,665**	4,674
Intangible assets	**0**	0
Total	**2,665**	4,674

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**
	£000	**£000**	**£000**	**£000**
Balances with other Central Government Bodies	492	0	1,862	0
Balances with Local Authorities	0	0	17	0
Balances with NHS Trusts and Foundation Trusts	1,061	0	3,882	0
Balances with other NHS Bodies	828	0	104	0
Balances with bodies external to government	1,535	0	10,280	0
At 31st March 2013	**3,916**	**0**	**16,145**	**0**
prior period:				
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 other NHS Bodies	1,155	0	1,029	0
Balances with bodies external to government	1,682	0	9,686	0
At 31st March 2012	**3,655**	**0**	**14,427**	**0**

Notes to the Accounts

28.Inventories

	Drugs	Consumables	Energy	Work in progress	Loan Equipment	Other	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	450	2,449	0	0	0	0	**2,899**
Additions	4,277	16,654	0	0	0	0	**20,931**
Inventories recognised as an expense in the period	(4,321)	(16,952)	0	0	0	0	**(21,273)**
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
Balance at 31 March 2013	406	2,151	0	0	0	0	**2,557**
Balance 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)
Balance at 31 March 2012	450	2,449	0	0	0	0	**2,899**

Notes to the Accounts

29. Trade and other receivables

29.1. Trade and other receivables

	Current		Non current	
	31st March 2013	31st March 2012	**31st March 2013**	31st March 2012
	£000	£000	**£000**	£000
NHS receivables	**1,752**	1,409	**0**	0
Receivables due from NHS Charities - Revenue	**0**	0	**0**	0
Other receivables with related parties - Revenue	**360**	1,629	**0**	0
Provision for impaired receivables	**(219)**	(560)	**0**	0
VAT	**146**	382	**0**	0
Prepayments	**493**	529	**0**	0
Accrued income	**1,247**	94	**0**	0
PDC receivable	**137**	68	**0**	
Other receivables - Revenue	**0**	104	**0**	0
Total	**3,916**	3,655	**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.

Notes to the Accounts

29.2. Provision for impairment of receivables

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
Balance at 1 April	**560**	240
Prior period adjustments	**0**	0
Restated balance at 1 April	**560**	240
Amounts utilised during the year	**(303)**	0
Unused amounts reversed	**(38)**	0
(Increase)/decrease in provision	**0**	320
Balance at 31 March	**219**	560

29.3. Impaired receivables past their due date

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
By up to 30 days	**55**	143
By 30 to 60 days	**2**	0
By 60 to 90 days	**10**	0
By 90 to 180 days	**17**	0
By over 180 days	**135**	417
Total	**219**	560

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

29.4. Receivables past their due date but not impaired

	Year ended 31st March 2013 £000	Year ended 31st March 2012 £000
By up to 30 days	**961**	843
By 30 to 60 days	**113**	87
By 60 to 90 days	**23**	756
By 90 to 180 days	**81**	72
By over 180 days	**164**	13
Total	**1,342**	1,771

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

Notes to the Accounts

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 2013 £000	31st March 2012 £000
Balance at start of period	**17,479**	17,264
Net change in year	**(2,689)**	215
Balance at end of period	**14,790**	17,479
Made Up Of		
Cash at commercial banks and in hand	**4**	58
Cash with the Government Banking Service	**14,786**	17,421
Other current investments	**0**	0
Cash and Cash Equivalents as in Statement of Financial Position	**14,790**	17,479
Bank overdraft	**0**	0
Cash and Cash Equivalents as in Statement of Cash Flows	**14,790**	17,479

33. Non-Current Assets Held for Sale

There are no Non Current Assets held for sale.

Notes to the Accounts

34. Trade and other payables

	Current		Non current	
	31st March 2013 £000	31st March 2012 £000	**31st March 2013 £000**	31st March 2012 £000
Receipts in Advance	**0**	21	**0**	0
NHS payables - revenue	**3,986**	2,854	**0**	0
NHS payables - capital	**0**	0	**0**	0
Other trade payables - revenue	**1,108**	2,995	**0**	0
Local Authority payables	**17**	62	**0**	0
Other trade payables - capital	**2,583**	837	**0**	0
Taxes payable	**1,217**	1,210	**0**	0
NHS Pension Scheme Liability	**645**	606	**0**	0
Other payables	**769**	249	**0**	0
Accruals	**5,820**	5,593	**0**	0
Total	**16,145**	14,427	**0**	0

35. Borrowings

	Current		Non current	
	31st March 2013 £000	31st March 2012 £000	**31st March 2013 £000**	31st March 2012 £000
Finance lease liabilities	**219**	287	**732**	798
Total	**219**	287	**732**	798

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 lease 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 £144k at 31st March 2013.

Notes to the Accounts

36. Finance lease obligations (continued)

	Minimum lease payments		Present value of minimum lease payments	
Amounts payable under finance leases:	**31st March 2013 £000**	31st March 2012 £000	**31st March 2013 £000**	31st March 2012 £000
Within one year	**266**	343	**219**	288
Between one and five years	**712**	821	**617**	682
After five years	**117**	117	**115**	115
Less future finance charges	**(144)**	(196)	**0**	0
Present value of minimum lease payments	**951**	1,085	**951**	1,085
Included in:				
Current borrowings	**(219)**	(287)	**(219)**	(287)
Non-current borrowings	**(732)**	(798)	**(732)**	(798)
	(951)	(1,085)	**(951)**	(1,085)

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 committments at 31st March 2013 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

Notes to the Accounts

40. Deferred Income

	Current		Non current	
	31st March 2013	31st March 2012	**31st March 2013**	31st March 2012
	£000	£000	**£000**	£000
Opening balance at 01/04/12	**1622**	1570	**0**	0
Deferred income addition	**498**	1656	**0**	0
Transfer to/from current/non current income	**(738)**		**738**	
Release to SOCI	**(594)**	(1,604)	**0**	0
Current deferred Income at 31 March 2013	**788**	1,622	**738**	0
Total other liabilities (current and non-current)	**1,526**	1,622		

41. Provisions

	Current		Non current	
	31st March 2013	31st March 2012	**31st March 2013**	31st March 2012
	£000	£000	**£000**	£000
Legal claims	**38**	20	**0**	0
Equal pay	**0**	556	**0**	0
Other	**1,119**	341	**396**	0
Total	**1,157**	917	**396**	0

	Legal claims £000	**Equal pay £000**	**Other £000**	**Total £000**
At 1st April 2012	20	557	340	**917**
Arising during the year	26	0	1395	**1421**
Used during the year - accruals	0	0	0	0
Used during the year - cash	(8)	(4)	(137)	**(149)**
Reversed unused	0	(553)	(83)	**(636)**
At 31st March 2013	38	0	1,515	**1,553**
Expected timing of cash flows:				
Not later than one year	38	0	1,119	**1157**
later than one year and not later than five years	0	0	396	**396**
later than five years	0	0	0	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	**£000s**
As at 31st March 2013	1,873
As at 31st March 2012	1,962

Notes to the Accounts

41. Provisions (continued)

The Foundation Trust has total provisions at 31st March 2013 of £1.553m. Other provisions of £1.515m includes amounts provided for a legal claim made by a former employee, restructuring costs and a permanent injury benefit award to a former employee.

The Foundation Trust has a provision for Liability to Third Parties legal claims of £38k 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.

42. Other Liabilities

	Current		Non current	
	31st March 2013 £000	31st March 2012 £000	**31st March 2013 £000**	31st March 2012 £000
Deferred grants income	**0**	38	**0**	0
Other deferred income	**788**	1,584	**738**	0
	788	1,622	**738**	0

43. Contingencies

43.1. Contingent Liabilities

	31st March 2013	31st March 2012
Other contingent liabilities	**(12)**	(10)
Total	**(12)**	(10)

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 .

Notes to the Accounts

44. Financial Instruments

44.1. Financial assets

	At fair value through Income & Expenditure £000	Loans and receivables £000	Total £000
NHS Trade & other receivables excluding non financial assets	0	1,348	1,348
Non-NHS Trade & other receivables excluding non financial assets	0	2,562	2,562
Other investments	0	0	0
Other financial assets	0	0	0
Cash and cash equivalents	0	14,790	14,790
Total at 31st March 2013	**0**	**18,700**	**18,700**
NHS Trade & other receivables excluding non financial assets	0	1,017	1,017
Non-NHS Trade & other receivables excluding non financial assets	0	2,186	2,186
Other investments	0	0	0
Other financial assets	0	0	0
Cash at bank and in hand	0	17,479	17,479
Total at 31st March 2012	**0**	**20,682**	**20,682**

44.2. Financial liabilities

	At fair value through Income & Expenditure £000	Other financial liabilities £000	Total £000
Obligations under finance leases	0	951	951
NHS Trade and other payables excluding non financial assets	0	5,283	5,283
Non-NHS Trade & other payables excluding non financial assets	0	8,851	8,851
Provisions under contract	0	1,553	1,553
Total at 31st March 2013	**0**	**16,638**	**16,638**
Obligations under finance leases	0	1,085	1085
NHS Trade and other payables excluding non financial assets	0	5,856	5856
Non-NHS Trade & other payables excluding non financial assets	0	6,337	6337
Provisions under contract	0	1,121	1121
Total at 31st March 2012	**0**	**14,399**	**14,399**

Provisions under contract are held at book value

Notes to the Accounts

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 2013 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.

Notes to the Accounts

46. Prudential Borrowing Limit

Liverpool Heart and Chest Hospital NHS Foundation Trust is required to comply and remain within a Prudential Borrowing Limit (PBL)

This is made up of two elements:

(a) The maximum cumulative amount of long term borrowing.
This is set annually by Monitor, based on the Trust's Annual Plan with reference to four ratio tests set out in Monitor's Prudential Borrowing Code. The Trust's Financial Risk Ratings are also reviewed and may have an impact on the calculation of long term borrowing

(b) The amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Foundation Trust has a PBL of £28.1m of which £20.5m relates to long term borrowing and £7.6m to a Working Capital Facility.

The Foundation Trust has borrowings of £951k against this limit . The table below confirms that the Foundation Trust was within the approved ratios.

	Year ended 31st March 2013		Year ended 31st March 2012	
	Actual Ratios	**Limits 2012/13**	Actual Ratios	Limits 2011/12
Minimum dividend cover times	4.24	>1 met	3.89	>1 met
Minimum Interest cover times	128	>3 met	77	>3 met
Minimum debt service cover times	18.4	>2 met	13.9	>2 met
Maximum debt service to revenue	0.4%	<2.5% met	0.5%	<2.5% met

The Trust has an approved working capital facility of £7.6m with Barclays. This facility was formally made available from 1st December 2011 following satisfaction of Agreement requirements.

Notes to the Accounts

47. Movement in Taxpayers Equity

	£000
2012/13	
Taxpayers' equity at 1st April 2012	**68,567**
Surplus for the financial period	**(2,482)**
Impairments	(266)
Taxpayers' equity at 31st March 2013	**65,819**

2011/12	**£000**
Taxpayers' equity at 1st April 2011	**67,160**
Prior period adjustment	0
Surplus for the financial period	588
Impairments	733
Revaluation upwards of Ensite velocity system	86
Taxpayers' equity at 31st March 2012	**68,567**

Notes to the Accounts

48. Related Party Transactions

Liverpool Heart and Chest Hospital NHS Foundation Trust is a public interest body authorised by Monitor, the Independent Regulator for NHS Foundation Trusts.

During the period to 31st March 2013 none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Liverpool Heart and Chest Hospital NHS Trust. The Trust Secretary who was in post until November 2012 is married to a director of Halton & St Helens PCT. The income from the PCT totals £1.3m. Neither party has any involvement in the commissioning process.

The trusts current Deputy Director of Finance acted up as Interim Director of Finance during the year. He is married to a member of staff at Liverpool PCT who is involved in a commissioning role with Liverpool Heart and Chest Hospital NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year Liverpool Heart and Chest Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income £000s	Expenditure £000s	Receivables £000s	Payables £000s
Strategic Health Authorities				
North West Strategic Health Authority	2678			
Primary Care Trusts				
Ashton, Leigh And Wigan PCT	91		2	
Barnsley PCT	8		5	
Bedfordshire PCT	1			
Birmingham East And North PCT	647	68		67
Blackburn with Darwen Teaching Care Trust Plus PCT	4		3	
Blackpool PCT	12		6	
Bolton PCT	3	24		
Bradford & Airedale Teaching PCT	4		1	
Brent Teaching PCT	1			
Buckinghamshire PCT	5			
Bury PCT	20		1	
Calderdale PCT	137			12
Central And Eastern Cheshire PCT	325		83	
Central Lancashire PCT	579		5	
Cornwall & Isles of Scilly PCT	1			
County Durham PCT	5		5	
Croydon PCT	11			
Cumbria Teaching PCT	3	1		
Derbyshire County PCT	3			
Doncaster PCT	33		24	

Notes to the Accounts

48. Related Party Transactions (continued)

	Income £000s	Expenditure £000s	Receivables £000s	Payables £000s
Dorset PCT	9			
Dudley PCT	14			
East Lancashire Teaching PCT	15		2	
East Riding Of Yorkshire PCT	13			
Eastern And Coastal Kent PCT	4			
Enfield PCT	8			
Halton And St Helens PCT	1300		24	2
Hampshire PCT	20		4	
Hertfordhsire PCT	1			
Heywood, Middleton And Rochdale PCT	16	38	3	
Hull Teaching PCT	9			
Kirklees PCT	61		89	
Knowsley PCT	4629			3
Leeds PCT	75		18	8
Leicestershire County And Rutland PCT	5			
Lincolnshire Teaching PCT	15			
Liverpool PCT	6258	88	92	3
Manchester PCT	2			
Medway PCT	6			
North East Lincolnshire Care Trust Plus PCT	6			
North Lancashire Teaching PCT	20		3	2
North Tyneside PCT	31			
North Yorkshire And York PCT	40			
Northamptonshire Teaching PCT	39		22	
Northumberland Care PCT	5			
Nottinghamshire County Teaching PCT	38		32	
Oldham PCT	6			
Oxfordshire PCT	1			
Peterborough PCT	8			
Rotherham PCT	2			
Salford PCT	37			
Sandwell PCT	63			
Sefton PCT	1589		39	
Sheffield PCT	5			
Shropshire County PCT	22		2	
Somerset PCT	5			
South East Essex PCT	3			
South Tyneside PCT	4			
Stockport PCT	63			
Suffolk PCT	6		5	
Surrey PCT	16		1	

Notes to the Accounts

48. Related Party Transactions (continued)

	Income £000s	Expenditure £000s	Receivables £000s	Payables £000s
Sutton & Merton PCT	1			
Tameside And Glossop PCT	8			
Trafford PCT	3	27		
Wakefield District PCT	3			
Waltham Forest PCT	27		27	
Warrington PCT	543		1	3
West Kent PCT	1			
West Sussex PCT	1		1	
Western Cheshire PCT	69926	263	33	
Wiltshire PCT	17			
Wirral PCT	919		29	4
NHS Trusts				
Barts Health NHS Trust				2
Bridgewater Community HealthCare NHS trust	5			5
East Cheshire NHS Trust				3
East Of England Ambulance Service NHS Trust		1		
Liverpool Community Health NHS Trust	107		2	2
Mersey Care NHS Trust	4	602	2	
North West Ambulance Service NHS Trust		1		
Oxford University Hospitals NHS Trust				1
Portsmouth Hospitals NHS Trust		2		1
Royal Liverpool Broadgreen Hospitals NHS Trust	1892	5707	745	3715
Southport And Ormskirk Hospital NHS Trust	61		17	2
St Helens And Knowsley Hospitals NHS Trust	80	14	111	
University Hospital of North Staffordshire Hospital NHS Trust			3	
Foundation Trusts				
Aintree University Hospitals NHS Foundation Trust	19	118	14	53
Alder Hey Childrens NHS Foundation Trust	3	38		21
Barnsley Hospital NHS Foundation Trust	35	0		
Birmingham Childrens Hospital NHS Foundation Trust		1		
Blackpool Fylde And Wyre NHS Foundation Trust		20		
Central Manchester University Hospitals NHS Foundation Trust	1	18	1	6
Chesterfield Royal Hospital NHS Foundation Trust		1		
Christie Hospital NHS Foundation Trust			1	
Clatterbridge Centre For Oncology NHS Foundation Trust	4	1	1	1
Countess Of Chester Hospital NHS Foundation Trust	33	43	67	
Lancashire Teaching Hospitals NHS Foundation Trust				3
Liverpool Womens Hospital NHS Foundation Trust	9	8	9	1
Northumbria Healthcare NHS Foundation Trust				56

Notes to the Accounts

48. Related Party Transactions (continued)

	Income £000s	Expenditure £000s	Receivables £000s	Payables £000s
Royal Brompton And Harefield NHS Foundation Trust	5	0	5	
Salford Royal NHS Foundation Trust				7
Tameside Hospital NHS Foundation Trust		3		3
The Walton Centre NHS Foundation Trust	2	20	7	1
University Hospital Southampton NHS Foundation Trust	20	0		
Warrington And Halton Hospitals NHS Foundation Trust	127	0	59	3
Wirral University Teaching Hospital NHS Foundation Trust	21	0	17	
NHS Blood and Transplant (excluding Bio Products Laboratory)	8			
NHS Litigation Authority		481		
NHS Business Services Authority		12		

In addition, The Foundation Trust has had a number of material transactions with other Government Departments and other central and local Government bodies, Most of these transactions have been with:

Care Quality Commission		55		
Department of Health (excluding PDC dividend)	291		128	
Knowsley Metropolitan Borough Council		55		8
Liverpool City Council		47		9
National Insurance Fund - Employer contributions		3,720		570
NHS Pension Scheme (Own staff employers and employees contributions)		4,923		645
HM Revenue & Customs - VAT			146	
HM Revenue & Customs - Other taxes and duties				647
Welsh Assembly Government (incl all other Welsh Health Bodies)	14,711		346	
Scottish Government	160			
The Audit Commission		2		

The Foundation Trust has also received revenue payments from a number of charitable funds. Some of the agents of the Corporate trustee are members of the Trust Board.
Liverpool Heart and Chest Hospital Charity is an umbrella charity made up of 33 funds with a combined balance at 31st March 2013 of £1.395m.

The Foundation Trust has benefited during the year from donations from Charitable Funds.
At 31st March 2013 the amount due from the charity was £15k. The Foundation Trust has received benefits from Charitable funds of approximately £1.057m.

Notes to the Accounts

49. Third Party Assets

The Trust held £582 cash at bank and in hand at 31 March 2013 (£502 - at 31st March 2012) which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

50. Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. In the year ended 31st March 2013 the Foundation Trust had 29 separate losses and special payments, totalling £141,019 (year ended 31st March 2012 41 payments totalling £88,592).

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