Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

# Annual Report and Accounts 2013/14

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

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# Chair and Chief Executive's Foreword

Since our last Annual Report, the Board of Directors has undergone changes and in October 2013 we welcomed Jane Tomkinson as our Trust's new Chief Executive.

Previously Director of Finance at NHS North of England, Jane took up the post following the departure of Raj Jain, who moved to Greater Manchester Academic Health Science Network as Managing Director after five years at the Trust. As Chairman, I believe Jane's vision, values, experience, and leadership, will ensure that we continue to deliver 'Excellent, Compassionate and Safe Care for our patients and their families.

It is appropriate that we once again acknowledge our staff who work so tirelessly to provide true patient and family centred care. Whilst the climate in which the NHS is operating has become increasingly difficult, it is their dedication that ensures we continue providing such high quality services. We value our staff highly and would like to thank them for their achievements in the past 12 months.

These achievements include being rated top in the country for overall patient care in the 2013 National Inpatient Survey, as well as winning the Patient Experience Network National Award 2013. Whilst we are delighted to receive this national recognition, we know that we can do even more and want to keep pushing the boundaries of great care. That is why we are moving forward with our vision for true patient and family centred care for 2013 and beyond.

In line with this vision, we continue to strive to provide the very best facilities for our patients. That is why we were delighted that our new innovative, lounge based day ward, Holly Suite, opened to patients in February 2014. This facility puts the Trust at the forefront of delivering daycase care and is the result of considerable investment and the determination, collaboration and dedication of the project team and all our staff and users.

We have also continued to invest heavily in technological advances to improve the way in which we deliver care for our patients. Our new and innovative electronic patient record system was launched in June 2013 as one of the most advanced in the country, representing a major step forward for our Trust.

We have continued to enhance our reputation and standing 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.

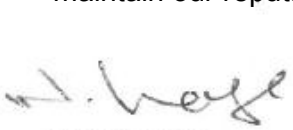
We delivered our nationally agreed healthcare targets and key priorities and met the responsibilities set out by our commissioners and regulator.

We continue to develop excellent working relationships with our Governors and our wider membership. Our Governors give up so much of their time willingly and constructively to support the work of the Trust and provide insight to the Board on a range of issues. We would like to place on record our continued appreciation for their invaluable contribution.

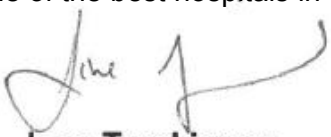
Finally we would like to thank our volunteers without whom the hospital would not be the same place. Patients and families appreciate the help that they offer so cheerfully, with one patient describing this by saying:

*"The volunteer visited me when I was feeling extremely distressed. She came and sat with me, chatting and put me at ease. I cannot praise her enough. She is an asset to the hospital and I feel lucky to have met her that day."*

We are committed to ensuring that Liverpool Heart and Chest Hospital continues to deliver 'Excellent, Compassionate and Safe Care for every patient, every day' going forward to maintain our reputation as one of the best hospitals in the country.



**Neil Large**
Chairman



**Jane Tomkinson**
Chief Executive

# Key Achievements in 2013/14

- Recognised for providing the 'best cardiac services' at the Advancing Quality Awards 2013.
- Named winner of the 'Support for Caregivers' category at the Patient Experience Network National Awards 2013 by a panel of judges, as well as being chosen by healthcare peers as overall PENNA winner for 2013.
- Rated as the top performing hospital for 'overall patient care' in the Care Quality Commission's 2013 National Inpatient Survey – the 7th time in 8 years.
- Successfully accepted as a cardiothoracic imaging training centre by the European Society of Radiology.
- Ranked by the Clinical Digital Maturity Index as one of the joint top three trusts in the country for digital capability.
- Knowsley Community Chronic Obstructive Pulmonary Disease Team named overall winner in the 'Respiratory Care' category at the Care Integration Awards 2013.
- Successfully implemented and launched one of the most advanced electronic patient record systems in the country in June 2013.
- Full roll out across the hospital of the Safe from Harm Vision and the updated vision for true Patient and Family Centred Care.
- Organiser of the first UK conference on Patient and Family Centred Care in April 2013 sharing the expertise of Liverpool Heart and Chest Hospital nursing and clinical staff with healthcare professionals from around the country.
- Third year of the Institute of Cardiovascular Medicine and Science, in collaboration with Royal Brompton and Harefield NHS Foundation Trust and Imperial College London; we have seen significant progress made on collaborative research, education and service development as a consequence of this venture.
- Completion of the two year HEAT-PPCI research trial – the largest single-centre trial ever undertaken in cardiovascular medicine.
- All minimum standards of care met or exceeded as defined by the Department of Health.
- 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.
- An increase again in our funding for research and innovation, which allows cutting edge treatments to be brought to our patients as early as possible.

# 1. Strategic Report

*This strategic report is prepared in accordance with:*

- *sections 414A, 414C and 414D[5] of the Companies Act 2006, as interpreted by the FReM (paragraphs 5.2.6 to 5.2.11). In doing so, foundation trusts must treat themselves as quoted companies. Sections 414A(5) and (6) and 414D(2) do not apply to NHS foundation trusts.*

*The accounts have been prepared under a direction issue by Monitor under the National Health Service Act 2006.*

## 1.1 Introduction

Liverpool Heart and Chest Hospital NHS Trust achieved foundation trust status in 2009, and operates as a public benefit corporation with the Board of Directors accountable to its membership through the Council of Governors, which is elected from public and staff membership along with nominated representatives from key stakeholder organisations.

### Our Vision is

*To be the premier cardiothoracic integrated healthcare organisation, delivering clinical excellence and a first class patient and family experience.*

### Our Mission is

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

**In this report you can read more about how Liverpool Heart and Chest Hospital is developing to ensure a clinically and financially sustainable future for its patient population.**

2013/14 was another strong year financially for the Trust, and having previously exploited its financial freedoms as a foundation trust to invest surpluses to improve and develop its estate and IT infrastructure, it is now utilising capital as an enabler to facilitate change, which is key to the delivery of its quality, productivity and efficiency agenda.

The Trust recognises that its staff are the most valuable asset and has continued to develop its Staff Experience Vision to ensure that they are involved in shaping the Trust's future, bringing forward their ideas for service improvement and innovation to deliver better clinical services at less cost through improved efficiency.

The Trust continues to enjoy a maturing relationship with its Governors who actively represent staff, partner organisations, members and the local community. Governors remain an integral part of the Trust's assurance processes participating in appraisal, audit, planning and capital projects.

During 2013/14 the Trust, working with its staff and governors, has undertaken a full strategic review, which together with our 2014/15 contract agreement with commissioners,

will enable it to embrace the challenges of the economic outlook and increasing requirements for care to be a thriving centre of excellence.

## 1.2 Business Review and Operating and Financial Review

### Our Business Model

Liverpool Heart and Chest Hospital is the largest single site specialist heart and chest hospital in the UK, providing specialist services in cardiothoracic surgery, cardiology, respiratory medicine including adult cystic fibrosis and diagnostic imaging**.**

The Trust serves a population of 3.8million spanning Merseyside, Cheshire, North Wales and the Isle of Man. The Trust also receives referrals from outside of its core population base for some of its highly specialised services such as aortics.

The Trust has 214 beds.

In 2013/14, it treated:

- 2,180 cardiac surgery inpatients
- 8,274 cardiology inpatients
- 701 respiratory inpatients
- 1,349 thoracic surgery inpatients
- 146 upper GI inpatients
- 614 other inpatients (including cystic fibrosis)
- 69,426 outpatients
- 23,662 community outpatients

As of March 31st, 2014 the Trust employs 1,430 staff and greatly values the support of its ever expanding cohort of volunteers.

The Trust aims to provide 'excellent**,** compassionate and safe care to every patient, every day' and has firmly embedded the values and behaviours that are expected of all its staff and volunteers. The vision remains, 'to be the premier cardiothoracic integrated healthcare organisation', and the five strategic goals underpinning this vision centre on the following areas:

- **Quality**: Delivering the highest quality, safest and best experience for patients and their families by providing reliable care.
- **Service and Innovation**: To develop our service portfolio for patients by expanding our current models of service and by developing innovative models of care underpinned by enhanced business systems.
- **Value**: To maintain financial viability, enhance service delivery and develop new models of care to improve the health of our patients and safely reduce costs through our programme of transactional and transformational change.
- **Workforce**: To be the best NHS Employer by 2019 with a demonstrable track record of motivating our high performing workforce.

- **Stakeholders**: To develop productive relationships and alliances with key stakeholders as effective and responsive partners in order to enhance the Trust's profile and reputation and thus secure LHCH clinical sustainability.

Furthermore, the vision, strategic objectives and all key activities are underpinned by three key philosophies:

- Safe from Harm
- Vision for Patient and Family Centred Care
- Staff Experience Vision.

The Trust currently has a strong position in the healthcare market, the changing health economy (both local and regional) and the potential impact of increased competition poses a number of threats and could expose weaknesses. The opportunities available to the Trust should not be underestimated and the financial stability the organisation holds along with our reputation for strong performance and high quality clinical services are a significant advantage.

The Trust faces challenge to retain and develop a portfolio of services that are clinically and financially sustainable in the current economic context and financial challenge facing the NHS and local authorities. Demand is increasing due to demographic and lifestyle factors. Heart and lung diseases continue to be amongst the biggest killers in the UK and all business decisions and opportunities are considered in the context of benefits for our patients. The Trust has a strong culture of research and innovation underpinning its excellent clinical outcomes.

The Trust has invested heavily in its IT infrastructure and estate, designing all new clinical areas with the needs of patients and families and their comfort and safety in mind. The Trust is determined to ensure its business model provides for the future to ensure that all its clinical areas attain these high standards.

The introduction of the single operating model and associated national service specifications has made entry into the Trust's markets more difficult, but not impossible. The Trust has developed a long term plan that it continues to execute with success. This plan continues to focus on:

- where it is possible to form strong clinical and organisational relationships we will do so; there is clear evidence that partnerships enhance the role of the Trust, improve patient care and outcomes at partner Trusts and reduce the motivation to offer competitive services
- where it is not possible to form effective partnerships, then the Trust will compete directly on the basis of patient outcomes, quality and effectiveness.

## Key Business Activities

Activity carried out by the Trust comprises 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 operating revenue for the Group in 2013/14 was £114.4m (inclusive of Charitable Funds which were consolidated for the first time this year) an increase of 2.2% from 2012/13. The Trust's operating revenue in 2013/14 was £114.0m an increase of 2.16%, however after normalising to take out the impact of the impairment reversal of £2.5m, there has been a marginal reduction in revenue of 0.5%.

The total income was derived from a number of key contracts; £63.7m from NHS England Cheshire, Warrington and Wirral Area Team for Tertiary Care activity, £15.1m from the Welsh Health Specialised Services Committee, £15.5m from North West Clinical Commissioning Groups for Secondary Care activity, £3.2m from Community contracts, £2.9m from Private Patient work, £2.8m for the Isle of Man Contract, £2.6m for Clinical Education and Training and £1.5m 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 | 2013/14 | 4 Year Growth |
|---|---|---|---|---|---|---|
| Surgery Inpatients | 3,572 | 3,604 | 3,356 | 3,728 | 3,724 | 4% |
| Cardiology Inpatients | 8,555 | 8,858 | 9,186 | 9,233 | 8,976 | 5% |
| Outpatients | 59,257 | 62,794 | 64,226 | 63,968 | 65,758 | 11% |

Welsh Commissioner's strategic repatriation plans continued in 2013/14, with some further pacing and ICD activity being undertaken in Wales rather than at LHCH. This is planned to continue in 2014/15 with further repatriation of catheterisation procedures following the development of a second Catheter Lab in North Wales.

## Analysis of 2013/14 Financial Performance

The Trust's financial plans for 2013/14 required the delivery of a surplus of £0.3m (after the achievement of a £4.1m cost improvement programme). The Trust delivered a normalised surplus (excluding the impact of impairment and charitable funds consolidation) of £0.1m as summarised in the table below.

| Financial Performance | 2013/14 Plan £000's | 2013/14 Actual £000's | Variance £000's |
|---|---|---|---|
| Revenue | 111,307 | 111,296 | (11) |
| **Costs** | | | |
| Pay | (61,615) | (61,109) | 506 |
| Direct Non-Pay | (36,642) | (38,464) | (1,822) |
| Overheads | (6,051) | (4,733) | 1,318 |
| **EBITDA** | **6,999** | **6,990** | **(9)** |
| Net Financing Costs | (6,690) | (5,553) | 1,137 |
| **Trust Suplus/(Deficit)** | **309** | **1,437** | **1,128** |
| Exceptional Items (included above)* | 0 | (1,331) | (1,331) |
| **Trust Normalised Surplus/(Deficit)** | **309** | **106** | **(203)** |
| Charitable Funds Surplus/(Deficit) | 0 | (55) | (55) |
| **Group Normalised Surplus/(Deficit)** | **309** | **51** | **(258)** |

*Exceptional Items include an impairment reversal of £2.622m; offset in part by an impairment of (£1.291)m

The Trust's normalised revenue at £111.3m is on plan for 2013/14. The main elements of this include:

The North West Specialist Commissioning and Secondary Care contracts combined, under performed by £0.2m. The main areas of underperformance were Day-cases (Catheters, Respiratory and EBUS), Non-Elective and Critical Care activity. This has been offset in part by over-performance against elective activity and high cost drugs.

The Welsh Contract over-performed by £0.63m. The main areas of over-performance have been ITU, electives and non-electives. This has been partially offset by underperformance in non-elective non-emergencies.

Activity from the Isle Man and non-contracted areas, over-performed by £0.25m and £0.26m respectively.

Income from the high cost drug Ivacaftor, used in the treatment of Cystic Fibrosis patients totals £2m for the year (and is included in the contract positions above). This income is directly offset with drugs costs, however it was agreed at a late stage in the contract negotiations and therefore wasn't included within the 2013/14 plan.

Private patient income underperformed by £0.55m during 2013/14. The average income per spell has increased from 2012/13, therefore the underperformance is driven by below plan activity.

Other income over-performed by £0.1m and included various sources of income including Grant/Commercial Trials and Research.

## Costs and Cost Improvement Programme

The Trust's total costs in 2013/14 were £112.5m. After normalising for the impact of the impairment of £1.3m, costs were slightly below plan by £0.1m.

Pay costs were £0.5m (0.8%) below plan. The average number of vacancies for the year was 58.65FTE. Within this position Locum, Bank, Agency and overtime costs of £2.7m were incurred to cover the vacancies whilst these are incurred at a premium rate, they are essential to maintain quality during periods of high occupancy.

Direct non pay costs were above plan by £1.8m (4.8%). This is mainly in relation to the Cystic Fibrosis drug Ivacaftor totalling £2m which is directly offset by the over-recovery of income.

The Trust also delivered a Cost Improvement Programme (CIP) of £4.1m or 3.9% of its operating expenditure over the period. The savings can be categorised as follows:

| CIP Performance by Category | Plan £000's | Actual £000's | Variance £000's |
|---|---|---|---|
| Revenue Generation | 435 | 419 | **(16)** |
| Pay | 937 | 1,415 | **478** |
| Non Pay | 2,763 | 2,275 | **(488)** |
| **Total** | **4,135** | **4,109** | **(26)** |

Key enabling strategies that produced 2013/14 cost savings included procurement practices, staffing 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. The Medical Director and Director of Nursing are required to approve all CIP schemes to provide assurance that they will not adversely impact upon patient care.

## Capital Investments and Cash Flow

During the 2013/14 financial year, the total capital investment in improving the hospital facilities was £6.7m. The main investments included £2m to build a new Day Ward facility called Holly Suite and £3m to implement an electronic patient record system.

The Trust's main project in year was the Electronic Patient Record with £3m invested in addition to £3.6m invested in this project in 2012/13. The project went live in June 2013 and includes the replacement of paper records with electronic patient records and will improve the availability of patient information for clinicians and nurses. In addition the availability of electronic patient information systems will allow the integration of numerous diagnostic programmes enhancing governance and improving efficiency.

The system will:

- enable staff to spend more time with patients and their families
- ensure that patients are not asked for the same information more than once when they see different health professionals, as everything will be held in one central place
- speed up the time for x-rays and blood tests, for example, to be ordered
- remove the time taken to find a patient's case notes.

Throughout the project, quality of care and the experience of patients were the two core guiding principles. For this reason, from the outset the project was driven by a team of senior clinicians, along with extensive engagement with executive directors, nursing, medical, non-clinical staff and allied health professionals.

The new Day Ward facility named Holly Suite opened on 17 February 2014 and is a new and innovative lounge environment and puts the Trust at the forefront of delivering day case care.

Replacement medical equipment costs were £0.6m as was investment in the estate infrastructure and £0.4m was spent on Information Technology systems.

| 2013/14 Capital Programme Summary | £'m |
|---|---|
| Electronic Patient Record | 3.0 |
| New Day Ward | 2.0 |
| Medical Equipment | 0.6 |
| Estates Infrastructure | 0.6 |
| Information Technology | 0.5 |
| Other | 0.1 |
| **Total Investment** | **6.7** |

After funding the capital programme outlined above, the Trust had a closing cash balance of £10.9m as at 31st March 2014. The closing cash balance of the group (including charitable funds consolidation) is £12.1m. The Trust's cash position was £1.9m ahead of plan and reflects favourable movements on working capital balances.

## Financing

Under its licence conditions, the Trust's ability to service borrowings is measured through the capital service capacity risk rating. The only form of borrowing the Trust has undertaken during the year is leasing of Medical Equipment. The total amount of lease obligations remaining as at 31st March 2014 is £0.7m.

The Trust decided not to renew the working capital facility when it expired in December 2013 having had no call to utilise it since it became an NHS Foundation Trust in December 2009. The ability to remove the working capital facility was facilitated by a change in governance arrangements from October 2013 by Monitor who are the regulator of Foundation Trusts. Prior to that point the Trust was required to have such a facility in place.

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 £40k of interest.

## Monitor Key Financial Indicators

In October 2013 Monitor replaced the Compliance Framework with the Risk Assessment Framework which included replacing the Financial Risk Ratings (FRR) with a Continuity of Services Risk Rating (CoSRR). The tables below show the Trust's performance for FRR up to September 2013 and CoSRR to March 2014.

| Financial Risk Ratings | Plan | Actual |
|---|---|---|
| Underlying Performance - EBITDA Margin | 3 | 3 |
| Achievement of Plan - EBITDA Achieved | 4 | 5 |
| Financial Efficiency - Return after Financing | 2 | 2 |
| Financial Efficiency - Net Surplus Margin | 2 | 2 |
| Liquidity | 3 | 3 |
| **Weighted Average Financial Risk Rating** | **3** | **3** |

| Continuity of Service Risk Ratings (CoSRR) | Plan | Actual |
|---|---|---|
| Capital Service Capacity | 4 | 4 |
| Liquidity | 3 | 3 |
| **Overall CoS Risk Rating** | **4** | **4** |

The Trust achieved an overall FRR of 3 to September 2013 in line with plan and a CoSRR of 4 to March 2014, also in line with plan.

## Principal Risks

### Repatriation of Welsh Patients

As part of the programme to deliver care closer to home the Welsh commissioners have served notice of their intention to repatriate a number of elective Cardiology procedures during the next 24 months. This repatriation has accordingly been reflected in our activity plans for the next two years.

### Risk of reduction in low complexity procedures due to competition

Despite the guidance from NHS England regarding the move towards the development of specialist centres as a key part of the future model of healthcare delivery there remains a risk that local commissioners may support new services being developed. This creates an added risk as low complexity procedures are moved out of specialist centres leaving only the complex procedures, which has both medical staff training, and tariff implications.

Diminished staff engagement satisfaction has given challenge to our pay bill. However, the Trust has continued to see improvements in its staff engagement score and in recommending LHCH as a place to work and receive treatment.

## Productivity, Efficiency and CIPs

The Board of Directors continue to be committed to managing the Trust's financial resources prudently and effectively, enabling the continued provision of high quality services, delivered by the exceptional teams at LHCH and from within a good infrastructure base. It is vital that the Trust remains financially viable, and is able to generate surpluses, so that it can continue to provide the services that it already delivers and develop new services to improve the health of the population of Merseyside, Cheshire, Wales and beyond. The financial strategy has again been informed by the economic environment we are working within.

The Trust has rightly recognised and debated the challenges it is facing but continues to see the opportunities that can present themselves to strengthen its position in delivering the vision of becoming the premier integrated cardiothoracic healthcare organisation. The Trust believes that it will continue to be successful and that commissioner focus on service quality notably through specialised service specifications (with LHCH fully compliant) and patient choice playing to the strengths of the Trust.

LHCH's Board of Directors, whilst fully cognisant of the pressure on NHS resources and the need to deliver both transactional and transformational efficiencies, is clear in its belief that they will not be delivered at any expense and at the risk of diminishing the quality of its clinical service offer to its patients.

LHCH fully recognises the need to move from a historical perspective of delivering efficiency through:

- 'trading out' via additional income under PbR
- in year ad hoc measures including holding of vacancies and top slicing of budgets

to an environment that can be best typified as one with either static or declining income assumptions forcing LHCH to move to a newer, more transformational approach in order to deliver sustained clinical, operational and financial improvement.

The Trust's approach can be best typified by using its highly developed mature directorate structures allowing a challenge to deeper clinical engagement, responsive financial and operational controls to manage our expenditure base with improved rigour in its programme of implementation and performance management.

In designing the LHCH programme of transactional and transformational change, the focus of attention has been to look primarily at the way in which services are delivered and to look at ways of re-designing services to improve the quality of service provided, which in turn can lead to better use of resources. Directorates have been, and continue to be, encouraged to benchmark wherever possible from both a clinical quality and use of resources perspective the way services are provided at LHCH compared to elsewhere and to both identify and execute delivery of agreed improvements based upon that work.

## 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 and reduce energy costs
- ensure that the Trust achieves compliance with relevant legislation and regulatory standards and guidance.

The Trust has implemented a number of low energy projects including lighting and has improved insulation of building fabric to help reduce heat loss in corridor areas, as well as continuing to work with the Simple Actions Campaign.

The Simple Actions Campaign ran across 10 Merseyside trusts and was designed to help staff cut energy and waste bills as well as its carbon footprint. It was devised by more than 120 staff from across 10 NHS trusts.

The campaign won gold for corporate social responsibility and silver for internal communications in the 2013 North West Chartered Institute of Public Relations (CIPR) Pride Awards.

The Trust has also implemented an environmental management system and policy Incorporating carbon management, travel and procurement and is working on a number of projects to continue improvements towards our environmental aims and objectives

## Board Membership

The Trust remains committed to having a diverse Board in terms of gender as well as diversity of experience, skills, knowledge and background. There were 11 members serving on the Board at 31st March 2014, of whom 8 were male and 3 were female.

## Senior Management

There were 25 senior managers at LHCH at 31st March 2014. Of this number, 7 were male and 18 were female.

## Employees

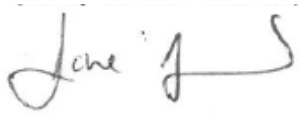
There were 1430 employees at LHCH as at 31 March 2014 of whom 369 were male and 1061 were female.

## 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 embedding and rollout of the Electronic Patient Record, which will underpin the delivery of further efficiencies, improve quality of care and improve the patient experience.



**Jane Tomkinson,** Chief Executive
**Date**: 27th May 2014

# 2. Directors' Report

This report is prepared in accordance with:

- Sections 415, 4165 and 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.

**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 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.

For the purposes of this declaration:

- relevant audit information means information needed by the 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.

## 2.1 Enhanced Quality Governance Reporting

The Trust has an established and well-developed risk management system in place that supports the identification, control and management of risks at both operational and strategic levels. Escalation of risks from ward to Board occurs through the escalation process that captures the level of concern. The departmental and directorate risk registers follow explicit criteria for how to escalate a concern and how this informs 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 will ensure responsibility to one of its five Board Assurance Committees for on-going review until the risk is downgraded or closed.

The Trust has reviewed its governance structures with changes being made within 2014.

The principal committees dealing with risks to quality and safety are the Clinical Quality Committee and the Patient and Family Experience Committee. Integrated information dashboards are used to ensure the Committees are fully informed of their key performance responsibilities. Both committees draw on a multitude of assurances that include clinical

audits, externally produced national reviews benchmarked to local practice that track on-going improvement against relevant quality and safety indicators and key strategies such as CQUIN and quality accounts .

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 2013/14 CQUIN Targets*** – this risk has centred on:

- The reduction in the prevalence of pressure ulcers (grades 2-4) and new pressure ulcers. The Trust started the year with a low number of ulcers as focus on the prevention had dramatically reduced the number and incidence over 2012/13. We started the year with a target of <1.6% increase in the number of ulcers. This has been particularly challenging; small grade 2 ulcers caused by medical devices over the nose and ears have been an issue at the beginning of the year, however, changes in practices and devices has resulted in a sharp reduction of these. .

- Delivery of timely communications to general practitioners. We continued this year with the work started in 2012/13 to further 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. The introduction of our own Electronic Patient Records system added another layer of complexity to the initial programme. The system has now been in use with a number of GPs although we have been unable to do a full roll out.

- Waiting times for urgent non-electives Cystic Fibrosis patients. All patients with cystic fibrosis referred to us had to have their admission on the specified date and before 8pm. The target set up for this was 100%, which is extremely high given the fact that a number of our patients come from Wales and other remote locations. These patients have travel time that needs to be taken into account and which often puts them outside the target admission time.

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 3 cases.

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. This is being further reviewed in line with the review of our assurance committees for 14/15.

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. The care quality commission have conducted two unannounced inspections to the trust in 2013/14.

The first was conducted in October 2013, where they reviewed Outcome 2 - consent, Outcome 4 - Care and Welfare of People, Outcome 8 cleanliness and infection control, Outcome 9 - management of medicines and Outcome 17 - complaints. The Trust was found to be compliant with all areas inspected apart from outcome 9 where some improvements were suggested. Outcome 9 was re-inspected in February 2014 and the Trust was compliant.

The second unannounced inspection was in relation to Outcome 13 staffing, Outcome 14 - supporting workers and Outcome 16 - quality of service provision. This inspection was pertaining to the critical care unit only. Following this unannounced inspection, the Trust has been found to be non-compliant with all three outcomes with minor concerns for Outcome 14 and 16 and a moderate concerns pertaining to Outcome 13. A detailed action plan has been devised to address the concerns raised and has been shared with the CQC.

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

- Responsiveness to Patients' Needs – full payment (£97.4k)
- Safety Thermometer – partial payment (£41.9k of £83.8k)
- Dementia – full payment (£83.8k)
- Venous Thromboembolism – partial payment (£41.9k of £83.8k)
- Advancing Quality care bundles – full payment (£36.3k)
- Ensuring Patient Quality & Safety – full payment (£72.6k)
- General Practitioner Communication – partial payment (£35.7k of £95.3k)
- Cancer Waiting Times – full payment (£72.6k)
- Effective Discharge Planning – full payment (£72.6k)
- Implementation of Clinical Dashboards – full payment (£122.3k)
- Waiting Times for Cystic Fibrosis Patients – partial payment (£458.6k of £611.5k)
- Urgent Cardiac Surgical Referrals treated < 7 days – full payment (£244.6k)

| | Annual Plan 2013/14 | Q1 | Q2 | Q3 (CoSRR) | Q4 |
|---|---|---|---|---|---|
| Financial risk rating | 3 | 3 | 3 | 3 | 4 |
| Governance risk rating | Green | Green | Green | 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
- Up skill 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.

## Any New or Significantly Revised Services

During 2014, the Trust opened its innovative the new Holly Suite as mentioned in the Chair and Chief Executive's foreword. This is based on the lounge model of care which the Trust had successfully introduced to its previous Day Ward five years ago, allowing patients to enjoy a relaxed environment. Holly Suite enables the Trust to broaden the scope of its lounge model of care to all cardiac and thoracic patients who come to LHCH for a daycase procedure.

## Research & Development

Liverpool Heart and Chest Hospital has research and development as one of its strategic objectives.

This year there has been significant research activity at the Trust. A number of commercially sponsored clinical trials were opened and recruited a significant number of patients.

As an example, the HEAT-PPCI trial, supported from a grant by The Medicines Company, has seen over 1,800 patients recruited at the Trust. This trial, led by Dr Rod Stables, has been an excellent example of research at the frontline. All patients seen at the Trust for emergency angioplasty were included in the trial. This was only possible thanks to the excellent management of the trial team and the excellent integration of catheter laboratory staff. The results from this trial were presented at the American Cardiology Society meeting on March 31st 2014.

The Trust's research fellows continue to work towards their higher degrees; equally a number of other non-medical staff are engaged on higher degrees and they have had their research work presented at several national and international meetings.

One of the Trust's fellows has been awarded the highest ranked abstract by the British Cardiovascular Society at its annual meeting. All the research carried out by the fellows, impacts directly on patient care; for instance, using new imaging methods such as computerised tomography instead of X-Ray for guiding a treatment for cardiomyopathy (heart muscle thickening) greatly improving accuracy and shortening the length of time of the procedure, with better patient experience.

## Engaging with External Organisations

The Trust is part of the Institute of Cardiovascular Medicine and Science, collaboration between LHCH and the Royal Brompton and Harefield Hospital, under the academic auspices of Imperial College London. This is a research, education and service development venture. A number of projects are running across both sites to provide excellent care to our patients. The cardiomyopathy service is an example of such activity; exchange of staff between the sites provides skills and expertise unavailable otherwise.

The Trust is also a member of the Liverpool Health Partnership (LHP); this has been created to tackle health issues in the Liverpool area by bringing together a number of NHS Trusts and the University of Liverpool. This collaboration has facilitated the creation of a new academic post for tuberculosis and infectious diseases based at the Trust.

The Liverpool Lung Cancer Alliance has been also formed, as part of LHP to concentrate on models of care for patients affected with lung cancer, a major health problem in this city. This Alliance is promoting greater integration of care between different Trusts and local services to improve the experience of care of lung cancer patients. Additionally, an academic post to concentrate on this important area is currently being developed which also will be based at the Trust.

The Trust is a member of the North West Coast Academic Health Science Network (NWCAHSN). The AHSNs have been created as a response to Innovation: Health and Wealth, and are the identified vehicle for implementation of innovation across the NHS. LHCH has been asked to be one of the two representative Trusts from Merseyside at the steering committee for innovation. LHCH is an innovative Trust; our community services have been recognised nationally as truly innovative. Ensuring that innovation is high on the agenda and in the culture of the Trust benefits patients, as they will receive the most up to date care by highly committed staff.

# 3. Remuneration Report

| Year ended 31st March 2014 | | | | | |
|---|---|---|---|---|---|
| **Name and Title** | **Salary (Bands of £5,000)** | **Other Remuneration (Bands of £5,000)** | **Benefits in Kind** | **Pension related benefits (Bands of £2,500)** | **Total (Bands of £5,000)** |
| | **£000's** | **£000's** | **£'s** | **£000's** | **£000's** |
| J Tomkinson - Chief Executive [1] | 75 - 80 | | | 15 - 17.5 | 90 - 95 |
| R Jain - Previous Chief Executive [2] | 70 - 75 | | 1,416 | 25 - 27.5 | 95 - 100 |
| G Russell - Medical Director | 25 - 30 | 160 - 165 | | 0 | 190 - 195 |
| D Jago - Deputy Chief Executive / Chief Finance Officer | 110 - 115 | | 1,285 | 62.5 - 65 | 175 - 180 |
| S Pemberton - Director of Nursing | 95 - 100 | | | 37.5 - 40 | 135 - 140 |
| C Pratt - Acting Director of Nursing [3] | 15 - 20 | | | 20 - 22.5 | 35 - 40 |
| M Jackson - Director of Research and Informatics | 85 - 90 | | | 35 - 37.5 | 125 - 130 |
| P N Large - Chair | 35 - 40 | | | | 35 - 40 |
| G Appleton - Non-Executive Director | 10 - 15 | | | | 10 - 15 |
| D Bricknell - Non-Executive Director | 10 - 15 | | | | 10 - 15 |
| L Cotter - Non-Executive Director [4] | 10 - 15 | | | | 10 - 15 |
| M Fuller - Non-Executive Director [5] | 10 - 15 | | | | 10 - 15 |
| M Savill - Non-Executive Director [6] | 10 - 15 | | | | 10 - 15 |
| P Firby - Non-Executive Director [7] | 0 - 5 | | | | 0 - 5 |
| B Leek - Non-Executive Director [8] | 0 - 5 | | | | 0 - 5 |
| R Toomey - Non-Executive Director [9] | 0 - 5 | | | | 0 - 5 |

[1] J Tomkinson commenced as Chief Executive on 8th October 2013
[2] R Jain left the Trust on 7th October 2013
[3] C Pratt was acting Director of Nursing from 11th October 2013 to 6th January 2014
[4] L Cotter commenced as Non-Executive Director on 1st June 2013
[5] M Fuller commenced as Non-Executive Director on 1st May 2013
[6] M Savill commenced as Non-Executive Director on 1st May 2013
[7] P Firby left the Trust on 31st May 2013
[8] B Leek left the Trust on 31st May 2013
[9] R Toomey left the Trust on 30th April 2013

| Year ended 31st March 2013 | | | | | |
|---|---|---|---|---|---|
| Name and Title | Salary (Bands of £5,000) | Other Remuneration (Bands of £5,000) | Benefits in Kind | Pension related benefits (Bands of £2,500) | Total (Bands of £5,000) |
| | £000's | £000's | £'s | £000's | £000's |
| R Jain - Chief Executive | 135 - 140 | | 3,247 | -137.5 – 140 | 0 - 5 |
| G Russell - Medical Director | 25 - 30 | 165 - 170 | | -20 - 22.5 | 175 - 180 |
| D Jago - Director of Finance [1] | 50 - 55 | | 634 | -20 - 22.5 | 30 - 35 |
| A Cummins - Previous Director of Finance [2] | 15 - 20 | | 678 | 20 - 22.5 | 35 - 40 |
| M Greatrex - Acting Director of Finance [3] | 20 - 25 | | | 15 - 17.5 | 35 - 40 |
| S Pemberton - Director of Nursing [4] | 85 - 90 | | | 115 - 117.5 | 205 - 210 |
| H Holmes - Previous Director of Nursing [5] | 5 - 10 | | 351 | 7.5 - 10 | 15 - 20 |
| M Jackson - Director of Research and Informatics | 80 - 85 | | | 27.5 - 30 | 110 - 115 |
| P N Large - Chair | 40 - 45 | | | | 40 - 45 |
| P Firby - Non-Executive Director | 10 - 15 | | | | 10 - 15 |
| R Toomey - Non-Executive Director | 10 - 15 | | | | 10 - 15 |
| B Leek - Non-Executive Director | 10 - 15 | | | | 10 - 15 |
| G Appleton - Non-Executive Director | 10 - 15 | | | | 10 - 15 |
| D Bricknell - Non-Executive Director | 10 - 15 | | | | 10 - 15 |

[1] D Jago commenced as Director of Finance on 24th September 2012
[4] S Pemberton commenced as Director of Nursing on 7th May 2012
[3] 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
[2] A Cummins left the Trust on 4th June 2012
[5] H Holmes left the Trust on 7th May 2012

| Name and Title | Real increase in Pension at age 60 (bands of £2,500) | Real increase in pension lump sum at aged 60 (bands of £2,500) | Total accrued pension at age 60 at 31st March 2014 (bands of £5,000) | Lump sum at age 60 related to accrued pension at 31st March 2014 (bands of £5,000) | Cash Equivalent Transfer Value at 31st March 2014 | Cash Equivalent Transfer Value at 31st March 2013 | Real increase /(decrease) in Cash Equivalent Transfer Value | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| J Tomkinson - Chief Executive | 0 - 2.5 | 2.5 - 5 | 55 - 60 | 165 - 170 | 1,018 | 949 | 69 | 0 |
| R Jain - Previous Chief Executive | 0 - 2.5 | 2.5 - 5 | 35 - 40 | 110 - 115 | 699 | 628 | 71 | 0 |
| D Jago - Deputy Chief Executive / Chief Finance Officer | 2.5 - 5 | 10 - 15 | 35 - 40 | 110 - 115 | 645 | 568 | 77 | 0 |
| S Pemberton - Director of Nursing | 0 - 2.5 | 5 - 7.5 | 25 - 30 | 80 - 85 | 460 | 413 | 47 | 0 |
| C Pratt - Acting Director of Nursing | 0 - 2.5 | 2.5 - 5 | 20 - 25 | 60 - 65 | 346 | 270 | 76 | 0 |
| M Jackson - Director of Research and Informatics | 0 - 2.5 | 5 - 7.5 | 25 - 30 | 85 - 90 | 557 | 504 | 53 | 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 2013/14 was £192.5k (2012/13, £197k). This was 7 times (2012/13, 8 times) the median remuneration of the workforce, which was £26k, (2012/13 £25k).

The median remuneration of the workforce has increased by £1k for 2013/14 compared to 2012/13. The increase can be attributed to incremental drift and the public sector pay award.

In 2013/14, nil (2012/13, 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 pension related benefits, employer pension contributions and the cash equivalent transfer value of pensions.

## Reporting related to the Review of Tax Arrangements of Public Sector Appointees (off-payroll arrangements)

Reporting entities are required to disclose off-payroll engagements with a cost of more than £220 per day and that last for a period longer than six months.

**Table 1: For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last for longer than six months.**

| Number of existing engagements as of 31 March 2014 | 2 |
|---|---|
| Of which: | |
| Number that have existed for less than one year at time of reporting | |
| Number that have existed for between one and two years at time of reporting | 1 |
| Number that have existed for between two and three years at time of reporting | |
| Number that have existed for between three and four years at time of reporting | 1 |
| Number that have existed for four or more years at time of reporting | |

A risk based assessment has been undertaken on the two engagements reported and from April 2014 both will become employees of the Trust.

**Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months.**

| Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014 | 2 |
|---|---|
| Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations | 0 |
| Number for whom assurance has been requested | 0 |
| Of which: | |
| Number for whom assurance has been received | 0 |
| Number for whom assurance has not been received | 0 |
| Number that have been terminated as a result of assurance not being received | 0 |

There were two contracts which commenced prior to the disclosure requirements for off-payroll engagements and therefore assurance was not sought. These two contracts have now ceased.

There were no off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2013 and 31 March 2014.

## Expenses of the Directors and Governors

### Directors

In 2013/14 the total number of directors in office was 16 (2012/13, 14). The number of directors receiving expenses in the reporting period was 10 (2012/13, 12). The aggregate sum of expenses paid to these directors in the reporting period was £8,742 (2012/13, £11,587).

## Governors

In 2013/14 the total number of governors in office was 25 (2012/13, 32). The number of governors receiving expenses in the reporting period was 10 (2012/13, 12). The aggregate sum of expenses paid to these governors in the reporting period was £8,338 (2012/13, £4,824).

**Jane Tomkinson**
Chief Executive
**Date:** 27th May 2014

# 4. NHS Foundation Trust Code of Governance

This section of the annual report explains how the Trust is governed.

The role of the Board of Directors is to set the strategy and organisational culture and be responsible for all aspects of the operation and performance of the Trust.

The Council of Governors provides a key role in ensuring local accountability for the Board's decisions to members and the public.

The Board of Directors and the Council of Governors are committed to continue to operate to the highest standards of corporate governance. The way in which the Trust's governance operates is set out in the Trust's constitution. (http://www.lhch.nhs.uk/Library/About-LHCH/performance_plans/Liverpool%20Heart%20and%20Chest%20NHS%20FT%20Constitution%20July%202013.pdf)

The Board of Directors met seven times in 2013/14 in order to discharge its duties which include:

- Providing leadership within a framework of processes and controls which enable risk to be assessed and managed
- Ensuring that the Trust complies with the licence, its constitution, contractual obligations and other regulatory and statutory requirements
- Setting the strategic aims and plans, taking consideration of the views of governors
- Challenging decisions and proposals on priorities, risk mitigation, values, standards and strategy.

Board members share accountability as a unitary board.

The Board delegates operational management, including the execution of strategy to executive management. The Board has an established committee structure to facilitate the effective discharge of its responsibilities.

The Council of Governors met four times in order to discharge its statutory roles and responsibilities as set out in the 2006 Act and amended by the 2012 Health and Social Care Act. The Council has a duty to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and to represent interests of the members of the Trust and of the public. In addition to appointing and deciding on the remuneration of non-executive directors and appointing the auditor, the Council of Governors must approve changes to the Trust's constitution, approve significant transactions, approve applications to change the nature and structure of the Trust and ensure that the principal purpose of providing NHS services is protected. (Refer also 4.1 below).

The Chairman has ensured that the Board of Directors and Council of Governors have worked together effectively; and that Directors and Governors have received appropriate, accurate and timely information for them to effectively discharge their respective duties. Governors receive the agenda and minutes of all Board meetings and these are also published on the Trust's website. Board members routinely attend the Council of Governors' quarterly meetings in order to present information requested and /or respond to any questions raised by the Governors.

All Board and Council meetings are held in public.

The Senior Governor during 2013/14 was Ken Blasbery.

The Senior Independent Director during 2013/14 was David Bricknell.

Governors are actively engaged in informing the Trust's forward plans, through a programme of joint strategy development work, incorporating presentations from clinical leads and regular review of the vision, strategic objectives and capital investment plans. Governors have used surveys, attended patient engagement events and hosted community events and member health days to obtain feedback on the Trust's services from members and the public, in order to inform the forward plans. Patient stories and customer care reports feature at every meeting of the Council of Governors.

The Council of Governors established a number of interest groups, each hosted by an executive director and sponsored by a non-executive director, which met throughout 2013/14. This process has enabled the Board to further develop an understanding of the views of governors and provided governors with an informal setting in which to work with and question members of the Board.

In addition to the interest groups, the Trust has provided formal training and development to support Governors in their roles. This has included the provision of an annual induction day for new governors, an externally facilitated development day for all governors, bespoke training to meet specific needs and access to NW Governors' forum and FTN training and development events.

Directors hold at least four Development Days each year, which supplement induction and personal development plans.

The Trust maintains a register of interests, detailing company directorships and other significant interests held by Directors or Governors. In 2013/14 the Chair had no other significant commitments that conflicted with the business of the Trust or impacted upon his ability to meet his responsibilities as Chair.

Both the Board of Directors and Council of Governors have reviewed the respective registers and have confirmed that there are no interests that conflict or have any material impact on individuals' day to day responsibilities.

At the start of every Board and Council meeting, all members are asked to declare any interests that relate the agenda items listed, in order that any individual may

withdraw from discussion on a particular topic in the event of a conflict. Any such declarations are recorded in the minutes.

The Register of Interests is available to the public and can be accessed on request by writing to the Associate Director of Corporate Affairs, Liverpool Heart and Chest NHS Foundation Trust, Thomas Drive, Liverpool, L14 3PE.

The Board recognises that good governance is essential to the provision of safe, sustainable and high quality care and seeks to comply with The NHS Foundation Trust Code of Governance, published by Monitor the independent regulator.

The Code was updated in December 2013 (effective from 1st January 2014) to take account of the new regulatory and policy landscape and in particular, the new duties for governors and boards imposed by the Health and Social Care Act 2012.

In the Board's view, the Trust has been fully compliant throughout the accounting period with the relevant provisions of the Code, with the exception of the following:

- Provision B.6.2 states that evaluation of the Board of Directors should be externally facilitated at least every 3 years. This is a new Provision that came into effect on 1st January 2014 and Monitor has conducted a consultation exercise which will inform the publication of a new Board Leadership and Governance Framework. The Board last completed a full external evaluation in 2009 as part of its preparatory work for foundation trust status. Whilst it has not yet followed up with a comprehensive externally facilitated Board evaluation exercise, the Board did commission a governance review in the latter part of 2013/14 involving a review of the Board Committee structure and the findings and recommendations of this review will be implemented during the first quarter of 2014/15. Going forward, it is the Board's intention to comply fully with this Provision.

Further details of how the Trust has applied the Code principles and complied with its provisions are set out within this section and throughout this annual report. Further information on the Code can be found on Monitor's website at http://www.monitor.gov.uk/FTcode

## 4.1 Council of Governors

**Role and Composition**:
The Council of Governors has responsibility for representing the interests of the members, partner organisations and members of the public 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 non-executive directors, individually and collectively, to account for the performance of the Board of Directors
- to feedback information about the Trust, its vision and its performance to the constituencies and partner organisations that elected or nominated them, along with members of the public
- to approve 'significant transactions'
- approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- approve amendments to the Trust's constitution.

**The Council of Governors comprises 25 Governors of whom:**

- 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)
- 5 have been nominated from partner organisations (1 seat each from the following):
    - Liverpool John Moores University (LJMU)
    - Association of Voluntary Organisations in Wrexham (AVOW)
    - Friends of Robert Owen House (FRoH), Isle of Man
    - Cystic Fibrosis Trust (CFT) – position vacant
    - Liverpool City Council (LCC) - position vacant.

At the Council of Governors and Board of Directors joint development day, held on 13th November 2013, Governors evaluated the performance of the Council of Governors and identified actions and objectives for the next 12 months. This was also an opportunity for the Council of Governors to engage with the Board of Directors and contribute to the setting of the Trust's strategic objectives and planning. Following this, the Council of Governors joined the Board of Directors for a subsequent development day on 25th February 2014 to discuss and contribute further to the 2014/15 planning round.

The names of those who have served as Governor in 2013/14 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).

There were no elections held in the period 1st April 2013 – 31st March 2014.

**Governor Development**:
The Trust provides many opportunities for Governors to be actively involved and this work makes a real difference to our 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 Board members.
- 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 and the Annual Members' Health Day. These events also facilitate the opportunity for Governors to engage with members and the public.
- 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 Centred Care (regularly attend organised patient and family engagement events).
- 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 convened a governance group under the leadership of the Chair to review the Trust's governance arrangements.

In addition to the above, the Trust has encouraged development through the provision of training and support including, attendance at external Governor development events, working groups/ seminar such as work supporting research projects, individual discussions with the Chair and Trust Secretary and walkabouts to meet with staff and view facilities.

## Governor Attendance at Council of Governor Meetings 2013/14

| Governor Name | Council of Governor Meeting Dates 2013/14 | | | |
|---|---|---|---|---|
| | 3rd June 2013 | 3rd September 2013 | 2nd December 2013 | 3rd March 2014 |
| **Public Constituency** | | | | |
| **Merseyside** | | | | |
| Vera Hornby | ✓ | ✓ | ✓ | ✓ |
| Debbie Mawson | x | x | x | ✓ |
| Paula Pattullo | ✓ | x | ✓ | ✓ |
| Roy Stott | ✓ | ✓ | ✓ | ✓ |
| Brian Roberts | ✓ | ✓ | ✓ | ✓ |
| Neil Marks | ✓ | ✓ | ✓ | ✓ |
| **Cheshire** | | | | |
| Kenneth Blasbery | ✓ | ✓ | ✓ | ✓ |
| Michael Brereton | ✓ | x | x | ✓ |
| David Hicks | ✓ | ✓ | ✓ | ✓ |
| Judith Wright | ✓ | ✓ | x | ✓ |
| North Wales | | | | |
| Roy Griffiths | ✓ | ✓ | ✓ | ✓ |
| Denis Bennett | ✓ | ✓ | ✓ | ✓ |
| Mike Bowyer | ✓ | ✓ | x | x |
| **Rest of England and Wales** | | | | |
| John (Tony) Roberts | ✓ | x | ✓ | ✓ |
| **Staff Constituency** | | | | |
| **Registered Nurses and Non-Registered Nurses** | | | | |
| Peter Hannaford | ✓ | ✓ | ✓ | ✓ |
| Neville Rumsby | ✓ | ✓ | ✓ | x |
| **Non Clinical** | | | | |
| Christine Bell | ✓ | ✓ | ✓ | ✓ |
| Anthony Grimes | ✓ | ✓ | ✓ | x |
| **Allied Health Professionals, Technical and Scientific** | | | | |
| Doreen Russell | ✓ | ✓ | ✓ | x |
| **Registered Medical Practitioners** | | | | |
| Michael Desmond | x | ✓ | x | ✓ |
| **Nominated Governors:** | | | | |
| Michelle Laing (appointed October 2013) | | | ✓ | ✓ |
| Glenda Corkish (Friends of Robert Owen House) | x | ✓ | ✓ | ✓ |
| Menna Harland (Liverpool John Moores University) (resigned | x | | | |

| Governor Name | Council of Governor Meeting Dates 2013/14 | | | |
|---|---|---|---|---|
| | 3rd June 2013 | 3rd September 2013 | 2nd December 2013 | 3rd March 2014 |
| September 2013) | | | | |
| Jake Morrison (Liverpool City Council) (resigned May 2013) | **x** | | | |
| Janet Radford | ✓ | x | x | ✓ |
| **Board Members in attendance:** | | | | |
| Raj Jain | ✓ | ✓ | | |
| Jane Tomkinson | | | ✓ | ✓ |
| David Jago | ✓ | ✓ | ✓ | ✓ |
| Mark Jackson | ✓ | ✓ | ✓ | ✓ |
| Sue Pemberton | ✓ | ✓ | | ✓ |
| Clare Pratt | | | ✓ | |
| Marion Savill | ✓ | ✓ | ✓ | ✓ |
| Lawrence Cotter | ✓ | ✓ | ✓ | ✓ |
| David Bricknell | ✓ | ✓ | ✓ | ✓ |
| Geoffrey Appleton | | ✓ | ✓ | ✓ |
| Mark Fuller | ✓ | 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 licence conditions, 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 and Quality, Chief Finance Officer and a Director of Research and Informatics.

During 2013/14, three new non-executive directors took up post.

The independent advice of the Trust Secretary (Associate Director of Corporate Affairs) 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 Associate Director of Corporate Affairs 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. The Chair of the Audit Committee holds a relevant financial qualification and has recent financial experience. Appropriate clinical leadership is also provided from within the complement of executive and non-executive directors. 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 in 2013. A new Chief Executive appointment was made in October 2013. The Chief Executive leads the Executive and Associate Directors and the organisation.

During 2013/14, the Board commissioned an external review of governance and will implement and embed a new committee structure and Board assurance process during 2014/15. The Council of Governors has evaluated its effectiveness, with the support of an external facilitator and has set itself clear objectives for 2014/15. The Chair leads and ensures the effectiveness of the Board of Directors and Council of Governors, ensuring effective engagement and working relationships between the Board and the Council. As noted earlier, the Board will commission an external review of Board leadership and governance in 2014/15 in accordance with the recommendations of Monitor's new framework which is pending publication at the time of writing.

**The Non-Executive Directors in 2013/14 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 2016 |
| **David Bricknell** *Master in Research and PhD in strategic decision making with a career in the legal industry.* | Senior Independent Director | 2nd March 2010 | 28th February 2016 |

| | | | |
|---|---|---|---|
| **Geoffrey Appleton** *LLB (Hons) and MA in Criminology with extensive experience in legal and personnel roles.* | Deputy Chair | 2nd March 2010 | 28th February 2016 |
| **Lawrence Cotter** *Consultant Cardiologist and honorary Professor of Medical Education at Manchester University.* | Non-Executive Director | 1st June 2013 | 31st May 2017 |
| **Mark Fuller** *Chartered Accountant and extensive venture capital business experience* | Non-Executive Director and Chair of Audit Committee | 1st May 2013 | 30th April 2017 |
| **Marion Savill** *Experienced business investor and board level strategic advisor.* | Non-Executive Director | 1st May 2013 | 30th April 2017 |
| **Pat Firby** *Registered nurse with 25 years' experience in nurse education, MSc in Social Research Methods.* | Non-Executive Director | 1st December 2009 | 28th February 2013<br><br>Term extended to 31st May 2013 |
| **Rob Toomey** *Qualified accountant and doctorate in economic history with experience of board level roles in a number of private sector organisations.* | Non-Executive Director | 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 |

The Council of Governors appointed Lawrence Cotter, Mark Fuller and Marion Savill in 2013/14 and determined that their initial terms of office should be for periods of four years.

The Board has determined that the Chair and each of the non-executive directors are independent in respect of the criteria for independence set out in the NHS Foundation Trust's Code of Governance.

The Board has confirmed that each Governor and director has met the 'fit and proper' persons test as outlined in the provider licence.

All non-executive directors, with the exception of the Chair, are members of the Audit Committee.

All non-executive directors, including the Chair, are members of the Nominations and Remuneration Committee (for Executive appointments).

**The Executive Directors in 2013/14 were as follows:**

| Name | Position |
|---|---|
| Raj Jain (until 7th October 2013)<br>*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 |
| Jane Tomkinson (wef 8th October 2013)<br>*Former Director of Finance at NHS North of England, and Director of Finance as well as Deputy Chief Executive at Countess of Chester Hospital NHS Foundation Trust.* | Chief Executive |
| David Jago<br>*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.* | Chief Finance Officer and Deputy Chief Executive |
| Glenn Russell<br>*Consultant Anaesthetist (Member of Liverpool Society of Anaesthetists) with extensive experience in cardiac anaesthesia both in the UK and overseas.* | Medical Director |
| Sue Pemberton (absent 11.10.13 to 6.1.14)<br>*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 and Quality |
| Clare Pratt (Acting 11.10.2013 until 05.01.2014)<br>*Previous roles have included Deputy Director of* | Acting Director of Nursing |

| | |
|---|---|
| *Nursing, and Assistant Director of Nursing for Cardiology and Chest Medicine at LHCH; Assistant Director of Clinical Governance at Royal Liverpool and Broadgreen University Teaching Hospitals.* | |
| Mark Jackson<br>*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 |

**Attendance at Board of Directors Meetings 2013/14**

| Director | 30th April 2013 | 28th May 2013 | 30th July 2013 | 7th Oct 2013 | 26th Nov 2013 | 28th Jan 2014 | 25th March 2014 |
|---|---|---|---|---|---|---|---|
| *Chair* | | | | | | | |
| Neil Large | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| *Chief Executive* | | | | | | | |
| Raj Jain | ✓ | ✓ | ✓ | ✓ | | | |
| Jane Tomkinson | | | | | ✓ | ✓ | ✓ |
| *Non-Executive Directors* | | | | | | | |
| David Bricknell | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ |
| Geoffrey Appleton | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Rob Toomey | ✓ | | | | | | |
| Pat Firby | ✓ | ✓ | | | | | |
| Bridget Leek | ✓ | x | | | | | |
| Mark Fuller | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Marion Savill | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Lawrence Cotter | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| *Executive Directors* | | | | | | | |
| David Jago | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Glenn Russell | x | x | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sue Pemberton | ✓ | ✓ | x | ✓ | | ✓ | ✓ |
| Clare Pratt | | | | | ✓ | | |
| Mark Jackson | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

## 4.3 Audit Committee

The Audit Committee is a committee of the Non-Executive Directors (excluding the Chairman) and is chaired by Mark Fuller (wef 1st May 2013), previously Rob Toomey (until 30th April 2013).

**The Committee met on** 6 occasions during 2013/14.

## Attendance at Audit Committee meetings 2013/14

| Member | 16th April 2013 | 23rd May 2013 | 15th July 2013 | 28th Oct 2013 | 14th Jan 2014 | 11th Mar 2014 |
|---|---|---|---|---|---|---|
| Mark Fuller (Chair) | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Rob Toomey (Chair) | x | | | | | |
| Pat Firby | ✓ | x | | | | |
| David Bricknell | ✓ | ✓ | ✓ | ✓ | x | ✓ |
| Geoffrey Appleton | ✓ | ✓ | ✓ | ✓ | ✓ | x |
| Marion Savill | | ✓ | x | ✓ | ✓ | ✓ |
| Lawrence Cotter | | | ✓ | ✓ | ✓ | ✓ |
| Bridget Leek | ✓ | x | | | | |

## Role of the Audit Committee

The Audit Committee provides the Board of Directors with an independent and objective review of its system of integrated governance, risk management and internal controls, covering the breadth of Trust activities in fulfilling the delivery of the Trust's corporate objectives.

The work of the Audit Committee in 2013/14 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.

## Principal Review Areas in 2013/14

The narrative below sets out the principal areas of review and significant issues considered by the Audit Committee during 2013/14 reflecting the key objectives of the committee as set out in its terms of reference.

- **Internal Control and Risk Management**

  The Committee has reviewed relevant disclosure statements for 2013/14, in particular the draft Annual Governance Statement, MIAA Board Assurance Framework opinion which when combined together with receipt of the Director of Audit Opinion, external audit opinion and other appropriate independent assurances.

  The Trust has embedded risk management systems in place in 2013/14. The Committee believes that the systems for risk management, following receipt at its October 2012 meeting of MIAA Risk Management strategy report with significant

assurance received, that there is an appropriate risk management strategy in place, covering key elements of the risk management process which has been disseminated to staff alongside clear links between the Departmental/Ward Risk Registers, Directorate Risk Registers.

From the report, the Committee took assurance that risks in Directorate Risk Registers are reported to the relevant Assurance Committees via Board Assurance Framework 'Key issues reports and minutes' of the Directorate Governance meetings.

The Committee has undertaken a rolling programme of reviews during 2013/14 that test the effectiveness of the Assurance Committees and is satisfied that the assurance mechanisms are fit for purpose in terms of discharging the responsibilities delegated by the Board of Directors. This rolling programme was supported via MIAA review of Assurance Committee effectiveness, which helped support the internal self-assessment process which alongside identifying areas of good practice, also identified areas for improvement that have been broadly acknowledged and incorporated.

Other risks identified by the Committee for review during 2013/14, included combined financial systems, information governance agenda, CQC compliance systems and processes, payroll and integrated performance reporting.

- **Internal Audit**

Throughout the year, the Committee has worked effectively with internal audit to ensure that the design and operation of the Trust's internal control processes are sufficiently robust.

The Committee has given considerable attention to the importance of follow up in respect of internal audit work and recommendations in order to gain assurance that appropriate management action has been implemented.

The Committee has considered the major findings of internal audit and where appropriate has sought management assurance that remedial action has been taken. In instances where only 'limited assurance' has been assigned to a review, the Committee has requested sight of the full report including management response and attendance at the next meeting by the responsible manager. This has further strengthened the Committee's response to major audit findings in 2013/14 and ensured that any control weaknesses are understood by the Audit Committee and are quickly addressed.

The Committee reviewed and approved the internal audit strategy, operational plan and detailed programme of work for 2013/14 at its March 2013 meeting. This included a range of key risks identified through discussion with Management and Executives and review of the Trust's Board Assurance Framework. Reviews were identified across a range of areas, including combined financial systems, IM&T, Performance, Clinical Quality, Workforce, Governance and Risk.

- **Counter Fraud**

The Committee reviewed and approved the counter fraud policy and work plan for 2013/14 at its March 2013 meeting, noting coverage across all mandated areas of strategic governance, inform and involve, prevent and deter and hold to account. During the course of the year, the Committee also regularly reviewed updates on proactive counter fraud work.

- **External Audit**

The Committee routinely received progress reports from the external auditor, including an update annual accounts audit timetable and programme of work, updates on key emerging national issues and developments which may be of interest to Committee members alongside a number of challenge questions in respect of these emerging issues which the Committee may wish to consider.

- **Management Assurance**

The Committee has frequently assessed the adequacy of wider corporate assurance processes as appropriate and has requested and received assurance reports from Executives, managers and wider Committee representation throughout the year. This has included review of actions in respect of internal audit findings for payroll, disaster recovery, quality account review, reference cost assurance review and a review of the clinical audit programme.

- **Financial Assurance**

The Committee has reviewed the accounting policies and annual financial statements prior to submission to the Board and considered these to be accurate. It has ensured that all external audit recommendations have been addressed.

- **Other Assurance**

The Committee routinely received reports during 2013/14 on Losses and Special Payments and Single Source Tender Waivers.

The Committee has reviewed and updated the Governance Manual including Standing Financial Instructions and Schemes of Delegation.

The Committee has undertaken a rolling programme of Assurance Committee reviews involving a structured discussion with the Committee's Executive Chair and assigned Non – Executive Director member. Each Committee produced a formal annual report for consideration by the Board of Directors in April 2014.

Members of the Committee have met privately with the auditors, without the presence of any Trust officer.

The Audit Committee met privately with the auditors on at least one occasion during the year.

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 2013/14, 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. Within this effectiveness review the Audit Committee questioned the effectiveness of the external audit process and found that during 2013/14 this largely had been effective.

The Trust's external auditors, Grant Thornton, were appointed by the Council of Governors in September 2012 following a formal procurement exercise for a three year period.

## 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 and Remuneration Committee (Non-Executive)

Membership: Chaired by the Trust Chairman 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).

During this financial year, the committee met on 1 occasion and considered the results of the Chair's annual appraisal and the 'Policy on the Composition of Non-Executive Directors' before recommending that Neil Large be re-appointed as Chair for a further 3 year term. This recommendation was subsequently supported by the Council of Governors.

### Nominations and Remuneration Committee (Executive)

Membership: Chaired by the Trust Chairman with all other Non-Executive Directors as members.

The Committee met on 6 occasions in 2013/14.

Attendance at Nominations and Remuneration Committee (Executive) in 2013/14:

| Member | 3rd June 2013 | 12th July 2013 | 24th July 2013 | 27th August 2013 | 7th October 2013 | 28th January 2014 |
|---|---|---|---|---|---|---|
| Neil Large (Chair) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| David Bricknell | ✓ | x | ✓ | ✓ | ✓ | x |
| Geoffrey Appleton | x | x | ✓ | x | ✓ | ✓ |
| Mark Fuller | ✓ | ✓ | ✓ | x | ✓ | ✓ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Marion Savill | ✓ | ✓ | x | ✓ | ✓ | ✓ |
| Lawrence Cotter | ✓ | x | x | ✓ | ✓ | ✓ |

During 2013/14 the Committee approved the release of the outgoing Chief Executive in accordance with contractual terms and dealt with the appointment and remuneration of the new Chief Executive. The appointment of the Chief Executive was subsequently approved by the Council of Governors.

The Committee also approved the nomination and remuneration of David Jago as Deputy Chief Executive and considered the new Chief Executive's proposals for revisions to the Executive structure. The Committee gave approval to the proposal to appoint to a new executive Board position – Director of Strategy and Organisational Development.

## 4.5 Membership

The Trust is committed to ensuring that members are representative of the population it serves. 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, as well as continuing to engage with members of the public.

The Council of Governors is responsible for reviewing, contributing to and supporting the Membership Strategy and making recommendations to the Board of Directors, for approval of revisions to the strategy. The implementation of the Membership Strategy is monitored by the Membership and Communications Sub Committee 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 growing a membership that is representative of the demographics of its patient population, whilst also being mindful of the public population, rather than increasing membership size
- continually increase the quality of engagement and participation through the involvement of members in all sectors of the communities served - specifically seeking 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 whilst achieving value for money.

The target for public membership was to maintain an optimum number of 10,100 members by 31st March 2014, which was achieved successfully. Governors are encouraged to engage within their own constituencies, including any community groups with whom they are personally involved. This engagement is supported by the Trust's Membership Office which helps to facilitate opportunities for such activities. For example, the Trust has continued to organise a series of highly successful and popular 'Medicine for Members' events at which clinical specialists have hosted talks and discussion in local community settings. These events have also been advertised to members of the community in order to encourage engagement between Governors and members of the public.

Following on the success of last year's event, a second Members' Health Day was held to provide members with an opportunity to tour the hospital facilities, receive health checks and lifestyle advice. This event was organised in response to feedback received through a bi-annual members' survey conducted in summer 2013, when members stated overwhelmingly that they wanted more similar events. The event provides Governors with an opportunity to meet and engage with both members and members of the community.

In order to manage its turnover and to improve representation, Governors attended a number of recruitment events throughout the year, including Freshers Fairs, Disability Awareness Day and other local university events.

This is in addition to recruitment mailshots carried out by the Trust's Membership Office to recently discharged patients. These aim to target those areas illustrated in the Membership Strategy as being under represented, being mindful of both the Trust's patient population and the general population of areas served. For public members, these include geographical areas of Merseyside and Cheshire along with an age range of 50-79 years old.

### Membership profile

| Constituency | | | |
|---|---|---|---|
| **Public Constituency** | **As at 1st April 2013** | **As at 31st March 2014** | **Increase/ Decrease (%)** |
| **Cheshire** | **2,358** | **2376** | **+0.76** |
| **Merseyside** | **4,994** | **5010** | **+0.32** |
| **North Wales** | **2,035** | **2081** | **+2.26** |
| **Rest of England and Wales** | **763** | **791** | **+3.67** |
| **Total - Public Constituency** | **10,150** | **10,258** | **+1.06** |
| **Staff Constituency** | **1,384** | **1359** | **-1.81** |

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

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

# 5. Quality Report

## Introduction to Liverpool Heart & Chest Hospital NHS Foundation Trust

Liverpool Heart & 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 & the Isle of Man. It provides the full range of heart and chest services with the exception of organ transplantation. Throughout 2013/14, 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 & 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 Patient Experience Network National Awards (PENNA) for overall care and for “Support for Caregivers’ for the ‘Development of a Nursing Model of Care for Patient and Family Centered Care’.

Also, one of our Advanced Nurse Practitioners won an award for best abstract and presentation at the Christie’s ANP Conference. The presentation detailed how the advanced nurse role has been established at LHCH and acknowledged the positive impact the role has had on quality of care for patients and families. The introduction of this nursing role has reduced length of stay, streamlined care and reduced the waiting times for patients requiring transfer into the Trust from referring hospitals.

We also have a developing reputation in the delivery of high quality community cardiovascular and chronic obstructive pulmonary services confirmed by the renewal of our contract by Knowsley CCG in December 2013.

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

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

# 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 **one** of the four priorities we set ourselves last year. This was:

1. Improve recommendation of our Hospital to Friends and family

We have partially met **two** of the four priorities we set ourselves last year. These were:

2. Improve the Timeliness of our Communications to General Practitioners at the Point of Discharge
3. Development and Implementation of a Health Economy Wide Discharge Checklist

We have just fallen short of meeting **one** target for:

4. Reduce pressure ulcers across the health economy but have made an improvement nonetheless, as we have seen a marked improvement in LHCH Hospital acquired ulcers.

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, Healthwatch, relevant Local Authority Overview & Scrutiny Committees and other interested parties such as the staff working in the Hospitals with whom we work.

# Part 1: Statement on Quality from the Chief Executive Officer

It is my pleasure to introduce to you the fourth Quality Account to be published by the Liverpool Heart & Chest Hospital NHS Foundation Trust.

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

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

And our vision:

*"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.

This year has been a good year for the quality of the care provided to our patients:

- Patients have voted us to be the best provider in the country for overall patient care for the 7th time in 8 years.
- We continue our registration with the independent health regulator, the Care Quality Commission without any conditions. However over the course of 2013/14 the CQC have asked us to take action on 4 separate outcomes following unannounced inspections. Details of actions required are as follows:
    - In October 2013 the Trust was subject to an unannounced inspection that highlighted an area for improvement
        - Outcome 9 - Management of Medicines – Action needed.
    - Following a re-inspection of the Outcome the CQC have now reported that they are happy with the progress made by the Trust and found the Trust to be fully compliant with this standard.
    - In February 2014 the Trust was subject to a further unannounced inspection and highlighted 3 areas for improvement
        - Outcome - 13 Staffing – Action needed
        - Outcome - 14 Supporting Workers – Action needed
        - Outcome - 16 Assessing and Monitoring Service Provision – Action needed
    - Following receipt of the final report from the Care Quality Commission a detailed action plan has been implemented and the CQC are happy actions taken to date and with the proposed actions in relation to these 3 Outcomes.
- 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.
- Host of the First National Conference on Patient Centred Care in the summer 2013.
- Won the Patient Experience Network overall national award for patient experience.

- Organiser of several prestigious medical conferences that were centred on sharing the expertise of Liverpool Heart & Chest Hospital clinicians with others from around the country.
- An increase again in our funding for research and innovation, which allows cutting edge treatments to be brought to our patients as early as possible.
- Third year of the Institute of Cardiovascular Medicine and Science, in collaboration with Royal Brompton and Harefield NHS Foundation Trust and Imperial College London; we have seen 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.

Jane Tomkinson
Chief Executive Officer

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

## Review of Priorities from 2013/2014

**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 four quality accounts. We wish to continue this work over the coming two years and broaden its appeal to families also. Results from the Friends and Family test 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 of 90. This is an exceptionally high target, given most industries achieve scores of 20 to 40. A Net Promoter Score is calculated from the responses, 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.

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.

Current status:

**Exceeded.** We achieved a net promoter score of 92 for 2013/14

Improvements achieved:

- Recognised families as important members of the heathcare, this has involved patients and families in all aspects of planning, delivery and evaluation of care at LHCH by roll out of the care partner programme.
- Development of a Patient Family centred nursing care model.

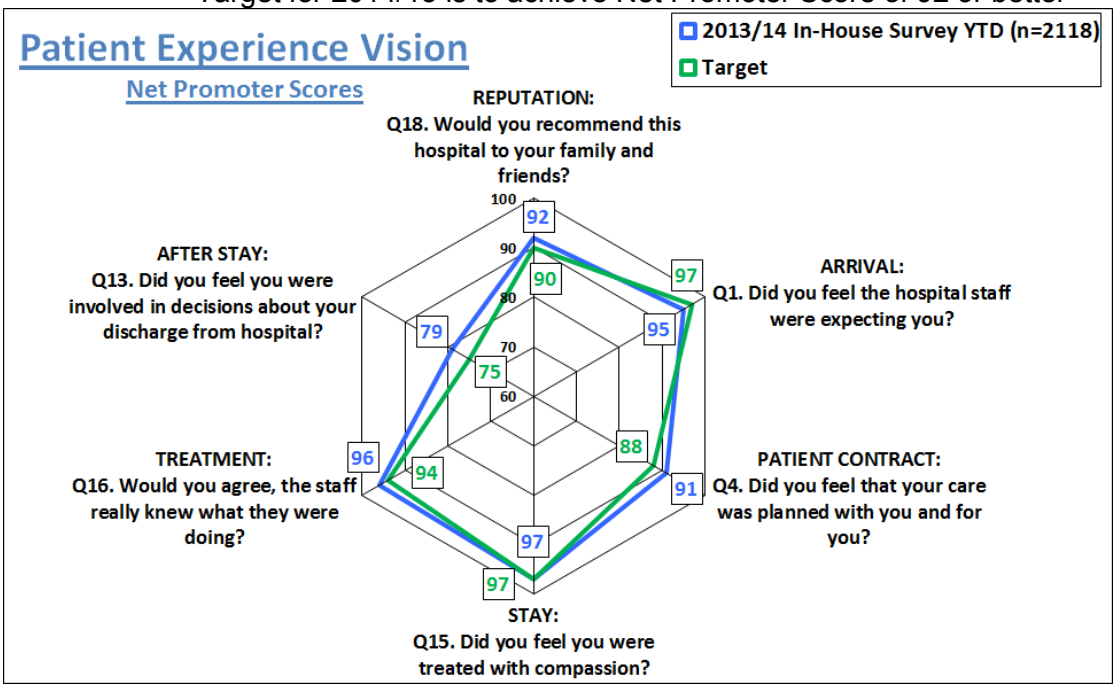
- We have made easy and accessible the opportunities for patients and families to ask questions.
- We have developed an iPad based tool which captures patient and family feedback real time, and we can therefore act promptly on patients' suggestions or recommendations. We continue to identify areas for improvement from patients' feedback and have acted on patients' recommendations.
- Completed over 100 patient and family shadows of care.
- Rolled out the dementia friends training.
- Developed training and education sessions for the patient and family centred care champions over 70 staff have attended.
- Incorporated PFCC training into junior doctors induction, HCA development days and also preceptorship.
- Undertaken 4 patient and family engagement events and acted on the feedback we have received.
- Undertook the patient led assessment of the care environment with 12 members of the public.
- Hosted the first friends and family test national conference and acted as a key note speaker.
- Shared our work on shadowing at the improvement network in Manchester.

Keep it as a future priority:

No, although this is one of our national CQUINs and as such will continue to be high on our overall priorities and will be monitored regularly by our Assurance Committees.

Improvements identified:

- Target for 2014/15 is to achieve Net Promoter Score of 92 or better



## 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 patients 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 in-patient stay on the day of discharge, and a formal discharge letter that follows attendance as an out-patient, ideally within two weeks.

How much:

Our aim is to ensure 95% of in-patients have their discharge summary electronically transmitted to GP within 24 hours of discharge and for 95% out-patients have discharge letter electronically transmitted to GP within two weeks of out-patient attendance.

By when:

March 2014

Who collects the data and how:

At present, we rely on faxed discharge summaries for in-patient discharges and typed & posted letters for out-patient 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:

**Partially Achieved**. The Trust has established an electronic discharge summary with a number of neighbouring GP practices. Although our plan for this year was to have the system rolled out to all practices working with the Trust, as not all GPs practices have taken part on the electronic discharge project, we have been unable to roll out to all practices working with us. However, as we believe this is an important element for patient experience and our effectiveness, we are continuing the work next year.

Carried forward to next year?

Yes, albeit it requires full cooperation and integration with all our GP practices.

Improvements achieved:

- There is a project part of the Electronic Patient Record work aiming at setting this up formally rather than having a manual exercise, as it's the current practice.
- Continuing the engagement with our commissioners and GP practices.

Keep it as a future priority:

Yes, this will continue to be a priority for us and was selected by our Council of Governors as a priority for 2014/15.

Improvements identified:

- Target for next year remains that 95% of in-patients will have a discharge summary that meets the minimum data set electronically transmitted to GP within 24 hours of discharge.

## 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 of 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:

**Partially achieved**. The checklist has been developed using a core criteria across the health economy. At LHCH our checklist has been incorporated into EPR and is utilised for patients. Currently we have no system for undertaking audit of completion of checklist for every patient. This will be progressed during 2014/15 and will form part of the reporting system provided by EPR.

Improvements identified:

- Feedback discharge checklist compliance results to staff via ward dashboards.

## Priority Four: Reduce Pressure Ulcers across the Health Economy

Category:

Safety

What:

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

Why:

Pressure ulcers 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 three 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 ulcers 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 ulcer is reduced.

How much:

We want to reduce the percentage of patients who have had a pressure ulcer, either in the Trust that referred them to us, or 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 ulcers, and if so, was that pressure ulcer present on admission (ie they acquired the ulcer 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:

**Not achieved**. Although we have seen a marked improvement in the number of grade 2 and grade 3 pressure ulcers in the last 6 months, the poor engagement from across the healthcare system has resulted in our inability to achieve this priority.

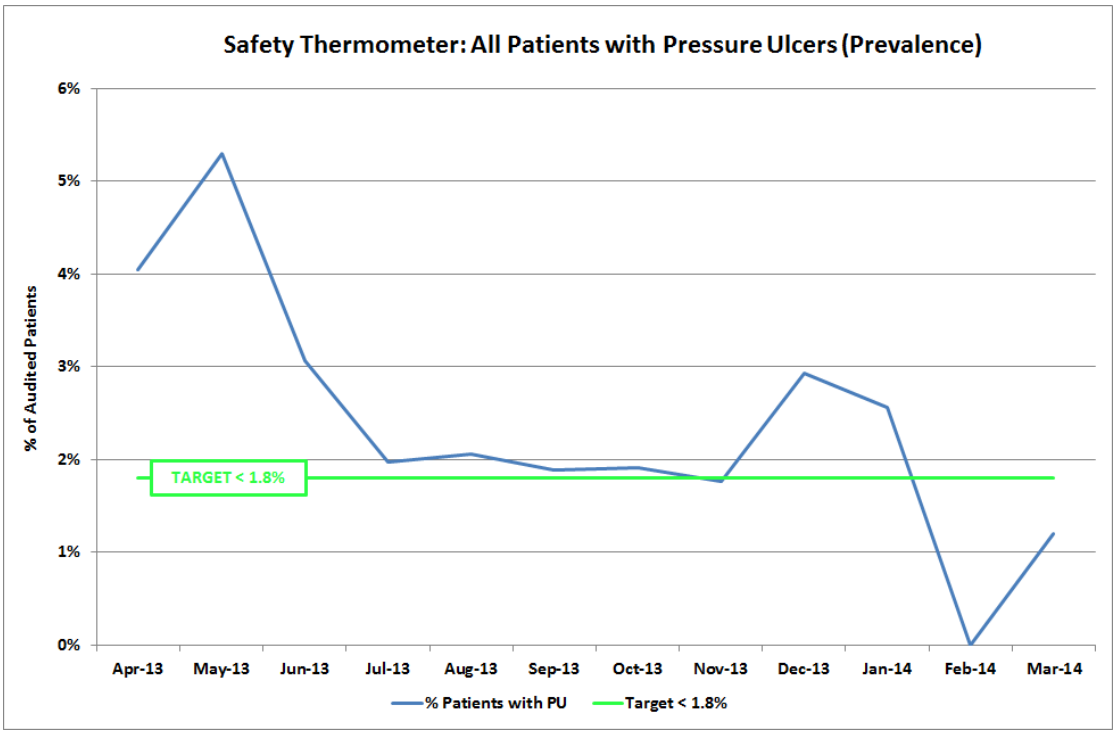
We have been looking at the prevalence of all pressure ulcers using the national safety thermometer which concentrates on a spot check audit of pressure ulcers on a given week each month. As patients with long stays will be counted more than once, this means double reporting can occur, giving an inflated number and not a true representation of the actual situation. Also, this includes patients who have acquired pressures ulcers at other referring organisations.

Improvements identified:

There is a desire to continue this work but its 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. If this can be achieved we would aim to:

- Define best practice.

- Devise terms of reference for this health economy wide group to come together.
- Share the number of pressure ulcers 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 ulcers to ensure the effectiveness of our efforts.



## Priorities for 2014/15

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

The Trust is committed to improve the following areas in 2014/15:

**Priority One: To ensure that patients with Dementia are identified and assessed whilst under our care and are referred to their GP for investigation at discharge.**

Category:

Patient Experience

What :

Ensure that in-patients (excluding Day Case patients) over the age of 75 are appropriately assessed for the potential of having dementia within 72 hours of admission. The GP of those assessed as potentially having Dementia will be informed to ensure that, when appropriate, specialist care can be accessed

Why:

There are an estimated 163,000 new cases of dementia identified each year in England and Wales. Dementia also increases with age:

- 6.7 per 1,000 person years at age 65-69.
- 68.5 per 1,000 person years at age 85 and above

Early diagnosis and care planning is essential to ensure the best treatments can be delivered. The key to diagnosis is a good history of progressive impairment of memory and other cognitive functioning (usually requiring the help of a spouse, relative or friend).

During this assessment we will take specific notes on the following:

- Attention and concentration ability.
- Orientation - time, place, person.
- Memory - both short- and long-term.
- Praxis - whether they can get dressed, lay a table, etc.
- Language function (usually evident during questioning).
- Executive function - problem-solving, etc.

Conduct a formal screen for cognitive impairment –The results if positive will be shared with the Patients GP and a memory screening clinic if appropriate.

How much:

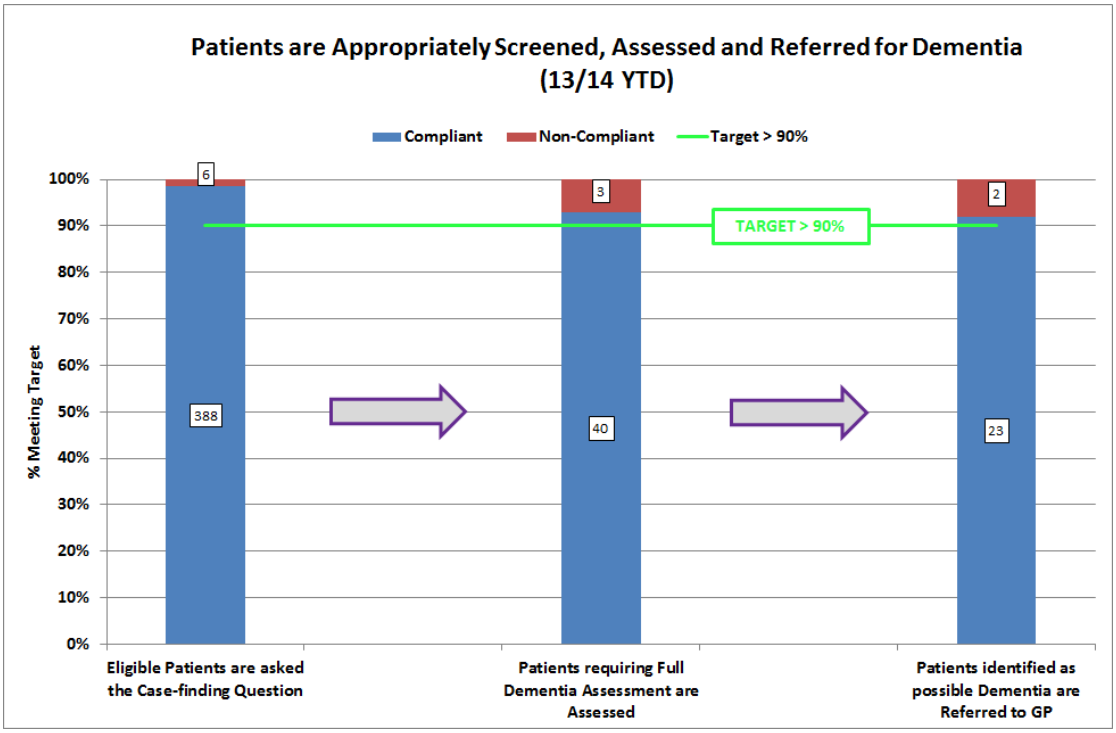
Our aim is to ensure that 95% of patients are appropriately assessed and that 90% of those requiring an onward referral receive it

By when:

March 2015

Who collects the data and how:

Ward Staff complete the initial assessment on admission and document the outcome in the Electronic Patient Record. If a positive result is found, a report is generated from the assessment and faxed direct to the GP. During 2014/15 the Trust will be improving our ability to report on performance directly from EPR. This will enable Ward Managers to be able to monitor how often appropriate assessments and referrals are made and to identify any areas for improvement.




Improvements identified:

There are a number of improvements and initiatives planned for 2014/15 some of the key projects are:

- Dementia friends training for clinical and non-clinical staff to increase understanding and awareness.
- Working towards dementia friendly community alongside Liverpool Dementia Action Alliance.
- Completion of Carers Audit to ensure that we do all we can to support Carers

**Priority Two: Reduce Pressure Ulcer Development**

Category:

Safety

What:

It is our desire that patients in our care will receive Harm Free Care. To ensure that this happens we will work with clinical teams to ensure that they have access to the best support, training and resources to facilitate a 50% reduction in the development of Hospital acquired Pressure Ulcers of Grade 2 and above.

Why:

Pressure ulcers are painful, provide a site for infection, can prolong hospital stay and increase healthcare costs. With appropriate care Pressure Ulcer development is largely preventable. Our Trust has done great work over the past few years in reducing the number of pressure sores in our patients by 75%. The Trust has a 5 year improvement target to reduce the development of avoidable Pressure Ulcers to 0%

How much:

We want to reduce the number of patients who have had a hospital acquired pressure ulcer as a consequence of the care we provide by 50%.

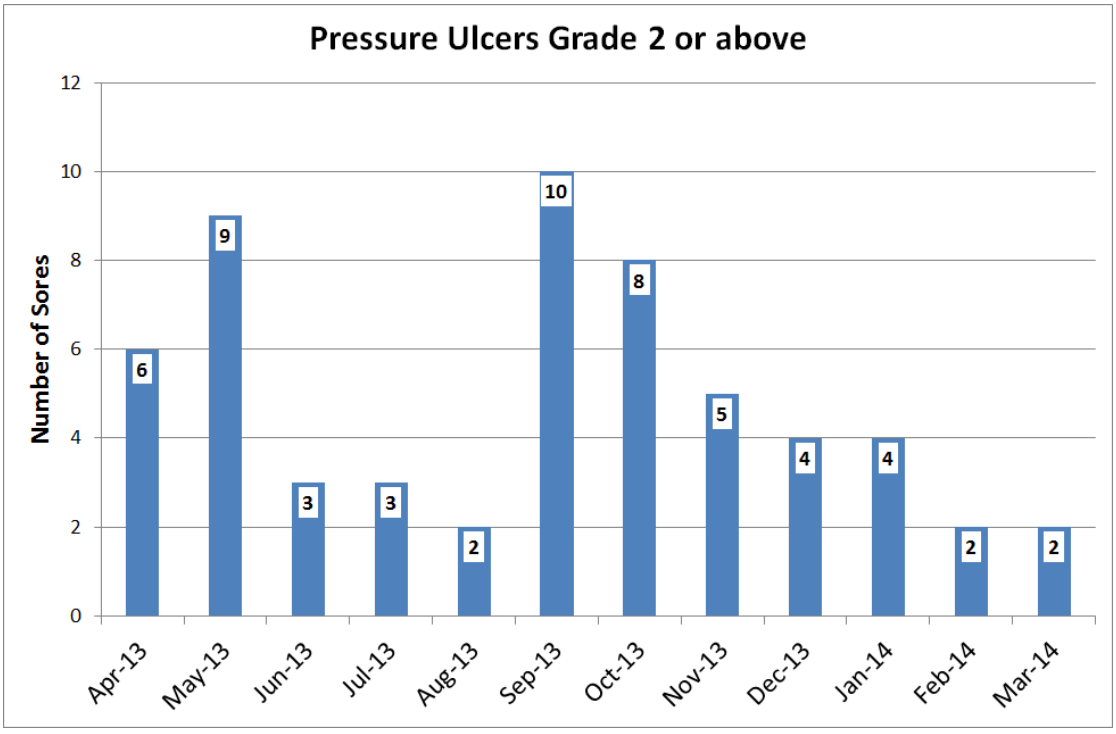
By when:

March 2015

Who collects the data and how:

Each month the Trust publishes data related to the number of Pressure Ulcers of Grade 2 and above that have developed in our care. The information is reported to NHS England as part of the Transparency Project and allows us to share best practice with other regional organisations.

Current status:




Improvements identified:

- Improve consistency of recording assessment, care planning and evaluation of care within the Electronic Patient Record.

- In April 2014 the Trust will deliver a project to display information about Pressure Ulcer Development in an open and transparent way at the entrance to wards. This initiative will enable patients and their families to see how each area is delivering on the Trusts ambition to drive down the development of pressure ulcers.

- Additional e-learning training has been developed to ensure that all relevant staff have access to update training to compliment face to face training.

- The Director of Nursing and Quality works closely with the Tissue Viability Specialist Nurse and front line staff to undertake a review of care when a patient does develop a pressure ulcer. In doing so we can be sure that any potential for improvement and shared learning is captured and actioned

**Priority Three: Reduce the number of patient falls**

Category:

Safety

What:

It is our desire that patients in our care will receive Harm Free Care. To ensure that this happens we will work with clinical teams to ensure that they have access to the best support, training and resources to facilitate a sustained reduction in the number of falls.

Why:

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The likeliness of falling is increased in patients who are often medicated, weakened due to their medical condition, have reduced mobility post-surgery and are in unfamiliar surroundings.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall.

Last year patients in our care fell 73 times

How much:

We want to reduce the number of patients who fall whilst in out care by 50%.

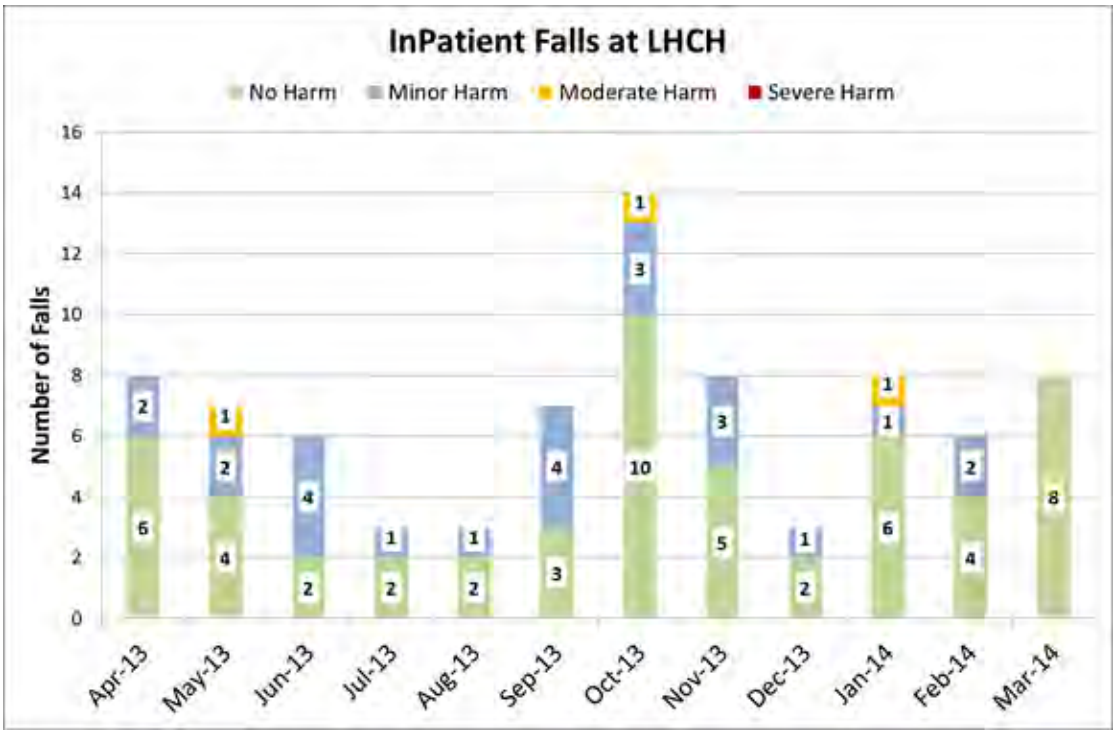
By when:

March 2015

Who collects the data and how:

All falls are reported via Clinical Incident reports using the Prism System.

Current status:




Improvements identified:

- Improve consistency of recording falls assessment, care planning and evaluation of care within the Electronic Patient Record.

- In April 2014 the Trust will deliver a project to display information on falls in an open and transparent way at the entrance to wards. This initiative will enable patients and their families to see how each area is delivering on the Trusts ambition to drive down the frequency of falls.

**Priority Four: 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:

This was a Quality Accounts Target for us in 2013/14. Significant progress was made in developing the systems required but we believe that this is still a priority area were we can make more progress. General Practitioners perform a really important role in continuing the care of patients following an in-patient episode. It is important for them to receive information about a patient's treatment as soon after discharge as possible. This ensures that all management and preventative measures associated with the patients care are implemented in a timely way, minimising the patient's chances of becoming unwell and even perhaps needing to be readmitted to hospital. A discharge summary which should be issued following an in-patient stay on the day of discharge.

How much:

Our aim is to ensure 95% of in-patients have a discharge summary that meets the minimum data set electronically transmitted to GP within 24 hours of discharge

By when:

March 2015

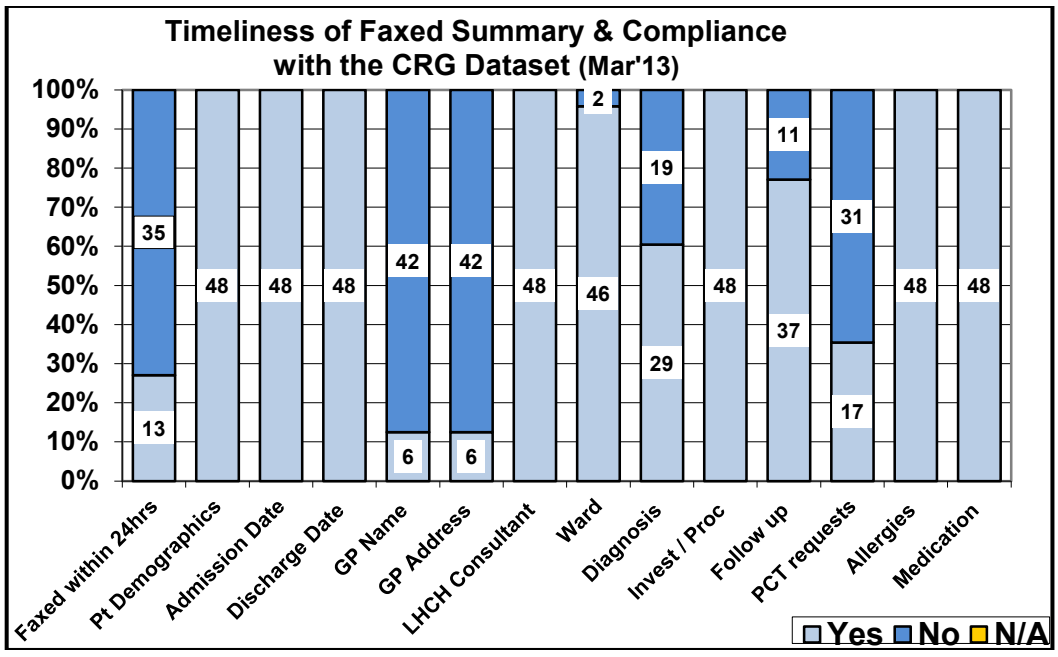
Who collects the data and how:

At present, we rely on faxed discharge summaries for in-patient discharges and typed & posted letters for out-patient attendances. In June 2013, the Trust implemented electronic patient record, which provides the functionality to both electronically transmit and then track the timeliness of all patient correspondence. The success of this target will rely on utilising this function fully. 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 2013/14 with a small number of neighbouring GP practices. There is a risk associated with the Trust achieving this Quality Account priority, however there is a strong belief that we must strive to improve our performance and set challenging targets for ourselves because good communication is vital to ensure that our patients on-going health care needs are met.

The risk identified centres on the Trust's ability to achieve consistently high percentage of electronic correspondence as this is reliant on a single system being in place for all Liverpool GPs. Liverpool CCG is working to ensure that all GPs can receive electronic communication as this is not currently the case. Different forms of communication for different Liverpool GPs will lead to confusion at ward level and seriously impact on our ability to achieve 95%. We have audited our compliance with this scheme and 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.

**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 2013/14 we led a continuous and comprehensive consultation exercise focussed on the identification of those priorities for improvement which would bring the biggest benefits to the people we serve. By people, this naturally includes our patients, but importantly also the carers, our Foundation Trust members and other health and social care professionals with whom we interact daily.

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

1. Staff delivering front line services who know where improvements need to be made
2. The Executive team who have considered the wider agenda in terms of national targets, new policy directives and quality incentive schemes (e.g. Commissioning for Quality & Innovation (CQUIN) and Advancing Quality)
3. Our quality, safety and patient experience Council of Governors sub-group, who are continuously identifying priorities from the Trust's 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. 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 Council of Governors and 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 Trusts Clinical Quality Committee who approved the final shortlisted priorities on behalf of the Board of Directors.

Like previous years this process has resulted in at least one of the suggestions from stakeholders external to the Trust being accepted as a priority. This year, one of the suggested priorities have been influenced by our stakeholders, one by our Council of Governors, one through priorities identified by our staff and one from national indicators in the Safety Thermometer

- Priority One: To ensure that patients with dementia are identified and assessed whilst under out care and are referred to their GP for investigation at discharge – chosen via the Stakeholder Group.

- Priority Two: Reduce pressure ulcer development – National Target (Safety Thermometer).

- Priority Three: Reduce the number of patient falls – chosen by LHCH staff as a Quality Priority.

- Priority Four: Improve the timeliness of our communications to General Practitioners at the point of discharge – chosen by the Council of Governors.

# Review of services

During 2013/14 the Liverpool Heart & Chest Hospital NHS Foundation Trust provided and/or sub-contracted 12 relevant health services.

Liverpool Heart & Chest Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 12 of these NHS services.
The income generated by the relevant health services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by the Liverpool Heart & Chest Hospital NHS Foundation Trust for 2013/14.

**Participation in Clinical Audits**
During 2013/14, 15 national clinical audits and 2 national confidential enquiries covered relevant health services that Liverpool Heart and Chest NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, 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: 2013-14 Clinical Audit**

| A list of national clinical audits and national confidential enquiries | | | |
|---|---|---|---|
| | Eligible to participate in | Participated in Yes / No | % cases submitted |
| | Acute | | |
| 1 | Adult critical care (ICNARC CMP) | Yes | Data is submitted on a quarterly basis:<br><br>Submitted 1166 / 1166 patients (100%) who were admitted to Critical Care for quarters 1 and 2 (April – September)<br><br>Due to send the data on patients who were admitted during quarter 3 (October to December) of 2013/14 within the next week or so to ICNARC. Currently we have a completion rate of 94.5% (521/551) for data in this quarter.<br><br>Also have nearly 300 patients admitted during quarter 4 of 2013/14 and this, along with the rest of the admissions is the quarter, is not due to be submitted to ICNARC until the deadline in early May. |
| 2 | Emergency use of oxygen (British Thoracic Society) | Yes | 74/74 (100%) submitted for Oct 2013 period as per study criteria |
| 3 | National Confidential Enquiry into Patient Outcome and Death (NCEPOD)<br>- Tracheostomy care | Yes | Submitted 20/20 (100%) cases and completed all relevant questionnaires and case note returns for this study (100%) |
| 4 | National Confidential Enquiry into Patient Outcome and Death (NCEPOD)<br>- Gastro-intestinal haemorrhage | Yes | Gastro-intestinal haemorrhage - submitted the patient identifier spread sheet for this study as per criteria. |
| 5 | National emergency laparotomy audit (NELA) | Yes | Organisational questionnaire completed and submitted. Data collection commenced 07/01/2014 and to date 1 /1 (100%) case submitted. |
| | Blood and transplant | | |
| 6 | National Comparative Audit of Blood Transfusion programme<br>- 2013 Audit of patient information and consent | Yes | LHCH registered to participate in the 2013 Organisational Questionnaire completed and submitted.<br>Audit of patient information and consent. Data collection commenced on 13/01/2014 and is on-going for 12 weeks. |
| 7 | National Comparative Audit of Blood Transfusion programme<br>- 2014 survey of red cell use | Yes | LHCH registered to participate in the 2014 survey of red cell use. Data collection is over two periods, each lasting seven days, the first being planned for the week commencing Monday, 24th February 2014, and the second period planned for mid-May 2014. |

| | | | |
|---|---|---|---|
| | Cancer | | |
| 8 | Lung cancer (NLCA) | Yes | 0/362 (0%) have been submitted having been first seen at LHCH in 2013 as per this audit's criteria.<br><br>0/377 (0%) 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.<br><br>Work is on-going to further validate cases before deadline |
| 9 | Oesophago-gastric cancer (NOGCA) | Yes | 0/298 (0%) cases submitted. Data submission for cases seen between April 2013 and March 2014 is due 1/10/2014. |
| | Heart | | |
| 10 | Acute coronary syndrome or Acute myocardial infarction (MINAP) (subscription funded from April 2012) | Yes | 823/ 991 (83%) cases submitted to NICOR<br>0/ 16 Takotsubo cases submitted<br>496/ 774 (64%) NSTEMI / ACS<br>(Time period April 13 – March 14).<br>Deadline for submission 31/05/2014 |
| 11 | Cardiac Rhythm Management (CRM) | Yes | A total of 1391 (100%) pacing and implantable cardiac defibrillators cases and 1180 (100%) EPS cases have been submitted for the reporting period Jan 13 – Dec 13 |
| 12 | Congenital Heart Disease (Paediatric cardiac surgery) (CHD) | Yes | 133/133 (100%) submitted Congenital.<br>3/7 (43%) submitted Infective Endocarditis.<br>33/38 (87%) submitted ICD & Pacing.<br>(Time period April 13 – March 14).<br>Deadline for submission 02/05/2014 |
| 13 | Coronary angioplasty | Yes | A total of 2857 /2857 including coronary pressure studies and IVUS (2649 PCI's) cases for 2013 (100%) submitted. |
| 14 | National Adult cardiac surgery audit | Yes | Adult cardiac surgery data submissions are undertaken every 12 weeks as required by CCAD.<br>FY 13/14<br>Q1 x 459 Cases Submitted (100%)<br>Q2 x 523 Cases Submitted (100%)<br>Q3 x 497 Cases Submitted (100%)<br>Q4 x approximately 487 Cases to be submitted by 30/06/2014 |
| 15 | National Cardiac Arrest Audit (NCAA) | Yes | April – December 2013. 118/118 (100%) cases submitted. Q4 data to be submitted April 2014 |
| 16 | National Heart failure Audit | Yes | 26/ 33 (79%) cases submitted to CCAD<br>(Time period April 13 – March 14) |

| | | | |
|---|---|---|---|
| | | | Deadline for submission 31/05/2014 Participation requirement is 20 cases per month. |
| | Long term conditions | | |
| 17 | National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme | Yes | LHCH has registered to participate in the pulmonary rehabilitation work stream of this audit programme. |
| | Total: 17 | Yes =17 | |

The reports of 10 national clinical audits were reviewed by the provider in 2013/14 and Liverpool Heart and Chest NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

*Intended actions to improve the quality of healthcare*

**Adult critical care (Case Mix Programme – ICNARC CMP)**
We have received the first report from the new ICNARC Cardio-Thoracic sub-group. The report noted the trust had the lowest SMR (Standardised Mortality Ratio) and a low percentage of patients were classed as being a unit out of hours discharges. Of concern was the high number of patients who had a unit discharge delayed for 4 hours or more. This was significantly higher than the other trusts in the report though our percentage was not unexpected.

We expect to receive further reports from ICNARC in the coming months

**British Thoracic Society Emergency Oxygen Audit 2013 (Liverpool Heart and Chest Hospital inpatient oxygen audit 2013)**
2013 saw the introduction of EPR and with it some problems around prescribing oxygen. Routine checks post introduction of EPR encountered some issues. Prior to the audit, analysis of the situation by the EPR team demonstrated either no or incomplete prescribing. To combat this, fields within the prescription were made mandatory and the audit proceeded as scheduled.

Given the issues above, prescribing this year sits at 77% (79% 2012) against a national average of 55% indicating that we continue to practice well.
Lack of signatures to indicate that oxygen has been administered remains an issue with only 9.5% of oxygen administered having a signature against a national average of 21.4%. So, poor nationally but significant improvement required at LHCH.

Actions for improvement:

- Last year's train the trainer pilot was postponed due to lack of response and lead senior nurse for the pilot leaving the trust.
- A new approach – Work with pharmacy to provide PGD training specific to oxygen and an overview of the guidance with regards to accountability around administration of oxygen.

## Cancer

### Lung cancer (National Lung Cancer Audit)

Published December 2013

There are two main 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 2013**

Recommendations within the report are already being met at LHCH. The only minor action required is as follows:

LHCH undertake a readmissions audit within its directorates. We will continue with this audit working in collaboration with our colleagues from The Royal Liverpool and Broadgreen University Hospital NHS Trust.

## Heart

### Acute coronary syndrome or Acute myocardial infarction (MINAP)

**Published October 2013**

All patients admitted to Liverpool Heart and Chest Hospital that was clinically diagnosed with ST-Elevation Myocardial Infarction (STEMI) is uploaded to NICOR as part of the MINAP audit programme. The results from the recently published report comparable to LHCH are as follows: Time period National 2012-13

| Criteria | LHCH % | National % |
|---|---|---|
| Proportion of patients with STEMI that received PPCI compared to thrombolytic treatment | 99.8 | 95.3 |
| Eligible patients who received primary PCI within 90 minutes of arrival at Heart Attack Centre (door-to-balloon) | 98.2 | 91.7 |
| Median of door-to-balloon | 31 | 40 |
| Eligible patients that received primary PCI within 150 minutes of calling for help (call-to-balloon) including those admitted directly or transferred to Heart Attack | 83.5 | 81.7 |
| Median call-to-balloon | 102 | 112.5 |
| Eligible patients that received primary PCI within 150 minutes of calling for help (call-to-balloon) with direct admission to Heart Attack Centre | 98.3 | 86.8 |
| Eligible patients that received Primary PCI within 150 minutes of calling for help for patients transferred to Heart Attack Centre | 61.3 | 55.3 |

Actions required:
In previous years, LHCH has been excluded from submitting NSTEMI/ ACS patients to the national audit; however, since April 2013, we've had a designated auditor to upload all cases. Results will be gathered following the deadline and reported accordingly.

**Cardiac arrhythmia (HRM) Published January 2013**
The NICOR Device Survey for 2012 reveals the following:

1. Pacemaker implantation rate below national target and national average for Merseyside and Cheshire.
2. ICD implantation rate below national target and national average for Merseyside and Cheshire, very low in Warrington and Southport / Sefton regions.
3. CRT implantation rate above national target and national average for both Merseyside and Cheshire.

Actions
1. Pacemaker implant rate is responsibility of DGHs and will be dictated by them.
2. ICD rates low so piloting research project with Medtronic to increase referrals from both primary and secondary care using screenlink technology. HF education event also planned.
3. CRT rates very high – will be helped by workstream for ICDs and have benchmarked against top hospitals in Europe by independent agency.

Quality data will be mandatory from 1/4/2014 and LHCH are well placed to complete 100% data submission. We have already collected data for 5 years and are about to publish our benchmark from 2008-10 with one year follow up.

**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 Feb 2014 a trust level report was produced by NICOR (time period of care addressed 2012-13).

On the whole, the data was accurate and well documented in the theatre and cath lab log books. The Data Quality Indicator for this period was 97.5% (previously 91%, an increase by over 6% which is a great achievement.

Action plan addressed following recommendations from the 2014 report.

- It was recommended that entries in both cath lab and theatre log books to identify clearly whether or not a procedure is for congenital heart disease. This was implemented by introducing a stamp just for congenital patients but does not seem to be embedded properly.
- Implement a more robust report to keep all clinicians up to date on their activity. This will assist in uploading cases that are appropriate congenital case mix and data is complete.
- Instigate a new consent process for our congenital patients. All patients are routinely consented appropriately. However for the purposes of 'external audit review' which is undertaken annually by NICOR we are looking for a more robust method instead of retrospectively getting consent by letter. The introduction of a consent template to be scanned in

EDMS has been suggested for short-term measures. The future plan is to include this document as part of EPR. Discussion is underway to identify the logistics of implementation.

**Coronary angioplasty Published January 2014**
Expansion in the use of Percutaneous Coronary Intervention (PCI) is seeing more patients with acute coronary syndromes treated more quickly waiting less than 96 hours, according to the latest National Audit of PCI (This is a recommendation for MINAP for LHCH 2013/14 as never before audited).

With Primary PCI now being the preferred treatment for heart attack patients instead of traditional 'clot busting' drugs, In 2012 86% Nationally(LHCH (68%) of all patients were treated within 120 minutes of calling for professional help and 90% (LHCH (98.8%) treated within 90 minutes of arriving at the PCI centre. This compares very favourably with international data.

Transfers delayed treatment by about 40 minutes (43 LHCH) LHCH has 31% transfers compared 19% nationally.

Key steps to maintaining and improving high quality treatment is measuring what we are doing. Providing detailed information about the procedures we carry out, so that the information can be collated and analysed at both a local and national level. These data provide considerable insight into the practice of PCI, showing not only how practice is evolving over the years, but also how different clinicians compare with each other.

From 01/01/2014 a new PCI dataset has been rolled out awaiting date for installation at LHCH from Philips (expected Summer-Autumn 2014).

New BCIS PCI risk model due to be tested awaiting more information from BCIS.

More data completeness fields and all Interventional Diagnostic procedures (OCT, IVUS and Pressures studies) to be included in 2014 data submission.

**Heart failure (HF) Published November 2013**
National Heart Failure Audit results are used to benchmark LHCH performance against national data and LHCH comparable data confirms we are above national average for all but one of the recommendations. This one recommendation not currently being met (as we have not previously measured) relates to patients being seen by a member of the multi-disciplinary heart failure team, within two weeks of leaving hospital. The following actions to further improve include:

- The heart failure nurse specialist (HFNS) team supported by the designated database manager will monitor and review suitability of the patients to be seen by a member of the multi-disciplinary heart failure team, within two weeks of leaving hospital to ensure best practice is being met.
- Although meeting the criteria for discharge medication, we will monitor practice and review those patients that haven't been prescribed first-line treatment.
- Utilise the E-referral system in EPR as a good way of monitoring referrals that are made by the heart failure nurse specialist (HFNS) team.

**National Cardiac Arrest Audit (NCAA)**
Having reviewed the 2012/13 NCAA returns you can see we are above the national average for observed to expected ROSC > 20 minutes and observed to expected ROSC > 20 minutes for in-hospital arrests and equal to the national average for observed to expected survival to hospital discharge and observed to expected survival to hospital discharge in-hospital arrests. Going forwards we will:

- Review and act on new and improved NCAA Report when received which will incorporate risk-adjusted comparative analyses
- Utilise the EPR as a good way of tracking arrest call time, date and who attended the arrest call.

The reports of 11 local clinical audits were reviewed by the provider in 2013/14 and Liverpool Heart and Chest Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

**Theatre audit activity**
World Health Organisation (WHO) theatre checklist and fasting remain our focus. Developing Briefs from the safety and culture perspective and Debriefs to focus on situational awareness and improving teamwork will be our main objective next year.

**WHO check list audit**
Results demonstrate a noticeable improvement in the safety culture, teamwork and communication within theatres, with a change in culture regarding the completion of the checklist and significant improvement in engagement between team members.

- Continue to build on this success and re-audit to ensure sustaining improvement.

**Fasting policy audit**
Extensive work has been led and undertaken through a fasting group.

- On-going education to be delivered regarding the Preoperative Fasting of Adults Policy to ensure patients are not fasted unnecessarily.
- Anaesthetists/ Consultants to ensure light early breakfast and fluids prescribed on Electronic Patient Record.
- Further work is required to ensure letters are appropriate and personalised for patients regarding their nil by mouth status for same day admission.

**VTE policy audit**

- VTE risk assessments have been made accessible to medical staff in order to facilitate and improve completion of documentation on the Electronic Patient Record. Re-audit will take place to monitor the changes made.

**Radiology alert process audit**

- Streamline the process for radiology alerts into the Electronic Patient Record.
- Implemented an urgency status of all radiology reports in the Electronic Patient Record.
- Re-audit will take place to monitor the changes made.

**Revascularisation Multi-Disciplinary Team (MDT) audit**
A robust MDT forum for the discussion of elective revascularisation cases is now in place.

- Development of an electronic MDT referral form which includes the completion of a minimum dataset required for effective discussion.
- Development of a standard document recording the MDT decision.
- Attendance by cardiology and surgical trainees should be encouraged as it would provide a valuable learning experience for trainees in both specialities.

**Transfusion policy audit**

- Laboratory has in place a policy on refusing samples where the minimum data set is not present and is applying zero tolerance going forward.
- Introduced mandatory fields in EPR for transfusion sampling to ensure forms are completed in full.
- Continue administration and collection competency training and assessment for all staff.
- Regular spot check audits to continue to ensure best practice and compliance with the policy.

**Pharmacy / Medicines Management Audit activity**
**Pharmacy**
The Pharmacy Department has an annual audit plan which includes audits to monitor the Trust's compliance with some of the policies involving medicines e.g. the Medicines Policy, Misuse of Drugs Policy. The Department also audits its own practice e.g. pharmacist intervention audit, to take out (TTO) audit, counselling of patients newly prescribed warfarin and timeliness audits (to maintain good turnaround times for prescriptions).

**Medicines Management**
The pharmacy department conducts several audits on behalf of the Trust to ensure patients are prescribed medicines in a safe manner, e.g. some in response to NPSA alerts, some in response to changes in practice. The department also carries out audits to ensure patients receive their medicines in a timely manner to maintain their safety e.g. surgical prophylaxis audit.

The department has also been conducting regular reports following the implementation of the EPR system to try to reduce risks linked to its implementation and training. These audits/reports will not fall to the department on a long term basis.

**Telemetry audit**

- Continue education and competency assessment for staff in ward and Critical Care Unit areas on the process for managing telemetry patients
- Further review of policy and standard operating procedures to incorporate use of the Electronic Patient Record.

**Inoculation injuries policy audit**

- Revise and update policy and needle safe protocol for use throughout the trust
- Review and agree existing weekly communication system and the content of communications and subsequent actions required.

**Device Pain Audit**
The audit demonstrated that the routine use of IV paracetomol and titrated fentanyl significantly reduced the pain reported by patients during device procedures to negligible levels.

Going forward, work around referral pathways is being planned.

**Delirium re-audit**

- Create an EPR document for diagnosis/symptom assessment.
- Expand on the pharmacological management in the clinical guideline.
- Create a paper based resource folder for the wards.
- Continue to work with outreach and wards for training/education.

## Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Liverpool Heart & Chest Hospital NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 1,386.

Liverpool Heart & Chest Hospital NHS Foundation Trust was involved in conducting 17 clinical research studies in the cardiovascular specialty, 9 clinical research studies in the cancer speciality, 4 clinical research studies in the surgery / critical care specialty, 4 clinical research studies in the respiratory specialty and 6 clinical research studies in quality of life / outcomes during 2013/14.

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

In the last three years, a total of 125 peer-reviewed publications have resulted from general research activity. Our engagement with clinical research also demonstrates Liverpool Heart & Chest Hospital NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques.

Research is an essential component of the Trust's activities. It provides the opportunity to generate new knowledge about new treatments or models of care truly deliver the quality improvements anticipated. An excellent example of the high quality research taking place at the Trust is:

- **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 have now recruited in excess of 1800 patients undergoing PPCI at Liverpool Heart and Chest Hospital over a period of 28 months. These patients were randomly allocated into one of the two groups either receiving Heparin or Bivalirudin. All other treatments were the same for both groups according to standard PPCI treatments. Both groups of patients had 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 is also comparing the effects of Heparin and Bivalirudin on platelet function. Patients were followed up for 28 days to look for any difference between the two groups for heart attacks, additional angioplasty procedures, stroke and death.

The results of this major trial have been presented at the American Cardiology Conference 2014 as a Breaking News Trial.

One of the many publications from the Trust has been on a nurse-led research project, the TIDES trial (Prevalence and impact of depression and anxiety in people with CF and their parent caregivers) which was looking at anxiety and depression on patient affected with cystic fibrosis at a national level. LHCH was the lead site but patients from all cystic fibrosis units in the country participated in this important trial. The publication entitled "Depression and anxiety in adolescents and adults with cystic fibrosis in the UK: a cross-sectional study " has been accepted for publication in Journal of Cystic Fibrosis this year.

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.

## Goals Agreed with Commissioners

A proportion of Liverpool Heart & Chest Hospital NHS Foundation Trust income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Liverpool Heart & Chest Hospital NHS Foundation Trust and the relevant Clinical Commissioning Groups for the provision of NHS services through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The CQUIN indicators for Liverpool Heart & Chest Hospital NHS Foundation Trust in 2013/14 were 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

£1.67m was conditional upon achieving the above quality improvement and innovation goals; Liverpool Heart & Chest Hospital NHS Foundation Trust achieved most goals with an underachievement on seven day transfer for cardiac surgery.

The CQUIN indicators for Liverpool Heart & Chest Hospital NHS Foundation Trust in 2014/15 are to:

1. Improve the experience of patients and measure success through the Friends and Family test
2. NHS Safety Thermometer
3. Dementia clinical leadership, assessment, referral and carer support
4. Improve the outcomes and experience of care in heart attack, heart failure and bypass grafting patients (Advancing Quality)
5. Communication: timely electronic discharge summaries and letters
6. Develop an effective discharge planning protocol and to monitor its usage and implementation

Further details of the agreed goals for 2013/14 and for the following 12 month period are available upon request from Mrs Sue Pemberton, Director of Nursing and Quality (e-mail sue.pemberton@lhch.nhs.uk or telephone 0151 600 1249).

## 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 Trust has participated in an unannounced review by the Care Quality Commission on the 16th and 17th October 2013. Five standards were reviewed on this occasion:
Outcome 2 – Consent to care and treatment – Met Standard
Outcome 4 – Care and welfare of people - Met Standard
Outcome 8 – Cleanliness and infection control - Met Standard
Outcome 9 – Management of Medicines – Action Needed
Outcome 17 – Complaints - Met Standard

On 13th and 14th February the Trust was subject to an unannounced re- inspection to review progress made towards compliance in Outcome 9 – Management of Medicines
On this occasion the Care Quality Commission were very happy with the progress made by the Trust and found the Trust to be fully compliant.

An unannounced visit occurred on the 7th February. Three outcomes were reviewed:
Outcome – 13 Staffing – Moderate Concern - Action needed
Outcome -14 Supporting Workers – Minor Concern - Action needed
Outcome -16 Assessing and Monitoring Service Provision – Minor Concern - Action needed

The Trust has received the final report from the Care Quality Commission and a detailed action plan has been implemented.

The Care Quality Commission has not taken enforcement action against Liverpool Heart and Chest Hospital NHS Foundation Trust during 2013/14.
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 2013/14.

## Data Quality

**NHS Number and General Medical Practice Code Validity**
Liverpool Heart & Chest Hospital NHS Foundation Trust submitted records during 2013/2014 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% | 99.7% |
| Valid General Medical Practice Code was: | 99.9% | 99.5% |

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

**Information Governance Assessment Report Attainment Levels**
Liverpool Heart & Chest Hospital NHS Foundation Trust's Information Governance Toolkit overall compliance score for 2013/14 was 73% against a planned 74%. All components of the toolkit were submitted as compliant at level 2 or higher, except for IG training which was submitted as level 1. Action plans are in place to increase the level of IG training compliance.

**Clinical Coding Error Rate**
Liverpool Heart & Chest Hospital NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2013/14 by the Audit Commission. Although the Trust received for the third year running in 2013 the CHKS Data Quality Award for Specialist Trusts which is given in recognition of the quality of clinical coding data.

The last Payment by Results clinical coding audit which was undertaken for the Trust 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 latest internal clinical coding audit report undertaken in 2013 as part of Information Governance requirements found the following error rates:

Primary diagnoses incorrect – 2.0%
Secondary diagnoses incorrect – 3.3%
Primary procedures incorrect – 1.0%
Secondary procedures incorrect – 2.8%

**Data Quality**
Liverpool Heart & 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 Intelligent Monitoring Report) and internal sources (e.g. Critical Information Reporting Reviews or adhoc issues raised by staff). The Group is to be incorporated with the Trust's Business Intelligence Group to broaden the agenda with the new Electronic Patient Record.

- 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.

**Themes in Common with our Priorities Arising from Complaints**

The Trust received 63 complaints from 1st April 2013 to 31st March 2014.

This is a decrease of 7% of complaints received in comparison to the 70 received the previous year.

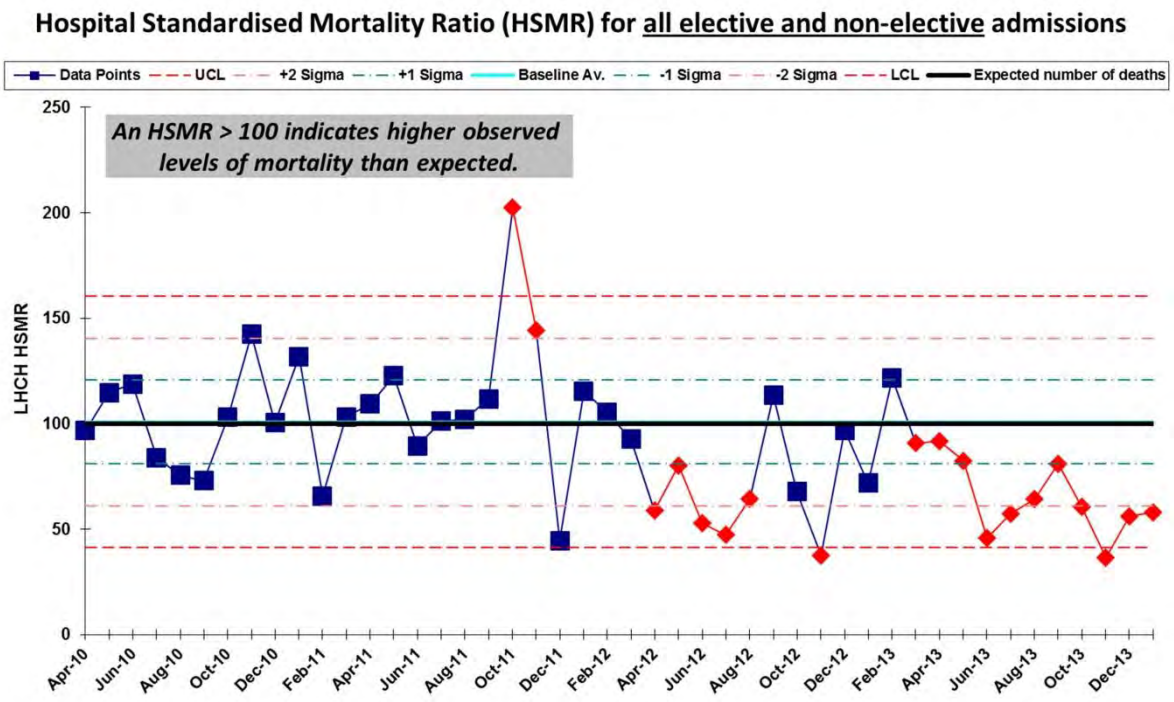
100% of complaints were acknowledged within the DoH timeframe of 3 days and 100 % responded to within the negotiated timeframe with improvements tailored to the circumstances of the complainant's experience.

14 of the 63 closed complaints were considered to have valid issues and to be well founded requiring action and improvements made. All those requiring action plans were presented and actions monitored until complete through relevant Directorate Governance Committees.

# 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 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 Trusts 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.
The spike in October 2011 was thoroughly investigated by reviewing all cases; no recurring themes were identified. In addition, the fall on mortality the following months, gave us reassurances about mortality falling to acceptable levels.

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

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

**Patients receiving an appropriate care bundle**
The Liverpool Heart and Chest Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

| | Target 12/13 | Performance 12/13 | Target 13/14 | Performance 13/14 |
|---|---|---|---|---|
| The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the Trust | 95% | 100% | 95% | 100% |

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

- The Trust continues to provide patients with an appropriate care bundle for all that are eligible with suspected ST elevation myocardial infarction. No action required.

**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 12/13 | Performance 12/13 | Target 13/14 | Performance 13/14 |
|---|---|---|---|---|
| Percentage of patients aged 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust | None | 1.20% | 1.20% | 0.76% |

NB. We monitor readmission rates up to 30 days post-discharge, not 28. Figures include cystic fibrosis patients which have previously been excluded from readmission analysis.

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

- Introduction of a direct line for patients following discharge.

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

Personal needs is a composite of a number of aspects of care, including the provision of advice on medication following discharge. This year, we have improved our performance markedly on this part of the indicator from last year through the embedding of teach back – asking the patients to repeat back what they had been told about taking their medications.

| | Target 12/13 | Performance 12/13 | Target 13/14 | Performance 13/14 |
|---|---|---|---|---|
| Trust's responsiveness to the personal needs of its patients | 79.5% | 78.2% | none* | 82.3% |

*this indicator target was replaced this year by the Friends and Family Test

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.
- Making the 6Cs culture business as usual.

**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 12/13 | Performance 12/13 | Target 13/14 | Performance 13/14 |
|---|---|---|---|---|
| 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% | *90% | 92% |

*the Trust had set up its own target of 90%, albeit there was no national target set for this.

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:

- Increased communication of results through internal systems, such as directorate meetings, team briefs, etc.

**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. However, due to the introduction of our Electronic Patient Record system through the year, we had some irregularities on the recording of VTE assessment through the implementation period of the electronic system. This at no time has impacted in the quality of the care provided.

| | Target 12/13 | Performance 12/13 | Target 13/14 | Performance 13/14 |
|---|---|---|---|---|
| Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism | 90% | 96.17% | 95% | 95.4% |

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 for 2013/14 was reduced to 3, which is the lowest level recorded since a robust data collection system has been in place.

| | Target 12/13 | Performance 12/13 | Target 13/14 | Performance 13/14 |
|---|---|---|---|---|
| Rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over | <=4 | 8 | <=4 | 3 |

Commissioner targets shown. Monitor de minimis target has been 12 for these last two 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

- Ensuring samples are sent appropriately when an infection is suspected
- Ensuring appropriate precautions are taken when an infection is suspected or confirmed
- Ensuring a robust surveillance system is in place

**Patient safety incidents**

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

| | Target 12/13 | Performance 12/13 | Target 13/14 | Performance 13/14 |
|---|---|---|---|---|
| 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 | 1064 incidents 8.2 per 100 admissions (12978 admissions)<br><br>3 (0.3%) resulted in severe harm or death | None | 1316 incidents 9.9 per 100 admissions (13260 admissions)<br><br>1 (0.06%) resulted in severe 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 vision for safety – Safe from Harm
- Implementation of the Speaking up Safely campaign
- Development of the new Quality Strategy which is patient focused.

# Part 3: Other information

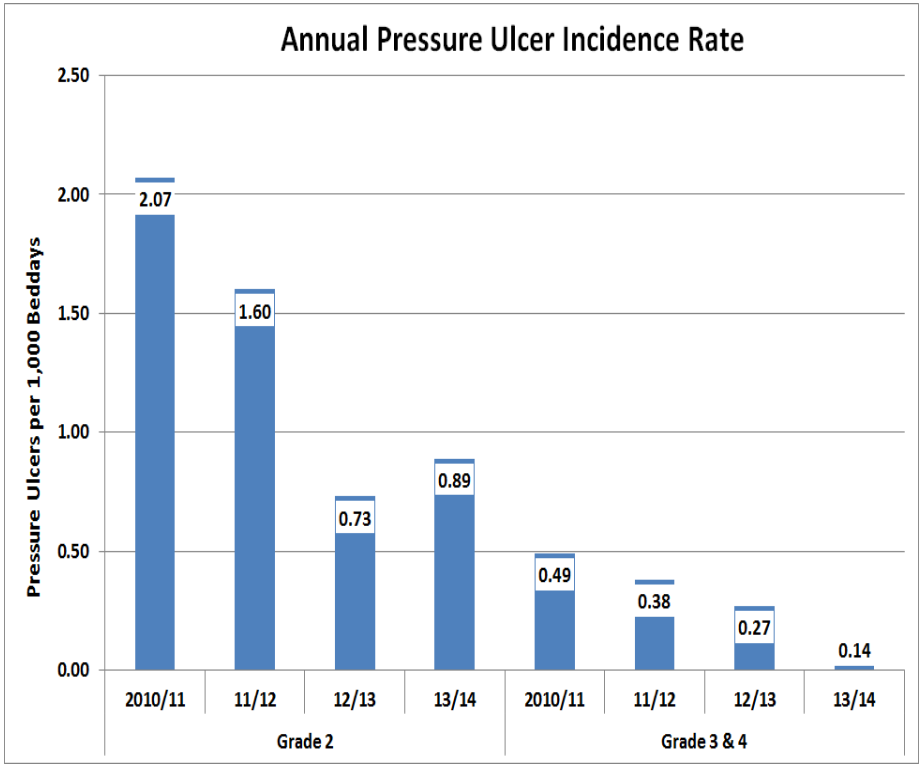
**Performance Review**

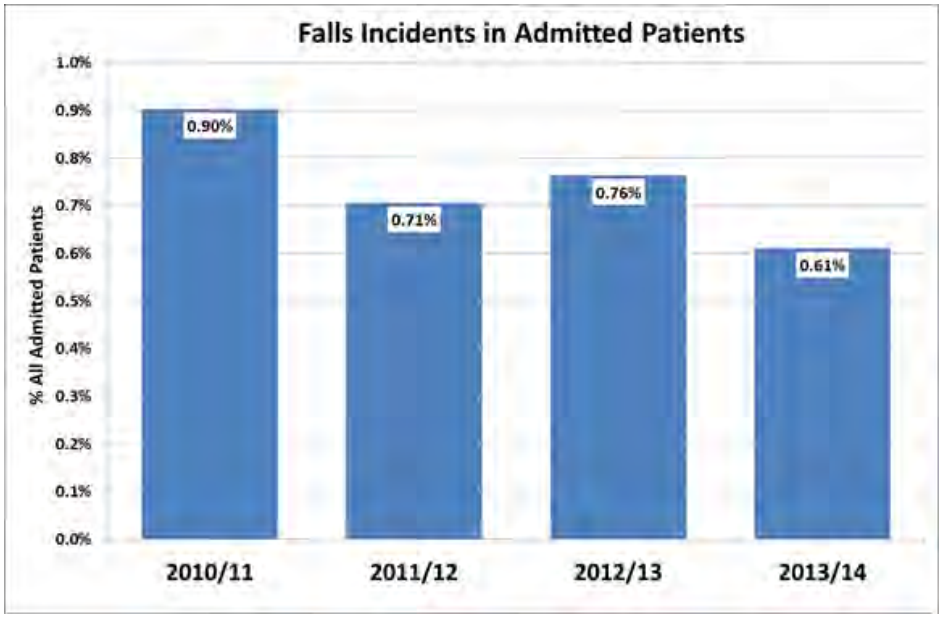
This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2013/14. Presented are:

- Quantitative metrics, that is, aspects of safety, effectiveness and patient experience which we measure routinely to prove to ourselves the quality of care we provide. Some of these metrics are Commissioning for Quality & Innovation (CQUIN) indicators which are included in our contract with our Clinical Commissioning Group.
- Performance against relevant indicators from the Risk Assessment Framework

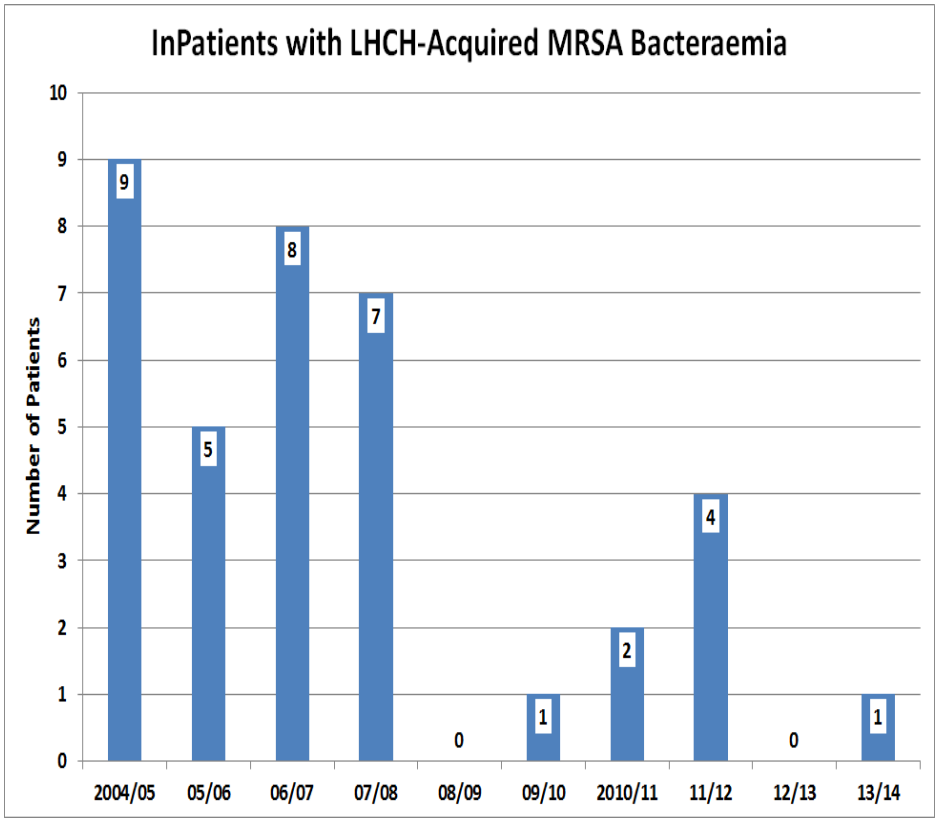
## Quantitative Metrics

| 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<br><br>2.Establishment of the Pressure Ulcer Bundle with a focus on pressure ulcer prevention |
| **LHCH Performance 2013/14** | Grade 2 = 0.89 (~4 ulcers per month)<br><br>Grade 3+ = 0.14 (< 1 ulcer per month) | **LHCH Performance 2012/13** | Grade 2 = 0.73 (~4 ulcers per month)<br><br>Grade 3+ = 0.27 (1.3 ulcers per month) |
| **Interpretation of Results** | Unfortunately we saw an increased number of Grade 2 pressure ulcers reported in 2012/13. Review of incidence of pressure ulcers indicated that the majority were seen at the site of Medical Devices, were small and healed in a short period of time. An improvement programme was put in place and since October 2013 we have seen a decrease in the number of reported pressure ulcers. The number of more severe grade 3 ulcers was almost halved compared to last year. There were no grade 4 pressure ulcers reported during the year. | | |

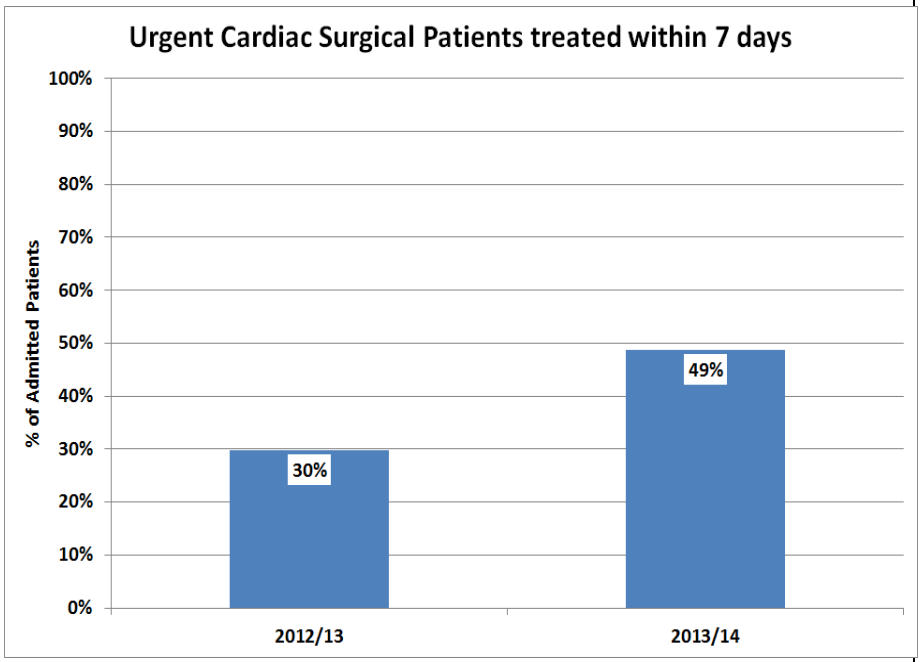


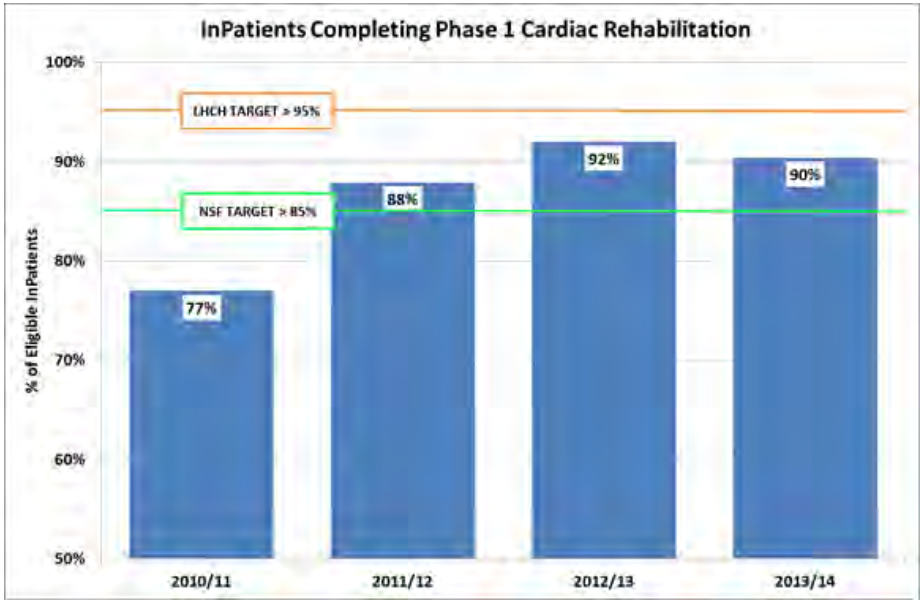
| Safety | | | | |
|---|---|---|---|---|
| **Metric** | No. patient falls | **Organisation Wide or Service Specific** | Organisation wide |  |
| **Derived From** | Incident reporting | **Why metric chosen** | Falls have the potential to cause significant harm. Nursing high impact action; local CQUIN 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 2013/14** | 0.61% (81 falls in 13,255 admissions) | **LHCH Performance 2012/13** | 0.76% (104 falls in 13,619 admissions) | |
| **Interpretation of Results** | The number of falls in 2013/14 was significantly lower than last year. The risk profile of our inpatients has become more challenging recently. However, falls rates still remain lower than they were 3 years ago. We will continue to strive to reduce the number of falls our patients experience. | | | |

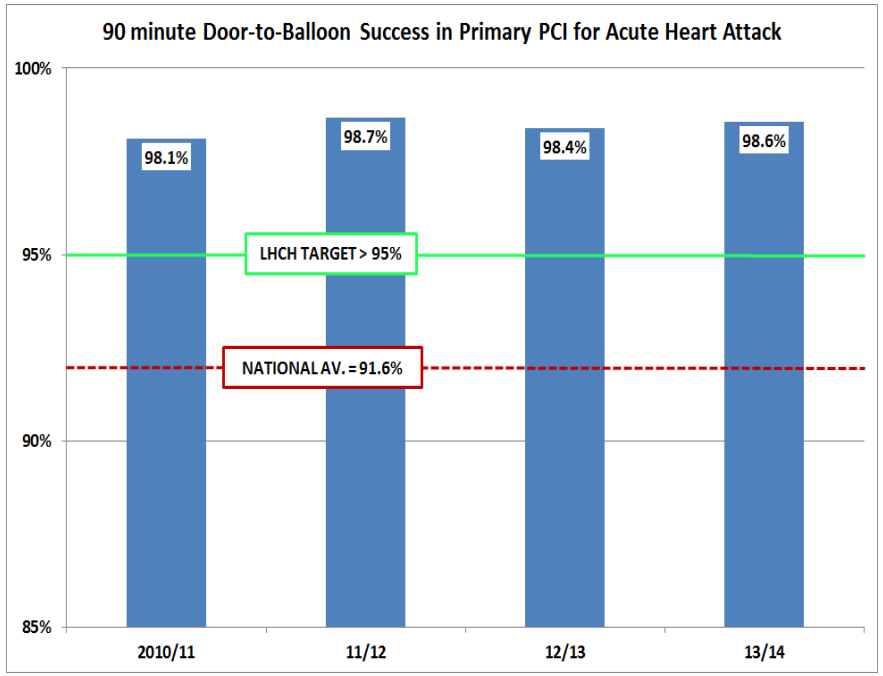
| Safety | | | |
|---|---|---|---|
| **Metric** | Number of patients acquiring MRSA bacteraemia whilst in hospital | **Organisation Wide or Service Specific** | Organisation wide |
| **Derived From** | Infection prevention team | **Why metric chosen** | Major concern of patients; Department of Health 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 out in place last year:<br>1. Surgical site infection check<br>2. MRSA screening audits<br>3. Central lines bundle |
| **LHCH Performance 2013/14** | 1 patient | **LHCH Performance 2012/13** | 0 patients |
| **Interpretation of Results** | There was a single case of MRSA bloodstream infection 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. | | |

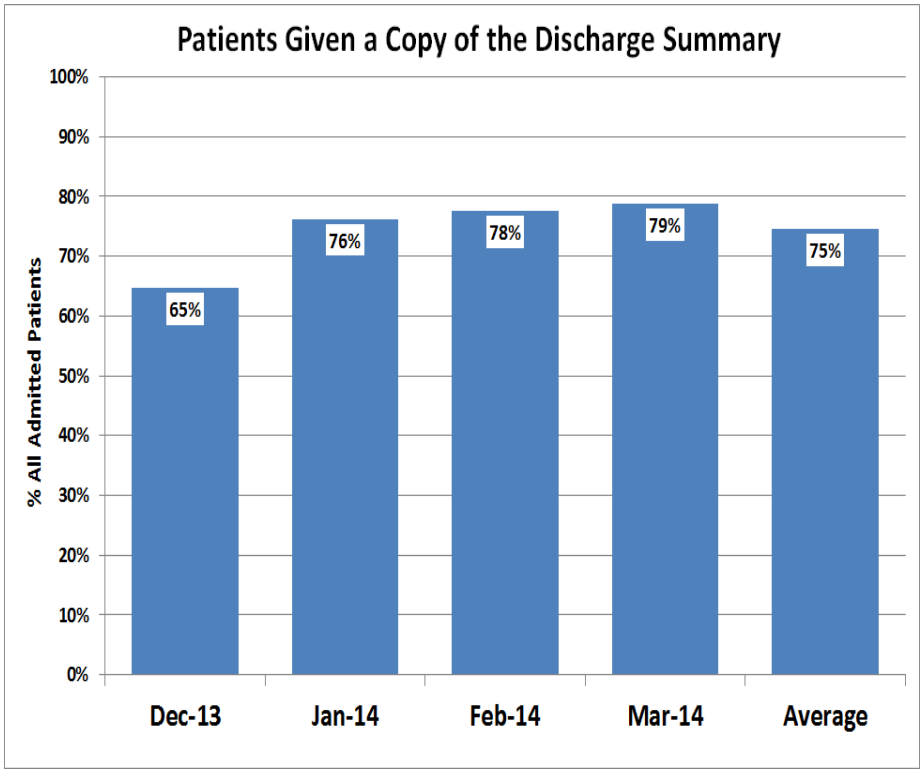


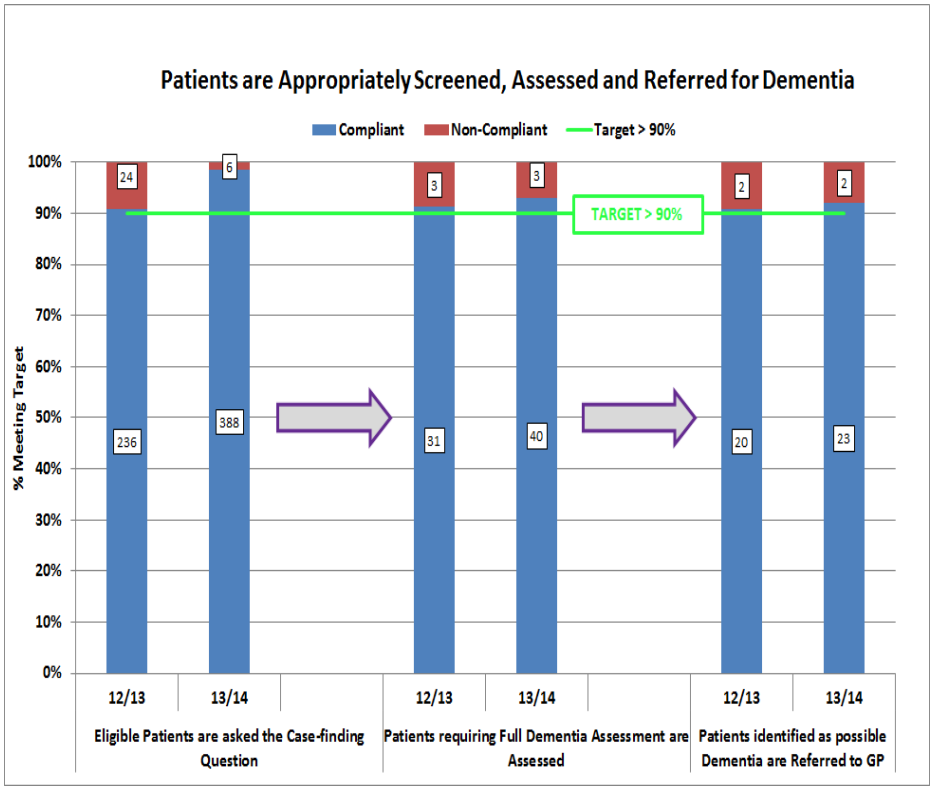
| Effectiveness | | | | |
|---|---|---|---|---|
| **Metric** | Cardiac Surgery – inpatient waits within 7 days. | **Organisation Wide or Service Specific** | Surgical directorate | |
| **Derived From** | Surgical Directorate Urgent Referral Database | **Why metric chosen** | Reducing the time patients wait for their surgery will demonstrate systems and processes are in place between Trusts and patients access treatment in a timely manner, decreasing the number of patients who acquire hospital infections, pressure ulcers, chest infections, DVT etc. | |
| **How is data collected** | Data are collected routinely on referral | **Improvements planned** | Improve referral information provided to reduce delays at referring hospitals (education to referrers) | |
| **LHCH Performance 2013/14** | 178 of 365 patients (49%) | **LHCH Performance 2012/13** | 117 of 393 patients (30%) | |
| **Interpretation of Results** | The Trust managed to improve on the previous year in 2013/14. However, this standard remains challenging as both elective and non-elective patients must be treated in a timely manner. Improvements in waiting times will again be a priority for 2014/15. | | | |

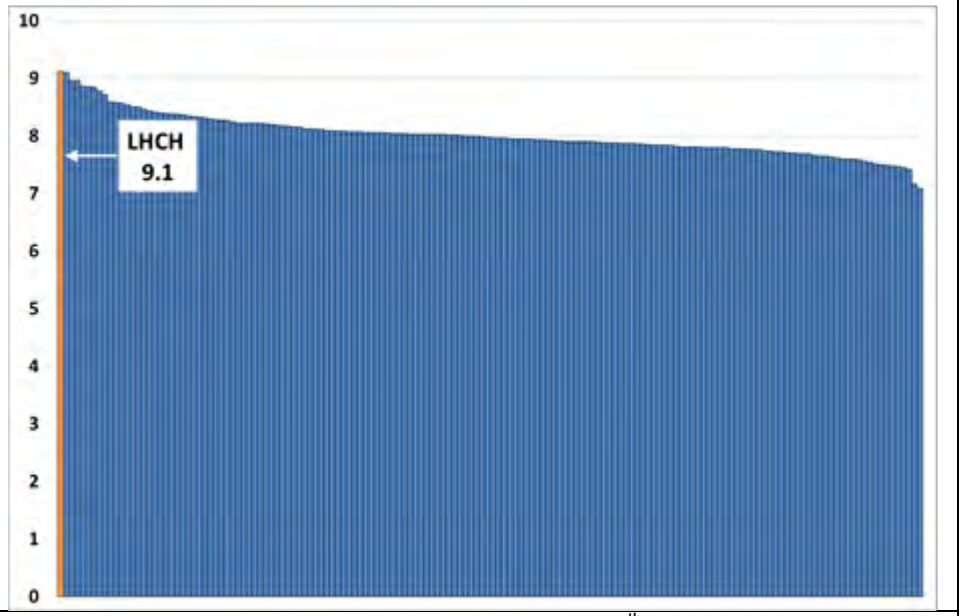


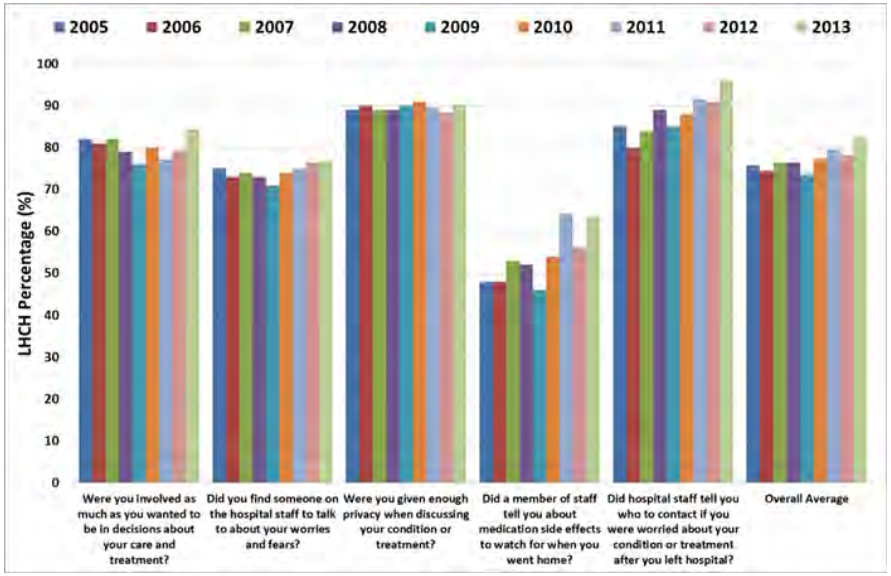
| Effectiveness | | | | |
|---|---|---|---|---|
| **Metric** | % patients completing phase one Cardiac rehabilitation | **Organisation Wide or Service Specific** | Organisation wide – phase 1; |  |
| **Derived From** | Local audit figures | **Why metric chosen** | Promotes lifestyle change and reduces 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 2013/14** | 90% | **LHCH Performance 2012/13** | 92% | |
| **Interpretation of Results** | We have exceeded the 2013/14 target set for this indicator, although it is a small drop from last year. We will continue the excellent service provided by having ward specific cardiac rehabilitation trainers, and by having a new member of staff in the health promotion team. | | | |

| 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 2013/14** | 98.6% | **LHCH Performance 2012/13** | 98.4% | |
| **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** | % of patients who received a copy of their discharge summary to the GP | **Organisation Wide or Service Specific** | Service specific – Support Services |  |
| **Derived From** | Nursing Discharge Checklist in the Electronic Patient Record | **Why metric chosen** | Patients should receive a copy of their discharge summary, so they are aware of and can convey to community services details pertinent to their stay at LHCH and ongoing care. | |
| **How is data collected** | Nursing staff confirm whether or not the patient has received a copy of their discharge summary at the point of discharge, recording this information in the EPR. | **Improvements planned** | Our Electronic Patient Record (EPR) system includes a module for generating patient correspondence. Development of standard documentation across the health economy as part of our CQUIN. Training of appropriate staff will also be undertaken to ensure improvement in 2014/15. | |
| **LHCH Performance 2013/14** | 75% | **LHCH Performance 2012/13** | None | |
| **Interpretation of Results** | The new EPR Discharge Checklist was introduced in December 2013. A small but steady improvement in the number of patients taking a copy of their summary has been seen in early 2014. We hope to see this rate increase to 95% in 2014/15. | | | |

| Patient Experience | | | | |
|---|---|---|---|---|
| **Metric** | Dementia referral | **Organisation Wide or Service Specific** | Organisation wide |  |
| **Derived From** | Local audit began in August 2012 | **Why metric chosen** | Patients assessed and identified with dementia need to be referred for specialist care | |
| **How is data collected** | By nursing staff in ward at assessment and entered into Patient Administration System | **Improvements planned** | Dementia awareness training | |
| **LHCH 2013/14** | 383 of 394 Patients Treated Appropriately<br><br>(97%) | **LHCH 2012/13** | 231 of 260 patients treated appropriately<br><br>(89%) | |
| **Interpretation of Results** | The improvement in results for this standard is testament this process is now embedded well within the Trust. Patients with dementia and their carers can be assured that LHCH will help to ensure appropriate care is provided for this condition. | | | |

| Patient Experience | | | | |
|---|---|---|---|---|
| **Metric** | % patients reporting good or excellent overall quality of care– Inpatients | **Organisation Wide or Service Specific** | Organisation wide |  |
| **Derived From** | National patient survey results | **Why metric chosen** | This question is an overall measure of the patients experience | |
| **How is data collected** | 850 LHCH patients are invited to complete a questionnaire about their in-patient stay. Results are benchmarked with other Trusts in England. | **Improvements planned** | Continuing the Implementation of the Patient and Family centred care plan | |
| **LHCH Performance 2013/14** | 9.1 (91%) | **LHCH Performance 2012/13** | 8.7 (87%) | |
| **Interpretation of Results** | We have had a marked improvement in our overall performance rates. We have come top in the country for the 7th year in the last 8 years. We had suffered a small drop last year, but the work we have put in has achieved the desired effect. 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 in-patient stay. Results are benchmarked with other Trusts in England. | **Improvements planned** | Embedding Teach back, to make sure patients know exactly what their discharge summary means, and what to expect from their medication<br><br>Embed a generic discharge summary with clear instructions and information | |
| **LHCH Performance 2013/14** | 82.3% | **LHCH Performance 2012/13** | 78.2% | |
| **Interpretation of Results** | We have seen an improvement in our responsiveness to patient's needs. Patient and family centred care has now been implemented for a year, and we start to see the results as patients reflect their satisfaction with the care received at the Trust. However, as we keep this as one of our objectives, we will continue to embed the systems in place and work towards further improvements. | | | |

**Mandatory indicators from Risk Assessment Framework**

| Indicator | Target 2012/13 | Performance 2013/14 |
|---|---|---|
| Maximum time of 18 weeks from point of referral to treatment in aggregate-admitted | 90% | 90.37% |
| Maximum time of 18 weeks from point of referral to treatment in aggregate- non admitted | 95% | 96.5% |
| Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway | 92% | 95.98% |
| All cancers: 62 day wait for first treatment from:<br>• Urgent GP referral for suspected cancer<br>• NHS cancer screening service referral | <br>79% #<br>90% | <br>88.93%<br>N/A |
| All cancers: 31 day wait for second or subsequent treatment comprising:<br>• Surgery<br>• Anti-cancer drug treatments<br>• Radiotherapy | <br>94%<br>98%<br>94% | <br>100%<br>N/A<br>N/A |
| All cancers: 31 day wait from diagnosis to first treatment | 96% | 98.81% |
| Cancer: two week wait from referral to date first seen, comprising:<br>• All urgent referrals (cancer suspected) | <br>93% | <br>97.92% |
| Data completeness: community services comprising:<br>• Referral to treatment information<br>• Referral information<br>• Treatment activity information | <br>50%<br>50%<br>50% | <br>N/A<br>99.75%<br>100% |

# Trust has a locally agreed lower threshold with Monitor and Commissioners

# Annex 1: Statements of Commissioners, local Healthwatch, and Overview & Scrutiny Committees

## Statement for the Liverpool Clinical Commissioning Group

*Liverpool CCG welcomes the opportunity to comment on Liverpool Heart and Chest Hospital NHS Foundation Trust Quality Account for 2013/14, since the national introduction of Quality Accounts.*

*As Lead Commissioner of care services and on behalf of our co-commissioning CCGs and the local population, we believe this Quality Account demonstrates a commitment to quality improvement and high quality services. NHS England "Everyone Counts: Planning for Patients 2014-15 to 2018/19" sets out NHS England ambitions and commitment in ensuring high quality care for all, now and for future generations and describes quality as spanning three areas: safe, effective and personalised care. This Quality Account provides an overview of these areas and presents a true reflection of the provider's achievement of quality of service delivery against the backdrop of a changing NHS. Delivering care and treatment in an organisation with a wide range of services requires commitment to continuously monitor and deliver high quality patient care.*

*Liverpool CCG along with our Co-Commissioning CCGs is aspiring through strategic objectives and 5 year plans to develop an NHS that delivers great outcomes, now and for future generations. That means reflecting the Government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and paramount to our success.*

*The CCG recognises that the Trust acknowledges that improvements are required in certain areas and have referenced these in the report. The CCG looks forward to the implementation of these schemes to enhance the quality of service delivered.*

*The CCG looks forward to the implementation of these schemes to enhance the quality of service delivered. With the quality systems and programmes Liverpool Heart and Chest NHS Foundation Trust has demonstrated, and the introduction of improvements, Liverpool CCG and co-commissioning CCG are confident that patient safety, clinical effectiveness and patient experience on the whole, is a positive encounter whilst under the care and treatment of the NHS.*

*Liverpool CCG is pleased to note the extensive engagement and consultation with stakeholders that led up to the publication of this Quality Account and commend the Trust for taking its responsibilities for engagement seriously.*

*The CCG enjoys a conducive and productive working relationship with the Trust and looks forward to continuing this collaborative approach and to strive for excellence and deliver high quality care and treatment to our local population.*

Katherine Sheerin 27 May 2014

**Katherine Sheerin**
**Chief Officer**

## Statements from Healthwatch

***Commentary by Healthwatch Wirral for Liverpool Heart and Chest Hospital NHS Foundation Trust Quality Account 2013/14***

***Report reviewed was Quality Account 2013/14 Final draft***
*Healthwatch Wirral would like to thank Liverpool Heart and Chest Hospital NHS Foundation Trust for the opportunity to comment on the Quality Account for 2013/14.*

*Healthwatch Wirral were invited to attend a focus group on 27th February to comment on the Trust's priorities and the Quality Account group met on 6th May to compile this statement. We also congratulate the Trust on being awarded the Patient Experience Network National Awards (PENNA) for overall care and for "Support for Caregivers' for the 'Development of a Nursing Model of Care for Patient and Family Centered Care'.*

*It is commendable that the Trust has been voted the best provider in the country for overall patient care for 7th time in 8 years. The Trust's extensive consultation with staff, Foundation Trust membership, patients, carers, commissioning bodies and others ensures focus on aspects of quality improvement will bring benefit to the people who use their services.*

***Review of priorities from 2013/14***

***Friends and Family Test.***
*It was good to note that the Trust had exceeded its target of 90% in the Friends and Family Test net promoter score.*

***Communications to General Practitioners at the Point of Discharge.***
*This target was partially achieved. Healthwatch Wirral noted that, to reach the target in the future, will depend on the co-operation of all GP practices taking part in the electronic discharge project. The number of practices included in the project was unclear and there*

*were significant amount of 'missing data' on current discharge communications to GP's, especially diagnosis.*

***Development and Implementation of a Health Economy Wide Discharge Checklist.***
*Healthwatch Wirral felt that this was a good initiative and would be beneficial to both staff and patients.*

***Reduce Pressure Ulcers across the Health Economy***
*We were concerned to note that the Trust did not achieve its target of a 25% reduction in pressure ulcers across the Health economy and would encourage a collaborative approach with other providers to focus the health and social care economy on zero harm in 2014/15. It was gratifying to read that there had been a marked reduction in the number of grade 2 and grade 3 pressure ulcers in the last 6 months.*

***Priorities for 2014/15***
***To ensure that patients with Dementia are identified and assessed whilst under our care and are referred to their GP for investigation at discharge.***
*Healthwatch Wirral were impressed with the assessment/referral process and also the initiatives and key projects planned.*

***Reduce Pressure Ulcer Development.***
*It is commendable that the Trust will work with clinical teams to ensure that they have access to the best support, training and resources to facilitate a 50% reduction in the development of Hospital acquired Pressure Ulcers of Grade 2 and above.*
*Healthwatch Wirral were pleased that Trust will deliver a project to display information about Pressure Ulcer Development in an open and transparent way at the entrance to wards. This initiative will enable patients and their families to see how each area is delivering on the Trust's ambition to drive down the development of pressure ulcers. There is considerable work identified in relation to pressure ulcers and Healthwatch Wirral would like to see evidence of sharing and learning from good practice.*

***Reduce the number of patient falls.***
*Healthwatch Wirral noted that none of the falls had resulted in any serious harm to patients and felt that the information about falls being displayed at ward entrances is good practice.*

***Goals Agreed with Commissioners***
*The CQUINS (Commissioning for Quality and Innovation) for 2013/14 and 2014/15 were noted.*

***What others say about the Provider***
*Healthwatch Wirral noted the CQC visit report and would like assurances that the detailed action plan produced after the CQC final report on 7th February 2014 has been implemented.*

***Metrics against Department of Health Quality Indicators***
***Readmission within 28 days.***
*Healthwatch Wirral thought that this was a good initiative and showed good practice by introducing a direct line for patients following discharge.*

***Staff recommending the Trust to family and friends.***
*The trust had remained at the same level of 92% over the last two years. Although this is a very good achievement Healthwatch Wirral were impressed that Liverpool Heart and Chest Hospital are taking actions to improve this percentage.*

***Venous thromboembolism (VTE) assessment.***
*Healthwatch Wirral would like to see increased reporting to reduce incidents of severe harm or death.*
*The Quantitative Metrics and Mandatory indicators from Risk Assessment Framework were noted.*

*Healthwatch Wirral look forward to receiving reviews from the Trust on progress with the implementation of the Quality Account.*

***Karen Prior***
***Healthwatch Wirral Manager***
***On behalf of Healthwatch Wirral***

**Statement from the Host Overview & Scrutiny Committee**

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

*This Committee has met twice throughout the year.*
*We have reviewed the Quality Accounts for 2013/14 for the Trust and are confident they represent a true account of the performance of the Trust based on the audited figures presented.*

*The Annual Public Meeting was 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.*
*At this meeting a selection of work was selected to be considered by the Clinical Directorate for the coming year.*

*Concerns were again raised regarding financial constraints 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, o the problems of the year ahead, and we are assured that at present, there is no impact to the quality of care to the patients.*

**Ken Blasbery**
**Chairman of the Quality Account Task and Finish Group**

## Acknowledgements

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

- Clinical and managerial staff of the Liverpool Heart & Chest Hospital NHS Foundation Trust

- Clinical Commissioning Groups:
    - Halton Clinical Commissioning Group
    - Liverpool Clinical Commissioning Group
    - Wirral Clinical Commissioning Group
    - St Helens Clinical Commissioning Group
    - Knowsley Clinical Commissioning Group

- The Council of Members Quality, Safety & Patient Experience Subgroup:
    - Ken Blasbery
    - David Hicks
    - Vera Hornby
    - Debbie Mawson
    - Brian Roberts
    - Tony Roberts
    - Roy Stott
    - Judy Wright
    - Menna Wyn-Harland
    - Dr Saad Al Shukri
    - Paula Pattullo
    - Michael Brereton
    - Denis Bennett
    - Mike Bowyer
    - Roy Griffiths
    - Trish Bennett
    - Glenda Corkish

- Attendees at the Quality Account priorities focus group (drawn from the Trusts membership and non-executive directors):
    - Audrey Meacock, Healthwatch Wirral
    - Keith Wilson, member of SURE group
    - Sam Semoff, member of SURE group
    - Dr Saad Al Shukri, Council of Governors
    - Michelle Laign, Liverpool John Moore University
    - Gaynor Hales, NHS England, Merseyside
    - Pauline Sinnott, Halton Health Scrutiny Board
    - Geof Zygadllo, Halton Health Scrutiny Board
    - Ken Blasbery, Council of Governors
    - Lesely Davies, Healthwatch

    - David Hicks, Council of Governors
    - Dilys Quinlan, Knowsley Clinical Commissioning Group
    - Brian Roberts, Council of Governors
    - Denis Bennett, Council of Governors
    - Arthur Newby, volunteer, member of SURE group
    - Kath Griffiths, LHCH support group
    - Roy Griffiths, Council of Governors
    - Tony Roberts, Council of Governors
    - Graham Deacon, member of SURE group

- Local Healthwatch Members:
    - Liverpool: Lesley Davies
    - Wirral: Audrey Meacock
    - Knowsley: Paul Mavers
    - Sefton: Diane Blair
    - St Helens: Gerry O'Connell

- Host Overview and Scrutiny Committee:
    - Peter Seddon, Legal Services, Liverpool City Council

- Patients, carers and members of the public who have participated in our programme of surveys, focus groups and medicine for members events.

## How to Provide Feedback on the Quality Account

Liverpool Heart & 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:
Mrs Sue Pemberton, Director of Nursing and Quality
(E-mail sue.pemberton@lhch.nhs.uk or telephone 0151 600 1249).

# 6. Our Staff

As of March 31st 2014, the Trust employed 1430 staff totalling 1308.1 whole time equivalents.

Staff continue to deliver outstanding levels of patient care during a challenging time for the NHS.

### Our Vision for Staff

During 2013, 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.

## 6.1 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: 'Sun Awareness' through the Ivan facility on site, 'STOPTOBER' and 'Dry January'.

### 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 on-going initiative. The response to this campaign has been positive. The last figures submitted showed that over 69% 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, the key activities are detailed below:

- **Cycling**: The Trust supports national cycle week and encourages employers to cycle for physical activity and health and also mode of commute to the workplace.

  In addition there are a number of 'Cycle Doctor' sessions throughout the year where staff can have their bikes checked and maintained to support and encourage long term cycling. A cycle first aid kit is held onsite and is available to staff to carry out emergency repairs to their cycles with a comprehensive tool/repair kit and items available also include emergency back-up batteries for bike lights.

  A 'get home guarantee' operates where employees who cycle to the workplace that may require a taxi home for urgent/emergency situations have the reassurance that taxi fare is available. Finally, there are cycle shower facilities with lockers and two cycle storage areas that are available to employees.

- **Walking/running:** Walk to work week is supported by the Trust and includes challenges and signposting to community based walking groups.

  There is an onsite signposted walking route of various distances that is accessible to all staff and is promoted to encourage walking and physical activity within the workplace. Further, local walking groups and walk for health schemes within the local community are promoted to staff and their families. For employees wanting a further challenge, a running club is available once a week to support beginners.

- **Onsite staff gym:** Staff have access to an onsite gym facility that is accessible 24 hours a day. In addition, employees can access health/fitness advice, monitoring and assessment including body composition, BMI, body weight, hydrations levels, strength, fitness and flexibility.

### 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.

## 6.2 Recognising our Talented Staff

Our fourth annual awards evening for 'Our Team's Got Talent' was held on Friday 7th June at the Crowne Plaza in Liverpool City Centre. 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 Cath Lab Primary PCI Team
- Outstanding Example of the Patient Vision in Action Award to the Day Ward
- Going Above and Beyond Award to the Infection Prevention Team
- Outstanding Example of Putting Patients First Award to the Aortic Team

- Governors' Award to the Little and Often Support Group
- Chairman's Award to the Research Team

## 6.3 Learning and Development

In December 2013, a new education strategy was agreed with a strong focus on the delivery of Inter-professional Learning. An Education Governance Committee (The Strategic Education Board) has been set up to ensure effective implementation of the strategy and the Learning and Development Department has been rebranded as The Education Centre to reflect these important changes. The Trust is also working in partnership with Edge Hill University to develop its own cardiothoracic degree pathway. The pathway will be open to all interprofessional staff in the Trust and is expected to be rolled out to external staff in 2014/5 thus enhancing the Trust's ambition to be a leader in the delivery of cardiothoracic education.

In 2013/4, The Trust received national recognition and was identified as an exemplar site for the development opportunities it provides for Healthcare Assistants (HCAs). By May 2014 all HCAs would have undertaken the internal HCA Development Programme which has a strong focus on Patient and Family Centred Care with a drive to keep our patients Safe from Harm. This ensures full compliance with government recommendations for the introduction of a certificate of fundamental care for HCAs ahead of a planned schedule for implementation. In addition, our Junior Doctor education programme "The Effective Doctor" has received praise from the Deanery and is due to be presented at a national conference. Innovative approaches to optimising the student learning experience across the multi-professional workforce has shown a month by month increase in student engagement, generated strong positive feedback and received recognition both at national and international conference.

In support of a stronger focus on trust values and behaviours, the induction process has been fully revised. A "Market Place" approach has been implemented to the Corporate Induction Programme which facilitates greater interaction between subject experts and our new staff providing a much improved "welcome" to the Trust.

A new Education Centre website has also been launched to significantly improve communication and increase staff awareness of the development opportunities available to them. The website can also be accessed externally and will improve the Trust's reputation as a leader in the delivery of education.

## 6.4 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 2013 which saw the Trust's engagement score rise from 3.92 to 3.97 placing LHCH 7th out of all the Acute and Specialist Acute Trusts who took part in the survey.

The survey also provides good evidence of our continuous improvements over recent years and we are delighted that we had the lowest score of all specialist acute and acute Trusts in the following key areas:

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

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

| Year | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|
| Response Rate | 63% | 64% | 63% | 62% | 55% |
| % of staff agreeing appraisal helped them to do job better | 57% | 61% | 63% | 69% | 60% |
| % of staff agreeing they feel satisfied with quality of work and patient care they are able to deliver | 84% | 85% | 83% | 85% | 85% |
| % of staff who would be happy for a friend or relative to be treated at LHCH | 89% | 88% | 91% | 92% | 92% |
| Staff agreeing they are satisfied with their job (maximum score = 5) | 3.55 | | | 3.72 | 3.76 |
| % of staff who would recommend LHCH as a place to work | 64% | 59% | 62% | 72% | 74% |
| Overall Staff Engagement Score (out of 5) | 3.78 | 3.80 | 3.85 | 3.92 | 3.97 |

| | 2012 | | 2013 | | |
|---|---|---|---|---|---|
| **Top 4 Improved Scores** | **Trust** | **National Average** | **Trust** | **National Average** | **Trust Improvement** |
| KF26. % having equality and diversity training in last 12 months | 55.2% | 56% | 60% | 60% | 4.8% |
| KF14. % reporting errors, near misses or incidents witnessed in the last month | 87.5% | 90% | 90% | 90% | 2.5% |
| KF4. Effective team working | 75.5% | 74.4% | 77% | 75% | 1.5% |
| KF6. % receiving job-relevant training, learning or development in last 12 months | 81.6% | 81% | 83% | 81% | 1.4% |

| | 2012 | | 2013 | | |
|---|---|---|---|---|---|
| Top 4 Deteriorated Scores | **Trust** | **National Average** | **Trust** | **National Average** | **Trust Deterioration** |
| KF12. % saying hand washing materials are always available | 73% | 59% | 64% | 59% | 8.2% |
| KF5. % working extra hours | 63% | 70% | 67% | 70% | 3.7% |
| KF7. % appraised in last 12 months | 89 % | 82% | 87% | 84% | 2.8% |
| KF10. % receiving health and safety training in last 12 months | 79% | 74% | 78% | 76% | 1.9% |

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 internal surveys.

### Workforce key performance indicators

Sickness absence performance has improved in 2013/14 and is below 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.

Appraisal and mandatory training performance is slightly below target at the end of the year, but we anticipate that this target will be improved during 2014/15.

Turnover is 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 2013/14 | Turnover | Mandatory Training | Appraisal |
|---|---|---|---|---|
| 1430 | 3.34% | 8.4% | 85% | 75% |
| Target | 3.6% | 9% | 95% | 85% |

## 6.5 Corporate Social Responsibility

Delivery of apprenticeships continues at the Trust in support of its pledge to ensure all staff have the opportunity to gain a minimum level 2 qualification.

The Access to Medicine Programme's third cohort started in February 2014 with a record number of 37 students form the local area accessing it. The Programme has received significant praise from Health Education North West (HENW) and will be formally evaluated as part of a national project on Widening Participation. Early indications from last year's programme show that over ten students have gained access into Medical School.

The Trust is also offering dementia friends training to its local community, working alongside Dementia Action Alliance Liverpool to support their work in making Liverpool a Dementia Friendly Community.

## 6.6 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 (EDHR) 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), 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:

1. Patients, carers and communities can readily access services and should not be denied access on unreasonable grounds
2. 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
3. Staff are free from abuse, harassment and bullying violence from patients their relatives and colleagues, with redress being open and fair to all
4. 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.

| | 2012/13 | % | 2013/14 | % |
|---|---|---|---|---|
| **Age Band** | | | | |
| 16 - 20 | 6 | 0.42% | 1 | 0.07% |
| 21 - 25 | 116 | 8.08% | 93 | 6.50% |
| 26 - 30 | 149 | 10.38% | 154 | 10.77% |
| 31 - 35 | 174 | 12.12% | 151 | 10.56% |
| 36 - 40 | 210 | 14.62% | 209 | 14.62% |
| 41 - 45 | 206 | 14.35% | 191 | 13.36% |
| 46 - 50 | 233 | 16.23% | 216 | 15.10% |
| 51 - 55 | 195 | 13.58% | 222 | 15.52% |
| 56 - 60 | 88 | 6.13% | 110 | 7.69% |
| 61 - 65 | 43 | 2.99% | 54 | 3.78% |
| 66 - 70 | 15 | 1.04% | 25 | 1.75% |
| 71 & above | 1 | 0.07% | 4 | 0.28% |
| | | | | |
| **Gender** | | | | |
| Male | 384 | 26.74% | 369 | 25.80% |
| Female | 1,052 | 73.26% | 1,061 | 74.20% |
| Transgender | | | | |
| | | | | |
| **Recorded Disability** | | | | |
| | 40 | 2.79% | 42 | 2.94% |
| | | | | |
| **Sexual Orientation** | | | | |
| Bisexual | 5 | 0.35% | 6 | 0.42% |
| Gay | 6 | 0.42% | 8 | 0.56% |
| Heterosexual | 892 | 62.12% | 939 | 65.66% |
| I do not wish to disclose | 148 | 10.31% | 158 | 11.05% |
| Lesbian | 3 | 0.21% | 5 | 0.35% |
| Undefined | 382 | 26.60% | 314 | 21.96% |

| | 2012/13 | % | 2013/14 | % |
|---|---|---|---|---|
| **Religion or Belief** | | | | |
| Atheism | 81 | 5.64% | 94 | 6.57% |
| Buddhism | 5 | 0.35% | 9 | 0.63% |
| Christianity | 738 | 51.39% | 759 | 53.08% |
| Hinduism | 12 | 0.84% | 16 | 1.12% |
| I do not wish to disclose | 144 | 10.03% | 156 | 10.91% |
| Islam | 13 | 0.91% | 18 | 1.26% |
| Jainism | 1 | 0.07% | | 0.00% |
| Judaism | 2 | 0.14% | 2 | 0.14% |
| Other | 57 | 3.97% | 59 | 4.13% |
| Sikhism | 1 | 0.07% | 3 | 0.21% |
| Unspecified | 362 | 25.56% | 314 | 21.96% |
| | | | | |
| **Ethnic Origin** | | | | |
| White - British | 1,217 | 84.75% | 1,213 | 84.83% |
| White - Irish | 22 | 1.53% | 22 | 1.54% |
| White - Any other White background | 30 | 2.09% | 34 | 2.38% |
| Mixed - White & Black Caribbean | 1 | 0.07% | 2 | 0.14% |
| Mixed - White & Black African | 2 | 0.14% | 5 | 0.35% |
| Mixed - White & Asian | 3 | 0.21% | 4 | 0.28% |
| Mixed - Any other mixed background | 3 | 0.21% | 3 | 0.21% |
| Asian or Asian British - Indian | 98 | 6.82% | 97 | 6.78% |
| Asian or Asian British - Pakistani | 7 | 0.49% | 8 | 0.56% |
| Asian or Asian British - Any other Asian background | 9 | 0.63% | 7 | 0.49% |
| Black or Black British - Caribbean | 2 | 0.14% | 2 | 0.14% |
| Black or Black British - African | 13 | 0.91% | 9 | 0.63% |
| Black or Black British - Any other Black background | 2 | 0.14% | 1 | 0.07% |
| Chinese | 6 | 0.42% | 6 | 0.42% |
| Any Other Ethnic Group | 8 | 0.56% | 8 | 0.56% |
| Undefined | 5 | 0.35% | | 0.00% |
| Not Stated | 8 | 0.56% | 9 | 0.63% |
| | | | | |
| **Total** | **1,416** | | **1,430** | |

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. Engagement events are also facilitated and views are sought from people who are seldom heard.

The Trust recognises that hard to reach groups do not often respond to surveys and therefore a variety of methods are used 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.

Partnerships have been developed 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. Patients and members of the public with different needs and certain protected characteristics are encouraged to volunteer with the Trust as part of its scheme, which helps people participate in public life.

# 7. Other disclosures in the public interest

**Consultations**

There have been no public consultations during 2013/14 and none are planned for the forthcoming year.

# 8. Statement of Accounting Officer's Responsibilities

**Statement of the chief executive's responsibilities as the accounting officer of Liverpool Heart and Chest Hospital NHS Foundation Trust**

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by 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;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; 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*.

Jane Tomkinson
Chief Executive
Date: 27th May 2014

# 9. 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 on-going 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 2014 and up to the date of approval of the annual report and accounts.

## Capacity to Handle Risk

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 and Quality who is supported by the Head of Governance.

The Risk Management Strategy and Policy provides a framework for managing risks across the organisation. Its aim is to enhance and reinforce a culture of candour, 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, business continuity and emergency planning. The Corporate Readiness Committee periodically 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.

These committees of the Board triangulate their work to ensure all significant risk is properly reviewed and managed according to the Board's appetite for 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 participation in 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.

Risk is routinely monitored from ward to Board.

The directorate governance structures facilitate organisational learning and enable the sharing of 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), the Central Alerting System (CAS) 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 test 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 and included 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 implemented 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.

Data quality and data security risks are managed and controlled via the risk management system with assurances provided to the Corporate Readiness Committee. Independent assurance is provided by the Payment by Results Data Assurance Framework Review by external audit and the information governance self-assessment review by internal audit; both are received by the Audit Committee.

Information governance is managed through the board assurance framework process which includes Executive accountability and a clear performance monitoring and management process via the Information Management and Technology Programme Board. The Trust's Information Governance Toolkit submission is reviewed by independent auditors and has received a significant assurance opinion for the v11 submission. However, the Trust has declared a level 1 for this year (73%) as a consequence of a shortfall in Information Governance training. All other standards have been met fully.

The Trust has had one reportable Information Governance Serious Incident Requiring Investigation during March 2014 relating to lost or stolen paperwork. The incident was reported to the Information Commissioner's Office and all data subjects involved were informed. The Information Commissioner has advised the Trust that no enforcement action is to be taken.

The Trust has in place a rigorous process for assessing compliance with the CQC standards across all services and assurance is enhanced through regular walkarounds conducted by members of the Board and Governors.

The Trust received its annual unannounced inspection from the Care Quality Commission in November 2013 and minor compliance issues were identified for Outcome 9 relating to standards for the management of medicines. An action plan was agreed with the CQC and has been quickly and fully delivered resulting in confirmation from the CQC that the Trust is now compliant with Outcome 9. In respect of four other outcomes reviewed as part of this inspection, the Trust was found to be fully compliant.

In February 2014, the Trust received a responsive visit from the CQC in relation to concerns raised by staff in critical care. The inspection focused on Outcome 13 – staffing, Outcome 14 - supporting workers, and Outcome 16 – monitoring the quality of service provision. Two minor concerns have been raised by the CQC in relation to Outcome 14 supporting workers and Outcome 16 monitoring the quality of service provision with a moderate concern attached to Outcome 13, staffing. A detailed and comprehensive action plan has been devised and has been shared with the CQC including engagement events and the appointment of an external facilitator for 6 months. The Trust has immediately taken action to improve staff engagement in critical care and will launch a 'Speak out Safely' campaign on 1st April 2014 to further support staff to raise and address areas of concern internally. The

Board is satisfied that these concerns have not impacted adversely on clinical outcomes or patient experience.

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

In relation to compliance with the NHS foundation trust condition 4 (FT governance), the Trust has undertaken a review of its governance arrangements with support from internal audit and external due diligence secured by KPMG as external advisors. As a result of this review, the Board Committee structure will be refreshed in 2014/15 to ensure alignment with best practice and ensure the Trust's processes are future-proof. A new Assurance Committee structure, chaired by non-executive directors will provide a stronger focus on assurance and data integrity in respect of quality and integrated performance and align to the challenge that Monitor, the independent regulator, has posed to the FT sector in respect of the quality of strategic planning. The Board has set aside designated strategic planning days within its annual business cycle. There will be a clearer distinction between assurance and operational management.

The Board Assurance Framework will also be refreshed to add greater value to the work of the Board as a tool for monitoring regulatory and legal compliance and risks to delivery of strategic plans. The Board Assurance Framework will clearly identify the evidence required by the Board to validate its Corporate Governance Statement and the work of the Committees will ensure the integrity of this evidence.

The Board undertook a detailed review compliance with the provider licence in 2013/14 and has introduced a monitoring process for on-going review by the Audit Committee.

## Key In-Year Risks:

i) The Trust received limited assurance reports from internal audit in respect recruitment and also its payroll service which is outsourced to a third party. The Trust has escalated its performance management process around delivery by the contractor and put in place additional control systems managed directly by the Trust; the Trust is actively pursuing contractual remedy.

ii) Whilst the Trust has achieved compliance in aggregate with the 18 week 'Referral to Treat' target, compliance was breached at specialty level in respect of the admitted patient pathway at Quarter 2. This was a planned breach that facilitated a reduction in the backlog of patients waiting for treatment. Specialty compliance was achieved at Quarter 3.

iii) In 2013/14, the Trust's efficiency target was set at £4.1m and is forecast to be delivered, albeit with a risk of £0.89m which has been achieved non-recurrently and will therefore carry forward to 2014/15.

iv) As previously noted, minor compliance issues were identified by the CQC in relation to the management of medicines. These have now been addressed. A comprehensive action plan is in place in relation to the CQC's concerns relating to critical care (Outcomes 13,14 and 16 as outlined above);

v) The Trust successfully managed the implementation of a significant change programme in relation to the electronic patient record in collaboration with its commercial partner, Allscripts. Realisation of significant benefits in relation to quality and outcomes, patient safety and staff experience are anticipated going forwards.

## Future Risks:

i) Through its financial planning process, the Trust has identified an efficiency requirement of circa £10m over the 2 year operational period (2014/15 – 2015/16). The Trust has an historical track record of delivering its financial plans and meeting efficiency requirements. Through the provision of external advice and support, the Trust will ensure its structures and processes are capable of delivering the future challenges.

ii) Given NHS England's requirement to see a reduction in the number of specialised centres, the Trust continues to work collaboratively with its key stakeholders, including district general hospitals to ensure clinical service sustainability.

iii) Within the financial plans set, the Trust has accommodated commissioning intentions in respect of repatriation of activity to Wales.

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

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

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

## Review of Economy, Efficiency and Effectiveness of the Use of Resources

The financial plan is approved by the Board and submitted to Monitor. The plan, including forward projections, is monitored in detail by the Finance Committee, a formal Committee of the Board on a monthly basis with key performance indicators and Monitor metrics additionally reviewed by the Board. 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*.

The Trust's goal is to deliver the best outcomes and be the safest integrated healthcare organisation in the country and throughout 2013/14 consultation work with patients, families, carers, Governors, Foundation Trust members and other health and social care professionals on the identification of priorities to support this goal has continued.

A number of internal and external consultation events have successively refined the decision making processes by which quality priorities are selected. The final selection has emerged from a synthesis of priorities contributed from:

i) Staff delivering frontline services who know where improvements need to be made

ii) 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)

iii) The Quality Account Task and Finish Council of Governors sub-group, who are continuously identifying priorities from the Trust's 10,000 public members

iv) Members and the general public, who have provided suggestions for improvement throughout the year via patient and family engagement events, focus groups, feedback from the friends and family test and member engagement events

v) Healthwatch involvement in patient engagement events and attendance at the patient and family experience committee

vi) Issues raised by patients arising from both national and local surveys.

vii) Key stakeholders including Governors, Healthwatch, our staff, Executive Team, and our members met in February 2014 to discuss the priorities for 2014/15. Priorities were shortlisted by the Executive Team, discussed with Governors and approved by the Board of Directors.

The Trust has as annual external audit of the Quality Account, confirming the reporting of a balanced view of the Trust's performance on quality.

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 recently revised dashboards at Directorate and Ward level which helps staff maintain focus on the Trust's overall priorities for quality and safety. In 2014/15, the Trust will launch electronic monitors at the entrance to all wards which will display quality information and staffing levels for patients and families.

## 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.

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.

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.

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, and its Standing Committees. 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

There were no significant control issues identified in 2013/14, however during the year the Trust has improved Medicines management processes and is working actively to address actions required in critical care.

Jane Tomkinson
Chief Executive Date: 27th May 2014

# 10. Annual Accounts

**Directors' Responsibility for Preparing Financial Statements**
The directors of the Trust consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

## 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;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; 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.

**Jane Tomkinson**
Chief Executive
Date: 27th May 2014

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

Summarisation schedules numbers FTC01 to FTC41 and accompanying WGA sheets for 2013/14 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 2013/14 issued by Monitor.

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

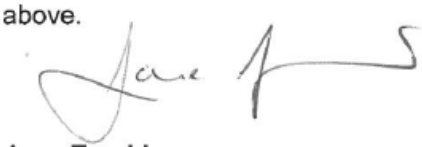
3. I certify that the information in the FTC schedules is consistent with the financial statements of the NHS Foundation Trust.

**David Jago**
Chief Finance Officer
27th May 2014

## 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.



**Jane Tomkinson**
Chief Executive
27th May 2014

**Data entered below will be used throughout the workbook:**

| | |
|---|---|
| Trust name: | Liverpool Heart and Chest Hospital NHS Foundation Trust |
| This year | 31st March 2014 |
| Last year | 31st March 2013 |
| This year ended | 31st March 2014 |
| Last year ended | 31st March 2013 |
| This year commencing: | 1st April 2013 |

## Foreword

The accounts for the year ended 31st March 2014 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.

**Jane Tomkinson**
Chief Executive
27th May 2014

## CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31st March 2014

| | | Group | | Trust | |
|---|---|---|---|---|---|
| | NOTE | **2013/14 £000** | 2012/13 £000 | **2013/14 £000** | 2012/13 £000 |
| **Revenue** | | | | | |
| Operating income | 6 | **103,971** | 105,432 | **103,971** | 105,432 |
| Other operating revenue | 7 | **10,476** | 6,624 | **9,992** | 6,604 |
| Operating expenses | 11 | **(111,161)** | (113,236) | **(110,609)** | (112,788) |
| **Operating surplus (deficit)** | | **3,286** | (1,180) | **3,354** | (752) |
| **Finance costs:** | | | | | |
| Investment revenue | 17 | **53** | 91 | **40** | 74 |
| Finance costs | 19 | **(47)** | (57) | **(47)** | (57) |
| Share of profit/(loss) of joint ventures | 24 | **(44)** | 0 | **(44)** | 0 |
| **Surplus/(Deficit) for the financial period** | | **3,248** | (1,146) | **3,303** | (735) |
| Public dividend capital dividends payable | | **(1,866)** | (1,747) | **(1,866)** | (1,747) |
| **Retained surplus/(deficit) for the period** | | **1,382** | (2,893) | **1,437** | (2,482) |
| **Other comprehensive income** | | | | | |
| Revaluation gains/(losses) and impairment losses on property, plant and equipment | 23.1 | **2,492** | (266) | **2,492** | (266) |
| Fair Value gains/(losses) on Available-for-sale financial investments | 24.3 | **3** | 27 | **0** | 0 |
| **Total comprehensive income for the period** | | **3,877** | (3,132) | **3,929** | (2,748) |

Income and Operating Surplus are derived from the Group's continuing operations.

The notes on pages 133 to 172 form part of these accounts.

The Trust has revalued its Estate at 31st March 2014, as a consequence:

Operating income includes a reversal of previous impairments of £2.622m.

Operating expenses includes an impairment of (£1.291m).

The normalised surplus position before these movements reported to Monitor the independent regulator of NHS Foundation Trusts is £105k.

## CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT 31st March 2014

| | | Group | | | Trust | | |
|---|---|---|---|---|---|---|---|
| | NOTE | **31st March 2014** £000 | 31st March 2013 £000 | 01st April 2012 £000 | **31st March 2014** £000 | 31st March 2013 £000 | 01st April 2012 £000 |
| **Non-current assets** | | | | | | | |
| Property, plant and equipment | 21 | **69,340** | 63,739 | 61,590 | **69,340** | 63,739 | 61,590 |
| Intangible assets | 22 | **857** | 992 | 995 | **857** | 992 | 995 |
| Investments | 24 | **508** | 249 | 222 | **6** | 0 | 0 |
| **Total non-current assets** | | **70,705** | 64,980 | 62,807 | **70,203** | 64,731 | 62,585 |
| **Current assets** | | | | | | | |
| Inventories | 28 | **2,542** | 2,557 | 2,899 | **2,541** | 2,557 | 2,899 |
| Trade and other receivables | 29 | **4,103** | 3,946 | 3,628 | **4,221** | 3,916 | 3,655 |
| Cash and cash equivalents | 32 | **12,070** | 16,150 | 19,696 | **10,906** | 14,790 | 17,479 |
| | | **18,715** | 22,653 | 26,223 | **17,668** | 21,263 | 24,033 |
| Non-current assets held for sale | 33 | **6** | 0 | 0 | **6** | 0 | 0 |
| **Total current assets** | | **18,721** | 22,653 | 26,223 | **17,674** | 21,263 | 24,033 |
| **Total assets** | | **89,426** | 87,633 | 89,030 | **87,877** | 85,994 | 86,618 |
| **Current liabilities** | | | | | | | |
| Trade and other payables | 34 | **(13,889)** | (16,204) | (14,875) | **(13,868)** | (16,145) | (14,427) |
| Borrowings | 35 | **(195)** | (219) | (287) | **(195)** | (219) | (287) |
| Provisions | 41 | **(358)** | (1,157) | (917) | **(358)** | (1,157) | (917) |
| Other liabilities | 42 | **(2,082)** | (788) | (1,622) | **(2,082)** | (788) | (1,622) |
| **Net current assets/(liabilities)** | | **2,197** | 4,285 | 8,522 | **1,171** | 2,954 | 6,780 |
| **Total assets less current liabilities** | | **72,902** | 69,265 | 71,329 | **71,374** | 67,685 | 69,365 |
| **Non-current liabilities** | | | | | | | |
| Borrowings | 35 | **(538)** | (732) | (798) | **(538)** | (732) | (798) |
| Provisions | 41 | **(105)** | (396) | 0 | **(105)** | (396) | 0 |
| Other liabilities | 42 | **(983)** | (738) | 0 | **(983)** | (738) | 0 |
| **Total assets employed** | | **71,276** | 67,399 | 70,531 | **69,748** | 65,819 | 68,567 |
| **Financed by taxpayers' equity:** | | | | | | | |
| Public dividend capital | | **62,799** | 62,799 | 62,799 | **62,799** | 62,799 | 62,799 |
| Retained earnings | | **(4,887)** | (6,379) | (4,039) | **(4,887)** | (6,379) | (4,039) |
| Revaluation reserve | | **11,836** | 9,399 | 9,807 | **11,836** | 9,399 | 9,807 |
| NHS Charitable Funds reserve | 51 | **1,528** | 1,580 | 1,964 | **-** | - | - |
| **Total taxpayers' equity** | | **71,276** | 67,399 | 70,531 | **69,748** | 65,819 | 68,567 |

The financial statements and notes on pages 129 to 187 were approved by the Board on and signed on its behalf by:

Signed: ..... (Chief Executive) Date: 23rd May 2014

## CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

| Group | NHS Charitable Funds reserve £000 | Public dividend capital (PDC) £000 | Retained earnings £000 | Revaluation reserve £000 | Total £000 |
|---|---|---|---|---|---|
| **Changes in taxpayers' equity for 2013-14** | | | | | |
| **Balance at 1st April 2013** | **1,580** | **62,799** | (6,379) | **9,399** | **67,399** |
| Total Comprehensive Income for the period: | | | | | |
| Retained surplus/(deficit) for the period | **177** | **0** | **1,205** | **0** | **1,382** |
| Net gain on revaluation of property, plant and equipment | **0** | **0** | **0** | **2,492** | **2,492** |
| Net gain on revaluation of intangible assets | **0** | **0** | **0** | **0** | **0** |
| Net gain on revaluation of financial assets | **0** | **0** | **0** | **0** | **0** |
| Net gain on revaluation of Charitable Fund assets | **0** | **0** | **0** | **0** | **0** |
| Impairments and reversals | **0** | **0** | **0** | **0** | **0** |
| Fair value gains/(losses) on available for sale financial investments | **3** | **0** | **0** | **0** | **3** |
| Transfer to retained earnings on disposal of assets | **0** | **0** | **11** | (11) | **0** |
| Movements on other reserves | (232) | **0** | **232** | **0** | **0** |
| Transfer between reserves | **0** | **0** | **44** | (44) | **0** |
| **Balance at 31st March 2014** | **1,528** | **62,799** | (4,887) | **11,836** | **71,276** |
| **Changes in taxpayers' equity for 2012-13** | | | | | |
| **Balance at 1st April 2012** | 0 | 62,799 | (4,039) | 9,807 | 68,567 |
| Prior period adjustment | 1,964 | 0 | 0 | 0 | 1,964 |
| **Balance at 1st April 2012 - restated** | 1,964 | 62,799 | (4,039) | 9,807 | 70,531 |
| Total Comprehensive Income for the period: | | | | | |
| Retained surplus/(deficit) for the period | 301 | 0 | (3,194) | 0 | (2,893) |
| Net gain on revaluation of property, plant and equipment | 0 | 0 | 0 | 0 | 0 |
| Net gain on revaluation of intangible assets | 0 | 0 | 0 | 0 | 0 |
| Net gain on revaluation of financial assets | 0 | 0 | 0 | 0 | 0 |
| Net gain on revaluation of Charitable Fund assets | 0 | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | (266) | (266) |
| Fair value gains/(losses) on available for sale financial investments | 27 | 0 | 0 | 0 | 27 |
| Transfer to retained earnings on disposal of assets | 0 | 0 | 37 | (37) | 0 |
| Movements on other reserves | (712) | 0 | 712 | 0 | 0 |
| Transfer between reserves | 0 | 0 | 105 | (105) | 0 |
| **Balance at 31st March 2013** | 1,580 | 62,799 | (6,379) | 9,399 | 67,399 |

| Trust | Public dividend capital (PDC) £000 | Retained earnings £000 | Revaluation reserve £000 | Total £000 |
|---|---|---|---|---|
| **Changes in taxpayers' equity for 2013-14** | | | | |
| **Balance at 1st April 2013** | **62,799** | (6,379) | **9,399** | **65,819** |
| Total Comprehensive Income for the period: | | | | |
| Retained surplus/(deficit) for the period | **0** | **1,437** | **0** | **1,437** |
| Net gain on revaluation of property, plant and equipment | **0** | **0** | **2,492** | **2,492** |
| 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** | **0** | **0** |
| Fair value gains/(losses) on available for sale financial investments | **0** | **0** | **0** | **0** |
| Transfer to retained earnings on disposal of assets | **0** | **11** | (11) | **0** |
| Movements on other reserves | **0** | **0** | **0** | **0** |
| Transfer between reserves | **0** | **44** | (44) | **0** |
| **Balance at 31st March 2014** | **62,799** | (4,887) | **11,836** | **69,748** |
| **Changes in taxpayers' equity for 2012-13** | | | | |
| **Balance at 1st 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) |
| Fair value gains/(losses) on available for sale financial investments | 0 | 0 | 0 | 0 |
| 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 |

## CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31st March 2014

| | NOTE | Group for period ended 31st March 2014 £000 | Group for period ended 31st March 2013 £000 | Trust for period ended 31st March 2014 £000 | Trust for period ended 31st March 2013 £000 |
|---|---|---|---|---|---|
| **Cash flows from operating activities** | | | | | |
| Operating surplus/(deficit) | | **3,286** | (1,180) | **3,354** | (752) |
| Depreciation and amortisation | | **5,052** | 4,654 | **5,052** | 4,654 |
| Impairments | | **1,291** | 3,489 | **1,291** | 3,489 |
| Reversal of impairments | | **(2,622)** | (84) | **(2,622)** | (84) |
| (Increase)/decrease in trade and other receivables | | **(242)** | (192) | **(297)** | (247) |
| (Increase)/decrease in inventories | | **16** | 342 | **16** | 342 |
| Increase/(decrease) in trade and other payables | | **(397)** | 27 | **(397)** | 27 |
| Increase/(decrease) in other current liabilities | | **1,539** | (96) | **1,539** | (96) |
| Increase/(decrease) in provisions | 41 | **(1,090)** | 636 | **(1,090)** | 636 |
| Increase/(decrease) in Charitable Funds net working capital | | **(196)** | (501) | **0** | 0 |
| Tax (paid)/received | | **0** | 0 | **0** | 0 |
| **Net cash inflow/(outflow) from operating activities** | | **6,637** | 7,095 | **6,846** | 7,969 |
| **Cash flows from investing activities** | | | | | |
| Interest received | | **40** | 74 | **40** | 74 |
| Purchase of Intangible assets | | **(6)** | (61) | **(6)** | (61) |
| (Payments) for property, plant and equipment | 21 | **(8,625)** | (8,489) | **(8,625)** | (8,489) |
| Inflow/(outflow) from Charitable Funds investing activities | | **13** | 17 | **0** | 0 |
| **Net cash inflow/(outflow) from investing activities** | | **(8,578)** | (8,459) | **(8,591)** | (8,476) |
| **Net cash inflow/(outflow) before financing** | | **(1,941)** | (1,364) | **(1,745)** | (507) |
| **Cash flows from financing activities** | | | | | |
| Capital element of finance leases | | **(218)** | (309) | **(218)** | (309) |
| Interest element of finance lease | | **(47)** | (57) | **(47)** | (57) |
| PDC dividend paid | | **(1,874)** | (1,816) | **(1,874)** | (1,816) |
| **Net cash inflow/(outflow) from financing** | | **(2,139)** | (2,182) | **(2,139)** | (2,182) |
| **Net increase/(decrease) in cash and cash equivalents** | | **(4,080)** | (3,546) | **(3,884)** | (2,689) |
| **Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year** | | **16,150** | 19,696 | **14,790** | 17,479 |
| **Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year** | 32 | **12,070** | 16,150 | **10,906** | 14,790 |

# 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 2013/14 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 Consolidation

The results of the Liverpool Heart and Chest Hospital Charity are consolidated into the results of the NHS Foundation Trust. References to 'Group' within the financial statements refer to the results and balances of the Foundation Trust and Charity, whilst references to 'Trust' refer only to those of the Foundation Trust.

**NHS Charitable Fund**

The NHS Foundation Trust is the corporate trustee to Liverpool Heart and Chest Hospital Charity (Charity Registration Number 1052813). The Foundation Trust has assessed its relationship to the Charity and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the Charity so as to obtain benefits from its activities for itself, its patients or its staff.

Prior to 2013/14, the FT ARM permitted the NHS Foundation Trust not to consolidate the charitable fund. From 2013/14, the Foundation Trust has consolidated the charitable fund and has applied this as a change in accounting policy. Due to the change in accounting policy, Group (consolidated) comparatives are shown for 2012/13, together with an opening balance sheet as at 1st April 2012.

The Charity's statutory accounts are prepared to 31st March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). Where the accounting policies of the Charity are not aligned with those of the Foundation Trust, the amounts are adjusted during consolidation where the differences are material. However, there are no such differences at the reporting date.

On consolidation, necessary adjustments are made to the Charity's assets, liabilities and transactions to eliminate intra-group transactions, balances, gains and losses.

The Charity's Reserves are Unrestricted Funds. These include those funds which the Trustee is free to use for any purpose in furtherance of the Charity's objects. Unrestricted funds include designated funds which the Trustee has chosen to earmark for set purposes.

Separate Charity accounts are still prepared in accordance with the UK Charities SORP and submitted to the Charity Commission. A summary Statement of Financial Activities and summary Balance Sheet for the charity are shown in note 51 to the Accounts.

**Other 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'.

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

**1.2 Consolidation (continued)**

**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 established by the partners is a company limited by guarantee "The Institute of Cardiovascular Medicine & Science Ltd" (ICMS), to which the partners each contributed £50,000. Draft Accounts of the company have been prepared for the year ended 31st March 2014 and the results are reflected in the accounts of the group in this financial year.

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'.

**1.3 Acquisition and Discontinued Operations**

Activities are considered to be 'acquired' only if they are taken on from outside the Public Sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public body to another.

**1.4 Critical accounting judgements and key sources of estimation uncertainty**

In the application of the Group'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.

**1.5.1 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 Group 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 2013/14 Foundation Trust Annual Reporting Manual (FT ARM). The Accounting Policies contained in the FT ARM apply International Financial Reporting Standards as adapted or interpreted for an NHS Foundation Trust.

**Consolidation of Charitable Fund**

The results of the Liverpool Heart and Chest Hospital Charity are consolidated into the results of the NHS Foundation Trust and reported as Group figures. This is because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

**Income**

Accounting standards and guidance within the 2013/14 Foundation Trust Annual Reporting Manual (FT ARM) leave scope for judgement in the recognition of income when earned rather than received in cash terms.

There are a number of instances where the Trust has not performed all of planned activity or achieved quality standards on which contracts are based and so have been overpaid.

Overpayments will be recouped in future periods by short payments on income. These overpayments of £1.701m have been treated as deferred income

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

### 1.5.2 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 Sue Hall MRICS who is external to the entity as an independent valuer to value its land and buildings at March 31st 2014.

Basis of valuation – 'undertaken in accordance with IFRS as interpreted and applied by, respectively, the NHS Manual for Accounts, or the NHS Foundation Trust Annual Reporting Manual, each of which is largely compliant with HM Treasury Financial Reporting Manual (FReM) guidance for the United Kingdom public sector. The valuations also accord with the requirements of the RICS valuation – Professional Standards 2014 UK edition (known as the Red Book), including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance.'

All properties were internally / externally inspected for the purposes of this exercise between 16th January 2014 and 13th February 2014.

The last full valuation took place at 1st April 2009

Asset Lives - Useful economic lives of buildings are determined by the Valuer when valuing the land and buildings, while other asset classes are assessed when acquired by the Foundation Trust. A degree of estimation is occasionally required in assessing useful economic lives of assets.

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 recalculated this provision for 2012/13 based on a sample of circa 200 staff which confirmed that the original holiday pay accrual should be increased from £243k to £275k. This holiday pay accrual has been retained at this value for 2013/14.

Provisions - Provisions have been made for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period in which such determination is made. The amounts of the provisions are detailed in Note 41.

### 1.6 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 National Loan Fund. All investments have been undertaken in accordance with the Foundation Trust's Treasury Management Policy.

### 1.6.1 Charitable Income

The main sources of income for the Charitable Fund are donations, legacies, fundraising events and other charitable activities (tea shop income and income from Robert Owen House accommodation for patients families). Income is recognised in full when the resource is receivable or the charity's right becomes enforceable, when it is reasonably certain that the resource will be received and the monetary value can be measured with sufficient reliability.

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

**1.7 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.

**1.8 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 the 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.

**1.9 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.

**1.10 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.

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.

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

**1.10 Property, Plant and Equipment (continued)**

**Valuation**

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the 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 valuation of the Trust's capital property assets at 31st March 2014.

Until 31st March 2008, the depreciated replacement costs of specialised assets have been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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.

**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.

**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.

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

### 1.11 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'.

### 1.12 Impairments

At each reporting period end, the Foundation Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

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

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

### 1.13 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 has an IE33 Echocardiograph 2D Cardiac Ultrasound System which is classified as held for sale.

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

**1.14 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. 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 availability 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 measured 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.

**1.15 Borrowing Costs**

Borrowing costs are recognised as expenses as they are incurred.

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

### 1.16 Donated Assets

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

### 1.17 Government Grants

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

Following the accounting policy change outlined in the Treasury FREM for 2011/12, a Government grant reserve is no longer maintained. The value of assets received by means of a Government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition.

The Trust does not currently have any Government grants.

### 1.18 Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter, the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

### 1.19 Operating Leases

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

### 1.20 Leases of Land and Buildings

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

### 1.21 Inventories

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

### 1.22 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of The Foundation Trust's and Charity's cash management.

The Trust has been unable to invest cash with UK Commercial banks which are compliant with Investment requirements within the Trust's Treasury Management Policy. As a consequence the Trust mainly deposits with Government Banking Service or National Loans Fund.

The Trust's working capital facility ceased from December 2013.

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

### 1.23 Provisions

The Group 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 Foundation Trust has provided for a permanent injury award made by the NHS Injury Benefits Scheme. This provision has been discounted at 1.80% (2012/13 - 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 Foundation Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Group 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 expenditure arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

### 1.24 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 41 but is not recognised in the NHS Foundation Trust's accounts.

### 1.25 Non-Clinical Risk Pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

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

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

The Charity has a combined liability/professional indemnity policy held with a commercial insurance company.

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

### 1.26 EU Emissions Trading Scheme

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

### 1.27 Contingencies

A contingent asset (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 probability 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 occurrence 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.

### 1.28 Non Current Asset Investments

**Recognition and measurement**

Non current asset investments are stated at fair value at the balance sheet date.

**Realised and unrealised gains and losses**

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening fair value (or cost if purchased since the previous period end). Unrealised gains and losses are calculated as the difference between fair value at the year end and the opening fair value (or cost if purchased since the previous period end).

### 1.29 Financial Assets

Financial assets are recognised when the Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through income and expenditure; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

**Financial Assets at 'Fair Value Through Income & Expenditure'**
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through Income & Expenditure. They are held at fair value, with any resultant gain or loss recognised in calculating the Foundation Trust's surplus (or deficit) for the year. The net gain or loss incorporates any interest earned on the financial asset. The Foundation Trust does not hold any of this class of assets.

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

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

**1.29 Financial Assets (continued)**

**Loans and Receivables**

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

The Group'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.

At the end of the reporting period, The Group 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 Group 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 Group'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 licence conditions as set by 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 Group 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 Group 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 Group 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 31st 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 held by the NHS Foundation Trust (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in Note 49 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) average daily cash balances held with the Government Banking Services (GBS) and National Loan Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1 April 2013, and (iv) 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 of 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 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 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IAS 32 Financial Instruments: Presentation - 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

## 2 Operating Segments

The Group has one segment for the provision of healthcare which generated income of £114.45m.

| | 2013/14 £000 | 2012/13 £000 |
|---|---|---|
| **The main sources of income received were:-** | | |
| North West Specialist Commissioning Team | **63,713** | 69,386 |
| Health Commission Wales | **15,091** | 14,711 |
| North West Secondary Contract | **15,450** | 9,053 |

Half way through 2012/13, identification rules were applied to the Trusts activity to give a split of Secondary (non-specialist) and Tertiary (specialist). In 2013/14 the Trust has seen the full year effect of this. Therefore this explains the slight change in the split of income between North West Specialist Commissioning and our North West Secondary Contract.

| | Healthcare Segment | |
|---|---|---|
| | 2013/14 £000 | 2012/13 £000 |
| Income | **114,447** | 112,056 |
| Surplus/(Deficit) | **1,382** | (2,893) |
| Net Assets | **71,276** | 67,399 |

## 3 Income generation activities

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

## 4 Operating Revenue analysed by classification

| | Group | | Trust | |
|---|---|---|---|---|
| | 2013/14 £000 | 2012/13 £000 | 2013/14 £000 | 2012/13 £000 |
| Elective income | **51,633** | 50,577 | **51,633** | 50,577 |
| Non elective income | **29,510** | 31,738 | **29,510** | 31,738 |
| Outpatient Income | **13,270** | 12,558 | **13,270** | 12,558 |
| Other NHS clinical income* | **6,205** | 5,302 | **6,205** | 5,302 |
| Private patient income | **2,855** | 2,886 | **2,855** | 2,886 |
| Other clinical income | **498** | 2,371 | **498** | 2,371 |
| **Total Income from activities** | **103,971** | 105,432 | **103,971** | 105,432 |
| Research & Development | **1,507** | 1,213 | **1,507** | 1,213 |
| Education and training | **2,616** | 2,694 | **2,616** | 2,694 |
| Received from NHS charities: Receipt of grants/donations for capital acquisitions - Grant | **0** | 0 | **45** | 595 |
| Charitable and other contributions to expenditure | **0** | 0 | **0** | 13 |
| Other charitable and other contributions to expenditure | **0** | 0 | **0** | 0 |
| Non-patient care services to other bodies | **145** | 197 | **145** | 197 |
| Reversal of impairments of property, plant and equipment | **2,622** | 84 | **2,622** | 84 |
| NHS Charitable Funds: Incoming Resources excluding investment income | 529 | 628 | **0** | 0 |
| Other income | **3,057** | 1,808 | **3,057** | 1,808 |
| **Total other operating revenue** | **10,476** | 6,624 | **9,992** | 6,604 |
| **Total Operating income** | **114,447** | 112,056 | **113,963** | 112,036 |

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

## 5 Analysis of Other NHS Clinical Income

| | 2013/14 £000 | 2012/13 £000 |
|---|---|---|
| Cystic Fibrosis Inpatients | **4,460** | 4,135 |
| CQUIN | **1,688** | 0 |
| PCT/CCG Income - Non Contracted | **57** | 1,052 |
| Drugs and Devices - Non Contracted | **0** | 115 |
| | **6,205** | 5,302 |

## 6 Revenue from patient care activities - Group and Trust

| | Year ended 31st March 2014 £000 | Year ended 31st March 2013 £000 |
|---|---|---|
| NHS Foundation Trusts | **0** | 200 |
| NHS Trusts | **0** | 1,431 |
| Strategic Health Authorities | **0** | 1 |
| Department of Health | **0** | 57 |
| CCG's and NHS England** | **83,107** | 0 |
| Primary Care Trusts** | **0** | 85,876 |
| NHS Other | **99** | 8 |
| Local authorities | **0** | (1) |
| Non NHS: | | |
| - Private patients | **2,855** | 2,886 |
| - Overseas patients (non reciprocal) | **51** | 0 |
| - NHS Injury Scheme | **1** | 0 |
| - Other* | **17,858** | 14,974 |
| | **103,971** | 105,432 |

** Other Operating Income consists mainly of income received from Health Commission Wales and Isle of Man*
*** Primary Care Trusts ceased to exist on 31st March 2013. From 1st April 2013, the corresponding revenue is received from Clinical Commissiong Groups (CCG's) and NHS England.*

## 7 Other Operating Revenue

| | Group | | Trust | |
|---|---|---|---|---|
| | Year ended 31st March 2014 £000 | Year ended 31st March 2013 £000 | Year ended 31st March 2014 £000 | Year ended 31st March 2013 £000 |
| Research & Development | **1,507** | 1,213 | **1,507** | 1,213 |
| Education and training | **2,616** | 2,694 | **2,616** | 2,694 |
| Received from NHS charities: Receipt of grants/donations for capital acquisitions - Grant | **0** | 0 | **45** | 595 |
| Charitable and other contributions to expenditure | **0** | 0 | **0** | 13 |
| Other charitable and other contributions to expenditure | **0** | 0 | **0** | 0 |
| Non-patient care services to other bodies | **145** | 197 | **145** | 197 |
| Reversal of impairments of property, plant and equipment | **2,622** | 84 | **2,622** | 84 |
| NHS Charitable Funds: Incoming Resources excluding investment income | **529** | 628 | **0** | 0 |
| Other income* | **3,057** | 1,808 | **3,057** | 1,808 |
| | **10,476** | 6,624 | **9,992** | 6,604 |

**Other income is analysed in Note 8 below*

## 8 Analysis of Other Operating Revenue - Other income - Group and Trust

| | Year ended 31st March 2014 £000 | Year ended 31st March 2013 £000 |
|---|---|---|
| Clinical excellence awards | **263** | 418 |
| Estates recharges | **43** | 0 |
| IT recharges | **17** | 0 |
| Pharmacy sales | **2** | 5 |
| Other | **2,732** | 1,385 |
| | **3,057** | 1,808 |

## 9 Income from activities arising from Commissioner Requested Services - Group and Trust

| | Year ended 31st March 2014 £000 | Year ended 31st March 2013 £000 |
|---|---|---|
| Commissioner Requested Services | **100,432** | 96,866 |
| Non-Commissioner Requested Services | **3,539** | 8,567 |
| | **103,971** | 105,433 |

## 10 Revenue

Revenue is predominantly from the supply of services. Revenue from the sale of goods is not material. The main sources of income for the Charitable Fund are donations, legacies, fundraising events and other charitable activities.

## 11 Operating Expenses

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31st March 2014** | Year ended 31st March 2013 | **Year ended 31st March 2014** | Year ended 31st March 2013 |
| | **£000** | £000 | **£000** | £000 |
| Services from NHS Foundation Trusts | **161** | 178 | **161** | 178 |
| Services from NHS Trusts | **3,940** | 4,000 | **3,940** | 4,000 |
| Services from Primary Care Trusts | **0** | 245 | **0** | 245 |
| Services from CCGs and NHS England | **65** | 0 | **65** | 0 |
| Services from other NHS bodies | **3** | 0 | **3** | 0 |
| Employee Expenses - Executive directors | **602** | 429 | **602** | 429 |
| Employee Expenses - Non-executive directors | **116** | 70 | **116** | 70 |
| Employee Expenses - Staff | **59,441** | 58,812 | **59,323** | 58,706 |
| Supplies and services - clinical (excluding drug costs) | **25,641** | 26,245 | **25,641** | 26,245 |
| Supplies and services - general | **1,783** | 2,231 | **1,783** | 2,231 |
| Establishment | **1,235** | 1,486 | **1,235** | 1,486 |
| Research and Development (not included in employee expense) | **0** | 0 | **0** | 0 |
| Research and Development (included in employee expense) | **833** | 789 | **833** | 789 |
| Transport | **78** | 98 | **78** | 98 |
| Premises | **3,419** | 3,246 | **3,419** | 3,246 |
| Increase/(decrease) in provision for impairment of receivables | **4** | (38) | **4** | (38) |
| Increase in other provisions | **0** | 0 | **0** | 0 |
| Change in provisions discount rate | **4** | 0 | **4** | 0 |
| Inventories consumed (excluding drugs) | **0** | 0 | **0** | 0 |
| Drugs inventories consumed | **6,227** | 4,321 | **6,227** | 4,321 |
| Rentals under Operating leases - Minimum lease payments | **60** | 39 | **60** | 39 |
| Depreciation on property, plant and equipment | **4,912** | 4,590 | **4,912** | 4,590 |
| Amortisation on intangible assets | **140** | 64 | **140** | 64 |
| Impairments of property, plant and equipment | **1,291** | 3,489 | **1,291** | 3,489 |
| Audit fees - Statutory audit | **65** | 66 | **57** | 58 |
| Other auditor's remuneration | **0** | 0 | **0** | 0 |
| Clinical negligence | **436** | 481 | **436** | 481 |
| Legal fees | **21** | 89 | **21** | 89 |
| Consultancy costs | **333** | 193 | **333** | 193 |
| Training courses and conferences | **203** | 237 | **203** | 237 |
| Patient travel | **14** | 12 | **14** | 12 |
| Car parking and Security | **20** | 12 | **20** | 12 |
| Redundancy (not included in employee expenses) | **0** | 0 | **0** | 0 |
| Redundancy (included in employee expenses) | **0** | 21 | **0** | 21 |
| Insurance | **115** | 112 | **115** | 112 |
| Other services, e.g. external payroll | **0** | 0 | **0** | 0 |
| Losses, ex gratia & special payments (not included in employee expenses) | **(666)** | 1,120 | **(666)** | 1,120 |
| Losses, ex gratia & special payments (included in employee expenses) | **0** | 0 | **0** | 0 |
| Other | **308** | 263 | **239** | 265 |
| NHS Charitable funds: Other resources expended | **357** | 336 | **0** | 0 |
| | **111,161** | 113,236 | **110,609** | 112,788 |

## 12 Audit Fees and Other Remuneration

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31st March 2014 £000** | Year ended 31st March 2013 £000 | **Year ended 31st March 2014 £000** | Year ended 31st March 2013 £000 |
| Statutory Audit | **65** | 66 | **57** | 58 |
| Other Auditors remuneration: | | | | |
| Regulatory reporting | **0** | 0 | **0** | 0 |
| | **65** | 66 | **57** | 58 |

The liability agreement in place with the external auditors (Grant Thornton UK LLP) is £2m.

## 13 Operating leases - Group and Trust

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. During the year the Foundation Trust entered into a new contract for photocopiers under a 7 year agreement. The preceding 5 year lease term for photocopiers lapsed during the year but where the Trust has agreed to extend these leases there is no on-going contractual commitment.

### 13.1 As lessee

| **Payments recognised as an expense** | **Year ended 31st March 2014 £000** | Year ended 31st March 2013 £000 |
|---|---|---|
| Minimum lease payments | **60** | 39 |
| Contingent rents | **0** | 0 |
| | **60** | 39 |

| **Total future minimum lease payments** | **Year ended 31st March 2014 £000** | Year ended 31st March 2013 £000 |
|---|---|---|
| Payable: | | |
| Not later than one year | **56** | 15 |
| Between one and five years | **174** | 13 |
| After 5 years | **50** | 0 |
| **Total** | **280** | 28 |

There are no future sublease payments expected to be received.

### 13.2 As lessor

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

## 14 Employee benefits and staff numbers

### 14.1 Employee expenses - Group

| | Year ended 31st March 2014 | | | Year ended 31st March 2013 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently Employed | Other | Total | Permanently Employed | Other |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Salaries and wages | 50,646 | 49,727 | 919 | 50,338 | 48,019 | 2,319 |
| Social Security Costs | 3,979 | 3,852 | 127 | 4,063 | 3,765 | 298 |
| Employer contributions to NHS Pension scheme | 5,090 | 5,090 | 0 | 4,951 | 4,951 | 0 |
| Pension costs - other contributions | 0 | 0 | 0 | 0 | 0 | 0 |
| Other post employment benefits | 0 | 0 | 0 | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 | 21 | 21 | 0 |
| Agency and contract staff | 2,046 | 0 | 2,046 | 1,670 | 0 | 1,670 |
| **Total gross employee benefits** | 61,761 | 58,669 | 3,092 | 61,043 | 56,756 | 4,287 |
| Recoveries from DH Group bodies in respect of staff cost netted off expenditure | (89) | (89) | 0 | (47) | (47) | 0 |
| **Total net employee benefits** | 61,672 | 58,580 | 3,092 | 60,996 | 56,709 | 4,287 |
| Employee benefits capitalised as part of assets | 796 | 272 | 524 | 945 | 392 | 553 |
| **Analysed into Operating expenditure:** | | | | | | |
| Employee Expenses - Staff | 59,441 | 56,873 | 2,568 | 58,812 | 55,078 | 3,734 |
| Employee Expenses - Executive directors | 602 | 602 | 0 | 429 | 429 | 0 |
| Research & development | 833 | 833 | 0 | 789 | 789 | 0 |
| Redundancy | 0 | 0 | 0 | 21 | 21 | 0 |
| **Total Employee benefits excl. capitalised costs** | 60,876 | 58,308 | 2,568 | 60,051 | 56,317 | 3,734 |

### 14.1 Employee expenses - Trust

| | Year ended 31st March 2014 | | | Year ended 31st March 2013 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently Employed | Other | Total | Permanently Employed | Other |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Salaries and wages | 50,646 | 49,727 | 919 | 50,338 | 48,019 | 2,319 |
| Social Security Costs | 3,979 | 3,852 | 127 | 4,063 | 3,765 | 298 |
| Employer contributions to NHS Pension scheme | 5,090 | 5,090 | 0 | 4,951 | 4,951 | 0 |
| Pension costs - other contributions | 0 | 0 | 0 | 0 | 0 | 0 |
| Other post employment benefits | 0 | 0 | 0 | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 | 21 | 21 | 0 |
| Agency and contract staff | 2,046 | 0 | 2,046 | 1,670 | 0 | 1,670 |
| **Total gross employee benefits** | 61,761 | 58,669 | 3,092 | 61,043 | 56,756 | 4,287 |
| Recoveries from DH Group bodies in respect of staff cost netted off expenditure | (89) | (89) | 0 | (47) | (47) | 0 |
| Recoveries from Other bodies in respect of staff cost netted off expenditure | (118) | (118) | 0 | (106) | (106) | 0 |
| **Total net employee benefits** | 61,554 | 58,462 | 3,092 | 60,890 | 56,603 | 4,287 |
| Employee benefits capitalised as part of assets | 796 | 272 | 524 | 945 | 392 | 553 |
| **Analysed into Operating expenditure:** | | | | | | |
| Employee Expenses - Staff | 59,323 | 56,755 | 2,568 | 58,706 | 54,972 | 3,734 |
| Employee Expenses - Executive directors | 602 | 602 | 0 | 429 | 429 | 0 |
| Research & development | 833 | 833 | 0 | 789 | 789 | 0 |
| Redundancy | 0 | 0 | 0 | 21 | 21 | 0 |
| **Total Employee benefits excl. capitalised costs** | 60,758 | 58,190 | 2,568 | 59,945 | 56,211 | 3,734 |

### 14.2 Average number of people employed - Group and Trust

| | Year ended 31st March 2014 | | | Year ended 31st March 2013 | | |
|---|---|---|---|---|---|---|
| **Trust** | Total | Permanently Employed | Other | Total | Permanently Employed | Other |
| | Number | Number | Number | Number | Number | Number |
| Medical and dental | 139 | 134 | 5 | 138 | 131 | 7 |
| Administration and estates | 294 | 277 | 17 | 281 | 256 | 25 |
| Healthcare assistants and other support staff | 238 | 213 | 25 | 231 | 218 | 13 |
| Nursing, midwifery and health visiting staff | 545 | 520 | 25 | 538 | 515 | 23 |
| Scientific, therapeutic and technical staff | 222 | 214 | 8 | 217 | 206 | 11 |
| Social care staff | 3 | 0 | 3 | 3 | 0 | 3 |
| Bank & agency staff | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 1 | 0 | 1 | 1 | 0 | 1 |
| **Total** | 1,442 | 1,358 | 84 | 1,409 | 1,326 | 83 |
| Of the above - staff engaged on capital projects | 21 | 4 | 17 | 22 | 10 | 12 |

For the Group, 2.57 Whole Time Equivalent (WTE) members of staff employed by the Trust are recharged to the Charitable Fund. This would increase the Administration and estates staff number noted above to 297 and total staff to 1,445.

### 14.3 Management and Administration Costs - Trust

| | Year ended 31st March 2014 £m | Year ended 31st March 2013 £m |
|---|---|---|
| Management costs | **5.845** | 5.550 |
| Income | **111.381** | 112.036 |
| Percentage of Management Costs to Income | **5.25%** | 4.95% |

### 14.4 Staff Sickness Absence

| | Year ended 31st March 2014 | Year ended 31st March 2013 |
|---|---|---|
| Days Lost (Long Term) | **10,975** | 14,784 |
| Days Lost (Short Term) | **7,295** | 7,201 |
| **Total Days Lost** | **18,270** | 21,985 |
| **Total Staff Years** | **1,253** | 1,323 |
| Average working days lost | **14.6** | 16.6 |
| Total Staff Employed in Period (Headcount) | **1,620** | 1,610 |
| Total Staff Employed in Period with no absence (Headcount) | **861** | 748 |
| **Percentage Staff with no Sick Leave** | **53.15%** | 46.46% |

### 14.5 Exit Packages agreed in 2013-14

| Exit package cost band (including any special payment element) | 31st March 2014 Number of compulsory redundancies | 31st March 2014 Number of other departures agreed | 31st March 2014 Total number of exit packages by cost band | 31st March 2013 Number of compulsory redundancies | 31st March 2013 Number of other departures agreed | 31st March 2013 Total number of exit packages by cost band |
|---|---|---|---|---|---|---|
| | Number | Number | Number | Number | Number | Number |
| Less than £10,000 | **0** | **0** | **0** | 0 | 1 | 1 |
| £10,001-£25,000 | **0** | **0** | **0** | 0 | 1 | 1 |
| £25,001-£50,000 | **0** | **0** | **0** | 0 | 0 | 0 |
| £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 | 0 | 0 |
| >£200,000 | **0** | **0** | **0** | 0 | 0 | 0 |
| **Total number of exit packages by type (total cost** | **0** | **0** | **0** | 0 | 2 | 2 |
| **Total resource cost (£000s)** | **0** | **0** | **0** | 0 | 20 | 20 |

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

## 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. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on the valuation data as 31 March 2013, updated to 31 March 2014 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.

**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) has been used and replaced 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 - Group and Trust

For the year ended 31st March 2014 there was nil early retirements at a cost of £nil from The NHS Foundation Trust agreed on the grounds of ill-health. (31st March 2013: 2 at a cost of £55k)

## 17 Investment Revenue

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31st March 2014 £000** | Year ended 31st March 2013 £000 | **Year ended 31st March 2014 £000** | Year ended 31st March 2013 £000 |
| Investment revenue | **13** | 17 | **0** | 0 |
| Interest revenue: Bank accounts | **40** | 74 | **40** | 74 |
| **Total** | **53** | 91 | **40** | 74 |

## 18 Other Gains and Losses - Group and Trust

There are no other gains or losses.

## 19 Finance Costs - Group and Trust

| | **Year ended 31st March 2014 £000** | Year ended 31st March 2013 £000 |
|---|---|---|
| Interest on obligations under finance leases | **47** | 57 |
| **Total** | **47** | 57 |

## 20 Better Payment Practice Code - Group and Trust

### 20.1 Better Payment Practice Code - measure of compliance

| | **Year Ended 31st March 2014** | | Year ended 31st March 2013 | |
|---|---|---|---|---|
| | **Number** | **£000s** | Number | £000s |
| Total Non-NHS trade invoices paid in the period | **29,487** | **47,590** | 30,517 | 47,937 |
| Total Non NHS trade invoices paid within target | **28,380** | **46,505** | 29,392 | 44,204 |
| Percentage of Non-NHS trade invoices paid within target | **96.2%** | **97.7%** | 96.3% | 92.2% |
| | | | | |
| Total NHS trade invoices paid in the period | **940** | **16,310** | 778 | 13,265 |
| Total NHS trade invoices paid within target | **722** | **14,276** | 648 | 11,037 |
| Percentage of NHS trade invoices paid within target | **76.8%** | **87.5%** | 83.3% | 83.2% |

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 - Group and Trust

| | **Year ended 31st March 2014 £000** | Year ended 31st March 2013 £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 |

## 21 Property, plant and equipment - Group

| 2013/14: | Land | Buildings excluding dwellings | Dwellings | Assets under construct and poa | Plant and machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1st April 2013 | 3,235 | 44,150 | 490 | 5,353 | 21,750 | 5,141 | 2,260 | 82,379 |
| Prior period adjustment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions purchased | 0 | 2,164 | 0 | 254 | 939 | 3,272 | 67 | 6,696 |
| Additions leased | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 687 | 0 | (5,306) | 31 | 4,588 | 0 | 0 |
| Revaluations | 65 | 670 | 322 | 0 | 0 | 0 | 0 | 1,057 |
| Impairments | 0 | (1,291) | 0 | 0 | 0 | 0 | 0 | (1,291) |
| Reversal of Impairments | 0 | 2,622 | 0 | 0 | 0 | 0 | 0 | 2,622 |
| Transfers to/from assets held for sale and assets in disposal groups | 0 | 0 | 0 | 0 | (29) | 0 | 0 | (29) |
| Disposals | 0 | 0 | 0 | 0 | (287) | 0 | 0 | (287) |
| **At 31st March 2014** | 3,300 | 49,002 | 812 | 301 | 22,404 | 13,001 | 2,327 | 91,147 |
| Depreciation at 1st April 2013 | 0 | 0 | 0 | 0 | 13,290 | 3,584 | 1,766 | 18,640 |
| Prior period adjustment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Charged during the year | 0 | 1,421 | 14 | 0 | 2,221 | 1,114 | 142 | 4,912 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | (1,421) | (14) | 0 | 0 | 0 | 0 | (1,435) |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfers to/from assets held for sale and assets in disposal groups | 0 | 0 | 0 | 0 | (23) | 0 | 0 | (23) |
| Disposals | 0 | 0 | 0 | 0 | (287) | 0 | 0 | (287) |
| **Depreciation at 31st March 2014** | 0 | 0 | 0 | 0 | 15,201 | 4,698 | 1,908 | 21,807 |
| **Net book value** | | | | | | | | |
| Purchased | 3,300 | 49,002 | 812 | 301 | 6,403 | 8,303 | 419 | 68,540 |
| Finance Leased | 0 | 0 | 0 | 0 | 800 | 0 | 0 | 800 |
| Donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total at 31st March 2014** | 3,300 | 49,002 | 812 | 301 | 7,203 | 8,303 | 419 | 69,340 |

Assets donated by the charity are classified as purchased assets in the Group accounts.

## 21.1 Property, plant and equipment - Trust

| 2013/14: | Land | Buildings excluding dwellings | Dwellings | Assets under construct and poa | Plant and machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1st April 2013 | 3,235 | 44,150 | 490 | 5,353 | 21,750 | 5,141 | 2,260 | 82,379 |
| Prior period adjustment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions purchased | 0 | 2,158 | 0 | 238 | 917 | 3,272 | 67 | 6,652 |
| Additions leased | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions donated | 0 | 6 | 0 | 16 | 22 | 0 | 0 | 44 |
| Reclassifications | 0 | 687 | 0 | (5,306) | 31 | 4,588 | 0 | 0 |
| Revaluations | 65 | 670 | 322 | 0 | 0 | 0 | 0 | 1,057 |
| Impairments | 0 | (1,291) | 0 | 0 | 0 | 0 | 0 | (1,291) |
| Reversal of Impairments | 0 | 2,622 | 0 | 0 | 0 | 0 | 0 | 2,622 |
| Transfers to/from assets held for sale and assets in disposal groups | 0 | 0 | 0 | 0 | (29) | 0 | 0 | (29) |
| Disposals | 0 | 0 | 0 | 0 | (287) | 0 | 0 | (287) |
| **At 31st March 2014** | 3,300 | 49,002 | 812 | 301 | 22,404 | 13,001 | 2,327 | 91,147 |
| Depreciation at 1st April 2013 | 0 | 0 | 0 | 0 | 13,290 | 3,584 | 1,766 | 18,640 |
| Prior period adjustment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Charged during the year | 0 | 1,421 | 14 | 0 | 2,221 | 1,114 | 142 | 4,912 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | (1,421) | (14) | 0 | 0 | 0 | 0 | (1,435) |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfers to/from assets held for sale and assets in disposal groups | 0 | 0 | 0 | 0 | (23) | 0 | 0 | (23) |
| Disposals | 0 | 0 | 0 | 0 | (287) | 0 | 0 | (287) |
| **Depreciation at 31st March 2014** | 0 | 0 | 0 | 0 | 15,201 | 4,698 | 1,908 | 21,807 |
| **Net book value** | | | | | | | | |
| Purchased | 3,300 | 48,465 | 503 | 285 | 6,128 | 8,303 | 414 | 67,398 |
| Finance Leased | 0 | 0 | 0 | 0 | 800 | 0 | 0 | 800 |
| Donated | 0 | 537 | 309 | 16 | 275 | 0 | 5 | 1,142 |
| **Total at 31st March 2014** | 3,300 | 49,002 | 812 | 301 | 7,203 | 8,303 | 419 | 69,340 |

### Revaluation Reserve Balance for Property, Plant & Equipment - Group and Trust

| | Land | Buildings excluding dwellings | Dwellings | Plant and machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **At 1st April 2013** | 1,903 | 6,443 | 214 | 707 | 0 | 132 | 9,399 |
| Movement in year | 65 | 2,073 | 353 | (40) | 0 | (14) | 2,437 |
| **At 31st March 2014** | 1,968 | 8,516 | 567 | 667 | 0 | 118 | 11,836 |

## 21.2 Property, plant and equipment - Group

| 2012/13: | Land | Buildings excluding dwellings | Dwellings | Assets under construct and poa | Plant and machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1st April 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 | 2,914 | 0 | 5,092 | 1,648 | 435 | 146 | 10,235 |
| Additions leased | 0 | 0 | 0 | 0 | 175 | 0 | 0 | 175 |
| Additions donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 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 | 0 | 0 | 0 | 0 | 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 | 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 | 0 | (84) |
| Revaluations | 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 | 44,150 | 490 | 5,353 | 7,478 | 1,557 | 494 | 62,757 |
| Finance Leased | 0 | 0 | 0 | 0 | 982 | 0 | 0 | 982 |
| Donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total at 31st March 2013** | 3,235 | 44,150 | 490 | 5,353 | 8,460 | 1,557 | 494 | 63,739 |

Assets donated by the charity are classified as purchased assets in the Group accounts.

## 21.3 Property, plant and equipment - Trust

| 2012/13: | Land | Buildings excluding dwellings | Dwellings | Assets under construct and poa | Plant and machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1st April 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 | 0 | 0 | 0 | 0 | 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 | 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 | 0 | (84) |
| Revaluations | 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 - Group and Trust

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

### 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 2014.

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 | 11 | 55 |
| Dwellings | 34 | 35 |
| Assets under Construction & POA | 0 | 1 |
| Plant & Machinery | 0 | 8 |
| Information Technology | 0 | 10 |
| Furniture and Fittings | 0 | 7 |
| Software | 0 | 5 |
| Licences & Trademarks | 0 | 9 |

The Foundation Trust has written down an IE33 Echocardiograph 2D Cardiac Ultrasound System to its recoverable amount of £6k which is based on an offer received in March 2014.

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 - Group and Trust

| 2013/14: | Computer software - purchased | Assets under Construction | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| Gross cost at 1st April 2013 | 532 | 769 | 1,301 |
| Additions | 5 | 0 | 5 |
| Reclassifications | 769 | (769) | 0 |
| **Gross cost at 31st March 2014** | 1,306 | 0 | 1,306 |
| Amortisation at 1st April 2013 | 309 | 0 | 309 |
| Charged during the year | 140 | 0 | 140 |
| **Amortisation at 31st March 2014** | 449 | 0 | 449 |
| **Net book value** | | | |
| Purchased | 857 | 0 | 857 |
| Donated | 0 | 0 | 0 |
| **Total at 31st March 2014** | 857 | 0 | 857 |

## 22 Intangible assets - Group and Trust (continued)

| 2012/13: | Computer software - purchased | Assets under Construction | Total |
|---|---|---|---|
| | £000 | £000 | £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 |

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

These assets have useful economic lives of no more than 9 years.

Intangible fixed assets held for operational use are valued at historic cost and are depreciated over the estimated useful life of the asset on a straight line basis. The carrying value of intangible fixed assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over a shorter of the term of the licence and their useful economic lives.

### 22.1 Revaluation Reserve Balance for Intangible Assets

There is no Revaluation Reserve for Intangible Assets.

## 23 Impairments

The Foundation Trust engaged the Valuation Office Agency to revalue its estate using Modern Equivalent Asset methodology effective from 31st March 2014. There has been an overall increase in the value of land and buildings of £3.823m as a result of this revaluation.

Within this sum there has been :-

- Positive movement credited to income as a reversal of impairments on Property, Plant & Equipment of £2.622m;
- Negative impairment charged to operating expenses of £1.291m in respect of Holly Suite; and
- Positive movement of £2.492m credited to the Revaluation reserve.

In addition there has been a transfer from the revaluation reserve to retained earnings for equipment disposals of £11k and an excess depreciation adjustment of £44k.

| 23.1 Analysis of impairments and reversals recognised in 2013-14 - Group and Trust | 31st March 2014 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 | 0 |
| Changes in market price - positive movement | 2,622 |
| Changes in market price - negative movement | (1,291) |
| **Total charged to Annually Managed Expenditure** | **1,331** |
| | |
| **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 | 0 |
| Changes in market price - positive movement | 2,492 |
| **Total impairments for PPE charged to reserves** | **2,492** |
| | |
| **Total Impairments of Property, Plant and Equipment** | **3,823** |
| | |
| **Total Impairments charged to Revaluation Reserve** | 2,492 |
| **Total Impairments charged to SoCI - DEL** | 0 |
| **Total Impairments charged to SoCI - AME** | 1,331 |
| **Overall Total Impairments** | **3,823** |

## 24 Investments

### 24.1 Investment in joint venture

| | 31st March 2014 £000 | 31st March 2013 £000 |
|---|---|---|
| **Carrying value at 1 April** | **0** | 0 |
| Acquisitions in year | **50** | 0 |
| Share of profit/(loss) | (44) | 0 |
| **Carrying value at 31 March** | **6** | 0 |

### 24.2 Disclosure of aggregate amounts for assets and liabilities in jointly controlled operations

| | | |
|---|---|---|
| Current assets | **129** | 0 |
| Non current assets | **0** | 0 |
| Total assets | **129** | 0 |
| | | |
| Current liabilities | (118) | 0 |
| Non current liabilities | **0** | 0 |
| Total liabilities | (118) | 0 |
| | | |
| **Net assets** | **11** | 0 |
| | | |
| Operating income | **45** | 0 |
| Operating expenses | (133) | 0 |
| **Surplus /(deficit) for the year** | (88) | 0 |

### 24.3 Other investments

| Group<br>2013/14: | NHS Charitable Funds: Other investments £000 |
|---|---|
| **Carrying value at 01st April 2013** | **249** |
| Acquisitions in year | 250 |
| Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income | 3 |
| **Carrying value at 31st March 2014** | **502** |

| 2012/13: | £000 |
|---|---|
| **Carrying value at 01st April 2012** | 0 |
| Prior period adjustment | 222 |
| **Carrying value at 01st April 2012 - restated** | 222 |
| Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income | 27 |
| **Carrying value at 31st March 2013** | 249 |

The investment portfolio consists of income units of the COIF Charities investment fund managed by CCLA Investment Management Limited

The Foundation Trust does not hold any other investments (2012/13 £nil).

### 25 Investment Property

The Trust does not have Investment Property.

### 26 Commitments

### 26.1 Capital commitments - Group and Trust

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

| | 31st March 2014 £000 | 31st March 2013 £000 |
|---|---|---|
| Property, plant and equipment | **29** | 2,665 |
| Intangible assets | **0** | 0 |
| **Total** | **29** | 2,665 |

### 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

| | Group | | Trust | |
|---|---|---|---|---|
| **Current** | **31st March 2014 £000s** | 31st March 2013 £000s | **31st March 2014 £000s** | 31st March 2013 £000s |
| **Receivables** | | | | |
| Balances with other Central Government Bodies | **226** | 492 | **226** | 492 |
| Balances with Local Authorities | **0** | 0 | **0** | 0 |
| Balances with NHS Trusts and Foundation Trusts | **1,063** | 1,061 | **1,063** | 1,061 |
| Balances with other NHS Bodies | **367** | 828 | **367** | 828 |
| Balances with bodies external to government | **2,447** | 1,565 | **2,565** | 1,535 |
| **At 31st March** | **4,103** | 3,946 | **4,221** | 3,916 |
| **Payables** | | | | |
| Balances with other Central Government Bodies | **1,893** | 1,862 | **1,893** | 1,862 |
| Balances with Local Authorities | **56** | 17 | **56** | 17 |
| Balances with NHS Trusts and Foundation Trusts | **1,744** | 3,882 | **1,744** | 3,882 |
| Balances with other NHS Bodies | **1,565** | 104 | **1,565** | 104 |
| Balances with bodies external to government | **8,631** | 10,339 | **8,610** | 10,280 |
| **At 31st March** | **13,889** | 16,204 | **13,868** | 16,145 |

Non-current intra-government and other balances (receivables and payables) are £nil (31st march 2013 - £nil).

## 28 Inventories - Group and Trust

| | Group | | | Trust | | |
|---|---|---|---|---|---|---|
| | Drugs | Consumables | Total | Drugs | Consumables | Total |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **Balance at 1st April 2013** | 406 | 2,151 | 2,557 | 406 | 2,151 | 2,557 |
| Additions | 6,267 | 18,697 | 24,964 | 6,267 | 18,696 | 24,963 |
| Inventories recognised as an expense in the period | (6,227) | (18,752) | (24,979) | (6,227) | (18,752) | (24,979) |
| Write-down of inventories (including losses) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of write-down previously taken to SoCI | 0 | 0 | 0 | 0 | 0 | 0 |
| **Balance at 31st March 2014** | **446** | **2,096** | **2,542** | **446** | **2,095** | **2,541** |

| **Inventories - Trust** | Drugs | Consumables | Energy | Work in progress | Loan Equipment | Other | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Balance at 1st 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)** |
| **Balance at 31st March 2013** | 406 | 2,151 | 0 | 0 | 0 | 0 | **2,557** |

## 29 Trade and other receivables

### 29.1 Trade and other receivables

| | Group | | | Trust | | |
|---|---|---|---|---|---|---|
| **Current** | **31st March 2014** | 31st March 2013 | 01st April 2012 | **31st March 2014** | 31st March 2013 | 01st April 2012 |
| | **£000** | £000 | £000 | **£000** | £000 | £000 |
| NHS receivables | **1,285** | 1,752 | 1,409 | **1,285** | 1,752 | 1,409 |
| Receivables due from NHS Charities - Revenue | **0** | 0 | 0 | **0** | 0 | 0 |
| Other receivables with related parties - Revenue | **1,222** | 190 | 1,514 | **1,447** | 360 | 1,629 |
| Provision for impaired receivables | **(223)** | (219) | (560) | **(223)** | (219) | (560) |
| VAT | **195** | 146 | 382 | **195** | 146 | 382 |
| Prepayments | **386** | 493 | 529 | **386** | 493 | 529 |
| Accrued income | **637** | 1,247 | 94 | **637** | 1,247 | 94 |
| PDC receivable | **145** | 137 | 68 | **145** | 137 | 68 |
| Other receivables - Revenue | **456** | 200 | 192 | **349** | 0 | 104 |
| **Total** | **4,103** | 3,946 | 3,628 | **4,221** | 3,916 | 3,655 |

Non current trade and other receivables are £nil (31st March 2013 - £nil).

The great majority of trade is with Clinical Commissioning Groups (CCG's) and NHS England, as commissioners for NHS patient care services. As CCG's and NHS England are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

Other receivables with related parties consists of transactions with Health Commission Wales (for the provision of patient care services in Wales), Insurance companies and private individuals for the provision of private patient care services and recharges from charitable funds. These are considered to be good quality receivables.

The Foundation Trust does not have financial assets that would otherwise be overdue for payment or impaired, whose terms have been renegotiated other than contracts with main commissioners which are invoiced at a standard amount each month based on an agreed level of activity. There may be credit notes issued periodically during the year where activity has been less than contracted or additional invoices where activity has exceeded contracted performance.

| 29.2 Provision for impairment of receivables - Group and Trust | 31st March 2014 | 31st March 2013 |
|---|---|---|
| | £000 | £000 |
| **Balance at 1st April** | **219** | 560 |
| Prior period adjustments | **0** | 0 |
| **Restated balance at 1st April** | **219** | 560 |
| Amounts utilised during the year | **0** | (303) |
| Unused amounts reversed | **0** | (38) |
| (Increase)/decrease in provision | **4** | 0 |
| **Balance at 31st March** | **223** | 219 |

| 29.3 Impaired receivables past their due date - Group and Trust | 31st March 2014 | 31st March 2013 |
|---|---|---|
| | £000 | £000 |
| By up to 30 days | **14** | 55 |
| By 30 to 60 days | **5** | 2 |
| By 60 to 90 days | **1** | 10 |
| By 90 to 180 days | **6** | 17 |
| By over 180 days | **197** | 135 |
| **Total** | **223** | 219 |

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

| 29.4 Receivables past their due date but not impaired - Group and Trust | 31st March 2014 | 31st March 2013 |
|---|---|---|
| | £000 | £000 |
| By up to 30 days | **1,128** | 961 |
| By 30 to 60 days | **267** | 113 |
| By 60 to 90 days | **87** | 23 |
| By 90 to 180 days | **211** | 81 |
| By over 180 days | **5** | 164 |
| **Total** | **1,698** | 1,342 |

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

**30 Other financial assets**

The Foundation Trust has no other Financial Assets.

**31 Other current assets**

The Foundation Trust has no other Current Assets.

**32 Cash and Cash Equivalents**

| | Group | | Trust | |
|---|---|---|---|---|
| | 31st March 2014 | 31st March 2013 | 31st March 2014 | 31st March 2013 |
| | £000 | £000 | £000 | £000 |
| Balance at start of period | **16,150** | 17,479 | **14,790** | 17,479 |
| Prior period adjustment | **0** | 2,217 | **0** | 0 |
| Balance at start of period (restated) | **16,150** | **19,696** | **14,790** | **17,479** |
| Net change in year | (4,080) | (3,546) | **(3,884)** | (2,689) |
| **Balance at end of period** | **12,070** | 16,150 | **10,906** | 14,790 |
| **Made Up Of** | | | | |
| Cash at commercial banks and in hand | **4** | 73 | **4** | 4 |
| Cash with the Government Banking Service | **12,066** | 16,077 | **10,902** | 14,786 |
| Other current investments | **0** | 0 | **0** | 0 |
| **Cash and Cash Equivalents as in Statement of Financial Position** | **12,070** | 16,150 | **10,906** | 14,790 |
| Bank overdraft | **0** | 0 | **0** | 0 |
| **Cash and Cash Equivalents as in Statement of Cash Flows** | **12,070** | 16,150 | **10,906** | 14,790 |

**33 Non-Current Assets Held for Sale**

The Trust has a IE33 Echocardiograph 2D Cardiac Ultrasound system (purchase date July 2005) for sale. The trust has received an offer of £6,000 for this asset in March 2014. As a consequence this asset has now been reclassified as held for sale and has been written down to the expected sale proceeds.

**34 Trade and other payables**

| | Group | | | Trust | | |
|---|---|---|---|---|---|---|
| **Current** | 31st March 2014 | 31st March 2013 | 01st April 2012 | 31st March 2014 | 31st March 2013 | 01st April 2012 |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Receipts in Advance | **0** | 0 | 21 | **0** | 0 | 21 |
| NHS payables - revenue | **3,038** | 3,986 | 2,854 | **3,038** | 3,986 | 2,854 |
| NHS payables - capital | **7** | 0 | 0 | **7** | 0 | 0 |
| Other trade payables - revenue | **3,120** | 1,167 | 3,443 | **3,099** | 1,108 | 2,995 |
| Local Authority payables | **56** | 17 | 62 | **56** | 17 | 62 |
| Other trade payables - capital | **646** | 2,583 | 837 | **646** | 2,583 | 837 |
| Taxes payable | **1,183** | 1,217 | 1,210 | **1,183** | 1,217 | 1,210 |
| NHS Pension Scheme Liability | **710** | 645 | 606 | **710** | 645 | 606 |
| Other payables | **53** | 769 | 249 | **53** | 769 | 249 |
| Accruals | **5,076** | 5,820 | 5,593 | **5,076** | 5,820 | 5,593 |
| PDC dividends payable | **0** | 0 | 0 | **0** | 0 | 0 |
| **Total** | **13,889** | 16,204 | 14,875 | **13,868** | 16,145 | 14,427 |

Non-current trade and other payables are £nil (31st March 2013 - £nil).

**35 Borrowings - Group and Trust**

| | Current | | | Non-current | | |
|---|---|---|---|---|---|---|
| | **31st March 2014** | 31st March 2013 | 01st April 2012 | **31st March 2014** | 31st March 2013 | 01st April 2012 |
| | **£000** | £000 | £000 | **£000** | £000 | £000 |
| Finance lease liabilities | **195** | 219 | 287 | **538** | 732 | 798 |
| **Total** | **195** | 219 | 287 | **538** | 732 | 798 |

**36 Finance lease obligations - Group and Trust**

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 £96k at 31st March 2014.

| **Amounts payable under finance leases:** | **Minimum lease payments** | | **Present value of minimum lease payments** | |
|---|---|---|---|---|
| | **31st March 2014** | 31st March 2013 | **31st March 2014** | 31st March 2013 |
| | **£000** | £000 | **£000** | £000 |
| Within one year | **232** | 266 | **195** | 219 |
| Between one and five years | **597** | 712 | **538** | 617 |
| After five years | **0** | 117 | **0** | 115 |
| Less future finance charges | **(96)** | (144) | **0** | 0 |
| Present value of minimum lease payments | **733** | 951 | **733** | 951 |
| Included in: | | | | |
| Current borrowings | **(195)** | (219) | **(195)** | (219) |
| Non-current borrowings | **(538)** | (732) | **(538)** | (732) |
| | (733) | (951) | (733) | (951) |

The Foundation Trust does not have sublease arrangements.

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

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

**38 Finance Lease Commitments**

The Trust does not have any Finance lease commitments at 31st March 2014 as all lease agreements are recognised within Finance lease obligations note 36.

**39 Other Financial Liabilities**

The Trust does not have any other Financial Liabilities.

**40 Deferred Income - Group and Trust**

| | Current | | Non-current | |
|---|---|---|---|---|
| | **31 March 2014** | 31 March 2013 | **31 March 2014** | 31 March 2013 |
| | **£000** | £000 | **£000** | £000 |
| **Opening balance at 1st April** | **788** | 1,622 | **738** | 0 |
| Deferred income addition | **2,141** | 498 | **111** | 0 |
| Transfer to/from current/non current income | **(325)** | (738) | **325** | 738 |
| Release to SOCI | **(522)** | (594) | **(191)** | 0 |
| **Balance at 31st March** | **2,082** | 788 | **983** | 738 |
| Total other liabilities (current and non-current) | **3,065** | 1,526 | | |

**41 Provisions - Group and Trust**

| | Current | | | Non-current | | |
|---|---|---|---|---|---|---|
| | **31st March 2014** | 31st March 2013 | 01st April 2012 | **31st March 2014** | 31st March 2013 | 01st April 2012 |
| | **£000** | £000 | £000 | **£000** | £000 | £000 |
| Legal claims | **63** | 38 | 20 | **0** | 0 | 0 |
| Equal pay | **0** | 0 | 557 | **0** | 0 | 0 |
| Other | **295** | 1,119 | 340 | **105** | 396 | 0 |
| **Total** | **358** | 1,157 | 917 | **105** | 396 | 0 |

| **Movement in current and non-current provisions** | **Legal claims** | **Other** | **Total** |
|---|---|---|---|
| | **£000** | **£000** | **£000** |
| **At 1st April 2013** | **38** | **1,515** | **1,553** |
| Change in the discount rate | | 4 | **4** |
| Arising during the year | 43 | 305 | **348** |
| Used during the year - accruals | 0 | 0 | **0** |
| Used during the year - cash | (18) | (169) | **(187)** |
| Reversed unused | 0 | (1,255) | **(1,255)** |
| **At 31st March 2014** | **63** | **400** | **463** |
| **Expected timing of cash flows:** | | | |
| Not later than one year | 63 | 295 | **358** |
| later than one year and not later than five years | 0 | 35 | **35** |
| later than five years | 0 | 70 | **70** |
| **Total** | **63** | **400** | **463** |

| **Amount included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:** | **£000s** |
|---|---|
| As at 31st March 2014 | 2,214 |
| As at 31st March 2013 | 1,873 |

**41 Provisions (continued)**

The Foundation Trust has total provisions at 31st March 2014 of £182k. Other provisions of £119k includes a permanent injury benefit award to a former employee and a provision in respect of an onerous contract.

The Foundation Trust has a provision for Liability to Third Parties legal claims of £63k 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 - Group and Trust**

| | Current | | | Non current | | |
|---|---|---|---|---|---|---|
| | **31st March 2014** | 31st March 2013 | 01st April 2012 | **31st March 2014** | 31st March 2013 | 01st April 2012 |
| | **£000** | £000 | £000 | **£000** | £000 | £000 |
| Deferred grants income | **0** | 0 | 38 | **0** | 0 | 0 |
| Other deferred income | **2,082** | 788 | 1,584 | **983** | 738 | 0 |
| | **2,082** | 788 | 1,622 | **983** | 738 | 0 |

**43 Contingencies - Group and Trust**

**43.1 Contingent Liabilities**

| | **31st March 2014** | 31st March 2013 |
|---|---|---|
| | **£000** | £000 |
| Other contingent liabilities | **(32)** | (12) |
| **Total** | **(32)** | (12) |

The Foundation Trust is advised by the NHS Litigation Authority of the full estimated liability associated with Liability to Third Party schemes. This liability is adjusted by applying a percentage probability to the full liability to calculate an amount to be provided. The difference between the full liability and the amount provided is recorded as a contingent liability. The contingent liability is reviewed each year as part of the advice from the NHSLA on the value of provisions in respect of legal claims.

**43.2 Contingent Assets**

The Foundation Trust does not have any contingent assets.

**44 Financial Instruments**

**44.1 Financial assets**

| | Group | | Trust | |
|---|---|---|---|---|
| | **2014 Loans and receivables** | 2013 Loans and receivables | **2014 Loans and receivables** | 2013 Loans and receivables |
| | **£000** | £000 | **£000** | £000 |
| Trade & other receivables excluding non financial assets | **3,908** | 3,940 | **3,801** | 3,740 |
| Other investments | **508** | 249 | **6** | 0 |
| Other financial assets | **0** | 0 | **0** | 0 |
| Cash and cash equivalents | **12,070** | 16,150 | **10,906** | 14,790 |
| **Total at 31st March** | **16,486** | 20,339 | **14,713** | 18,530 |

**44.2 Financial liabilities**

| | Group | | Trust | |
|---|---|---|---|---|
| | **2014 Other financial liabilities** | 2013 Other financial liabilities | **2014 Other financial liabilities** | 2013 Other financial liabilities |
| | **£000** | £000 | **£000** | £000 |
| Obligations under finance leases | **733** | 951 | **733** | 951 |
| Trade and other payables excluding non financial liabilities | **12,058** | 14,193 | **12,037** | 14,134 |
| Provisions under contract | **182** | 1,553 | **182** | 1,553 |
| **Total at 31st March** | **12,973** | 16,697 | **12,952** | 16,638 |

Provisions under contract are held at book value.

### 44.3 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups (CCG's) and NHS England and the way CCG's and NHS England 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 2014 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 CCG's and NHS England, which are financed from resources voted annually by Parliament. The Foundation Trust finances its capital expenditure from internally generated funds. 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.

## 46 Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1st April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

## 47 Movement in Taxpayers Equity

| 2013/14 | Group | Trust |
|---|---|---|
| | **£000** | **£000** |
| **Taxpayers' equity at 1st April 2013** | **67,399** | **65,819** |
| Surplus for the financial period | **1,382** | **1,437** |
| Revaluations and impairments | **2,492** | **2,492** |
| Fair value gains/(losses) on available for sale financial investments | **3** | **0** |
| **Taxpayers' equity at 31st March 2014** | **71,276** | **69,748** |

| 2012/13 | | |
|---|---|---|
| | £000 | £000 |
| **Taxpayers' equity at 1st April 2012** | 68,567 | 68,567 |
| Prior period adjustment | 1,964 | 0 |
| Surplus for the financial period | (2,893) | (2,482) |
| Revaluations and impairments | (266) | (266) |
| Fair value gains/(losses) on available for sale financial investments | 27 | 0 |
| **Taxpayers' equity at 31st March 2013** | 67,399 | 65,819 |

## 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 2014 none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Liverpool Heart and Chest Hospital NHS Trust.

One of the Trust's Associate Directors is married to an Associate Director of Business Development at Bridgewater Community Trust. The income from this Trust totals £4k for the year ended 31st March 2014. Neither party has had any involvement in the commissioning process.

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

| | Revenue | Expenditure | Receivables | Payables |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **NHS England** | | | | |
| NHS England - Core | 333 | | 54 | |
| NHS England - Core (legacy balances previously invoiced to/from PCTs) | | | 6 | |
| **Health Education England** | | | | |
| Health Education England | 2,619 | | | |
| **Local Area Teams** | | | | |
| Cheshire, Warrington & Wirral Area Team | 63,737 | | 5 | |
| Lancashire Area Team | 3 | | | |
| Merseyside Area Team | 60 | | 6 | |
| **Commissioning Support Units** | | | | |
| NHS Cheshire And Merseyside Commissioning Support Unit | | 65 | | |
| **Clinical Commissioning Groups** | | | | |
| NHS Airedale, Wharfdale And Craven CCG | 1 | | | |
| NHS Blackburn With Darwen CCG | 23 | | 3 | |
| NHS Blackpool CCG | 34 | | 7 | |
| NHS Bolton CCG | 18 | | | |
| NHS Bury CCG | 1 | | | |
| NHS Cambridgeshire And Peterborough CCG | 3 | | | |
| NHS Central Manchester CCG | 1 | | 1 | |
| NHS Chorley And South Ribble CCG | 27 | | 1 | |
| NHS Coastal West Sussex CCG | 3 | | | |
| NHS Coventry And Rugby CCG | 2 | | | |
| NHS Cumbria CCG | 42 | | 14 | |
| NHS Durham Dales, Easington And Sedgefield CCG | 4 | | | |
| NHS East Lancashire CCG | 12 | | 2 | |
| NHS East Riding Of Yorkshire CCG | 1 | | 1 | |
| NHS Eastern Cheshire CCG | 4 | | | |
| NHS Fylde & Wyre CCG | 15 | | 3 | |
| NHS Greater Huddersfield CCG | 2 | | 1 | |
| NHS Greater Preston CCG | 13 | | 1 | |
| NHS Halton CCG | 744 | | | |
| NHS Haringey CCG | 4 | | 3 | |
| NHS Hartlepool And Stockton-On-Tees CCG | 4 | | | |
| NHS Hastings And Rother CCG | 1 | | 1 | |
| NHS Herefordshire CCG | 1 | | | |
| NHS Herts Valleys CCG | 3 | | | |
| NHS Heywood, Middleton And Rochdale CCG | 6 | | | |
| NHS Knowsley CCG | 5,036 | | 16 | 95 |
| NHS Lancashire North CCG | 1 | | | |
| NHS Leeds North CCG | 4 | | | |
| NHS Liverpool CCG | 5,734 | | 3 | |
| NHS Nene CCG | 1 | | | |
| NHS Newham CCG | 1 | | | |
| NHS North Derbyshire CCG | 2 | | | |
| NHS North Manchester CCG | 1 | | 1 | |
| NHS North Staffordshire CCG | 1 | | | |
| NHS Oldham CCG | 4 | | | |
| NHS Rotherham CCG | 1 | | | |
| NHS Salford CCG | 5 | | 1 | |
| NHS Sheffield CCG | 1 | | | |
| NHS Shropshire CCG | 30 | | 7 | |
| NHS Solihull CCG | 1 | | | |
| NHS South Cheshire CCG | 27 | | 3 | |
| NHS South Manchester CCG | 3 | | | |
| NHS South Sefton CCG | 757 | | 2 | 12 |
| NHS South Tees CCG | 2 | | | |
| NHS South Warwickshire CCG | 2 | | 2 | |
| NHS Southern Derbyshire CCG | 1 | | | |
| NHS Southport And Formby CCG | 1,365 | | | 164 |
| NHS St Helens CCG | 1,066 | | | 45 |
| NHS Stockport CCG | 3 | | | |
| NHS Stoke On Trent CCG | 2 | | | |
| NHS Tameside And Glossop CCG | 1 | | | |
| NHS Telford And Wrekin CCG | 17 | | 4 | |
| NHS Trafford CCG | 14 | | | |
| NHS Vale Royal CCG | 82 | | 1 | |
| NHS Wakefield CCG | 1 | | | |
| NHS Wandsworth CCG | 1 | | 1 | |
| NHS Warrington CCG | 928 | | | 234 |
| NHS West Cheshire CCG | 933 | | 2 | 228 |
| NHS West Lancashire CCG | 954 | | 55 | |
| NHS West Leicestershire CCG | 1 | | | |
| NHS Wigan Borough CCG | 107 | | 3 | |
| NHS Wirral CCG | 1,511 | | 2 | 782 |
| NHS Wolverhampton CCG | 1 | | 1 | |
| NHS Wyre Forest CCG | 8 | | | |

**48 Related Party Transactions (continued)**

| | Revenue | Expenditure | Receivables | Payables |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **NHS Foundation Trusts** | | | | |
| 2Gether NHS Foundation Trust | 3 | | | |
| Aintree University Hospitals NHS Foundation Trust | 25 | 141 | 16 | 41 |
| Alder Hey Childrens NHS Foundation Trust | 3 | 39 | | 2 |
| Blackpool Fylde And Wyre NHS Foundation Trust | | 24 | | |
| Central Manchester University Hospitals NHS Foundation Trust | 5 | 85 | 8 | 8 |
| Christie Hospital NHS Foundation Trust | 1 | 1 | | 1 |
| Clatterbridge Centre For Oncology NHS Foundation Trust | 3 | | | |
| Countess Of Chester Hospital NHS Foundation Trust | 53 | 41 | 70 | |
| Guys And St Thomas NHS Foundation Trust | | 7 | | |
| Lancashire Care NHS Foundation Trust | 1 | | | |
| Lancashire Teaching Hospitals NHS Foundation Trust | | 61 | | 1 |
| Liverpool Womens Hospital NHS Foundation Trust | | 6 | | 2 |
| Northumbria Healthcare NHS Foundation Trust | | | | 74 |
| Oxford Health (was Oxford and Buckinghamshire) NHS Foundation Trust | | 7 | | 1 |
| Papworth Hospital NHS Foundation Trust | | 6 | | |
| Royal Bolton Hospital NHS Foundation Trust | | 1 | | |
| Royal Brompton And Harefield NHS Foundation Trust | 1 | 4 | | 4 |
| Salford Royal NHS Foundation Trust | 19 | 40 | | |
| Sheffield Teaching Hospitals NHS Foundation Trust | 1 | | | |
| South Devon Healthcare NHS Foundation Trust | | 12 | | 1 |
| Taunton And Somerset NHS Foundation Trust | | 12 | | |
| The Walton Centre NHS Foundation Trust | 9 | | | |
| University Hospital Of South Manchester NHS Foundation Trust | | | | 1 |
| University Hospital Southampton NHS Foundation Trust | 60 | | 3 | |
| Warrington And Halton Hospitals NHS Foundation Trust | 176 | 56 | 72 | 1 |
| Wirral University Teaching Hospital NHS Foundation Trust | 48 | | 36 | |
| **NHS Trust** | | | | |
| Avon And Wiltshire Mental Health Partnership NHS Trust | 1 | | | |
| Barts Health NHS Trust | | 1 | | |
| Bridgewater Community HealthCare NHS trust | 4 | 1 | | |
| East Cheshire NHS Trust | | 15 | | 1 |
| East Of England Ambulance Service NHS Trust | | 1 | | |
| Liverpool Community Health NHS Trust | 117 | | 69 | |
| Mersey Care NHS Trust | 18 | 449 | 1 | 36 |
| Oxford University Hospitals NHS Trust | | 11 | | 4 |
| Portsmouth Hospitals NHS Trust | | 2 | | |
| Royal Liverpool & Broadgreen University Hospitals NHS Trust | 1,802 | 5,708 | 726 | 1,565 |
| Southport And Ormskirk Hospital NHS Trust | 88 | | 32 | 1 |
| St Helens And Knowsley Hospitals NHS Trust | 88 | 11 | 29 | |
| University Hospital Of North Staffordshire Hospital NHS Trust | | | 1 | |
| NHS Blood & Transplant | 8 | | | |
| NHS Litigation Authority | | 502 | | 1 |
| NHS Business Services Authority (incl student bursaries) | | | | 2 |

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 (PDC dividend only) - not part of agreement of balances | | 1,866 | 145 | |
| Department of Health : Core trading & NHS Supply Chain (excluding PDC dividend) | 92 | 1 | 9 | |
| Knowsley Metropolitan Borough Council | | 73 | 0 | 18 |
| Liverpool City Council | | 40 | | 38 |
| National Insurance Fund (both Employee and Employer contributions o/s) | | | | 568 |
| National Insurance Fund (Employer contributions only - Revenue Expenditure) | | 3,844 | | |
| NHS Pension Scheme (both employee and employer contributions o/s plus other invoiced charges) | | | | 710 |
| NHS Pension Scheme (Own staff employers contributions only plus other invoiced charges) | | 5,058 | | |
| HM Revenue & Customs - VAT | | | 195 | |
| HM Revenue & Customs - Other taxes and duties | | | | 615 |
| Welsh Assembly Government (incl all other Welsh Health Bodies) | 15,124 | | 31 | |
| Scottish Government | 95 | | | |
| Community Health Partnerships | | 2 | | 2 |
| Department of Health, Social Services and Public Safety - Northern Ireland | 4 | | | |
| Driver and Vehicle Licensing Agency | 1 | | | |

## 49 Third Party Assets

The Trust held £812 cash at bank and in hand at 31 March 2014 (£582 - at 31st March 2013) 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 - Group and Trust

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. These payments are analysed as follows:-

| | **Total number of cases** | **Total value of cases** | Total number of cases | Total value of cases |
|---|---|---|---|---|
| | **31st March 2014 Number** | **31st March 2014 £000** | 31st March 2013 Number | 31st March 2013 £000 |
| **Losses:** | | | | |
| Losses of cash | **4** | **0** | 3 | 0 |
| Fruitless payments and constructive losses | **0** | **0** | 0 | 0 |
| Bad debts and claims abandoned | **0** | **0** | 0 | 0 |
| Damage to buildings and property (including stores losses) | **0** | **0** | 0 | 0 |
| **Total losses** | **4** | **0** | 3 | 0 |
| **Special payments:** | | | | |
| Extra-contractual payments | **2** | **46** | 0 | 0 |
| Extra-statutory and extra-regulatory payments | **0** | **0** | 0 | 0 |
| Compensation payments | **5** | **95** | 0 | 0 |
| Special severance payments | **0** | **0** | 2 | 21 |
| ex gratia payments | **19** | **64** | 24 | 120 |
| **Total special payments** | **26** | **205** | 26 | 141 |
| **Total losses and special payments** | **30** | **205** | 29 | 141 |

## 51 NHS Charitable Funds

Separate charity accounts are prepared for Liverpool Heart and Chest Hospital Charity in accordance with the UK Charities SORP and submitted to the Charity Commission. A summary Statement of Financial Activities and summary Balance Sheet are presented below.

### 51.1 Summary Statement of Financial Activities

| | 31st March 2014 | | | 31st March 2013 | | |
|---|---|---|---|---|---|---|
| | **Amounts in Charity Accounts £000** | **Intra-Group eliminations £000** | **Amounts consolidated in Group Accounts £000** | Amounts in Charity Accounts £000 | Intra-Group eliminations £000 | Amounts consolidated in Group Accounts £000 |
| **Incoming resources:** | | | | | | |
| Incoming resources from donations, legacies and other charitable activities | **529** | **0** | **529** | 628 | 0 | 628 |
| **Resources expended:** | | | | | | |
| Employee resources expended with the Foundation Trust | (118) | **118** | **0** | (106) | 106 | 0 |
| Other resources expended with the Foundation Trust | (114) | **114** | **0** | (606) | 606 | 0 |
| Other resources expended external to the Foundation Trust | (8) | **0** | (8) | (8) | 0 | (8) |
| **Total operating expenditure** | (240) | **232** | (8) | (720) | 712 | (8) |
| Investment income and income on short term deposits | **13** | **0** | **13** | 17 | 0 | 17 |
| **Net (outgoing) / incoming resources before other recognised gains and losses** | **302** | **232** | **534** | (75) | 712 | 637 |
| Gains/(losses) on investment assets | **3** | **0** | **3** | 27 | 0 | 27 |
| **Net movement in funds** | **305** | **232** | **537** | (48) | 712 | 664 |

### 51.2 Summary Balance Sheet

| | 31st March 2014 | | | 31st March 2013 | | | 01st April 2012 | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Amounts in Charity Accounts £000** | **Intra-Group eliminations £000** | **Amounts consolidated in Group Accounts £000** | Amounts in Charity Accounts £000 | Intra-Group eliminations £000 | Amounts consolidated in Group Accounts £000 | Amounts in Charity Accounts £000 | Intra-Group eliminations £000 | Amounts consolidated in Group Accounts £000 |
| **Non-current assets** | | | | | | | | | |
| Other investments | **502** | **0** | **502** | 249 | 0 | 249 | 222 | 0 | 222 |
| **Total non-current assets** | **502** | **0** | **502** | 249 | 0 | 249 | 222 | 0 | 222 |
| **Current assets** | | | | | | | | | |
| Inventories | **1** | **0** | **1** | 0 | 0 | 0 | 0 | 0 | 0 |
| Trade and other receivables | **107** | **0** | **107** | 200 | 0 | 200 | 88 | 0 | 88 |
| Cash and cash equivalents | **1,164** | **0** | **1,164** | 1,360 | 0 | 1,360 | 2,217 | 0 | 2,217 |
| **Total current assets** | **1,272** | **0** | **1,272** | 1,560 | 0 | 1,560 | 2,305 | 0 | 2,305 |
| **Current liabilities** | | | | | | | | | |
| Trade and other payables | (246) | **225** | (21) | (229) | 170 | (59) | (563) | 115 | (448) |
| **Total current liabilities** | (246) | **225** | (21) | (229) | 170 | (59) | (563) | 115 | (448) |
| **Total non-current liabilities** | **0** | **0** | **0** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net Assets** | **1,528** | **225** | **1,753** | 1,580 | 170 | 1,750 | 1,964 | 115 | 2,079 |
| **Funds of the Charity*** | | | | | | | | | |
| Unrestricted income funds** | **1,528** | | | 1,580 | | | 1,964 | | |
| **Total Charitable Funds** | **1,528** | | | 1,580 | | | 1,964 | | |

*The funds of the charity analyses the NHS Charitable Funds reserve in the Group Statement of Financial Position.

** Unrestricted funds are spent or applied at the discretion of the trustees to further the charity's objects. Unrestricted funds include designated funds which the trustee has chosen to earmark for set purposes. Designated funds with a value of at least £50,000 are detailed in note 51.3.

## 51 NHS Charitable Funds (continued)

51.3 Unrestricted funds - Designated funds

Designated funds with a value of at least £50,000:

| Name of fund | Note | Balance at 01 April 2013 £000 | Incoming resources £000 | Resources expended £000 | Gains and (losses) £000 | Balance at 31 March 2014 £000 |
|---|---|---|---|---|---|---|
| Robert Owen House | 1 | 362 | 156 | (155) | 2 | **365** |
| Heart Appeal | 2 | 129 | 1 | (6) | 0 | **124** |
| LHCH Appeal | 3 | 606 | 305 | (272) | 5 | **644** |
| Merseybeat | 4 | 103 | 1 | (37) | (2) | **65** |
| Aneurysm Project | 5 | 79 | 59 | (85) | (1) | **52** |
| Cystic Fibrosis | 6 | 114 | 1 | (6) | 0 | **109** |
| Lung Cancer | 6 | 57 | 1 | (1) | 0 | **57** |

1. Robert Owen House provides inexpensive relatives accommodation.
2. The Heart Appeal purchases equipment on behalf of the Foundation Trust.
3. The LHCH Appeal is for any charitable purpose or purposes relating to services provided by the Foundation Trust.
4. Merseybeat was relaunched as LHCH Appeal in September 2009. Balances raised prior to 2009 are ringfenced to apply to research.
5. The Aneurysm Project supports research into aetiology and frequency of thoracic aneurysms and also research projects on young patients who undergo aneurysm surgery to improve their outcomes. In addition this Fund supports the bienniel Aortic Symposium.
6. The Cystic Fibrosis and Lung Cancer funds facilitate education and research into adult cystic fibrosis and lung cancer and provide support for patients with this condition.

## INDEPENDENT AUDITORS' REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the NHS foundation trust consolidation schedules (FTCs) numbered 1 to 41 of Liverpool Heart and Chest Hospital NHS Foundation Trust for the year ended 31 March 2014, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to the Council of Governors and Board of Directors of Liverpool Heart and Chest Hospital NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust, the Trust's Governors as a body and the Trust's Board of Directors as a body, for our audit work, for this report, or for the opinions we have formed.

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

Grant Thornton UK LLP

Grant Thornton UK LLP

Grant Thornton, 4 Hardman Square, Spinningfields, Manchester, M3 3EB

29 May 2014

## Independent auditor's report to the Council of Governors and Board of Directors of Liverpool Heart and Chest Hospital NHS Foundation Trust

We have audited the financial statements of Liverpool Heart and Chest Hospital NHS Foundation Trust ('the Trust') for the year ended 31 March 2014 which comprise the group and Trust statement of comprehensive income, the group and Trust statement of financial position, the group and Trust statement of cash flow, the statement of changes in taxpayers' equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

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

- the table of salaries and allowances of senior managers and related narrative notes
- the table of pension benefits of senior managers and related narrative notes and
- the table of pay multiples and related narrative notes.

This report is made solely to the Council of Governors and Board of Directors of Liverpool Heart and Chest Hospital NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Governors and Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust, the Trust's Governors as a body and the Trust's Board of Directors as a body, for our audit work, for this report, or for the opinions we have formed.

### Respective responsibilities of accounting officer and auditor

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

The Accounting Officer is responsible for the maintenance and integrity of the corporate and financial information on the Trust's website. Legislation in the United Kingdom governing the preparation and dissemination of the financial statements and other information included in annual reports may differ from legislation in other jurisdictions.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts issued by Monitor, and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's (APB's) Ethical Standards for Auditors.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In

addition, we read all the financial and non-financial information in the annual report which comprises Strategic Report, Directors' Report, NHS Foundation Trust Code of Governance, Quality Report, Staff Survey, Annual Governance Statement and Other disclosures to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially inconsistent with the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

**Opinion on the financial statements**

In our opinion the financial statements:

- give a true and fair view of the state of the financial position of the group and Liverpool Heart and Chest NHS Foundation as at 31 March 2014 and of the group's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

**Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts**

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006 and the NHS Foundation Trust Annual Reporting Manual 2013-14 issued by Monitor
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we are required to report by exception**

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit
- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources
- the Trust's Quality Report has not been prepared in line with the requirements set out in the NHS Foundation Trust Annual Reporting Manual or is inconsistent with other sources of evidence.

**Certificate**

We certify that we have completed the audit of the financial statements of Liverpool Heart and Chest Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Jackie Bellard

Jackie Bellard
for and on behalf of Grant Thornton UK LLP

4 Hardman Square
Spinningfields
Manchester
M3 3EB

29 May 2014

Grant Thornton

**Independent Auditors' Limited Assurance Report to the Council of Governors of Liverpool Heart and Chest NHS Foundation Trust on the Quality Report**

We have been engaged by the Council of Governors of Liverpool Heart and Chest NHS Foundation Trust to perform an independent limited assurance engagement in respect of Liverpool Heart and Chest NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

**Scope and subject matter**
The indicators for the year ended 31 March 2014 subject to limited assurance consist of those national priority indicators mandated by Monitor:

- Percentage of patients aged 15 or over, readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

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

**Respective responsibilities of the Directors and Auditors**
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's *2013/14 Detailed Guidance for External Assurance on Quality Reports*; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2013 to 27 May 2014;
- Papers relating to quality reported to the Board over the period April 2013 to 27 May 2014;
- Feedback from the Commissioners dated 27 May 2014;
- Feedback from local Healthwatch organisations dated 9 May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13 May 2014;
- The national patient survey dated 2013, received May 2014;
- The national staff survey dated 201, received March 2014;
- Care Quality Commission quality and risk profiles dated 13 March 2014;

- The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2014; and

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Liverpool Heart and Chest NHS Foundation Trust as a body, to assist the Council of Governors in reporting Liverpool Heart and Chest NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Trust's Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Liverpool Heart and Chest NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

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

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

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

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

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

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Liverpool Heart and Chest NHS
Foundation Trust.

**Conclusion**
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above, and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

Grant Thornton UK LLP

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29 May 2014