Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Annual Report and Accounts 2015/16

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

Liverpool Heart and Chest Hospital NHS Foundation Trust

Annual Report and Accounts **2015/16**

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

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CHAIR AND CHIEF EXECUTIVE'S FOREWORD

We are delighted to welcome you to this year's annual report and accounts for 2015/16.

Despite the challenges of the past 12 months and the environment in which we, and all other NHS providers, continue to operate, it will be no surprise to anyone who comes into contact with our Trust that our achievements during 2015/16 have been impressive.

Our 1,400 staff approached the year with their focus on delivering the best care and services possible for every one of our patients and families. It was, therefore, pleasing at the beginning of the year to see that this dedication to '***being the best'*** was recognised in the Care Quality Commission's National Inpatient Survey.

As in the last 9 years, we again scored amongst the very best trusts in the country with the particular highlights being rated top in the country for '*nurses within the hospital'*, '*care and treatment of our patients'*, and '*cleanliness of wards*'.

We value our staff highly and would like to thank them for their achievements in the past 12 months and for sharing their views through the NHS Staff Survey, providing some of the best results in the country:

- Staff agreeing that their role makes a difference to patients – *2nd in the country*
- Staff not experiencing harassment, bullying or abuse – *2nd in the country*
- Staff engagement – *3rd in the country*
- Recommendation to work or receive treatment – *3rd in the country*

This year we have continued working closely with our commissioners and other stakeholders in the wider health economy, especially with the ongoing Healthy Liverpool Programme. The goal of this programme is to make health and social care in the city more sustainable by focussing on a number of key areas to help prevent illness, to improve the quality of life for people with long-term conditions, and to reduce pressure on the NHS.

As a key partner within this programme, we are committed to identifying ways to further improve healthcare and the services we provide for our patients and families into the future.

Whilst concerns about NHS finances remain, here at Liverpool Heart and Chest Hospital we were pleased to be able to invest in our services and the hospital environment. In August 2015, we realised our ambition of improving the services we provide for our cystic fibrosis patients by opening our brand new 10 bedded Cherry Ward. We also opened Mulberry Ward, our new discharge lounge which is already playing an important role in ensuring more and more of our patients are discharged home before lunch.

Looking ahead to the second half of 2016, we are eagerly anticipating the culmination of two major projects - our new hospital main entrance and our redesigned Outpatient Department. Both of these developments will deliver significant benefits to the experience of our patients and their families.

This year we have further enhanced our reputation as a learning organisation by launching our new patient safety campaign, HALT *(**H**ave you noticed this; **A**sk did you hear my concern; **L**et them know it is a patient/staff safety issue; **T**ell them to stop until it is safe to continue).* With the full backing of the Board of Directors, staff have our full support to use this new four step process, whenever and wherever necessary, to prevent a safety incident for our patients and staff.

It is initiatives like this, alongside our daily safety huddle, which saw us ranked 'Outstanding' – one of only 18 trusts in the country – in the Department of Health's new *'Learning from Mistakes League'* when it was published in March 2016.

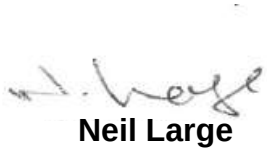
We firmly believe that being open, honest and accountable to our patients and the public, helps to drive improvements in the care that we deliver. It is pleasing to note that our hard work to develop an increasingly open and transparent culture, where staff feel confident to report incidents and contribute towards improvements, has been recognised nationally.

Since our last Annual Report, the Board of Directors was delighted to welcome Dr Raphael Perry as our new Medical Director in June 2015 and we would like to place on record our thanks to Dr Glenn Russell for his expertise and contribution after stepping down from the role in which he served for many years.

We are grateful once more for the contribution of our members and particularly for the invaluable support of our Governors who give their time voluntarily to raise awareness of the work of the hospital in their constituencies and to assist the Board of Directors on a range of issues.

Finally we would like to place on record our sincere thanks to all our volunteers without whom the hospital would not be the same place.

There is no doubt that 2016/17 will once again be challenging, if not more so, than 2015/16. But by maintaining a sharp focus on what they do best, our dedicated teams will ensure that our patients and families experience the excellent, compassionate and safe care that they deserve.



Neil Large
Chairman

Jane Tomkinson
Chief Executive

KEY ACHIEVEMENTS IN 2015/16

- Patients rated the Trust as the best in the country for ‘care and treatment’, ‘nurses within the hospital’ and ‘cleanliness of wards’ in the Care Quality Commission’s National Inpatient Survey. The Trust was also rated second in the country for ‘overall patient care’.

- The Trust was recognised as being ‘outstanding’ – one of only 18 trusts in the country - by the Department of Health for levels of openness and transparency in its new ‘Learning from Mistakes League’ reported in March 2015.

- Professor Aung Oo, Consultant Cardiac Surgeon, was awarded the post of honorary chair from the University of Liverpool.

- Professor Martin Walshaw, Consultant Respiratory Physician, was recognised as an honorary professor by the University of Liverpool.

- Mr Richard Page, Consultant Thoracic Surgeon, was voted the new President of the Society for Cardiothoracic Surgery.

- Dr Joseph Mills, Consultant Cardiologist, was appointed president of the British Association for Cardiovascular Prevention and Rehabilitation.

- Ms Jane Tomkinson, Chief Executive, was awarded an OBE in the Queen’s New Year Honours for services to NHS finance.

- LHCH was a shortlisted finalist in four categories at the Nursing Times Awards 2015.

- LHCH was announced as one of the ‘Best Places to Work in Healthcare’ as reported by the Health Service Journal, Nursing Times and NHS Employers.

- The Trust continues its registration with the independent health regulator, the Care Quality Commission without any conditions.

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

PART 1: PERFORMANCE REPORT

This 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 Overview

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 best 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.

Liverpool Heart and Chest Hospital is one of the largest single site specialist heart and chest hospitals 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 2.8million 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 2015/16, it treated:

- 2,120 cardiac surgery inpatients
- 8,821 cardiology inpatients
- 496 respiratory inpatients
- 1,427 thoracic surgery inpatients
- 644 other inpatients (including cystic fibrosis)
- 70,260 outpatients

As at March 31st 2016, the Trust employed 1,494 staff of whom 369 were male and 1,061 were female. There were also 29 senior managers, of whom 14 were male and 15 were female. The Trust also greatly values the support of its ever expanding cohort of volunteers.

The Trust aims to provide 'e*xcellent, 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, 'to be the best', 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 Trust's vision, strategic objectives and all key activities are underpinned by its safety culture, vision for Patient and Family Centred Care and its People Strategy.

The Trust is well placed within the Health Economy, with a reputation for the provision of high quality and specialised clinical services. The changing health economy (both local and regional) and the potential impact of increased competition poses a number of threats, and this has been evident through the impact of the national payment tariff structure going into 2016-17 – resulting in a significant reduction in income in a year where the average national income for providers across the country has increased. The Trust will continue to focus on its key strengths based on strong operational and clinical performance, whilst ensuring long term financial viability.

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 is a digitally enabled organisation and seeks to improve clinical and operational performance and the patient and family experience. Alongside significant investments in its

IT infrastructure, further investments have been made to the estate with all new clinical areas designed 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 Trust recognises the challenges it is facing but sees opportunities to strengthen its position through extending integrated models of care through collaborative working. The Trust has developed a long term plan that it continues to execute with success, which will help to ensure that the Trust continues to succeed and that commissioner focus on service quality (national standards, NICE implementation and delivery of the NHS Constitution) remains a key strength.

Within this context, the plan continues to focus on where it is possible to form strong clinical and organisational relationships. There is clear evidence that partnerships enhance the role of the Trust, improve patient care and outcomes at partner Trusts and reduce streamline patient pathways.

1.2 Performance Analysis

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. The Trust's core services are cardiology and chest medicine, cardiac and thoracic surgery and the provision of community-based care services for chronic long term conditions.

The total annual operating revenue for the Trust in 2015/16 was £122.7m - an increase of 4.6% from 2014/15.

The total income was derived from a number of key contracts; £73.0m from NHS England Cheshire, Warrington and Wirral Area Team for Tertiary Care activity, £14.9m from the Welsh Health Specialised Services Committee, £16.1m from North West Clinical Commissioning Groups for Secondary Care activity, £3.5m from Community contracts, £3.2m from Private Patient work, £3.5m for the Isle of Man Contract, £2.8m for Clinical Education and Training and £1.3m in support of Research and Development activities.

The table below demonstrates the movement in patient activity numbers since 2010/11.

Activity	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	5 Year Growth
Surgery Inpatients	3,604	3,356	3,728	3,724	3,709	3,653	1%
Medicine Inpatients	8,858	9,186	9,233	8,976	8,986	9,317	5%
Outpatients	62,794	64,226	63,968	65,758	73,029	72,711	16%

As at March 31st 2016, the Trust was compliant with all of the Monitor performance targets for 18 weeks, cancer, waiting times and diagnostic waiting times.

The Trust failed to meet the 18 week referral to treatment (RTT) target in three months of the year, but this did not impact on the Monitor governance risk rating.

Performance against the Welsh 26 week targets was below plan and actions to improve performance have been shared with the Trust's commissioning colleagues in Wales.

Analysis of 2015/16 Financial Performance

The Trust's financial plans for 2015/16 required the delivery of a deficit of £0.3m (after the achievement of a £4.6m cost improvement programme). The Trust delivered a normalised deficit (excluding the impact of impairments) of £1.2m (including actual delivery of CIP of £3.3m) as summarised in the table below.

Financial Performance	2015/16 Plan	2015/16 Actual	Variance
	£000's	£000's	£000's
Operating Revenue	**121,066**	122,660	**1,594**
Expenses:			
Employee expenses	**(65,934)**	(66,498)	**(564)**
Direct non pay expenses	**(40,850)**	(42,292)	**(1,442)**
Overheads	**(7,051)**	(7,984)	**(933)**
Earnings before interest tax, depreciation and amortisation (EBITDA)	**7,231**	**5,886**	**(1,345)**
Net financing expenses	**(7,530)**	(7,182)	**348**
Net surplus/(deficit)	**(299)**	**(1,296)**	**(997)**
Exception items (included above)*	**0**	**108**	**108**
Trust normalised surplus/(deficit	**(299)**	**(1,188)**	**(889)**

**Exceptional items include an impairment reversal of £0.027m; offset in part by impairment of £0.132m and loss on disposal of asset (£0.003m)*

The Trust's normalised revenue at £122.7m is some £1.6m above the plan for 2015/16. The main elements of this include the following.

- The tertiary contract with NHS England over-performed by £1.0m (1.4%). This is materially driven by recharged devices (£1.1m), Drugs (0.65m) and non- elective activity (£0.5m).
- The secondary care contracts experienced an over performance of some £0.8m. Materially the over performance is driven by outpatient activity. All areas of Outpatients have over-performed; outpatient first attendances (£0.33m), Outpatient procedures (£0.29m) and Radiology (£0.26m) all contributed greatly to the position.
- The Welsh contract was above plan by £0.1m (0.5%). Drugs were over plan (£145k) and non-elective activity was above plan (£98k), however both elective (£133k) and device recharges (£116k) were below plan.
- The Isle of Man contract was above plan by £0.6m (20%) above plan, driven by non-elective non-emergency activity (£192k), critical care (£136k) and devices (£120k).
- Private patient income was below plan by £0.6m (15%).
- Non patient related income was above plan by £0.6m above plan (8%) materially driven by SLA/Trust income.

Costs and Cost Improvement Programme

The Trust's total costs in 2015/16 were £124.0m. After normalising for the impact of impairment of £0.1m, costs were above plan by £2.5m.

Pay costs were £0.6m (0.9%) above plan. The average number of vacancies for the year was 114.88 FTE. Within this position locum, bank, agency and overtime costs of £5.1m 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 £1.5m (3.7%). This largely relates to clinical supplies, within which one of the key drivers of the position is in relation to high cost devices which are directly offset by the over-recovery of income.

The Trust also delivered a Cost Improvement Programme (CIP) of £3.3m or 2.9% of its planned operating expenditure over the period. The savings can be categorised as follows:

Cost Improvement Programme performance by cost category	Plan	Actual	Variance
	£000's	£000's	£000's
Revenue generation	**385**	862	**477**
Employee expenses	**1,825**	1,250	**-575**
Non Pay expenses	**2,350**	1,197	**-1,153**
Toal Cost Improvement Programme	**4,560**	**3,309**	**-1,251**

Key enabling strategies that produced 2015/16 cost savings included procurement practices, staffing skill mix reviews and additional revenue generation.

CIP schemes are identified by Trust divisions and are subject to review via the Trust Senior Management Team, overseen by the CIP Steering Group reporting to the Executive Team and providing assurance through the Integrated Performance Committee. Quality Impact Assessments are undertaken on all CIP schemes above a de minimus value and are reviewed through the Quality Committee to ensure that schemes are not agreed which will 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 2015/16 financial year, the total capital investment in improving the hospital facilities was £4.9m. The main investments included:

- £0.6m for the purchase of medical equipment
- £1.2m spent as part of the on-going development of the Cherry Ward, cystic fibrosis unit
- £0.8m development of a main entrance for Liverpool Heart and Chest Hospital
- £0.4m development / maintenance of the estate
- £0.4m IT investment and further development of the Electronic Patient Record system.

A breakdown of capital expenditure is detailed in the following table:

2015/16 Capital Programme Summary	Plan	Actual	Variance
	£000's	£000's	£000's
Medical Equipment	598	609	11
Estates Infrastructure	502	446	-56
IT Infrastructure	845	370	-475
Cherry Ward Redevelopment	1,111	1,167	56
Main Entrance Redevelopment	1,048	840	-208
Contingency	260	804	544
Slippage of schemes from 2014/15	941	708	-233
Total Capital Investment	5,305	4,944	-361

After funding the capital programme outlined above, the Trust had a closing cash balance of £7.9m as at 31st March 2016. The Trust's cash position was £0.9m ahead of plan and reflects favourable movements on working capital balances, combined with the underspend against the capital programme.

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 2016 is £0.4m.

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 £36k of interest.

Productivity, Efficiency and CIPs

The Board of Directors continues 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 a sufficient and sustainable operating cash flow, so that it can continue to provide the services that it 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 best 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 plays to its strengths. Specifically the Trust will continue to work closely with NHS Improvement and commissioners to ensure that reimbursement for services through tariff adequately reflects the complexity and cost of delivery.

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 patients.

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

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

to a position where growth is only included where it is realistic, fully understood and deliverable. Where growth is considered likely, the Trust discusses with commissioners at the earliest opportunity, to ensure effective planning. Growth included in the plans for 2015/16 has been largely offset by additional marginal and stepped costs, so income growth provides a modest contribution to the overall efficiency requirement. This approach will require that LHCH move to a more transformational approach in order to deliver sustained clinical, operational and financial improvement.

The Trust's approach can be best typified through use of its divisional structures which enable deeper clinical engagement, responsive financial and operational controls to manage its expenditure base with improved rigour in the 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. Divisions have been, and continue to be, encouraged to benchmark, wherever possible from both clinical quality and use of resources perspectives, the way services are provided at LHCH compared to elsewhere and to both identify and execute delivery of agreed improvements based upon that work.

Better Payment Practice Code

The *Better Payment Practice Code* requires trusts 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.

Performance against the Better Payment Practice Code has improved in 2015 /16 for non-NHS suppliers. However, there has been a slight deterioration in the payment of NHS invoices as older invoices previously in dispute have been settled during the year.

Better Payment Practice Code – measure of compliance	Number	£000's
Total Non-NHS trade invoices paid in the period	31,783	58,309
Total Non-NHS trade invoices paid in within target	30,297	54,164
Percentage of Non-NHS trade invoices paid within target	**95.3%**	**92.9%**
Total NHS trade invoices paid in the period	869	11,632
Total NHS trade invoices paid within the target	556	8,696
Percentage of NHS trade payables paid within target	**64.0%**	**74.8%**

Treasury Management

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust's treasury management activity is subject to review by internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The 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 Trust funds its capital programme from internally generated funds, therefore does not have any other loans and so is not exposed to significant interest rate risk.

Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies. The Trust has low exposure to credit risk. The maximum exposures as at 31st March 2016 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity Risk

The Trust's operating costs are incurred under contracts with CCGs and NHS England, which are financed from resources voted annually by Parliament. The Trust finances its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

Going Concern

After making enquiries, the Board of Directors has a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

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.

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 an executive lead for all environmental issues and continues to implement a number of low energy projects across the Estate. The Trust also undertakes feasibility studies into alternative energy projects that will provide more sustainable energy and more resilient services to the Trust.

Conclusion

2015/16 has been another extremely challenging year, and whilst the Trust has not managed to maintain the income and expenditure position within the planned deficit of £300k, the Trust has successfully managed to maintain the position within the revised forecast deficit of £1.2m (reported from month 6 onwards), which recognised service pressures including above plan use of agency.

Whilst the overall position is below plan, the Trust has been able to report a financial sustainability risk rating of 3 – which reflects an acceptable level of financial risk, and which is in line with the planned position. The Trust also delivered efficiencies of £3.3m.

Plans for 2016/17 have been set and aim to build upon this year's strong performance, with further investment in the Trust's Estate, IT Infrastructure and medical equipment.

Jane Tomkinson
Chief Executive

Date: 26th May 2016

PART 2: ACCOUNTABILITY 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

2.1 Directors' Report

This section of the annual report sets out the role and work of the Board of Directors and explains how the Trust is governed.

The Board of Directors

The Board of Directors has collective responsibility for setting the strategic direction and organisational culture; and for the effective stewardship of the Trust's affairs, ensuring that the Trust complies with its licence, constitution, mandated guidance and contractual and statutory duties. The Board must also provide effective leadership of the Trust within a robust framework of internal controls and risk management processes. The Board approves the Trust's strategic and operational plans, taking into account the views of Governors; it sets the vision, values and standards of conduct and behaviour, ensuring that its obligations to stakeholders, including patients, members and the wider public are met. The Board is responsible for ensuring the safety and quality 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 has a formal Schedule of Matters Reserved for Board Decisions and a Scheme of Delegation.

The unitary nature of the Board means that Non-Executive Directors and Executive Directors share the same liability and same responsibility for Board decisions and the development and delivery of the Trust's strategy and operational plans. The Board delegates operational management to its executive team and has established a Board Committee structure to provide assurances that it is discharging its responsibilities. The formal Schedule of Matters Reserved for the Board also includes decisions reserved for the Council of Governors as set out in statute and within the Trust's constitution.

During the period 1st April 2015 to 31st March 2016, the following were members of the Trust's Board of Directors:

Name / Profile Overview	Title	Notes
Neil Large *Qualified accountant and diverse NHS career spanning 40 years.*	**Chairman**	Also interim Non-Executive Director at Christie Hospital NHS FT
David Bricknell *Master in Research and PhD in strategic decision making with a career as a lawyer in industry.*	**Deputy Chair / Non-Executive Director / Senior Independent Director**	
Lawrence Cotter *Consultant Cardiologist and Honorary Professor of Medical Education at University of Manchester.*	**Non –Executive Director**	
Marion Savill *Business investor and Board level strategic advisor.*	**Non-Executive Director**	
Mark Jones *Senior executive with international career in pharmaceutical industry.*	**Non-Executive Director**	
Julian Farmer *Qualified accountant with senior level experience as an auditor within the health and local government sectors.*	**Non-Executive Director / Chair of Audit Committee**	Started 1st June 2015
Ken Morris *Accountant and management consultant; former Chair at Liverpool Women's NHS Foundation Trust.*	**Interim Non-Executive Director / Chair of Audit Committee**	Started 1st February 2015 and served until 31st May 2015
Jane Tomkinson *Qualified accountant and former Director of Finance positions– NHS England and Countess of Chester NHS Foundation Trust.*	**Chief Executive**	
David Jago *BA Hons, CPFA. Previous Director and Deputy Director of Finance roles in Tameside, University Hospital of South Manchester and Conwy & Denbighshire.*	**Chief Finance Officer / Deputy Chief Executive**	
Dr Glenn Russell *Consultant Anaesthetist with extensive experience in cardiac anaesthesia in UK and overseas.*	**Medical Director**	Served as Medical Director until 30th June 2015
Dr Raphael Perry *Consultant Interventional Cardiologist of national standing.*	**Medical Director**	Appointed Medical Director with effect from 1st July 2015
Sue Pemberton *BSc Hons, Diploma in Professional Nursing Practice; previous nurse leadership roles at LHCH and Salford Royal NHSFT.*	**Director of Nursing and Quality**	
Debbie Herring *Formerly Director of HR and OD at Aintree Hospital NHSFT with previous leadership roles within the NHS, local government and civil service.*	**Director of Strategy and Organisational Development**	

How the Board Operates

Throughout 2015/16 the Board comprised the Chairman, Chief Executive, five independent Non-Executive Directors (one of whom is designated Senior Independent Director) and five Executive Directors. The Board is supported by three additional non-voting directors – the Chief Operating Officer, the Director of Research and Informatics and Associate Director of Corporate Affairs (also the Company Secretary).

The Trust is committed to having a diverse Board in terms of gender and diversity of experience, skill, knowledge and background and these factors are given careful consideration when making new appointments to the Board. Of the 11 serving members of the Board at 31st March 2016, 4 are female and 7 are male. The Board regularly reviews the balance of skills and experience in the context of the operational environment and needs of the organisation. Strong clinical leadership is provided from within the complement of Executive and Non-Executive Directors.

There was a change in Medical Director during the year following Dr Glenn Russell's retirement from the role in June 2015. Dr Raphael Perry took up post on 1st July 2015. There have been no other changes.

Julian Farmer was appointed Audit Committee Chair in 2014/15 taking up post in June 2015, therefore an interim Director (Ken Morris) was appointed for the period, February to May 2015.

All Directors have full and timely access to relevant information to enable them to discharge their responsibilities. The Board met seven times during the year and at each meeting Directors received reports on quality and safety, patient experience and care, key performance information, operational activity, financial performance, key risks and strategy. The Board has in place a dashboard to monitor progress on delivery of strategic objectives and is responsible for approving major capital investments. The Board engages with the Council of Governors, senior clinicians and management, and uses external advisors where necessary. The proceedings at all Board meetings are recorded and a process is in place that allows any director's individual concerns to be noted in the minutes. Meetings of the Board are held in public and the minutes of these meetings along with agendas and papers are published on the Trust's public website.

Directors are able to seek professional advice and receive training and development at the Trust's expense in discharging their duties. The Directors and Governors have direct access to independent advice from the Company Secretary (Associate Director of Corporate Affairs), who ensures that procedures and applicable regulations are complied with in relation to meetings of the Board of Directors and Council of Governors. The appointment and removal of the Company Secretary is a matter for the full Board in consultation with the Council of Governors.

Outside of the Boardroom, the Directors conduct regular walkabouts to meet informally with staff and patients and to triangulate data received in relation to patient safety and quality of care.

Balance, Completeness and Appropriateness

There is a clear division of responsibilities between the Chairman and the Chief Executive.

The Chairman is responsible for the leadership of the Board of Directors and Council of Governors, ensuring their effectiveness individually, collectively and mutually. The Chairman ensures that members of the Board and Council receive accurate and timely information that is relevant and appropriate to their respective needs and responsibilities; and ensures effective communication with patients, members, staff and other stakeholders. It is the Chairman's role to facilitate the effective contribution of all Directors, ensuring that constructive relationships exist between the Board and the Council of Governors.

The Chief Executive is responsible for the performance of the executive team; for the day to day running of the Trust; and for the delivery of approved strategy and plans.

In accordance with the Code of Governance, all Non-Executive Directors are considered to be independent, including the Chairman. In line with Monitor's guidance, the term of office of Directors appointed to the antecedent NHS Trust are not considered material in calculation of the length of office served on the Board of the Foundation Trust.

Non-Executive Directors are normally appointed for 3 year terms subject to continued satisfactory performance. After serving two three year terms (6 years in total), careful consideration is given to any further re-appointment in the context of independence and objectivity. Any re-appointment beyond 6 years is on an annual basis and governors must be satisfied that exceptional needs of the Trust (e.g. to maintain continuity of leadership) outweigh any risk around maintaining independence. It is for the Council of Governors to determine the termination of any Non-Executive Director appointment.

The Directors' biographical details summarised above demonstrate the wide range of skills and experience that they bring to the Board. The Board recognises the value of succession planning and the Board's Nominations and Remuneration Committee undertakes an annual process of succession planning review for executive team members. The Trust has a programme of full Board and individual appraisal to support the succession planning process and ensure the stability and effectiveness of the Board in the context of new challenges and the dynamic external environment within which the Trust operates.

In response to the 'fit and proper persons' regulations for directors, which came into force on 27th November 2014 via the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust has conducted an audit, including review of employment history, qualifications and Disclosure and Barring Service checks for each Director which has been reviewed and certified by the Chairman (Senior Independent Director in the case of the Chairman). In addition, all Directors have been required to complete an annual self-declaration of compliance with the criteria. The Trust has

strengthened the due diligence applied to recruitment processes for new directors in respect of the new requirements. The aim of this added rigour is to strengthen corporate accountability and make safer recruitment decisions in the wake of events such as those that occurred at Mid Staffordshire NHS Foundation Trust. In March 2016, the Trust appointed a new Chief Finance Officer who will take up post in 2016/17. (David Jago resigned in 2015/16 but will remain in post beyond the end of this reporting period).

Board Meetings and Attendance

The Board met seven times during the year. Attendance at meetings is recorded in the table below.

Director	28th April 2015	26th May 2015	28th July 2015	20th Oct 2015	24th Nov 2015	26th Jan 2016	29th March 2016
Chairman							
Neil Large	✓	✓	X	✓	✓	✓	✓
Chief Executive							
Jane Tomkinson	✓	✓	✓	✓	✓	✓	✓
Non-Executive Directors							
David Bricknell	✓	✓	✓	✓	✓	✓	✓
Marion Savill	✓	✓	✓	✓	✓	✓	✓
Lawrence Cotter	✓	✓	✓	✓	✓	✓	✓
Mark Jones	✓	✓	✓	✓	✓	✓	✓
Ken Morris	✓	✓					
Julian Farmer			✓	✓	✓	✓	✓
Executive Directors							
David Jago	✓	✓	✓	✓	✓	✓	✓
Glenn Russell	✓	✓					
Sue Pemberton	✓	✓	✓	✓	✓	✓	✓
Debbie Herring	✓	✓	✓	X	✓	✓	✓
Raphael Perry			✓	✓	✓	✓	✓

Evaluation of Board and Committees

Each Board Committee has undertaken a review of its effectiveness in delivering its terms of reference and these reports are reviewed by the Audit Committee before being reported to the Board. Board members have evaluated the performance and conduct of the Board at the end of each Board meeting and have also participated in a survey on Board effectiveness which will inform further refinement of the Board's processes. The Board has designated four full days during the year to work on strategic planning and development.

All Directors received an individual appraisal in 2015/16. In the case of the Chief Executive, this was led by the Chairman; for the executive directors, the process was led by the Chief Executive; and for the Non-Executives by the Chairman. The Chairman's appraisal was led by the Senior Independent Director and followed a

process approved by the Council of Governors that involved all governors and directors having the opportunity to input relevant feedback.

Understanding the Views of Governors, Members and the Public

The Board recognises the value and importance of engaging with Governors in order that Governors may properly fulfil their role as conduit between the Board and the members, public and stakeholders.

The Board and Council of Governors meet regularly and enjoy a strong working relationship. The Chair ensures that each body is kept advised of the other's work and key decisions.

All members of the Board regularly attend Council of Governor meetings (quarterly) and Non-Executive Directors present reports on a cyclical basis of the work of the Board's Assurance Committees. A report from the Audit Committee is provided at every meeting of the Council of Governors.

The Council of Governors is provided with a copy of the agenda and minutes of every Board meeting and Governors are always welcome to attend to observe meetings of the Board which are held in public. Through observation of the Board in action, Governors have opportunity to observe the challenge and scrutiny of reports brought to the Board, helping them to better understand the work of the Board and how it operates.

Prior to every meeting of the Council of Governors, there is an opportunity for Governors to participate in an organised walkabout led by the Chairman. This is followed by informal 'interest groups' at which Governors divide into three groups, each led by an Executive Director and a Non- Executive Director sponsor to discuss topical issues relating to either 'quality and safety', 'patient and family experience' or 'finance and performance'. These informal sessions also provide opportunity for Governors to prepare further questions for debate at the formal Council meeting that follows.

At the start of each Council meeting the governors receive a patient story and also a short presentation from either a clinical or operational manager on a particular service, in order to enhance Governor understanding and awareness of the services provided by the Trust.

In addition to the Council of Governors meetings, the Chair hosts a quarterly informal lunch meeting, at which Governors are updated on news and have opportunity to network and feedback on any matters they wish to raise. These meetings are followed up with a Chair's Bulletin which is sent to all Governors, ensuring that every governor is updated on any communications, news and forthcoming events.

At every Council of Governors meeting the agenda includes a standing item for governors to feedback on any networks, events or issues raised by constituency members.

The Trust also organises an annual development day for governors at which part of the time is allocated to joint working with Directors.

It is through this variety of mechanisms that the Chairman ensures strong working relationships and effective flow of communication between the Board and Council such that the Board is able to understand and take account of the views of governors, members and the public.

Registers of Interests

The Trust maintains a register of interests of Directors and a register of interests of Governors and these are reviewed periodically by the respective bodies to identify any potential conflicts and where such conflicts are material, consider how these are to be managed. A copy of either Register of Interests is available on request by writing to the Company Secretary:

Associate Director of Corporate Affairs
Executive Office
Liverpool Heart and Chest Hospital NHS Foundation trust
Thomas Drive
Liverpool Heart and Chest Hospital
L14 3PE

Board Committees

The Board has three statutory committees.

1. Audit Committee
2. Charitable Funds Committee
3. Nominations and Remuneration Committees (Executive Directors)

There are three additional assurance committees.

- Quality Committee
- Integrated Performance Committee
- People Committee

Each of the above committees is chaired by an independent Non-Executive Director; the Nominations and Remuneration Committee (Executive Directors) is chaired by the Chairman.

A second Nominations and Remuneration Committee (Non-Executive Directors) deals with the nomination and remuneration of Non-Executive Directors and reports to the Council of Governors. This Committee is also chaired by the Chairman (or the Senior Independent Director when matters pertaining to the tenure or remuneration of the Chairman are to be discussed).

A report on the work of the Audit Committee is set out below along with reports on the Nominations and Remuneration Committee (Executives) and Nominations and Remuneration Committee (Non- Executives).

Statutory Committees

1. Audit Committee

The Audit Committee is a committee of the Non-Executive Directors (excluding the Chairman) and is chaired by Julian Farmer (from 1st June 2015), previously Ken Morris (until 31st May 2015).

The Committee met on four occasions during 2015/16.

Member	26th May 2015	7th July 2015	10th Nov 2015	9th Feb 2016
Ken Morris *(Interim Chair from 1st Feb 2015 – 31st May 2015)*	✓			
Julian Farmer *(Chair from 1st June 2015)*		✓	✓	✓
David Bricknell	✓	✓	✓	X
Marion Savill	✓	✓	✓	✓
Lawrence Cotter	✓	✓	✓	✓
Mark Jones	✓	✓	✓	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 2015/16 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.

Principal Review Areas in 2015/16

The narrative below sets out the principal areas of review and significant issues considered by the Audit Committee during 2015/16 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 2015/16, 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 provides assurances on the Trust's internal control and risk management processes.

The Trust has had embedded risk management systems in place throughout 2015/16. The Committee has received evidence that the systems for risk management are appropriate following review of the Trust's Risk Management policy at its May 2015 meeting and review of risk management KPIs in May and November 2015. Internal audit review has provided significant assurance in this area and confirmed the effective operation of the risk management process from 'Ward to Board', through review of Departmental/Ward Risk Registers, Divisional Risk Registers and the Corporate Risk Register.

The Committee can take assurance that risks identified at Divisional level are escalated to Operational Board with relevant risk issues reported to Assurance Committees and on to the Board via 'BAF Key Issues Reports'.

- ***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 latest follow up report received by the committee noted good progress with 42 out of 61 recommendations implemented. Of the outstanding 19, the committee agreed that given the timeframe, a further two outstanding recommendations could be removed.

The Committee reviewed and approved the detailed programme of work for 2015/16 at its March 2015 meeting. This included a range of key risks identified through discussion with management and executives and a review of the Board Assurance Framework. Reviews were identified across a range of areas, including financial systems, IM&T, performance, clinical quality, workforce, governance, risk and legality.

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 '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 2015/16 and ensured that any control weaknesses are understood by the Audit Committee and are quickly addressed.

- *Anti- Fraud*

The Committee reviewed and approved the anti- fraud services work plan for 2015/16 at its March 2015 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 anti-fraud work. The Committee reviewed updates on proactive counter fraud work noting 4 investigations to date with 3 closed and 1 active proceeding to formal investigation. From the NHS Protect 25 standards within this the Trust is rated as green on 19 with 6 rated as amber.

- ***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. The value of external audit services for the year was £50,500 (£56,000 in 2014/15); inclusive of the charitable funds audit.

- ***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, a review of the clinical audit programme and a review of NICE compliance.

- ***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 2015/16 on losses and special payments, single source tender waivers and use of the Trust seal.

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

The Committee Chair has held regular discussions with the Assurance Committee Chairs to discuss the effectiveness of the Committee structure and communication flows between Committees. Each Committee produced a formal annual report, including a review of terms of reference, for consideration by the Board of Directors in April 2016.

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

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 2015/16, the auditor has not been engaged in any non-audit activity.

The Audit Committee undertook its annual self-assessment via a facilitated workshop session by MIAA on the 9th February 2016 and from this a report and action plan for development will be produced. The assessment process involved reviewing the key elements of the Audit Committee self-assessment tool prescribed in the Audit Committee Handbook via the facilitated workshop.

The Audit Committee scheduled a workshop in February 2016 where it tested and confirmed continued adherence to good practice, reflecting on progress made against actions identified previously, new membership of committee last year and considered recommendations made by MIAA in its report.

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. An extension to this appointment for a further period of two years has been approved by the Council of Governors following recommendation from the Audit Committee.

Julian Farmer
Chair of Audit Committee
26th May 2016

2. Charitable Funds Committee

The Charitable Funds Committee comprises a Non-Executive Chair, two further Non-Executive Directors, Chief Executive, Chief Finance Officer, Associate Director of Corporate Affairs, Head of Fundraising and Financial Accountant. The Committee is responsible for the effective management of the LHCH Charitable Fund (Charity No 1052813).

The objective of the Charity is:
"For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the Liverpool Heart & Chest Hospital NHS Foundation Trust".

The majority of the 26 funds within the umbrella charity are for the charitable purposes of advancement of health or saving of lives or for the advancement of education.

The Board of Directors receives regular reports from the Charitable Funds Committee. In the year 2015/16, papers considered have included a new Fundraising Strategy for the Charity and the development of monitoring procedures for charity fundraising in response to the Etherington Review of fundraising practice.

The LHCH Charity website can be viewed at www.lhchcharity.org.uk

3. 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 to consider the Non-Executive Director succession plan. This was in relation to duration of remaining tenures and strength of the current Non-Executive Director team in respect of team fit, individual skills, competencies and alignment of behaviours with Trust values. The Committee considered diversity in relation to age profile, gender mix and ethnicity, acknowledging some possible gaps which had been a consideration in the 2014/15 recruitment search process. However, the over-riding requirement for the search was Board-level experience and ability to commit the necessary time to Board business.

In its annual review of the succession plan, the Committee concluded that the Non-Executive Director team comprised a good balance of skills and expertise with staggered tenures that provided resilience and continuity. The Committee noted the

importance of this given the challenges that the Trust faced within the wider context of the NHS.

The tenures of David Bricknell and Neil Large were considered as these were scheduled to end in February 2016 and October 2016 respectively, both having served 6 years at these dates.

The Committee was mindful of the Code of Governance in relation to terms beyond 6 years which could be relevant to the determining independence. After careful consideration, the Committee determined that it would recommend to the Council of Governors, 12 month appointments for both David Bricknell and Neil Large to February 2017 and October 2017 respectively.

The primary drivers being the need for continuity around the new charitable funds agenda which was in its infancy following a change of approach in 2015/16 (David Bricknell being Chair of the Charitable Funds Committee) and the need for Neil Large to continue as Chairman given the significant challenges facing the Trust.

The Council of Governors approved these recommendations in December 2015.

Nominations and Remuneration Committee (Executive)

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

The Committee met on six occasions in 2015/16 and appointed to the new post of Chief Finance Officer following the resignation of David Jago in 2015/16 and also reviewed the appraisals and remuneration of the executive team members and considered the Board succession plan.

Attendance at Nominations and Remuneration Committee (Executive) in 2015/16:

Member	23rd June 2015	28th July 2015	8th Sept 2015	13th October 2015	26th January 2016	29th March 2016
Neil Large (Chair)	✓	X	✓	✓	✓	✓
David Bricknell	✓	✓	✓	✓	✓	✓
Marion Savill	✓	✓	✓	✓	X	✓
Lawrence Cotter	✓	✓	X	✓	✓	✓
Mark Jones	✓	✓	✓	✓	✓	✓
Julian Farmer	X	✓	X	✓	✓	✓
Jane Tomkinson	✓	✓	✓	X	✓	✓

Assurance Committees

- **Quality Committee**
  The Quality Committee is established as an Assurance Committee of the Board of Directors in order to provide the Board with assurances in respect of quality governance. It is a Non-Executive Committee.

- **Integrated Performance Committee**
  The Integrated Performance Committee is established as an Assurance Committee of the Board of Directors in order to provide the Board with assurances in respect of the Trust's current and forecast performance and its operations in relation to compliance with the licence, regulatory requirements and statutory obligations. It is a Non-Executive Committee.

- **People Committee**
  The People Committee is established as an Assurance Committee of the Board of Directors in order to provide the Board with assurance in respect of workforce governance.

Quality Governance

The Trust is compliant with the required standards of Monitor's Quality Governance Framework as evidenced by an assessment undertaken by a Mersey Internal Audit Agency review which was completed in December 2014.

The report highlighted that the delivery of high quality safe care is central to the Trust's overall strategy and that there is strong evidence that the key quality issues are dealt with proactively and that the Board obtains assurances from the Executive about the commitment to improving the quality of care. There are performance indicator's for quality with robust action plans to address any shortfalls for the areas identified these actions are monitored by the Patient and Family Governance Committee and Operations Board.

Developing services and improving patient care using foundation trust status
Liverpool Heart and Chest Hospital became an NHS Foundation Trust on 1st December 2009.

Foundation Trusts have a duty to engage with local communities, encourage local people to become members and ensure that the membership is representative of the communities they serve. They need to demonstrate that the full range of potential members' interests is represented, and there is a proper balance between different groups.

Membership of the Trust is open to everyone over the age of 16 who resides in the communities it serves including Merseyside, Cheshire, North Wales and Rest of England and Wales. All permanent members of staff or, those who have worked for the Trust for over 12 months, are automatically a member of the Foundation Trust.

The Trust's members represent the different groups of people to whom it is accountable. The Council of Governors represent the views of members and the public, whilst holding the Board of Directors to account. Members have the opportunity to help shape Trust strategies such as quality priorities and any future plans.

Members have supported the work of the Trust in many ways.

- Contributing, supporting and influencing the work of the Trust - including having their say on quality account priorities and providing key feedback through the bi-annual members' survey.
- Attending the Trust's programme of member events, including Annual Members Meeting and Annual Members Health Day and Open Day.
- Keeping informed regarding the latest news and hospital developments through the Trust's Members Matters newsletter.
- Engaging with the Council of Governors, enabling them to effectively represent their views for example through patient and family engagement events. Standing for election or voting in elections to the Council of Governors.
- Attending meetings of the Council of Governors.

Working in collaboration with patients, families, members and governors ensures that the Trust continues on its journey in being an open, honest and transparent organisation that encourages a shared decision making approach.

LHCH was recognised in 2015 as being in the top for nursing care and cleanliness, in the Care Quality Commission's National Inpatient Survey. Its Friends and Family Test results are consistently high, achieving an average positive response of 99%. This is underpinned by 93% of staff who would recommend the hospital as a place to receive treatment.

The Trust continues to develop its patient and family centred care approach to truly involve families and carers in care. Its care partner programme has been rolled out, giving an opportunity for patients and families to be involved in care if they wish and the Trust no longer has fixed visiting hours, welcoming families and carers to be with their loved ones at times that suit them.

The Trust has fully considered key learning messages from national reviews including Francis, Keogh and the Berwick review, to inform its clinical priorities outlined within the Quality Improvement Strategy for 2014 – 2017.

Additionally, the key components of the Compassion in Practice Care Strategy (2012) namely the 6 Cs – *Compassion, Care, Commitment, Courage, Communication and Competence* - are embedded within the key priorities. The Trust will enable and

support its staff to deliver high quality, compassionate care, and to achieve excellent health and wellbeing outcomes for its patients and their families. These components are aligned to our Nursing and Allied Health Professional Strategy for 2016-2018.

The Trust has a clearly defined quality strategy and its quality goals are articulated. Improving the quality, safety and experience of care for patients and families remains a key strategic objective for LHCH. Therefore, it is fundamental that the Trust has a well-defined quality strategy.

The Trust is keen to develop an open and transparent culture and therefore has implemented a number of work streams to do this. These include:

- **Sign up to Safety:** The Trust's focus on safety across the organisation has resulted in LHCH being part of the national *Sign up to Safety* campaign. The Trust has developed the original improvement works with close monitoring of actions taken.

- **Culture Survey:** A Trust-wide culture survey was previously undertaken, obtaining a 68% response rate which has allowed the Trust to truly understand how staff rate components of their working lives – covering areas such as teamwork, stress recognition and safety climate. The Trust continuous its journey alongside clinical and non-clinical teams to understand and work with them in setting improvement priorities.

- **Speak out Safely**: The Trust has signed up to the Nursing Times campaign and has implemented confidential ways in which its staff can speak out. This has been extended to include our patients their families. Patients and families are encouraged to escalate their concerns when they are worried about care provision.

- **Safety Huddle:** The Trust has implemented a daily safety huddle where staff from across the organisation are encouraged to attend and raise potential safety issues. This has developed and grown over 2015, staff feel empowered to speak out when they have safety issues. The HALT initiative was launched in February 2016 staff have been supported to use this to prevent patient safety incidents occurring, staff have demonstrated good examples of HALT being used at the safety huddle.

Implementing Learning from Francis, Berwick and Keogh

Within the Trust's Quality Improvement Strategy, actions have been identified that need to be taken forward to ensure it learns from the Francis, Berwick and Keogh reports. To date, some key actions have been implemented:

- The Trust has patient boards above all inpatient beds identifying the consultant in charge of the patients care and the nurse who is caring for them on each shift.

- Staffing levels are displayed inside each ward area
- The Trust carries out mortality reviews on all patient deaths – a review is carried out by an identified doctor and a nurse.
- The Trust continually listens to patients and their families to hear first-hand their feedback on its services and seven listening events have been held this year.
- The Trust has launched its care partner programme where all patients' relatives and/or carers are invited to be involved in elements of care that they wish to be.
- The Trust reviews its nurse staffing levels every six months using evidence based tools to ensure the right staffing numbers are in place and publishes its staffing levels on a monthly basis.
- All the Trust's ward managers are supervisory and therefore have time to act in a supportive capacity for our staff, patients and families and are available to ensure that the high standards of care delivery LHCH aspires to deliver are maintained.
- A Trust-wide culture survey has been carried out to truly understand staff feedback in relation to teamwork, support they receive from senior management and their attitudes to safety. The Trust has good intelligence from its staff and will work with them to develop their local actions to improve the areas they have identified. The Trust will work with its staff to monitor progress with these throughout 2015/16.

Friends and Family Test – the test has been implemented in Outpatient Department, day cases and with staff, with improved response rates this year. Feedback is actively used to drive improvements which can be evidenced and testing is being extended to Day Ward, the Outpatient Department and in the community.

NHS Safety Thermometer – data collection targets being met together with significant reductions in pressure ulcer prevalence in 2015/16. Ward teams continue to prevent avoidable pressure ulcers by early detection and specialist advice.

Dementia – screening, assessment and referral are all being conducted at above target levels. A named clinical lead is in place and training is being delivered.

Advancing Quality – the Trust has achieved strong performance in Acute Myocardial Infarction and Coronary Artery Bypass Grafting.

Discharge Planning – performance against use of the discharge checklist, estimated date of discharge, production of the clinical management plan and patient and carer involvement is progressing well. The Trust supported the opening of a discharge lounge in September 2015. This has had an impact on allowing patients to be discharged form their ward areas in to a comfortable environment before going to their place of discharge.

Quality Dashboards – developed to improve quality indicators.

Cardiac Surgical Inpatients Waits within 7 days – strong performance against plan.

Clinical Trial Recruitment – on plan.

Patient and Family Experience

Shadowing

Shadowing has been implemented across the Trust since April 2012 and to date 365 staff have been trained with 135 shadows completed .Shadowing involves a committed empathic observer to follow and observe a patient and or a family member throughout a selected care experience, to observe and gain insight on the patients and families experience. The gathering of information through observation, discussion and analysis is used by care staff to understand, and thus perfect, the patient and family experience. LHCH ascertains good feedback from shadowing patients and families. This includes:

- **Positive themes**
  "Amazing staff, I felt safe, I felt really cared for, best hospital around."

- **Negative themes**
  "Untimely discharge, need to involve families more during care pathway, untimely medications on discharge, lack of information on discharge, too much information at pre-assessment clinics, lack of privacy on wards when discussing personal information, lack of communication."
  The themes that come from this are then followed up and discussed at the Patient & Family Listening events to get first hand feedback from patients themselves. The learning is shared with the divisional teams.

- **Improvements made**:
  The Trust has changed the design of patient gowns, implemented improved storage for patients' personal effects, and further developed bedside folders to provide more information. It has introduced the Care Partner programme where families and/or carers are given the opportunity to be involved in care. Shadowing continues to be a positive experience for LHCH teams, with lots of staff acknowledging that they found their shadowing enlightening.

  The Trust has invested in to ensuring our patients environment is conducive to their individual needs within our Post-Operative Critical Care Unit (POCCU). Our families have a relaxed spacious area where they can receive refreshments, that includes confidential comfortable areas when discussions are needed with our clinical teams.

  A new ward area for our cystic fibrosis patients designed with them to achieve the best in a modern purpose built unit equipment for all their needs.

Patient and Family Experience Engagement Events

The aim of engaging with patients and families is to enable us to truly understand their experience and to highlight any improvements required. This will then provide an opportunity to embed improvements where applicable. The events will be supported by representation from the Executive team, Non-Executives, Governors and clinical staff. The Trust facilitated eight events this year, including a session specifically looking at discharge planning.

More than 200 patients and their families have attended the events in a wide variety of locations and for the first time this also included the Isle of Man.

Each event has been supported by members of the executive team and Council of Governors, as well as Trust staff.

Some Comments and Actions

'*There should be invites to these kind of events, not formal letters, I was a bit anxious when I received mine & wondered what it was for`.* – Service Improvement Team has taken this on board and re-designed.

'All patients found the support groups a huge help, `Lifeline`, and the fact that they are available in local areas to patients is really good.'
A few patients believe that a counselling service could be offered, if someone is struggling to cope - this will be discussed as part of the new COPD tender.

'The Wi-Fi is poor in Robert Owen house I wanted to use face time to keep in touch as phoning is expensive'. This is being addressed by the Trust.

The Trust always asks if patients and families benefitted from attending the events. The response has always been positive and some families have suggested that these events should be like a monthly drop in.

Transparency Project

LHCH is one of 19 trusts that are being open and honest with the care provided, by displaying harms in relation to falls, pressure ulcers, venous thromboembolism (VTE) and catheter associated urinary tract infections. The Trust is currently delivering 97% harm free care with ambition to build upon this successful platform. Each month its transparency data is uploaded in a timely fashion, complete with a patient story and an improvement project. NHS England recognised the excellent work that is happening at the Trust.

Care Partner Programme

This involves staff asking family's members/carers if they would like to be involved in the care of their relative and which aspects of care they would like to take part in. This is a fundamental part of the Trust's family experience vision and is one of the ways in which LHCH articulates to patients its ambitions for them and their families to be

partners in care. The care partner is now identified on the EPR system to facilitate audit of this in practice.

The Trust's ambition is to develop this programme to truly realise the benefits of involving care partners in the care experience. Care partner programme is now in place on all ward areas, and all patients are asked on admission if they would like someone to be involved in their care. There is improvement work required within the EPR to facilitate this process further. The Trust is also in the process of an application for a research project for Care Partner with the National Institute for Health Research.

Dementia

The Trust is committed to delivering better outcomes for patients with dementia. Managing the care of people with dementia is a significant part of the work of our staff. In order to ensure that these patients and their care partners receive good quality care, we have:

- trained more than 1000 staff and members of our local community in basic awareness of dementia via the dementia friend's campaign
- signed up to the Local dementia Action Alliance working towards making Liverpool a dementia friendly community
- developed a dementia strategy implemented April 2015
- been working with Liverpool museum and over 20 staff have attended the House of Memories training
- rolled out the 'This is Me' document across the hospital and the community services
- developed a patient information leaflet on dementia for families.

Improving the Trust's Culture

The Trust has built on its Trust-wide culture survey undertaken in 2014, which resulted in a 68% response rate. The Trust now has the opportunity to work with its teams to understand their feedback in more detail and to work with them in setting improvement priorities. This work was progressed in 2015/16 by working closely with staff to improve the culture across the organisation.

Mortality Review Group

This group is a formal sub-group of the Patient and Family Experience Governance Committee with a remit to review deaths, major harm events and cardiac arrests. It is chaired by a Consultant Cardiac Surgeon and is attended by consultants from cardiac surgery, thoracic surgery, cardiology and respiratory medicine.

A nursing mortality review process commenced in June 2014 with all specialist and senior nurses undertaking reviews. Where possible, these are fed back at the same time as the medical mortality review. An action plan is updated by the Chair of the Committee and this is sent to Divisional Governance Committees for review.

Care Quality Commission (CQC)

The Trust will be inspected on the 26th – 29th April 2016, against the five Key Lines of Enquiries. The Trust has been actively supporting the inspection with all teams. The outcome of the inspection will be contained in the Quality Report 2016-2017.

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 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.

Additional Information

The Trust has not made any political donations during the year.

Additional information or statements which fall into other sections within the Annual Report and Accounts are highlighted below:

- A statement that accounting policies for pensions and other retirement benefits are set out in the notes to the accounts and details of senior employees' remuneration can be found below in Part 2; Accountability Report (page 43).
- Details of future developments and strategic direction of the trust can be found in Part 1; Performance Report (page 10).
- Trust policies on employment and training of disabled persons can be found in the Staff Report within the Accountability Report – Part 2 (page 48).
- Details of the Trust's approach to communications with its employees can be found in the Staff Report within the Accountability Report – Section 2 (page 48).

- Details of the Trust's financial risk management objectives and policies and exposure to price, credit, liquidity and cash flow risk can be found in the notes of the annual accounts.

Related Party Transactions

The Trust has a number of significant contractual relationships with other NHS organisations which are essential to business. A list of the organisations with whom the trust holds the largest contracts is included in the accounts.

Income Disclosures

The Trust has met the requirement of Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

The income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purpose.

2.2 Remuneration Report

Year ended 31st March 2016						
Name	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 Officer	155 - 160		4,905.80	7.5 - 10	165 - 170
G Russell	Medical Director	5 - 10	40 - 45	0.00		45 - 50
R Perry	Medical Director	145 - 150	0	0.00		145 - 150
D Jago	Deputy Chief Executive/Chief Finance Officer	125 - 130		7,328.95		130 - 135
S Pemberton	Director of Nursing	115 - 120		3,874.10	127.5 - 130	245 - 250
M Jackson	Director of Research and Information	85 - 90		0.00		85 - 90
D Herring	Director of Strategy & Organisational Development	100 - 105		5,017.90		105 - 110
T Wilding	Chief Operating Officer	90 - 95		0.00		90 - 95
L Lavan	Associate Director of Corporate Affairs	80 - 85		4,762.80		85 - 90
P N Large	Chair	40 - 45		0.00		40 - 45
D Bricknell	Non-Executive Director	15 - 20		0.00		15 - 20
L Cotter	Non-Executive Director	10 - 15		0.00		10 - 15
M Savill	Non-Executive Director	10 - 15		0.00		10 - 15
M Jones	Non-Executive Director	10 - 15		0.00		10 - 15
K Morris	Non-Executive Director	0 - 5		0.00		0 - 5
J Farmer	Non-Executive Director	10 - 15		0.00		10 - 15

G Russell ceased as Medical Director on 30th June 2015
R Perry commenced as Medical Director on 1st July 2015

Year ended 31st March 2015						
Name	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 Officer	155 - 160			2.5 - 5	160 - 165
G Russell	Medical Director	25 - 30	165 - 170			190 - 195
R Perry	Medical Director					
D Jago	Deputy Chief Executive/Chief Finance Officer	125 - 130		1,691	32.5 - 35	160 - 165
S Pemberton	Director of Nursing	100 - 105			17.5 - 20	120 - 125
M Jackson	Director of Research and Information	90 - 95			0	90 - 95
D Herring	Director of Strategy & Organisational Development	85 - 90			0 - 2.5	90 - 95
T Wilding	Chief Operating Officer	90 - 95			42.5 - 45	135 - 140
L Lavan	Associate Director of Corporate Affairs	80 - 85		4,229		85 - 90
P N Large	Chair	40 - 45				40 - 45
D Bricknell	Non-Executive Director	10 - 15				10 - 15
L Cotter	Non-Executive Director	10 - 15				10 - 15
M Savill	Non-Executive Director	10 - 15				10 - 15
M Jones	Non-Executive Director	0 - 5				0 - 5
K Morris	Non-Executive Director	0 - 5				0 - 5

D Herring commenced as Executive Director Strategy & Organisational Development on 2nd June 2014
G Appleton left the Trust on 31st October 2014
M Fuller left the Trust on 31st January 2015
M Jones commenced as Non-Executive Director on 2nd December 2014
K Morris commenced as Non-Executive Director on 1st February 2015

Name and Title	Real increase in Pension at Pensionable Age (bands of £2,500)	Real increase in pension lump sum at Pensionable Age (bands of £2,500)	Total accrued pension at Penasionable Age at 31st March 2016 (bands of £5,000)	Lump sum at Pensionable Age related to accrued pension at 31st March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 31st March 2016	Cash Equivalent Transfer Value at 31st March 2015	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	60 - 65	180 - 185	1,159	1,095	35	0
D Jago - Deputy Chief Executive / Chief Finance Officer	0 - 2.5	0 - 5	40 - 45	120 - 125	751	718	15	0
S Pemberton - Director of Nursing	5 - 10	15 - 20	35 - 40	110 - 115	634	510	111	0
M Jackson - Director of Research and Informatics	0 - 2.5	0 - 2.5	30 - 35	90 - 95	621	595	11	0
D Herring - Executive Director of Strategy and Organisational Development	0 - 2.5	0 - 2.5	30 - 35	90 - 95	569	545	10	0
T Wilding - Chief Operating Officer	0 - 2.5	0 - 2.5	10 - 15	35 - 40	217	216	(4)	0
L Lavan - Associate Director of Corporate Affairs	0 - 2.5	0 - 2.5	20 - 25	70 - 75	447	424	12	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 bodies 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 2015/16 was £195k (2014/15 £194k). This was 7 times (2014/15, 7 times) the median remuneration of the workforce, which was £28k, (2014/15 £28k). The median remuneration of the workforce for 2015/16 has remained consistent with 2014/15.

In 2015/16, 1 (2014/15, nil) employee 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.

The Trust employs two executives, the Chief Executive, and the Medical Director who are paid more than the Prime Minister. The Chief Executive’s remuneration was considered carefully on appointment and referenced to benchmarking data. She accepted the position on the same level of remuneration as her previous post and is paid at a level that is commensurate with her skills and experience. Since her appointment, her level of remuneration has been uplifted only by inflationary pay awards consistent with those

applicable to all NHS staff. The Medical Director is an interventional cardiologist of national standing, and holds regional and national responsibilities as the Cheshire & Merseyside Cardiac Network Clinical Lead, the Deanery Training Programme Director and is part of the RCP National Specialist Advisory Committee.

Expenses of the Directors and Governors

Directors

In 2015/16 the total number of directors in office was 16 (2014/15, 14). The number of directors receiving expenses in the reporting period was 12 (2014/15, 9). The aggregate sum of expenses paid to these directors in the reporting period was £13,875 (2014/15, £13,363).

Governors

In 2015/16 the total number of governors in office was 26 (2014/15, 27). The number of governors receiving expenses in the reporting period was 14 (2014/15, 13). The aggregate sum of expenses paid to these governors in the reporting period was £6,333 (2014/15, £7,573).

Pension Liabilities

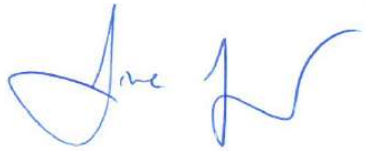
Early payment of a pension, with enhancement, is available to members of the NHS Pension Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension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

- **Number of early retirements due to ill health** 2
- **Value of early retirements due to ill health** £54,413.75

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 Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension costs 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 Trust commits itself to the retirement, regardless of the method or timing of payment.



Jane Tomkinson
Chief Executive
Date: 26th May 2016

2.3 Staff Report

Workforce Key Performance Indicators

The majority of workforce targets for 2015/16 were met with the exception of sickness absence which under-performed by 0.05%. 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 targets were met in 2015/16 showing a significant improvement from the previous financial year.

Voluntary turnover is also below target, again an improvement on the previous year's performance.

No of Staff	Sickness Absence 2015/16	Voluntary Turnover	Mandatory Training	Appraisal
1494	3.65%	6.5%	95%	90%
Target	3.6%	9%	95%	85%

As at March 31st 2016, the Trust employed 1,494 staff of whom 403 were male and 1,091 were female (see table below). There were also 29 senior managers, of whom 14 were male and 15 were female.

Workforce Profile

The workforce profile broadly reflects that of the local population demographics, which is categorised by low levels of racial and ethnic diversity. These populations contain a predominately white, British population, with a small percentage of Asian, black and mixed ethnic minority populations living in catchment areas for Liverpool Heart and Chest Hospital services and employment opportunities.

	2014/15	%	2015/16	%
Age Band				
<20	2	0.14%	1	0.07%
20-25	123	8.66%	135	9.04%
26-30	157	11.05%	185	12.38%
31-35	157	11.05%	162	10.84%
36-40	195	13.72%	187	12.52%
41-45	186	13.09%	200	13.39%
46-50	214	15.06%	201	13.45%
51-55	211	14.85%	210	14.06%
56-60	108	7.60%	143	9.57%
61-65	45	3.17%	45	3.01%
66-70	20	1.41%	22	1.47%
71+	3	0.21%	3	0.20%
Gender				
Male	369	25.80%	403	27%
Female	1,061	74.20%	1,091	73%
Transgender	Not Recorded	Not Recorded	Not Recorded	Not Recorded
Recorded Disability				
	42	2.94%	41	2.7%
Sexual Orientation				
Bisexual	6	0.42%	4	0.27%
Gay	8	0.56%	13	0.87%
Heterosexual	939	65.66%	993	66.47%
Lesbian	5	0.35%	3	0.20%
I do not wish to disclose	158	11.05%	180	12.05%
Undefined	314	21.96%	301	20.15%

	2014/15	%	2015/16	%
Religion or Belief				
Atheism	108	7.60%	120	8.03%
Buddhism	9	0.63%	10	0.67%
Christianity	723	50.88%	754	50.47%
Hinduism	15	1.06%	16	1.07%
I do not wish to disclose	184	12.95%	195	13.05%
Islam	16	1.13%	18	1.20%
Judaism	1	0.07%	1	0.07%
Other	63	4.43%	68	4.55%
Sikhism	3	0.21%	10	0.67%
Unspecified	299	21.04%	302	20.21%
Ethnic Origin				
White - British	1,201	84.52%	1,197	80.12%
White - Irish	22	1.55%	19	1.27%
White - Any other White background	31	2.18%	22	1.47%
Mixed - White & Black Caribbean	1	0.07%	1	0.07%
Mixed - White & Black African	4	0.28%	3	0.20%
Mixed - White & Asian	2	0.14%	1	0.07%
Mixed - Any other mixed background	2	0.14%	5	0.33%
Asian or Asian British - Indian	88	6.19%	83	5.56%
Asian or Asian British - Pakistani	7	0.49%	3	0.20%
Asian or Asian British - Any other Asian background	6	0.42%	6	0.40%
Black or Black British - Caribbean	2	0.14%	2	0.13%
Black or Black British - African	6	0.42%	7	0.47%
Black or Black British - Any other Black background	1	0.07%	2	0.13%
Chinese	9	0.63%	10	0.67%
Any Other Ethnic Group	7	0.49%	12	0.80%
Undefined	13	0.91%	104	6.96%
Not Stated	19	1.34%	17	1.14%
Total	**1,421**		**1,494**	

The Trust has a Recruitment and Selection Policy the aim of which is to ensure that it is compliant with current legislation for employing staff in accordance with the Equality Act, Immigration Rules and Disclosure & Barring Service (as applicable). It is a mandatory requirement for all managers with responsibility for recruitment and selection of staff to attend recruitment and selection training and update/refresher training is provided every two years via refresher training.

The Trust is positive about employing people with disabilities and promotes the 'Two Ticks' symbol. As such all applicants who declare that they have a disability and who meet the essential criteria for a post are shortlisted and invited to interview.

Support for staff who become disabled is provided under the Management of Attendance Policy and Performance Capability Policy.

Where medical advice recommends temporary or permanent changes such as reduced hours, lighter duties or alternative shift patterns, managers are required to consider flexible solutions to enable the employee to continue in their present role. Where service requirements prevent such changes being made every effort is made to redeploy staff to more suitable roles within the Trust. Redeployment may be on a temporary basis to facilitate and the support the employee to return to their substantive role or on a permanent basis depending on the circumstances. Suitability for redeployment is determined based on meeting the minimum criteria of the job description/person specification for the new role. It is Trust Policy that individuals cannot be rejected for redeployment because of their sickness record or current health.

With regard to performance issues, the requirements of the Performance Capability Policy include the proper assessment of applicants against the person specification for the job, all new employees receiving a proper induction to the Trust plus local orientation within the relevant ward or department, provision of initial and on-going job training and training needs are reassessments when there are job role changes, realistic expectation of work performance, employees kept informed of their progress and the provision of adequate training to equip them to carry out their duties through the use personal development plans. Overarching these provisions is the requirement to make reasonable adjustments in the case of employees with a disability.

Both of these Trust policies are supplemented by managers' toolkits which provide further advice and guidance in relation to disabled employees.

Communicating with Staff

- **Team Brief**
  The Team Brief approach to encourage staff involvement was further embedded throughout the Trust in 2015/16, with parts of Team Brief being delivered by staff from across the organisation. This included the introduction of the 'Your Chance to Shine' segment to engage staff from all areas in identifying and showcasing their own achievements, whilst also celebrating innovation and service improvements and sharing best practice with colleagues.

- **Corporate Hotboards**
  Following feedback received from members of staff across the Trust, especially ward-based staff and those in support service functions, that they were not able to routinely access important corporate news, highly visible corporate information boards were introduced into all wards and departments. These boards are routinely updated on a monthly basis.

- **Listening into Action**
  In May 2015, the Trust launched a new and exciting journey to put Listening into Action (LiA). In summary LiA is:
    - Really listening to staff to improve care
    - Enabling our teams to make improvements from the 'inside-out'
    - Giving 'permission to act' and simple processes to help
    - Cutting out non value-add activity and unblocking the way
    - Working together to do our best for patients
    - Feeling valued, engaged, proud.

  During the year, pulse check questionnaires were completed by staff and a number of 'Big Conversation' engagement events were held to identify improvements and changes needed, which were then developed into a series of staff-led projects. Some of these successfully completed projects have now been highlighted nationally.

- **Weekly Bulletin**
  Staff across the Trust receive a weekly ebulletin with a round-up corporate information, including workforce news, information governance updates, policy and procedure changes, as well as other operational issues.

Engaging with Staff

The Trust has an established Partnership Forum which is established as a Sub-Committee of the HR & Education Group to provide a forum for partnership working between management and joint staff side on matters relating to staff employed by the Trust. The primary objective of the forum is to provide a structure for engagement, consultation and negotiation, as appropriate, between management and trade unions/professional bodies, related to the management of staff in the provision of services with the objective of delivering the Trust Mission and People Strategy.

For medical staff, the Trust also has an established Local Negotiating Committee. Similar to the Staff Partnership Forum this Committee provides a forum for partnership working between management and joint staff side on matters relating to medical staff employed by the Trust. The primary objective of the forum is to provide a structure for engagement, consultation and negotiation between management and trade unions/professional bodies, related to the management of medical staff in the provision of services.

Other formal/informal consultation takes place in relation to specific issues for example the Strategic Options Appraisal for the Trust was informed by engagement sessions for staff across the Trust. Where organisational change is occurring the Trust is committed to ensuring full and early consultation with employees and their representatives in accordance with its Organisational Change Policy. Where it is anticipated that organisational change is necessary, consultation will begin at the earliest opportunity to minimise disruption and uncertainty, with particular attention being given to those employees directly affected by the proposed change. Where jobs are at risk, consultation will include consideration of ways of avoiding job losses, minimising the numbers of employees affected and mitigating the consequences of any potential redundancies.

Health and Safety Performance and Occupational Health

The Trust contracts with Aintree University Hospital NHS Foundation Trust for the provision of its Occupational Health Service. This contract provides for new employee health assessments, immunisations, inoculation injury management, advice on attendance management, case conferences, ill health retirement, lifestyle health assessments, specific health surveillance, night-worker health assessment. Occupational health staff are in attendance at the Trust's Health & Safety meetings, Infection Prevention meetings and staff health and well-being events. Monthly activity date and performance dashboards are provided against determined KPIs.

The Trust also has a contract with Merseycare NHS Trust for the provision of an Employee Assistance Programme for staff to support their health and wellbeing.

The Trust also has an established Health and Safety Committee, which reviewed its work against the terms of reference in January 2016 and achievements made against the terms of reference show positive results, evidencing that the Health and Safety Committee has operated effectively and in accordance with its terms of reference.

Awareness-raising about health and safety has continued with an on-going inspection regime being conducted annually to highlight any areas of weakness in clinical and non-clinical areas.

Information on Policies and Procedures with Respect to Countering Fraud and Corruption

The Trust has an Anti-Fraud, Bribery and Corruption Policy and Procedure. This policy is produced by the Anti-Fraud Specialist (AFS) and is intended as both a guide for all employees on the counter fraud, bribery and corruption activities being undertaken within the Trust and NHS; as well as informing all Trust staff of roles and responsibilities, and how to report any concerns or suspicions they may have. It incorporates codes of conduct and individual responsibilities.

Expenditure on Consultancy

Total expenditure during 2015/16 on Consultancy has totalled £674k.

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 2016, for more than £220 per day and that last for longer than six months

Number of existing engagements as of 31 March 2016	1
Of which:	
Number that have existed for less than one year at time of reporting	0
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	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, 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 2015 and 31 March 2016	0
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 no off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016.

Staff Exit Packages

During 2015/16 two members of staff received exit package payments, details of which are included in the tables below.

Exit Package Cost Band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	1	1
£10,000 - £25,000	0	1	1
£25,001 - £50,000	0	0	0
£50,001 - £100,000	0	0	0
£100,000 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
Total number of exit packages by type	**0**	**2**	**2**
Total resource cost (£000's)	0	**31**	**31**

Exit Packages - non compulsory departure payments	Agreements Number	Total Value of Agreements £000
Voluntary Redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirement in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	2	25
Exit payments following Employment Tribunals or court orders	2	5
Non contractual payments requiring HMT approval		
Total	**4**	**31**
Of which:		
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0

Staff Survey

Following the results of the 2014 Staff Survey reports were produced examining the outcomes from Trust, Divisional and Departmental level. These were shared with the relevant committees and areas and action plans were completed highlighting areas to be improved upon in the coming year.

Action plans were created within departments to ensure teams took ownership of their own development and progress against the plans was monitored though governance structure.

At Trust level the top 5 strengths and weaknesses were identified and are reported on page 57.

Staff Survey Results 2015

The 2015 NHS Staff Survey involved 297 NHS organisations in England. Over 741,000 NHS staff were invited to participate using a self-completion postal questionnaire survey or online. Responses were received nationally from 299,000 NHS staff, a response rate of 41% (42% in 2014). LHCH surpassed the national average with a response rate of 59% (63% in 2014).

LHCH has achieved excellent staff survey results for 2015, below are a few of the high ranking scores that the trust has achieved. This ranking is based upon the results of 244 Trusts across England (excluding CCGs).

✓ **2nd in the country for staff not experiencing discrimination at work**	✓ **3rd in the country for effective use of patient / service user feedback**
✓ **2nd in the country for staff not experiencing harassment, bullying or abuse from staff**	✓ **3rd in the country for staff confidence and security in reporting unsafe clinical practice**
✓ **2nd in the country for staff agreeing that their role makes a difference to patients**	✓ **3rd in the country for staff engagement**
	✓ **3rd in the country for support from immediate managers**

69% (64% in 2014) of NHS staff said that if a friend or relative needed treatment they would be happy with the standard of care provided by their organisation. In comparison LHCH has achieved the excellent result of 93% of staff who said that if a friend or relative needed treatment they would be happy with the standard of care provided, placing LHCH 3rd nationally. In addition, 89% of LHCH employees said that care of patients and service users is their organisation's top priority, placing 2nd overall in the country, compared to the national average of 73%.

This year's survey also highlighted that appraisals are more common now in all trust types: 86% of staff were appraised in last 12 months. Staff assessments of the quality of those appraisals show that across all organisations 73% of staff who had had a recent appraisal

said that it “definitely” or “to some extent” left them feeling that their work was valued by the organisation. LHCH performed below the national average with 80% of staff receiving appraisals however the Trust performed above the national average for the quality of appraisals with 78% agreeing that their appraisal left them feeling that their work was valued by the organisation.

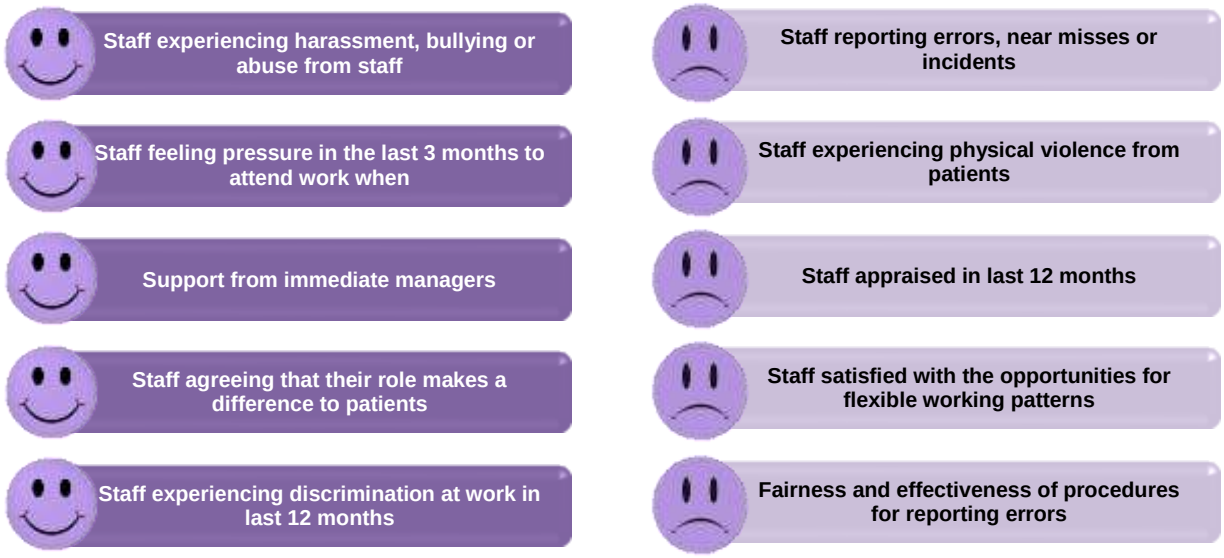
Nationally only 42% of all staff felt that their trust values their work, within LHCH this rises to 50%. The proportion of LHCH staff who indicated that they would recommend their organisation as a place to work has increased from 69% in 2014 to 70% in 2015. The national picture shows that 59% would recommend their Trust as a place to work.

48% of LHCH employees said that communication between senior managers and staff is effective (an improvement of 3%), this is higher than the national average of 38%. Less than a third of all NHS staff (30%) reported that senior managers act on feedback from staff, LHCH performed considerably better with a score of 45%.

15% of NHS staff reported experiencing physical violence from patients, their relatives or other members of the public in the previous 12 months. LHCH scores much lower with 8% of staff report experiencing physical violence from patients, their relatives or other members of the public in the previous 12 months.

15% of LHCH staff report that they experienced bullying, harassment and abuse from patients, their relatives or other members of the public in the previous 12 months compared with 28% of all staff nationally.

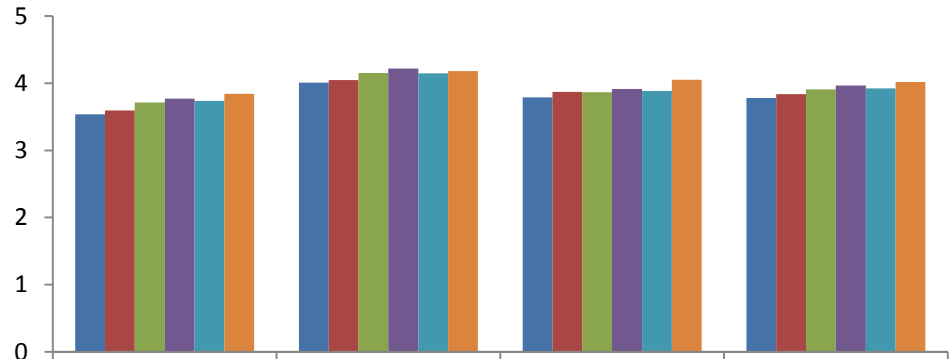
Top Five Trust Strengths and Weaknesses 2015



Staff Engagement 2010-2015

Staff engagement has improved to the highest level so far in LHCH, up to 4.02 in 2015 from 3.92 in 2014, with all the three areas of engagement improving on the previous year’s survey. A breakdown of the engagement score is shown in the chart below.

Staff Engagement 2010-2015



	Involvement	Advocacy	Motivation	Overall Engagement
2010	3.54	4.01	3.79	3.78
2011	3.59	4.05	3.87	3.84
2012	3.71	4.15	3.86	3.91
2013	3.77	4.22	3.91	3.97
2014	3.74	4.15	3.89	3.92
2015	3.84	4.18	4.05	4.02

Most Improved and Declined

The top 5 areas of improvement highlighted in the survey are shown below alongside the 5 areas that have shown the biggest decline.

	Improved	2014	2015	+ ↑		Declined	2014	2015	- ↓
1	Staff feeling pressure in the last 3 months to attend work when feeling unwell	46%	57%	11%	1	Percentage of staff appraised in last 12 months	88%	84%	4%
2	Staff reporting good communication between senior management and staff	40%	45%	5%	2	Percentage of staff working extra hours	65%	69%	4%
3	Staff able to contribute towards improvements at work	71%	76%	5%	3	Staff believing that the organisation provides equal opportunities for career progression or promotion	90%	88%	2%
4	Staff motivation at work	78%	81%	3%	4	Staff reporting errors, near misses or incidents witnessed in the last month	91%	88%	3%
5	Support from immediate managers	77%	79%	2%	5	Staff experiencing harassment, bullying or abuse from patients	14%	16%	2%

As in previous years, the results of the 2015 staff survey will be analysed as far as possible to Divisional and Department levels and disseminated and communicated through the organisation to all staff. This year we have arranged for neutral facilitators to provide

feedback and support managers and staff in identifying key areas for improvement and developing action plans. As part of the session, facilitators will encourage departments to explore the results and aim to support identifying actions that will be beneficial, good practice and quick wins.

Staff Friends & Family Test

The Friends and Family Test (FFT) for Staff is a national feedback tool which allows staff to give feedback on NHS Services based on recent experience. Staff FFT is conducted on a quarterly basis (except for the quarter when the Staff Survey is running). There is no set criterion for how many staff should be asked in each quarter, simply a requirement that all staff should be asked at least once over the year. The Trust opens the survey for all staff to complete for each of the 3 quarters.

For national feedback staff are asked to respond to two questions. The 'Care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need treatment or care. The 'Work' question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work. Staff are given a 6-point scale from which they can respond to each question. The scale includes the options; 'Extremely Likely', 'Likely', 'Neither Likely nor Unlikely', 'Unlikely', 'Extremely Unlikely' and 'Don't Know'.

LHCH scores are shown below, plotted alongside the National Staff Survey results.

Purple - Staff FFT Orange - National Staff Survey	2010	2011	2012	2013	2014/15 Q1	2014/15 Q2	2014	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015	2015/16 Q4
Recommendation for Treatment	92%	92%	92%	92%	97%	97%	92%	98%	94%	97%	98%	97%
Recommendation for Work	61%	62%	72%	74%	73%	68%	69%	75%	64%	71%	70%	66%

Corporate Social Responsibility

The Trust's highly successful Access to Medicine programme has proven to be an excellent approach in supporting local students obtain the work experience required to gain successful entry into Medical School.

The Trust continues to work with local Liverpool schools via Compass to provide work experience in a wide range of clinical and non-clinical areas. This helps students identify what it is like in healthcare with the added potential of attracting its future workforce and younger people to come and work in the NHS.

The Trust has provided dementia friends training to its local community, working alongside Dementia Action Alliance Liverpool to support their work in making Liverpool a dementia friendly community.

2.4 Disclosures set out in the NHS Foundation Trust Code of Governance

Compliance with the Code of Governance

Liverpool Heart and Chest Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain basis'. The NHS Foundation Trust Code of Governance, most recently revised in July 2014 is based upon the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors has established governance policies that reflect the principles of the Code, including:

- A Corporate Governance Manual which includes the constitution and procedures by which the Board of Directors and Council of Governors operate; the Scheme of Reservation and Delegation, the Board Committee structure and associated Terms of Reference and the Standing Financial Instructions.
- At least half the Board of Directors, excluding the Chair, comprises independent non-executive directors;
- The appointment of a Senior Independent Director;
- Regular meetings between the Chair and non-executive directors;
- Annual appraisal process for the Chair and non-executive directors that has been developed and approved by the Council of Governors;
- Register of Interests for Directors, Governors and senior staff;
- Council of Governors Policy for Raising Serious Concerns;
- Lead Governor appointed;
- Provision of Board minutes and summaries of the Board's private business to governors;
- Effective infrastructure to support the Council of Governors including sub committees, interest groups and informal meetings with the Chair;
- Process for annual evaluation of the Council of Governors and for setting key objectives / priority areas for the following year;
- Membership Strategy with KPIs reported to the Council of Governors;
- Two Nominations and Remuneration Committees for executive and non-executive appointments / remuneration respectively – in the case of non-executive appointments / remuneration recommendations are made to the Council of Governors for approval;
- High quality reports to the Board of Directors and Council of Governors;
- Board evaluation and development plan;
- Codes of Conduct for Governors and for Directors;
- Going concern report;
- Robust Audit Committee arrangements;
- Raising Concerns Policy and Anti-fraud policy and plan;
- A Council of Governors Policy for raising serious concerns;

- The LHCH Constitution sets out the procedures for the operations of the Board of Directors and Council of Governors, including a process for dealing with disagreements.

The Board of Directors conducts an annual review of the Code of Governance to monitor compliance and identify areas for further development.

The Board has confirmed that, with the exception of the following provision of the NHS Foundation Trust Code of Governance issued by Monitor and updated in July 2014, the Trust has complied with the provisions of the Code in 2015/16.

Provision B.6.2 requires an external evaluation at least every 3 years to check that the Trust is meeting the requirements of Monitor's 'Board Leadership and Governance Framework' (published 1st January 2014); **the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust.**

The Trust has now commissioned its first external evaluation, to be undertaken 2016/17. The review will be undertaken by Mersey Internal Audit Agency (MIAA). MIAA has an established relationship with the Trust as its internal auditor. However, MIAA has demonstrated to the Audit Committee and to the Board of Directors that it has the capacity and capability to conduct this review using the expertise of a range of associates and specialists who are separate and work independently of the internal audit team that work routinely with the Trust.

The Board has considered carefully and determined that the agreed terms of reference for this work meet the requirements of the Well Led Framework and will compliment and build upon previous governance reviews supported by MIAA, also providing best value in relation to cost.

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.

The membership plans are to:

- support greater engagement with the general public as well as membership
- continue to build a membership that is representative of the demographics of its patient population, whilst also being mindful of the public population, whilst maintaining an optimum membership size (c. 10,100 members
- continually increase the quality of engagement and participation through the involvement of members and members of the public 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 2016, 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 provide 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. In Summer 2015, the Trust issued the bi annual members' survey which achieved a 6.8% return rate. Feedback received has resulted in enhancements to the content of the Members Matters newsletter.

In addition to this, Governors attend regular patient and family listening events which provide further opportunity for effective engagement.

Following on the success and popularity of previous events, an annual Members' Health Day was held in 2015 to provide members and the public with an opportunity to tour the hospital facilities, receive health checks and lifestyle advice. The event provided Governors with an opportunity to meet and engage with both members and members of the community, whilst also raising the profile of membership and the Council of Governors.

It is through these activities that Governors canvass the views of members and the public in order to inform the Trust's forward plans, including its objectives, priorities and strategy. These views are communicated to the Board at quarterly Council of Governor meetings and at the annual Joint Board and Governor Development Day.

In order to manage its turnover and to improve representation, Governors attended a number of recruitment events throughout the year, including a Disability Awareness Day held in Cheshire, a meeting for Chester Heart Support Group and an event at Liverpool John Moores University.

This is in addition to recruitment mailshots carried out by the Trust's Membership Office to recently discharged patients and on-going recruitment of members as part of our hospital volunteer scheme. 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 50-74 years old.

Membership Profile

Constituency			
Public Constituency	**As at 1st April 2015**	**As at 31st March 2016**	**Increase/ Decrease (%)**
Cheshire	2,425	2,437	+0.49%
Merseyside	5,020	5,056	+0.72%
North Wales	2,026	1,994	-1.58%
Rest of England and Wales	817	816	-0.12
Total - Public Constituency	**10,288**	**10,303**	**+0.15%**
Staff Constituency	1,337	1,254	-6.2%

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

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)
    - Friends of Robert Owen House (FRoH), Isle of Man
    - Liverpool City Council (LCC)
    - Association of Voluntary Organisations in Wrexham (AVOW)*
    - Cystic Fibrosis Trust*
    -

*On 1st March 2016, following approval by the Board of Directors and the Council of Governors, an amendment to the constitution was made to remove two long term vacant nominated governor seats for the Association of Voluntary Organisations in Wrexham and the Cystic Fibrosis Trust and replace these with one appointed governor seat representing Knowsley Council. An additional Staff Governor – Registered and Non Registered Nurses seat was also approved increasing the number of staff governors in this staff class to three.

At the Council of Governors and Board of Directors joint development day, held on 18th November 2015, 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.

The names of those who have served as Governor in 2015/16 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).

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 are held, where Governors meet informally before the formal Council of Governors meeting. This provides a further way for Governors to interact and discuss items on the agenda, as well as networking with Board members.
- One-to-one 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 provide an opportunity for Governors to engage with members and the public.
- Governors have contributed to the production of new promotional material clearly summarising the role of staff membership and the Staff Governor role, which was identified as an action following their annual development day in November 2014. This leaflet will help Governors in their role to promote membership and increase visibility of the Council of Governors whilst also better explaining this role to potential Staff Governors interested in standing for election.
- Governors are closely involved in helping to determine the priority areas for improving quality, safety and patient experience.
- Governors are involved in work relating to key Trust initiatives such as the Trust's Vision for Patient and Family Centred Care. In particular, Governors are invited and attend organised patient and family listening events which provides the opportunity for them to interact with members and member of the public, whilst also promoting

membership and increasing the visibility of the Council of Governors. Governors have also supported the review and development of Trust values and behaviours and have supported judging panels for schemes such as employee of the month and annual staff awards.

- 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 dashboard monitoring reports for the Council of Governors.
- Governors have continued work with a governance group under the leadership of the Chair to review the Trust's governance arrangements including composition of the council of governors and finalising Council of Governor objectives for 2016.
- Staff Governors attend a quarterly meeting with the Chairman and Associate Director of Corporate Affairs to assist development in their role of Staff Governor and an opportunity to discuss any key Trust issues.
- Governors have supported the Trust's commitment to be Dementia Friendly and attended Dementia Friends sessions facilitated by the Trust's Dementia Friend Champions.
- There has been Governor representation and involvement on the Trust's Patient Safety aswell as on the Service Users Research Endeavours (SURE) Groups.
- Governors attend project meetings and have involvement in the design of key capital schemes e.g. new main entrance and outpatients re-design which has been designed specifically to enhance our inpatient journey.
- Governors have played an active role in the development of the new LHCH Charity branding, attending brand workshops and feedback sessions, whilst also contributing to the development of a new fundraising strategy.

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 Company Secretary and regular walkabouts to meet with staff and view facilities.

Elections

The Board of Directors can confirm that elections for Public and Staff Governors held in 2015/16 were conducted in accordance with the election rules as stated in the Trust's constitution.

Constituency/Class	No. of seats	Governors elected
Public		
Merseyside (Election Contested)	3	Vera Hornby Arthur Newby Brian Roberts
Cheshire (Election Uncontested)	2	Ken Blasbery Allan Pemberton
North Wales (Election Contested)	2	Roy Griffiths Ian Painter
Rest of England & Wales (Election Uncontested)	1	Tony Roberts
Staff		
Non Clinical (Election Contested)	1	Alexandra Thompson
Registered and Non Registered Nurses (Election Contested)	1	Lynn Trayer Dowell
Allied Healthcare Professionals, Technical and Scientific (Election Uncontested)	1	Doreen Russell
Registered Medical Practitioners (Election Uncontested)	1	Michael Desmond

The Governors named above were elected/re-elected for 3 years and their tenures will complete at the end of the 2018 Annual Members' Meeting.

Governor Attendance at Council of Governor Meetings 2015/16

Between 1st April 2015 and 31st March 2016 the Council of Governors' met formally on four occasions. The following tables provide the attendance at each Council of Governors meeting held in public. The meetings were also attended by Executive and Non-Executive Directors.

Governor Name	Council of Governor Meeting Dates 2015/16			
	15th June 2015	1st October 2015	7th December 2015	1st March 2016
Public Constituency				
Merseyside				
Vera Hornby	✓	X	✓	✓
Paula Pattullo	✓	✓	✓	✓
Roy Stott	✓	✓	✓	✓
Brian Roberts	✓	✓	✓	✓
Neil Marks	✓	✓		
Trevor Wooding	✓	✓	✓	X
Arthur Newby *(commenced following AMM 1st October 2015)*			✓	✓
Cheshire				
Kenneth Blasbery *(Senior Governor)*	✓	✓	X	✓
Michael Brereton	✓	X	✓	✓
Judith Wright	✓	X	✓	✓
Allan Pemberton *(commenced following AMM 1st October 2015)*			✓	✓
North Wales				
Roy Griffiths	✓	✓	✓	✓
Denis Bennett	✓	✓	✓	✓
Ian Painter *(commenced following AMM 1st October 2015)*			✓	✓
Rest of England and Wales				
John (Tony) Roberts *(resigned 14th February 2016)*	✓	✓	✓	
Staff Constituency				
Registered Nurses and Non-Registered Nurses				
Peter Hannaford	✓	✓		
Neville Rumsby	✓	X	✓	✓
Lynn Trayer-Dowell *(commenced following AMM 1st October 2015)*			✓	✓
Non Clinical				
Alex Thompson *(commenced following AMM 1st*			✓	✓

Governor Name	Council of Governor Meeting Dates 2015/16			
	15th June 2015	1st October 2015	7th December 2015	1st March 2016
October 2015)				
Anthony Grimes	X	✓		
Sharon Hindley	X	✓	X	✓
Allied Health Professionals, Technical and Scientific				
Doreen Russell	X	✓	✓	✓
Michael Desmond	✓	✓	✓	✓
Nominated Governors:				
Michelle Laing *(Liverpool John Moores University)*	X	X	✓	✓
Glenda Corkish *(Friends of Robert Owen House)*	✓	✓	X	✓
Ruth Hirschfield	✓	X	X	✓
Board Members in attendance:				
Neil Large	✓	✓	✓	✓
Jane Tomkinson	✓	✓	✓	✓
Debbie Herring	✓	✓	✓	✓
David Jago	✓	✓	✓	✓
Sue Pemberton	X	✓	✓	✓
Glenn Russell	X			
Raphael Perry		X	✓	✓
Marion Savill	X	✓	✓	✓
Lawrence Cotter	X	✓	X	X
David Bricknell	✓	✓	✓	✓
Julian Farmer	X	X	✓	✓
Mark Jones	X	✓	X	✓

2.5 Regulatory Ratings

Since 1 April 2013 all NHS foundation trusts have needed a licence from Monitor stipulating the specific conditions they must meet to operate, including financial sustainability and governance requirements. Monitor's assessment of a foundation trust under the Risk Assessment Framework aims to identify:

- significant risk to the financial sustainability of a provider of key NHS services that endangers the continuity of those services and/or
- poor governance at an NHS foundation trust, including poor financial governance and inefficiency.

NHS foundation trusts are assigned a financial sustainability risk rating calculated using a capital service metric, liquidity metric, income and expenditure (I&E) margin metric and variance from plan metric.

The financial sustainability risk rating is Monitor's view of the level of financial risk a foundation trust faces to the ongoing delivery of key NHS services and its overall financial efficiency. The rating ranges from 1, the most serious risk, to 4, the lowest risk. A rating indicating serious risk does not necessarily represent a breach of the provider licence. Rather, it reflects the degree of financial concern Monitor has about a provider and consequently the frequency of monitoring.

In June 2015, Monitor consulted on a number of proposed changes to the risk Assessment Framework to reflect the challenging financial context in which foundation trusts are operating and to strengthen the regulatory regime to support improvements in financial efficiency across the sector. The changes include:

- monitoring in-year financial performance and the accuracy of planning
- combining these two measures with the previously used continuity of services risk rating to produce a new four level financial sustainability risk rating.

The Trust's quarterly performance against the planned financial sustainability risk rating for 2015/16 is illustrated below.

Financial Sustainability Risk Rating 2015/16	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Capital Service Capacity	3	3	4	3	4	3	4	4
Liquidity	3	2	3	2	3	2	2	2
I&E Margin	1	1	2	1	2	2	2	2
I&E Margin Variance (%)	3	3	3	2	3	3	3	3
Overall Financial Services Risk Rating	2	2	3	2	3	3	3	3

During the year, the actual performance against the overall rating was behind plan at quarter 2, and whilst it was on plan in other quarters, individual metrics fell behind plan in quarters 1 and 3. This was driven by a lower than planned surplus, driven by below plan performance against the cost improvement programme. At the end of quarter 4, despite the net surplus being below plan, all of the individual metrics achieved planned levels.

The Governance Rating has been ‘Green’ throughout 2015/16.

There has been no requirement for formal intervention by Monitor during 2015/16.

2.6 Statement of Accounting Officer 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: 26 May 2016

2.7 Annual Governance Statement

Scope of Responsibility

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

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Liverpool Heart and Chest Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Liverpool Heart and Chest Hospital NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

I am accountable for risk management across all organisational, financial and clinical activities. I have delegated responsibility for risk management to the Director of Research & Informatics, who acts as the Chief Risk Officer. During 2015/16 the Chief Risk Officer has led the development and implementation of an enterprise-wide risk management strategy which has resulted in significant improvements to the risk management process, including the introduction of a new risk management policy that draws upon international best practice, electronification and integration of the risk registers and comprehensive risk management training for all levels of the organisation to provide our people with the skills to assess, describe, control, escalate and report risks from Ward to Board. This new approach is work in progress and will be fully embedded during 2016/17.

Risk management training is delivered via corporate and local induction programmes for new staff and thereafter by participation in mandatory training. The Trust's line management arrangements are designed to support staff and managers to manage risks and advice and guidance is available to all staff from the risk management team.

The Trust has mechanisms in place to act upon alerts and recommendations made by central bodies such as the National Patient Safety Agency (NPSA), the Central Alerting System (CAS) and the Health and Safety Executive (HSE).

The Chief Risk Officer also leads the Trust-wide effort on organisational learning, which seeks to ensure the cascade and implementation of learning from the Trust's own experiences and those of other organisations. This has resulted in the development of an

organisational learning policy, now at the early stages of implementation. Key features associated with this include reporting improvements as a consequence of experiences to the Operational Board, thereby providing the opportunity for all to learn, together with robust follow up of improvements to ensure sustainability.

The Risk and Control Framework

Risk Management is embedded in all activities of the organisation. Examples include:

- Regular briefs to staff on the top three risks in all Departments
- Application of the organisation-wide risk management assessment and control system to Quality Impact Assessments prior to implementation of any cost improvement scheme. These are reviewed and approved by the Quality Committee
- Comprehensive annual proactive risk analysis undertaken by the Executive Team to ensure all possible risks likely to affect the Trust are considered (rather than those facing us at the present time)
- The Trust's "Sign Up to Safety" campaign which has resulted in a 40% improvement in incident reporting over the last 12 months

Each department within the Trust has its own electronic risk register, which is integrated with all others such that the identification of a high scoring risk automatically appears in the relevant Divisional (scores above 8) or Corporate (scores above 10) risk register. Registers are available to staff in 'edit' (management staff) and 'read only' (all staff) modes to ensure complete visibility and transparency across the Trust.

Risks are categorised according to a 5x5 scoring matrix; comprehensive training on how to articulate risks together with identifying and applying relevant controls has been provided. Where risks are high scoring, the Chief Risk Officer meets with the relevant manager to ensure consistency in scoring and offer advice in risk management.

The organisational appetite for risk has been set by the Board, and is embedded in the risk register structures. This results in the acceptance of risks when appetite thresholds are reached or exceeded.

During 2016/17, the Trust will be implementing DATIX, one of the leading risk management software products in the UK. This will bring many benefits, including universal electronic incident reporting, integration of incidents, claims, complaints and risk registers, and vastly improved risk management reporting.

When things do go wrong, staff are encouraged to report incidents, whether or not there was any consequence, in order that opportunity for learning can be captured. Public stakeholders are involved in managing risks where there is an impact on them. For example, when a serious incident is investigated, members of the Trust speak to, and where possible, meet with those affected. The Trust follows a clear policy on being open and works to ensure that the duty of candour is adhered to. Relevant feedback from discussions and dialogue with stakeholders is considered and a final copy of the investigation report is shared, providing further opportunity for comment.

Quality governance is embedded within the Divisional structures, with monthly reporting to the Operational Board, where quality performance is reviewed. Cross-organisational quality initiatives are monitored and managed through a combined divisional quality governance meeting. A formal Board Assurance Committee for Quality meets bi-monthly and receives assurances on progress with all of the Trust's quality initiatives.

Compliance with CQC registration requirements are regularly tested through implementation of the Trust's own "Excellent, Compassionate, Safe" (ECS) framework. This bespoke assessment tool relies upon the integration of quality performance data, together with direct observation of clinical practice and the experiences of patients from each clinical area of the Trust. The result is a stratified performance score, the value of which determines the requirement for the frequency of re-inspections. Assurance is enhanced through regular walkarounds conducted by members of the Board and Governors.

The Trust has recently created a Cyber Security Working Group. The first task of the group was to undertake a comprehensive audit of the controls in place to prevent cyber incidents and ensure a speedy and seamless recovery. A number of improvements were identified which are currently being implemented. This group reports to the Trust's IM&T Programme Board.

Following a formal review of its governance arrangements, the Board implemented a new assurance committee structure in 2014/15 and this was enhanced in 2015/16 with the addition of a new People Committee to supplement the Quality Committee and Integrated Performance Committee. All three assurance committees comprise non-executive directors and enable effective challenge of assurances to support delivery of the Trust's strategic objectives and regulatory compliance. The Trust's Operational Board is chaired by the Chief Executive and comprises all members of the executive team, the three Divisional Triumvirate Leadership Teams (Associate Medical Directors, Heads of Nursing and Divisional Heads of Operations); and Clinical Leads for Research and IT. The Operational Board is accountable for all aspects of delivery and operational performance and reports routinely to the Board of Directors. The governance structure facilitates a clear distinction between assurance (non-executive led) and performance management (executive led).

The Board has set aside dedicated time within its annual business cycle to focus on strategic planning and Board development.

A comprehensive review of compliance with the provider licence is undertaken annually and reported to the Audit Committee; this is supplemented by use of a quarterly checklist to test compliance with key provisions on a quarterly basis.

In relation to oversight of the Trust's performance, the Board receives an integrated performance report at every meeting and exception reports with action plans are provided for any areas which are off target. This report is supplemented with issues raised by the Assurance Committees, reports from Operational Board and 'softer' intelligence gained from walkabouts and observation. The Board frequently receives presentations from clinical and non-clinical leaders to enable it to focus on key areas for development and learning.

The Board Assurance Framework (BAF) is used as a tool to prioritise the Board's time through documentation of the principal risks to strategic objectives and regulatory compliance, identification of controls and assurances and actions needed to address any gaps. There is a clear process for regularly reviewing and updating the BAF and the BAF drives the Board's agenda and business cycle. All Board and Committee papers are referenced to the BAF to enable any changes in risks or gaps in assurance to be highlighted. Each of the Assurance Committees reports on BAF key issues to the Board and this informs regular review of the BAF. The Trust has consistently achieved an internal audit opinion of 'significant assurance' in relation to its BAF processes and this has again been confirmed for 2015/16.

The Board assures itself of the validity of its corporate governance statement through:

- alignment of Board business cycle to the assurances required to support the Board declarations
- annual review of the effectiveness of the Assurance Committees, led by the Audit Committee
- incorporating within the internal audit programme an annual review of the sufficiency and quality of evidence brought to the Board and its Committees throughout the year to support the corporate governance statement.

A brief description of the Trust's major risks is set out below.

Key In-Year Risks

i) Compliance with provider licence condition 4 (FT governance) – the Trust has managed operational risks this year arising from the increasing acuity of patients, a growing proportion of non-elective work, a shortage of skilled staff available to recruit and industrial action by doctors in training. These factors have presented challenges in relation to financial performance, RTT compliance, cancelled operations, high reliance on agency staff and system-wide compliance with 62 day cancer pathway.

ii) The Trust has received two 'limited' assurance reports from internal audit in 2015/16 in respect of IT security of financial data (service line reporting system) and technical security of the data warehouse. The Audit Committee has received the respective management responses and action plans are in place.

iii) There have been three serious incidents reported in 2015/16:
   - An alert in respect of a redundant alarm button in the theatres staff room – no harm to patients and corrective action taken
   - A non-prescribed drug was administered to a patient by a member of agency staff – full investigation completed and report to Nursing & Midwifery Council for appropriate action
   - One 'never event' arising from use of wrong prosthesis – full root cause analysis and independent review commissioned. Organisational learning plans in place.

iv) During the year the Trust has worked to further improve safety through a focus on the management of sepsis, safe medication and timeliness of mortality reviews. A long term strategy for the management of multi-drug resistant infections was approved by the Board.

Future Risks

i) Delivery of the 2016/17 Financial Plan

The Trust has submitted a deficit plan of £4.3m with no external cash support requirement for 2016/17. The adverse impact of tariff in 2016/17 sees LHCH as the only provider with a tariff deflator in 2016/17. Whilst cash balances will fall to circa £2.0m the Trust can manage impact of this deficit plan in 2016/17.The Trust will continue to lobby for the introduction of HRG4+ in 2017/18 as this better reflects the difference in resource usage between routine and complex care of patients with a consequent upside to the clinical income plan of LHCH.

ii) Impact of external environment

The Trust continues to work with partners across the Liverpool health economy to support delivery of the Healthy Liverpool Programme and with commissioners to ensure clarity of understanding in relation to the impact of the tariff structure and the financial implications associated with provision of highly specialised services, such as aortic surgery. The external environment continues to change a rapid pace and the Board has set out a stakeholder management plan for 2016/17 and continues to ring-fence time for strategic planning and work with external commentators. The Trust has commissioned a strategic options appraisal (commissioned by Liverpool CCG) that will report in early 2016/17.

iii) Workforce

The Trust has in place a People Strategy and the successful delivery of this is critical to ensuring the mitigation of workforce risks, particularly in relation to recruitment of skilled staff to provide the increase in operational capacity required to deliver the 2016/17 operational plan and to mitigate the reduction in numbers of doctors in training, arising from national policy changes.

iv) Delivery of targets

Delivery of targets will continue to be a challenge, particularly in the context of the Trust's financial position in 2016/17 and the aim to repatriate outsourced cardiac surgical activity. The Trust's operational plan provides for the planned capacity requirement but the continuation of patient complexity and acuity, and increase in non-elective referrals remain a challenge.

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

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

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

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on 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 Integrated Performance Committee, a formal Assurance Committee of the Board. The Board itself reviews a report on financial performance provided by the Chief Finance Officer including key performance indicators and Monitor metrics at each Board meeting. 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 divisions 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 the integrated Performance Committee and Board of Directors as part of the sign off of annual plans.

Information Governance

Information governance risks are managed as part of the processes described above and assessed using the Information Governance Toolkit. The Trust has not experienced any serious or reportable information governance incidents during 2015/16, including data loss or confidentiality breach, with a compliant Information Governance Toolkit assessment submitted as at 31st March 2016.

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 formulation of the Annual Quality Report has been led by the Director of Nursing and Quality with the support of Medical Director, Divisional Heads of Operations, Informatics team and other teams as required, for example, Care Support Team and Safeguarding team. The Annual Quality Report 2015/16 has been developed in line with national guidance. All data within the Quality report is reviewed by the Quality Committee as part of a quality dashboard and is derived from a comprehensive 3 Year Quality Improvement Strategy, approved by the Board of Directors. The Quality Committee reports regularly to the Board via a 'BAF Key Issues Report'.

The Quality Report has been reviewed through both internal and external audit processes and comments have been provided by governors and local stakeholders including, patients, commissioners, Healthwatch and the local authority. These stakeholders have fed back on what is important to them and how the Trust can further improve the quality and safety of services for our patients and their families.

Implementation of the Quality Strategy and Organisational Learning Strategy supports delivery of the Trust's key objective to provide high quality and safe care. At the centre of these strategies is an ambition to continually improve the quality of service, including staff consistently demonstrating their compassion, confidence and skills to champion the delivery of safe effective care. The Organisational Learning Strategy focuses on how the Trust learns from all available information and feedback about services; this sharing learning and good practice is monitored through the Quality Committee and communicated widely across the Trust through Divisional Governance structures.

There are systems in place within the Trust to review and monitor performance and quality of care through performance dash boards at ward, service, divisional and Board level with a wide range of information available across the whole Trust. The Quality Committee makes use of a bespoke clinical quality dashboard to monitor the performance of the key indicators set out in the Quality Improvement Strategy. The use of electronic monitors at the entrance to all wards displays quality data and staffing levels to inform patients and families and to provide confidence around quality and safety.

The Trust has in place a dedicated 18 week validation team working alongside operational managers and consultants to routinely cleanse and validate waiting time data. The process is reviewed periodically as part of the Trust's internal audit programme.

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

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the 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 within 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 [and risk/ clinical governance/ quality committee, if appropriate] 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 and formal quarterly BAF review
- 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 CQC standards
- Internal audits of effectiveness of systems of internal control.

Conclusion

There were no significant control issues identified in 2015/16, however during the year the Trust has actively addressed the actions and organisational learning arising from the never event and has maintained an active oversight of the effectiveness of controls in place to mitigate the risk of harm and ensure delivery of operational targets.

Jane Tomkinson
Chief Executive
Date: 26th May 2016

PART 3: QUALITY REPORT

Introduction to Liverpool Heart and Chest Hospital NHS Foundation Trust

Liverpool Heart and Chest Hospital NHS Foundation Trust is a single site specialist hospital serving the population of 2.8 million people resident in Cheshire, Merseyside, North Wales and the Isle of Man. It provides the full range of heart and chest services with the exception of organ transplantation. Throughout 2015/16, this included:

1. Procedures used to visualise the coronary arteries and treat narrowings using balloons and stents (coronary angiography and intervention).
2. The implantation of pacemakers and other devices and treatments used to control and restore the normal rhythm of the heart (arrhythmia management).
3. Surgical procedures used to bypass coronary artery narrowings, replace the valves of the heart or deal with other problems with major vessels in the chest (cardiac surgery).
4. Surgical procedures used to treat all major diseases that can affect the normal function of the lungs which can include lung removal and surgery to the gullet (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 the Trust has been successful in the tendering of respiratory services. NHS Knowsley CCG commissioned LHCH in 2015 to provide a Community Respiratory Disease Service that will contribute to its overall plans to improve health outcomes for patient population. Specifically the CCG sought to reduce premature deaths from respiratory conditions and decrease unnecessary emergency care through improved diagnosis, treatment and management, which is accessible and meets the expectations of both patients and the public in Knowsley, in respect of the experience of the service. LHCH have demonstrated through this service model that patients enjoy access to high quality services closer to home, which demonstrates better outcomes and value for money.

New Environments
Cherry Ward, opened in September 2015. This ward gives an enhanced experience to patients with cystic fibrosis. Feedback from the patients and families includes the following:

- All families are always made to feel extremely comfortable.
- The ward is very clean and modern. All staff are so lovely and make it feel like home from home.
- I could not have been treated any better or been treated in better surroundings with access to superior facilities.

The Discharge Lounge within Mulberry Ward opened in September 2015. Patients who are ready for discharge home can relax in a comfortable environment, whilst waiting to be discharged from the hospital.

The Outpatient Department is being redesigned to improve the experience of patients and families.

Improvements were made to the Trust's family area within the Post Operative Critical Care Unit (POCCU). The environment offers a relaxed spacious area for families with confidential seating areas when discussions are needed with medical and nursing teams.

All clinical ward and operating theatres areas were assessed against the Trust's *Excellent Compassionate and Safe Care* standards (ECS) framework in 2015. All areas were awarded a green status with achievement plaques displayed outside each entrance.

Listening in Action saw projects being led by multidisciplinary teams Trust wide. The Trust has seen improvements made to the pathway of its patients that focus on quality and experience. Enabling patients to be discharged earlier in the day, reducing the number of moves a patient has during their care pathway and ensuring all medications and equipment are available before discharge.

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.

The Trust has one of the largest critical care units, alongside state of the art laboratories and operating theatres, in which to treat its patients.

Quality Account Summary

This quality account takes a look at the year past and reflects upon the promises the Trust has made to improve quality.

The Trust is pleased to announce that all its quality targets have been met for 2015-2016:

- Timeliness of patient discharge – Home for lunch project
- Families and carers to be offered the opportunity to be a care partner
- Patient, families and carers to be able to speak out safely
- Safe quality care for our vulnerable groups of patients

It has been another good year for improving the quality of care at LHCH, with the focus on improving the quality of care and experience for all its patients, their families and carers.

This Quality Account also reassures readers regarding work that is a key enabler of quality, including clinical audit, research, data quality, workforce management and leadership. It draws upon the results from our survey work with patients and other quality improvement work supporting the different services and functions of the Trust. The Quality Account has also been the subject of discussion with Clinical Commissioning Groups, Healthwatch, relevant Local Authority Overview & Scrutiny Committees and other interested parties such as the staff working in the hospitals with whom the Trust works.

Part 1: Statement on quality from the Chief Executive of Liverpool Heart and Chest NHS Foundation trust

It is my pleasure to introduce the Quality Account for 2015-2016 by Liverpool Heart and Chest Hospital NHS Foundation Trust, which demonstrates our commitment to deliver the very best in healthcare.

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 ambition to develop services which bridge the divide between general practitioners, local district hospitals and ourselves. Integration with our healthcare partners will allow us to reach further into the community and develop the high quality care and experience enjoyed by our patients.

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

- Patients have voted us to be the best in care and treatment and cleanliness as part of the Care Quality Commission's National Inpatient Survey.
- We have been voted the best in 9 out of 10 national patient survey results.
- We continue our registration with the independent health regulator, the Care Quality Commission without any conditions.
- In March 2015 LHCH was recognised as being one of 18 'outstanding' trusts by the Department of Health for levels of openness and transparency for reported incidents.
- All minimum standards of care met or exceeded as defined by the Department of Health.
- Achievement of all cancer waiting time targets.
- LHCH was a shortlisted finalist in four categories at the Nursing Times Awards 2015.
- Professor Aung Oo was award the post of Honorary Chair from the University of Liverpool.
- Professor Martin Walshaw was recognised as an honorary professor by the University of Liverpool.
- Mr Richard Page has been voted the new President of the Society of Cardiothoracic Surgery.
- Dr Joseph Mills was appointed President of the British Association for Cardiovascular Prevention and Rehabilitation.

Despite this excellent performance, we remain committed to improving the quality and safety of care given to our patients and their families and this Quality Account is the public statement to this.

We have led an extensive consultation exercise with our staff together with our Foundation Trust membership and the hospitals' commissioning bodies, patients, carers and other services we work with 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 details those aspects of clinical care we have selected over the coming twelve months, together with a review of our performance over the past year.

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

2.1 Priorities for improvement

Priority One:
Improve the experience in outpatient department for patients and families

Category:
Patient Experience

Why:
Our patients have said they are waiting over 30 minutes to see a doctor. This has a negative impact on their experience within the outpatient department.

How much:
Our aim is to improve the total of positive responses to Friends and Family test (FFT) “would you recommend our hospital” question.

By When:
March 2017

Who collects the data:
Friends and Family Test results

Monitoring of Data:
The hospital information team

Current Position:
Baseline data from April – June to be established

Priority Two:
Development of Care Pathways for patients with enhanced or complex needs

Category:
Safe

Why:
To ensure those patients who require more complex care needs are identified within our electronic health record with evidence of appropriate care needs delivered.

How much:
80% of those patients identified on admission as requiring enhanced care needs

By When:
March 2017

Who collects the data:
The electronic patient record

Monitoring of Data:
The hospital information team

Current Position:
Development of pathway April – June 2016. Implementation of pathway and training July – September 2016. Monitoring of care October – December 2016. Improvements January - March 2017.

Priority Three:
Patients receive frailty assessments

Category:
Safe

Why:
To ensure all patients identified as being frail receive an Occupational Assessment and referral to their GP for further intervention if required.

How much:
80% of those patients identified as requiring a frailty assessment and referral to GP

By When:
March 2017

Who collects the data:
The electronic patient record

Monitoring of Data:
The hospital information team

Current Position:
Development of frailty assessment document April – June 2016. Implementation July – September 2016. Monitoring of occupational assessment and referral to GP October – December 2016. Improvements January - March 2017.

Priority Four:
Post discharge from hospital support

Category:
Effective

Why:
Our patients who have undergone complex Aortic surgery would benefit from follow up care telephone calls following discharge

How much:
50% of all patients identified as having complex aortic surgery

By When:
March 2017

Who collects the data:
The electronic patient record

Monitoring of Data:
The Care Support Team

Current Position:
Identify the percentage of patients who are discharged following complex aortic surgery April – June 2016. Development of care follow up questionnaire document July – September 2016. Instigate care follow up telephone calls October – December 2016. Improvements January - March 2017.

How our priorities were selected

In the pursuit of its goal to deliver the best outcomes and be the safest integrated healthcare organisation in the country, throughout 2015/16 the Trust led a continuous and comprehensive consultation exercise. The focus was on the identification of those priorities for improvement which would bring the biggest benefits to the people the Trust serves. By people, this naturally includes patients, but importantly also carers, Foundation Trust members and other health and social care professionals with whom the Trust interacts with on a daily basis.

The Trust held a number of internal and external consultation events which have successively refined its decision making over which priorities to select. The 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).
3. The Trust's quality, safety and patient experience Council of Governors sub-group, who are continuously identifying priorities from the Trust's 10,300 members.
4. Patient and family listening events.
5. 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 run in the local communities served by the Trust.
6. Healthwatch, who were invited to the Trust's stakeholder event for Quality Accounts prioritisation.
7. Issues raised by LHCH patients arising from both national and local surveys.
8. Key stakeholders (the doctors, nurses and managers from referring hospitals, 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 Trust's Governors who discussed the priorities and approved the final shortlisted priorities on behalf of the Board of Directors on 29th February 2016.

Unlike previous years, this process has resulted in four of the five suggestions from stakeholders external to the Trust being accepted as a priority. This year, all of the suggested priorities have been influenced by our stakeholders and our Council of Governors, with engagement from staff.

Duty of Candour

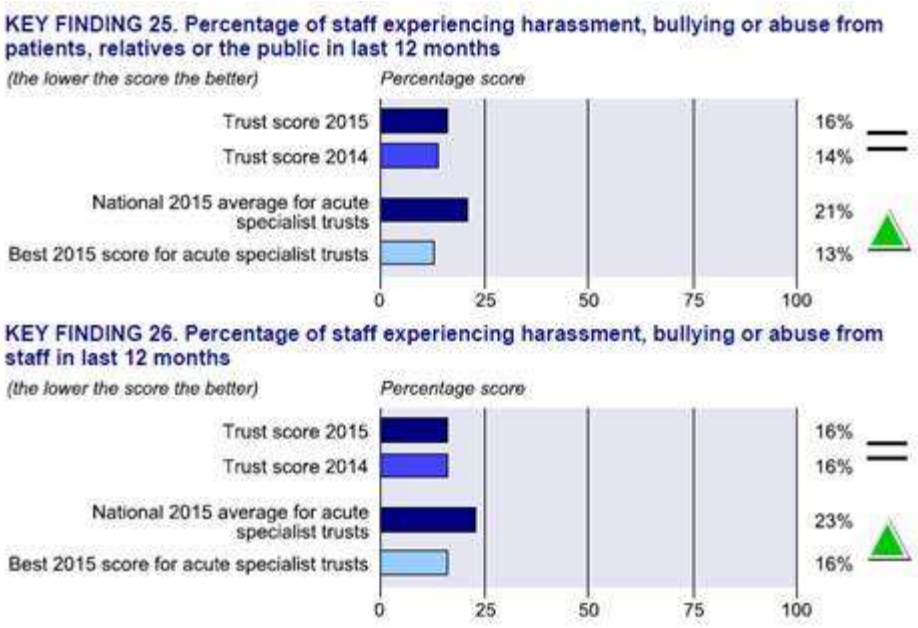
LHCH acknowledges the need for open and effective communication with all patients, carers and families. This effective communication begins at the start of the patients care pathway

and continues throughout their time spent at the hospital. Openness and transparency to our patients and their families when an incident has been identified as causing patient harm is both encouraged and supported by the Board of Directors. The Trust has initiated a number of ways for implementing the duty of candour. These include:

- awareness raising for all staff groups
- inclusion of duty of candour training within our mandatory training policy
- human factor training for clinicians
- training for Board of Directors
- leaflets and posters informing staff of our commitment for open and honest communications
- strengthening Trust policies and procedures supporting duty of candour.

NHS Staff Survey Results

The Trust made improvements in the staff survey KF25 – 26 % of staff experiencing harassment and bullying, and KF21 equal opportunities for career progression as described in the results below.



CQC Ratings

Following the inspection in April 2016 the Trust awaits the formal report. At the end of the inspection the CQC inspectors had no concerns in relation to patient safety; the final outcome of the inspection will feature in the Quality Report 2016-2017.

Review of Priorities from 2015/16

Priority One:
Timeliness of inpatient discharge

Category:
Patient Experience

What:
Improve the Timeliness of inpatient discharge from hospital

Why:
Timely discharge for our inpatients to ensure they have everything in place for a safe and timely return to their place of discharge by 12 midday. This gives the patients and their families a focus and something to look forward to when leaving the safety of a hospital setting. Patient experience is vital to us delivering a safe and quality service to meet our patient and their families' needs. Feedback from our patients suggests discharge delays have occurred due to not having their medications ready to enable them to leave the hospital early in the day.

Chosen via the Stakeholder Group

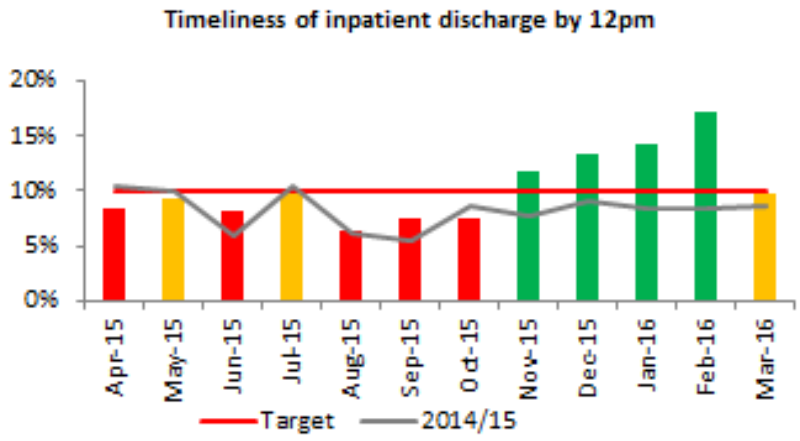
How Much:
Our aim was to have 10% of our patients discharged before 12midday.

By When:
March 2016

Who Collects the Data?
The Electronic Patient Record and our patient administration service will be used to collect the data.

Monitoring of Data:
The Quality and Patient Family Experience Committee will monitor the progress made.

Current Position:
The Trust achieved 10.3% as end March 2016.



Priority Two:
Family and Carers to be offered the opportunity to be a care partner

Category:
Effectiveness

What:
Promotion and involvement of our patient families and carers in the care delivered to our patients during their inpatient stay.

Why:
This aspect of care is pivotal to ensuring engagement with our patients' carers and families through sometimes the most difficult of times. Our vision is to enhance our relationships with our patients' carers and their families by providing them with the right level of support and to provide aspects of care to their loved ones whilst in hospital.

Chosen via the Stakeholder Group

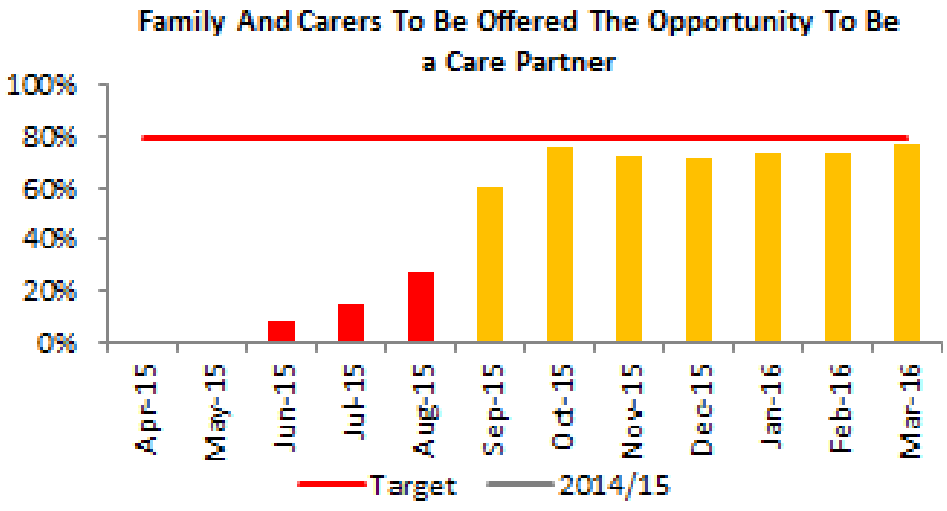
How Much:
Our aim was to evidence through the EPR record that an increasing percentage of carers are actively involved in the care given. This aspect of family participation was completed in 2015 supported by staff training. This will be closely monitored within 2016-2017.

By When:
March 2016.

Who Collects the Data?
The electronic patient record needed to be developed so we could collect this data.

Monitoring of Data:
The Quality and Patient Family Experience Committee monitored the progress made.

Current Position:
The Trust achieved 55.3% as of March 2016.



Priority Three: Patients, families and carers to be able to speak out safely

Category:
Safety

What:
We want to encourage all our patients, their families and carers to speak out in a safe and comfortable environment when they feel there is a need to do so.

Why:
It is important to us to recognise that our patients, their families and carers may on occasions want to speak out safely regarding aspects of care, or certain situations they are not happy with. We want to ensure our patients, families and carers are supported and encouraged to do this. As a learning and patient and family centred hospital we want to know when we do not get things right, so we can change, and adapt to make the experience for our patients, families and carers a positive and good experience when in the hospital. This performance target has been increasing over 2015-2016. This will continue to be monitored in 2016-2017.

Chosen via the Stakeholder Group

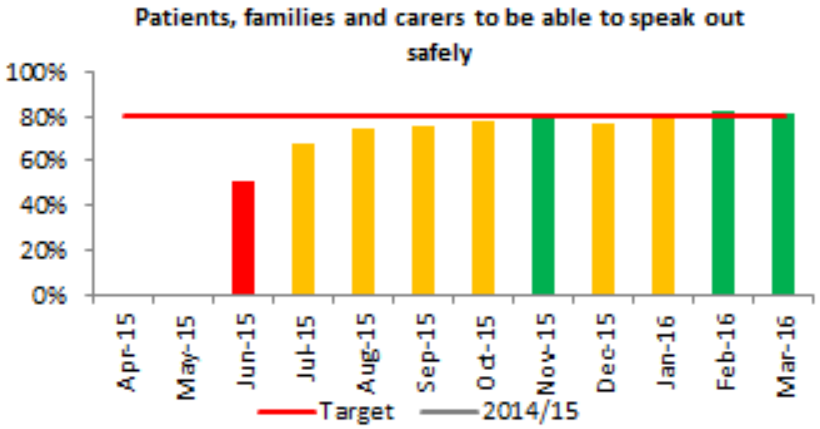
How Much:
We wanted to display on all our in-patient areas the process for speaking out safely this will be **Report, Escalate, Talk (RET)**. This process will inform all our patients, families and carers how to openly discuss their concerns. We wanted to collect all concerns raised through the implementation of a telephone SOS phone line and a dedicated e-mail address.

By When:
March 2016.

Who Collects the Data?
The administrator for the phone line and email communication.

Monitoring of Data:
The Quality and Patient Family Experience Committee monitored the progress made.

Current Position:
The Trust achieved 74.6% as of January 2016


Patients, families and carers to be able to speak out safely
100%
80%
60%
40%
20%
0%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Target
2014/15

Priority Four: Safe Quality Care for our vulnerable groups of patients

Category: Clinical Effectiveness

What:
Identifying and ensuring our vulnerable inpatients receive the best in quality safe care in accordance with their needs.

Why:
It is important to us to recognise that some of our patients have specific care needs due to their vulnerable clinical conditions. We would like to ensure that all specific care needs have been identified and acted upon, and that the identified specific care is always delivered.

How much:
We have added into our EPR system a flow chart that captures the specific vulnerable clinical condition and identifies the care required proportionate to the specific need of the patient. Our EPR documentation on identification of patients who require specific care needs for their vulnerability was added into our EPR system. Training for staff continues, this aspect of care will continue to be monitored in 2016/17.

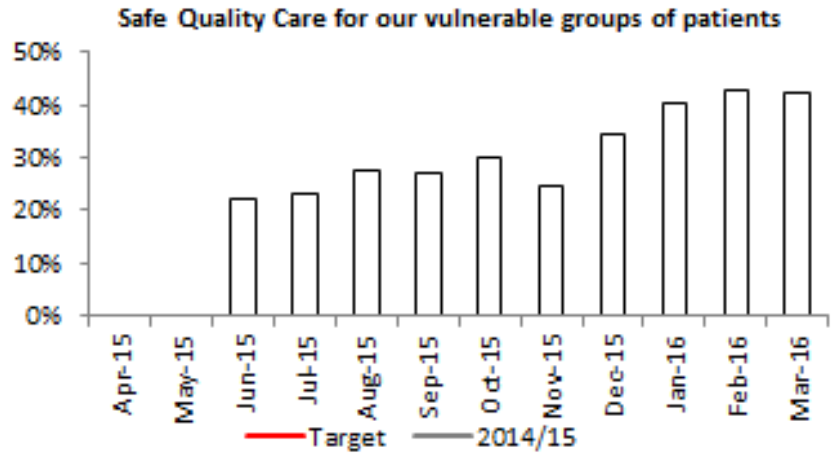
Chosen via the Stakeholder Group

By When:
March 2016.

Who Collects the Data?
The Electronic Patient Record.

Monitoring of Data:
The Quality and Patient Family Experience Committee monitored the progress made.

Current Position:
The Trust achieved 31.8% as of March 2016.



2.2 Statements of Assurance from the Board

During 2015/16 Liverpool Heart and Chest Hospital provided and/or sub-contracted 12 relevant health services.

Liverpool Heart and Chest Hospital has reviewed all the data available on the quality of care in all 12 of these NHS services.

The income generated by the relevant health services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of relevant health services by Liverpool Heart and Chest Hospital for 2015/16.

Participation in Clinical Audits
During 2015/16, 16 national clinical audits and 3 national confidential enquiries covered relevant health services that Liverpool Heart and Chest Hospital provides.

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

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital were eligible to participate in during 2015/16 are as follows in table 1.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital participated in during 2015/16 are as follows in Table 1.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital participated in, and for which data collection was completed during 2015/16, 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:

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	We are part of the ICNARC CMP, and part of the new Cardio-Thoracic sub-group, and the data is submitted on a quarterly basis: For 2015/16 submitted data on 1763 / 1763 (100%) of patients admitted to Critical Care
2	Emergency Use of Oxygen	Yes	55/55 (100%) submitted for Oct 2015 period as per study criteria
3	National emergency laparotomy audit (NELA)	Yes	NELA - year 2 (01/12/2014 - 30/11/2015): 14/14 (100%) cases submitted NELA - year 3 (01/12/2015 - 30/11/2016): 5/6 cases submitted to date
	Blood and transplant		
4	National Comparative Audit of Blood Transfusion programme - 2015 Audit of Patient Blood Management in Scheduled Surgery	Yes	Submitted data on 45 cases, which is 100% of the sample size requested by the terms of the audit.
	Cancer		
5	Lung cancer (NLCA)	Yes	Data for patients diagnosed in 2015 is now submitted via the trust's monthly Cancer Outcomes and Services Dataset submissions to the National Cancer Registration System. Currently 2072/2072 (100%) records for suspected lung cancer have been submitted for patients diagnosed from January to December 2015
6	Oesophago-gastric cancer (NOGCA)	Yes	Data submission for cases seen between April 2015 and March 2016 is 0/47 (0%). Data submission for 2014-15 data was only closed in Dec 2015 by NOGCA. LHCH 2015-16 data will be submitted by March 2016. Deadline for submission is 31/05/2016

	Heart		
7	Acute coronary syndrome or Acute myocardial infarction (MINAP) (subscription funded from April 2012)	Yes	914/ 1039 (88%) STEMI cases submitted to NICOR 0/16 (0%) Takotsubo cases submitted 13/1530 (1%) NSTEMI / ACS (Time period April 15 – March 16). Electronic bulk upload Apr -Dec data planned for 30/04/2016 . Deadline for submission 31/05/2016
8	Cardiac Rhythm Management (CRM)	Yes	1321 cases submitted for pacing and implantable cardiac defibrillators for period April 15 – March 16 (100%) and 1027 EPS cases have been submitted for the reporting period April 15 – December 15 (100%). Next submission date is 30/06/2016.
9	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	59/ 61 (97%) submitted Congenital. 0/8 (0%) submitted Infective Endocarditis 12 /12 (100%) submitted ICD & Pacing. (Time period April 15 – March 16). Deadline for submission 01/05/2016
10	Coronary angioplasty	Yes	A total of 2637/2637 (100%) including coronary pressure studies and IVUS (2347 PCI's) submitted for 2015/16
11	National Adult cardiac surgery audit	Yes	Adult cardiac surgery data submissions are undertaken every 12 weeks as required by CCAD. FY 15/16 Q1 x 503 Cases Submitted (100%) Q2 x 475 Cases Submitted (100%) Q3 x 444 cases Submitted (100%) Q4 due 30/06/2016
12	National Cardiac Arrest Audit (NCAA)	Yes	April 2015 – March 2016. FY 15/16 Q1 x 28 Cases Submitted (100%) Q2 x 27 Cases Submitted (100%) Q3 x 31 Cases Submitted (100%) Q4 due in May
13	National Heart failure Audit	Yes	72/ 80 (90%) cases submitted to NICOR (Time period April 15 – March 16) Deadline for submission 31/05/2016

	Long term conditions		
14	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: pulmonary rehabilitation work stream	Yes	The Trust registered 2 sites: Liverpool and Knowsley. Liverpool service 126/151 (83.4%) cases submitted Knowsley service 57/68 (84%) cases submitted. *(In the audit time frame 106 patients were assessed for Pulmonary Rehabilitation, 95 were asked to take part in the audit, 11 patients were not asked to participate, 38 did not consent. 57/ 57(100%) consented, all data was submitted*
5	UK Cystic Fibrosis Registry	Yes	283/283 (100%) submitted between 01/02/2015-15/01/2016 as per the UK Cystic Fibrosis Registry
16	Sentinel Stroke National Audit programme (SSNAP) - Post-acute provider organisational audit	Yes	Knowsley service provider Early supported discharge 42/43 (98%) *(for patients entered onto SSNAP by acute providers and completed episode of rehabilitation)* Community rehabilitation 78/84 (93%) *(for patients entered onto SSNAP by acute providers and completed episode of rehabilitation)* 38 patients are eligible to be submitted on completion of the rehabilitation programme (2 ESD and 36 CSR). We are still awaiting for 11 patients to be transferred over to the team from acute provider (2 ESD and 9 CSR)
	National Confidential Enquiry into Patient Outcome and Death		
17	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Sepsis	Yes	Submitted 4/4 (100%) 1 patient was excluded from study and NCEPOD informed. Organisational Questionnaire 1/1 (100%) completed and returned.
18	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Gastro-intestinal haemorrhage	Yes	Submitted 2/2 (100%) cases 3 patients were excluded from the study and NCEPOD informed. Organisational Questionnaire 1/1 (100%) completed and returned.
19	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Mental Health	Yes	Trust invited to participate. Do not meet criteria for submission of patient questionnaires. Organisational Questionnaire received (1) on 23/02/2016 and required to submit by 19/04/2016
	Total:	**Yes =19**	

The reports of 13 national clinical audits were reviewed by the provider in 2015/16, and Liverpool Heart and Chest intends to take the following actions to improve the quality of healthcare provided.

Note: The following national reports have not yet been published at the time of completing the the quality account:

- Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
- Cardiac Arrhythmia
- National Adult Cardiac Surgery Audit
- National Heart Failure Audit
- Adult Critical Care (Case Mix Programme – ICNARC CMP)

Note: The following heart disease reports have been published in April 2016 and will be reported in next year's quality account:

- Coronary Angioplasty (published 01/04/2016)
- Congenital Heart Disease (published 04/04/2016)

Intended actions to improve the quality of healthcare

Cancer

Lung Cancer (National Lung Cancer Audit) Published 2nd December 2015
This year's national audit has sustained the quality and accuracy level for the Liverpool Lung Cancer Service. The ongoing partnership between the Liverpool Heart and Chest Hospital and The Royal Liverpool University Hospital has ensured that the data has been captured in full with clinical input at all stages of the process. The continuing prospective collection and analysis of the data has divided the work in to a more manageable workload and the quicker turnaround times ensures a more accurate collection of data.

Lung cancer consultant outcomes publication published 16/03/2016
Consultant outcomes publication shows the number of lung cancer surgeries and 30 and 90 day post-operative survival by Trust. Results are searchable by an interactive map, name or, for consultant, GMC code and is available on the Society of Cardiothoracic Surgery (SCTS) website. A link is also available through My NHS - NHS choices website.

Oesophago-Gastric Cancer (NAOGC) Published 17th December 2015
It is believed that the recommendations are being met within the current service; however there is a need to improve our data quality to accurately reflect this. There have been significant challenges identifying the non-cancer patients' portion of this audit which has led to a national delay in the submission of this data. The Trust has been collaborating with the Royal Liverpool University Hospital to ensure that diagnostic and treatment records are joined together accurately. It is expected that this will be the final involvement in the Oesophago Gastric Cancer Audit due to the surgical service transferring fully over to the Royal Liverpool University Hospital in 2016.

Heart

Coronary Angioplasty
Consultant outcomes published 13th October 2015.
Consultant outcomes publication shows an analysis of each individual consultant PCI operator's activity and outcomes. Results are searchable on the British Cardiovascular Intervention Society (BCIS) web site. A link is also available through My NHS - NHS choices website.

National Adult Cardiac Surgery Audit
Consultant outcomes published in September 2015
Consultant outcomes publication shows the number and type of heart operations each consultant and hospital is carrying out, as well as the associated mortality rate. Results are searchable by an interactive map, name or, for consultant, GMC code and is available on the Society of Cardiothoracic Surgery (SCTS) website. A link is also available through My NHS - NHS choices website.

National Heart Failure Audit Published 20th October 2015 (2013-14 data period)
The report has been reviewed by the Heart Failure team and used to benchmark LHCH performance against national data. LHCH is performing above the national average in most standards measured. In 3 standards we are reported to fall below.

To further improve in these areas we will continue to monitor the following:

- Referral rates to community HF teams for all patients referred to the HF team with confirmed Left Ventricular Systolic Dysfunction.
- Two week follow up for all patients with true heart failure admission, as identified by member of the HF team. Patients who decline, due to local preference of follow up will continue to be referred to community teams.
- LHCH's 30-day mortality figures are higher than the national average. This is not an unexpected finding as our inpatient HF population is smaller than in district general hospitals due to the absence of A&E and as a tertiary cardiac centre the HF population referred to us are either post complex cardiac surgery or referred with refractory symptoms or for deactivation of ICDs, which puts our patients at a much higher risk than the average HF patient admission. All in-hospital deaths are already reviewed at the Mortality Review group. Going forwards, the HF team will identify the HF catchment of patients and review 30-day mortality, using a risk stratification model.

National Cardiac Arrest Audit (NCAA)
Published July 2015
The NCAA Report covering April 2014 to March 2015 this time specifically by risk adjusted comparative analyses compared the LHCH with five other cardiothoracic hospitals. The whole report in its entirety was presented to the Resuscitation and Quality Patient / Family Experience Committees for its findings to be reviewed.

In nearly all categories compared with all other hospitals the LHCH is performing better than

the national average and is also on a par in the patient survival to hospital discharge by shockable presenting / first documented rhythm is above average when compared directly with the five other cardiothoracic hospitals.

The Resuscitation Training Officer analysed every cardiac arrest were the report had predicted a probability of survival to discharge greater than 50%. Analysis of the majority of these cases showed the present limitations predicting the probable survival to discharge ratio, since it is unable to factor in extremely high-risk co-morbidities into their risk adjusted comparative analysis.

Going forwards for the next NCAA annual report:

- Each NCAA quarterly report will be closely analysed by the Resuscitation Committee and the annual NCAA report will be presented to the Resuscitation and Quality Patient / Family Experience Committees with an accompanying presentation of the salient points. This will include a detailed investigation of all suggested unexpected non-survivors, so that any areas of concern can be highlighted and measures for improvement initiated.

National Comparative Audit of Blood Transfusion Programme

2015 Audit of Patient Blood Management in Scheduled Surgery
Published Oct 2015
This report was reviewed by the Hospital Transfusion Team at LHCH and they were assured that patients were receiving appropriate care with no major concerns.

One area of good practice as identified in this national audit related to patients having intra operative transfusion where Patient Blood Management measures are in place, the National standard met 83%, LHCH 100%.

The report recommendations are as follows:

- To implement a pre-operative anaemia service - the implementation of this service is currently under discussion and a project group has been set up to plan its implementation.
- To establish a transfusion trigger - at LHCH the decision to transfuse is currently based on clinical judgement and patient consent at the pre-operative stage. Also, we promote a patient focused approach by ensuring patients have adequate information on transfusion available in order to support informed decision making.

Sentinel stroke (SSNAP) Post-acute organisational audit - National report

Published 2nd December 2015
Knowsley Community stroke team undertook a self-assessment against the recommendations from the SSNAP Post-acute Organisational Audit – Phase 2: Audit of post-acute stroke service providers' report 2015. The service is meeting all relevant recommendations except for one relating to Multi-disciplinary services as currently there is no permanent Speech And Language Therapist (SALT) in post. The Trust is in the recruitment phase to fill this gap, with locum SALT cover in the interim period.

Emergency Use of Oxygen

British Thoracic Society Emergency Oxygen Audit 2015 (Liverpool Heart and Chest Hospital inpatient oxygen audit 2015).

Consistently Liverpool Heart and Chest Hospital remains better than the national average for prescribing oxygen with the number of patients using oxygen with a prescription sitting at 80% against the national average of 57.5%. In 2014/15 some work has been done to improve the number of signatures that are applied to the oxygen prescription when oxygen is administered. Liverpool Heart and Chest Hospital achieved 40% against national average 28.4%. This is a significant improvement but still not satisfactory.

Actions for improvement:

- Currently due to the EPR (electronic patient record) system oxygen has to be documented twice, once on flow sheets (the MEWS chart) and once on the work list manager (the prescription). These could be completed by two separate people i.e. Student or Health Care Assistant performing observation but the prescription would be completed by the staff nurse. Also the same information is required twice.
  A meeting has been arranged with the divisional lead and EPR pharmacy technician to rationalise how much information is required. Guidance will also be sought from ward staff around what they think would work best.

UK Cystic Fibrosis Registry Published August 2015

The CF team have reviewed this report and it did not highlight any deficiencies in their service so they have not needed to develop an action plan

National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation workstream: Time to breathe better, published 18/11/2015

PR Liverpool

Areas highlighted requiring improvement from the Time to Breathe Better report were as follows:

1. Lack of practice tests is widespread raising concerns that accepted methodology for exercise testing is not being used
2. Standardised measurement of exercise performance is crucial for rigorous exercise prescription during PR and requires improvement
3. Provision of written discharge exercise plans should be universal for patients completing PR

The changes to practice or proposed action plans are as follows:

1. Due to the severe nature of their disease and fatigue, the practice test is not currently utilised in Liverpool as it may impact negatively on patient compliance with the programme.
2. The measure of exercise performance has been standardised to the Six Minute Walk Test from the 1st April 2015.
3. 100% of patients who complete the full PR programme receive a discharge exercise plan, however, this is not applicable to some patients who have been deemed to “complete” via brief interventions (local agreement with the CCG) with

the PR team and as this is not currently a widely used approach or completion definition within PR, this skewed the results from the audit.

PR Knowsley

Knowsley Pulmonary Rehabilitation team reviewed this report and based on the recommendations it was identified that we need to include muscle strength, as part of the clinical assessment. The team will use the Oxford Muscle Strength scale. No other actions were required.

Organisational report: Steps to Breathe Better published 10th February 2016
PR Liverpool

Liverpool Pulmonary Rehabilitation team reviewed this report and the service is meeting the report recommendations.

National Emergency Laparotomy audit (NELA)

First Patient Report published 30th June 2015

The report was considered by the Trust and self-assessment performed against the checklist provided. Assurance was received that patients were receiving appropriate care in a timely manner with no major actions outstanding.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Time to Get Control?
A review of the care received by patients who had a severe gastrointestinal haemorrhage published 3rd July 2015

The Trust no longer has an Upper Gastro Intestinal (UGI) service at LHCH. The standard therefore only applies to any of its (Cardiothoracic) patients who develop GI haemorrhage during their care with LHCH for which we have in place a Service Line Agreement with the gastro department at the Royal Liverpool Hospital. The only thing the Trust needs to ensure is that this is up to date as is the equipment we provide on-site at LHCH.

Just Say Sepsis!
A review of the care received by patients who were diagnosed with sepsis published 24th November 2015

The report has been reviewed and shared with the Trust Infection Prevention Committee. Recommendations regarding the management of patients with sepsis have been considered and the Trust concluded that its current protocol and procedures cover most of the recommendations within the report. The Trust's audit reports show high level of compliance with its sepsis bundle as per the national guidelines.

The Trust has highlighted areas for further improvement on which it plans to implement action plans.

- Increase education campaign to cover multi-disciplinary members of staff.
- Produce a patient information booklet to explain the process of managing patients with sepsis.
- Develop a system to inform a patient's GP on discharge if they develop sepsis during their hospital admission.

The reports of 25 local clinical audits were reviewed by the provider in 2015/16 and Liverpool Heart and Chest intends to take the following actions to improve the quality of healthcare provided:

Below are some examples of improvement work being undertaken as a result of auditing local practice.

Central Venous Catheterisation (CVC) Technique and Post-procedure Management
Spot check audits have been undertaken in Jan 2015, October 2015 and Feb 2016 where the insertion and on-going care of CVC was reviewed.

These audits have shown very good insertion practice, adhering to the CVC policy. Improvement was needed in documentation and aspects of on-going care.

To address this, the following has been undertaken:

- Electronic Patient Records flow sheet for medical devices has been reviewed, amended and improved to accurately keep track of the length of time in days CVC lines have been in for.
- An automatic reminder is now generated in the Electronic Patient Record for lines that are day 7 or longer.
- The education team continue to work with nursing and medical staff to improve documentation of the line site specifics per shift to ensure line duration and a plan for each CVC line is documented
- An evaluation of CVC dressings used has been completed. (Based upon NICE Medical Technology Guidance 25: The 3M Tegaderm CHG IV securement dressing for central venous and arterial catheter insertion sites and EPIC 3 recommendations). In high risk groups and those with long term lines the trust is implementing the use of these dressings.
- The CVC policy has been updated to reflect this change in practice

Delirium

Using the NICE quality standard on Delirium which covers the prevention, diagnosis and management of delirium in adults (18 years and over) in hospital or long-term care settings, further improvement work on the management of this condition has been undertaken in 2015 and is being implemented:

- Placing delirium care into mandatory learning for LHCH as part of safeguarding vulnerable adults
- Written a patient/family leaflet about delirium
- Aligning delirium with dementia care with regards to EPR assessment and care documentation and discharge communication to the GP
- Working with the EPR team to get some safeguards put in place about prescribing sedatives and haloperidol.
- The delirium policy has been updated to reflect above changes

Pressure Ulcers

An audit to monitor compliance with pressure ulcer prevention strategies, including

compliance with NICE (2014) pressure ulcer prevention & management clinical guideline has been undertaken in Aug 2015 and the following improvement work implemented:

- Changes were made to the Electronic Patient Record Skin Integrity and Pressure Ulcer Prevention Care Plan with additional prompts
- New changes to the Trust Pressure Ulcer Guideline (Sept 2015) including NICE 2014 guidance - this was made available on the staff Intranet and communicated via corporate communications. Clinical areas were visited by the Tissue Viability Service.
- Tissue Viability Service promoted the importance of providing the patient information leaflet.
- New pressure ulcer campaign in Oct 2015 - this included highlighting the new changes made to policy, NICE guidance, importance of providing the patient information leaflet and EPR requested changes.

Care of the Dying

Audit of LHCH practice in care of the dying benchmarking against the National care of the dying audit was undertaken in Feb 2016.
To further improve end of life care the following recommendations will be discussed at the End of Life Care steering group and an action plan agreed.

- Improve use of the "Plan of care for dying patient" document by the medical teams
- Improve recognition of dying and decision making when ceilings of care in place
- Improve and document discussions with the patient about dying and their plan of care where appropriate.
- Improvement in compliance with prescribing of anticipatory medications for the 5 key symptoms. Prescribed medication should detail the indication for use
- Improvement in documentation of decisions relating to nutrition and hydration

Falls

An audit to review assessment after a fall and preventing further falls was undertaken based on the NICE quality standard 86: Falls in older people quality measures.

The following actions are being evaluated to improve care:

A multidisciplinary Post Fall Review is to be incorporated into the Electronic Patient Record. This flowsheet will comprise a multidisciplinary review and include:

- Information regarding contact with next of kin
- Location and type of fall, date/time
- Brief description of incident and extent of injury
- Doctor’s review
- Review of medication
- Therapies review, where applicable

This information will populate into the discharge summary to notify the inpatient fall to the GP.

Anticoagulation Prescribing

This audit was undertaken in Jan 2015 and the following actions for improvement implemented include:

- Changes to improve the anticoagulation patient oral order in the Electronic Patient Record and make certain entries mandatory for patients prescribed warfarin
- Share the audit findings and highlight key recommendations in the pharmacy bulletin

Patient Quality of Pharmacy Service Survey
This survey was undertaken in May 2015 and the following actions have been undertaken from seeking the views of patients using the service:

- Inform all patients of anticipated waiting times.
- There is a counselling room available if needed which is advertised by a poster in the waiting room; an additional poster has been placed in a more prominent position in the waiting room.
- Improved awareness and advertising for the pharmacy shop.
- Stock multivitamins in pharmacy shop.
- Staff reminded that if any prescriptions are likely to take longer than average they should pass the prescriptions to other staff to keep the waiting times to a minimum .
- The door to the waiting room was reported as being hard to open for wheelchair users. The door has a device fitted to keep it open. Staff have been reminded to keep the door open during the working day .

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Liverpool Heart and Chest Hospital in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 671.

Liverpool Heart and Chest Hospital was involved in conducting 38 clinical research studies in the cardiovascular specialty, 8 clinical research studies in the cancer speciality, 6 clinical research studies in the surgery / critical care specialty, 7 clinical research studies in the respiratory specialty and 1 clinical research study in quality of life / outcomes during 2015/16.

The improvement in patient health outcomes in Liverpool Heart and Chest Hospital demonstrates that a commitment to clinical research leads to better treatments for patients. In the last three years, a total of 121 peer-reviewed publications have resulted from general research activity. Our engagement with clinical research also demonstrates Liverpool Heart and Chest Hospital'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, which truly deliver the quality improvements anticipated.

The following are examples of the high quality research taking place at the Trust:

- **Transcatheter Aortic Valve Implantation – TAVI**
  The purpose of the study is to compare surgical aortic valve replacement with TAVI in patients with severe narrowing of the aortic valve.

- **CASA AF**
  Catheter Ablation versus Thoracoscopic Surgical Ablation in Treating Long Standing Persistent Atrial Fibrillation (CASA AF) is a joint venture with the Royal Brompton & Harefield NHS Foundation Trust and Imperial College London. The principal objective of this industry-independent, multi-centre randomised controlled trial is to identify the most effective arrhythmia intervention for treating LSPAF by comparing Thoracoscopic surgical AF ablation to conventional percutaneous catheter ablation.

- **Vertex 106, 108 and 110**
  These trials are aimed at assessing the benefits of combined treatment involving the use of the drug ivacaftor for patients that have inherited two copies of the faulty cystic fibrosis genes F508del-CFTR. Cystic fibrosis is an inherited disease caused by a fault in the gene for controlling the movement of salt and water in and out of body cells called CF gene F508del mutation. In patients with cystic fibrosis, the faulty gene causes the lungs and the guts to become clogged up with thick sticky mucus which increases the risk of infections and prolongs the time spent in hospital.

Goals Agreed with Commissioners

In 2015/16, the Trust chose a contract option which does not mandate participation in any local, regional or national CQUINS schemes. However, the Trust recognises the need to maintain momentum on key initiatives for the good of our patients and also to be well placed when CQUINS is picked up again in 2016/17. As such, improvement work continued to be monitored in the spirit of CQUINS in the following areas:

1. Acute Kidney Injury
2. Sepsis
3. Dementia assessment, referral and carer support
4. Improve the outcomes and experience of care in heart attack and bypass grafting patients (Advancing Quality – "Lite" option)
5. Digital Maturity

Further details are available upon request from Dr Mark Jackson, Director of Research & Informatics (e-mail mark.jackson@lhch.nhs.uk or telephone 0151 600 1332).

What others say about the Provider

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

The Care Quality Commission has not taken enforcement action against Liverpool Heart and Chest Hospital NHS Foundation Trust during 2015/16

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 2015/16.

Data Quality

NHS Number and General Medical Practice Code Validity

Liverpool Heart and Chest Hospital submitted records during 2015/2016 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 can be seen in the table below:

	For admitted patient care	For outpatient care
Valid NHS number was:	99.2%	99.4%
Valid General Medical Practice Code was:	99.9%	99.8%

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

Information Governance Assessment Report Attainment Levels

Liverpool Heart and Chest Hospital's Information Governance Toolkit assessment for 2015/16 was submitted with an overall score of 74% 'green-satisfactory' achieving level 2 or above for all requirements. The Trust also received independent assurance from the Mersey Internal Audit Agency in March 2016 obtaining a 'significant' assurance opinion.

Clinical Coding Error Rate

Liverpool Heart and Chest Hospital has not been subject to a Payment by Results clinical coding audit during 2015/16.

The last Payment by Results clinical coding audit undertaken for the Trust in 2014/15 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 diagnoses and treatment coding (clinical coding) were:

- Primary diagnoses incorrect – 2.0%
- Secondary diagnoses incorrect – 0.5%
- Primary procedures incorrect – 0.5%
- Secondary procedures incorrect – 0.9%

As part of Information Governance requirements, the Trust has undertaken a clinical coding audit in 2015/16, which was carried out by external auditors that found the following error rates:

- Primary diagnoses incorrect – 0.5%
- Secondary diagnoses incorrect – 2.9%
- Primary procedures incorrect – 0.6%
- Secondary procedures incorrect – 1.3%

Results should not be extrapolated further than the actual sample audited.

Data Quality

Liverpool Heart and Chest Hospital 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.

Pivotal to this strategy is the adoption of the six dimensions of data quality.

Producing data that is fit for purpose should be an integral part of an organisation's operational performance management and governance arrangements. As such, this new process seeks to provide more rigor to deriving the assurances on data quality the Trust requires, focused on non- financial data.

Figures You Can Trust; *A Briefing on Data Quality in the NHS (Audit Commission, 2009) presents the six dimensions of data quality.*

Dimension	Description
Accuracy	Data should be sufficiently accurate for its intended purposes, representing clearly and in sufficient detail the interaction provided at the point of activity. Data should be captured only once, although it may have multiple uses. Accuracy is most likely to be secured if data is captured as close to the point of activity as possible. Reported information that is based on accurate data provides a fair picture of performance and should enable decision making at all levels. The need for accuracy must be balanced with the importance of the uses of the data, and the costs and efforts of collection. For example, it may be appropriate to accept some degree of inaccuracy where timeliness is important. Where compromises have to be made on accuracy, the resulting limitations of the data should be clear to its users.
Validity	Data should be recorded and used in compliance with relevant requirements, including correct application of any rules or definitions. This will ensure consistency between periods and with similar organisations. Where proxy data is used for an absence of actual data, organisations must consider how well this data is able to satisfy the intended purpose.
Reliability	Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.
Timeliness	Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Relevance	Data captured should be relevant to the purposes for which it is used. This entails periodic review of requirements to reflect changing needs. It may be necessary to capture data at the point of activity which is relevant only for other purposes, rather than current intervention. Quality assurance and feedback processes are intended to ensure the quality of such data.
Completeness	Data requirements should be clearly specified based on the information needs of the organisation and data collection processes matched to those requirements. Monitoring missing, incomplete, or invalid records can provide an indication of data quality and can also point to problems in the recording of certain data items.

The Trust's Business Intelligence Committee will oversee the adoption of the six dimensions of data quality, and ensure it is applied to the Trusts Strategic Objectives

and underlying Dashboards comprising of Clinical Quality, Performance and Workforce indicators.

Continuation of the Trust's Business Intelligence 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. Indicator reviews using the six dimensions of data quality approach). The Committee is to be supported by a System User/Data Quality Group which oversees key working groups designed to tackle key data quality issues.

Adoption 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 Business Intelligence 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 the Trust reports is built upon a firm foundation of data quality which will allow it to be ever more confident in its statements regarding the quality of its services and the outcomes it generates.

2.3 Reporting against Core Indicators

Responsiveness to Personal Needs

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

Personal needs are 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 13/14	Performance 13/14	Target 14/15	Performance 14/15
Trust's responsiveness to the personal needs of its patients	none*	82.3%	none*	81.8%

Liverpool Heart and Chest Hospital 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 6C's culture business as usual.

Hospital-Level Mortality

Liverpool Heart and Chest Hospital 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 Trust's Quality Committee.

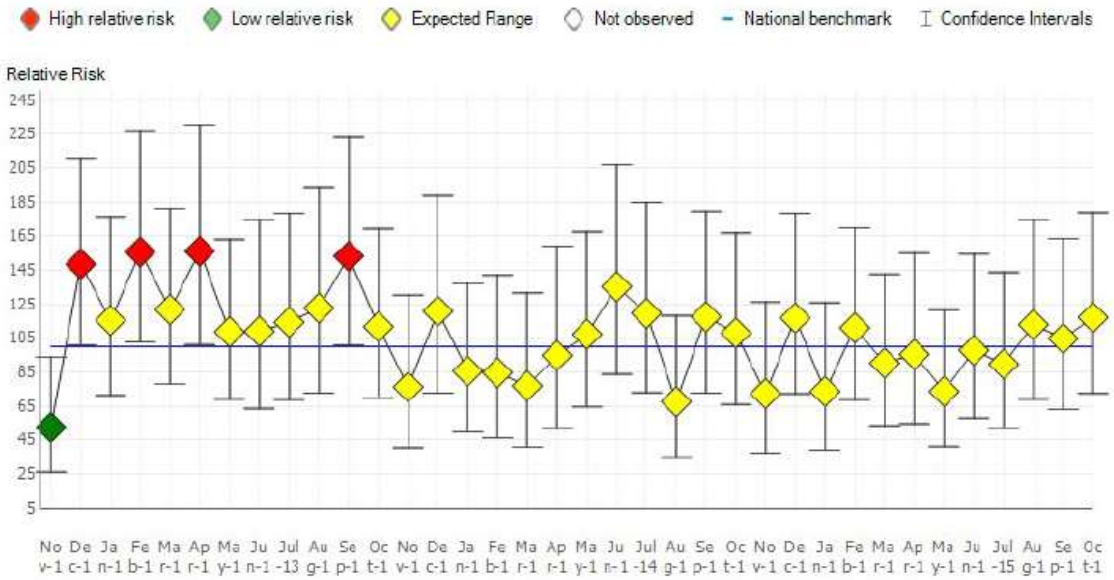
To achieve statistical significance using confidence intervals:

- To be high, a hospital must have HSMR and the lower confidence interval above 100. A hospital above 100 but with lower confidence interval below 100 is classed as 'within the expected range'.

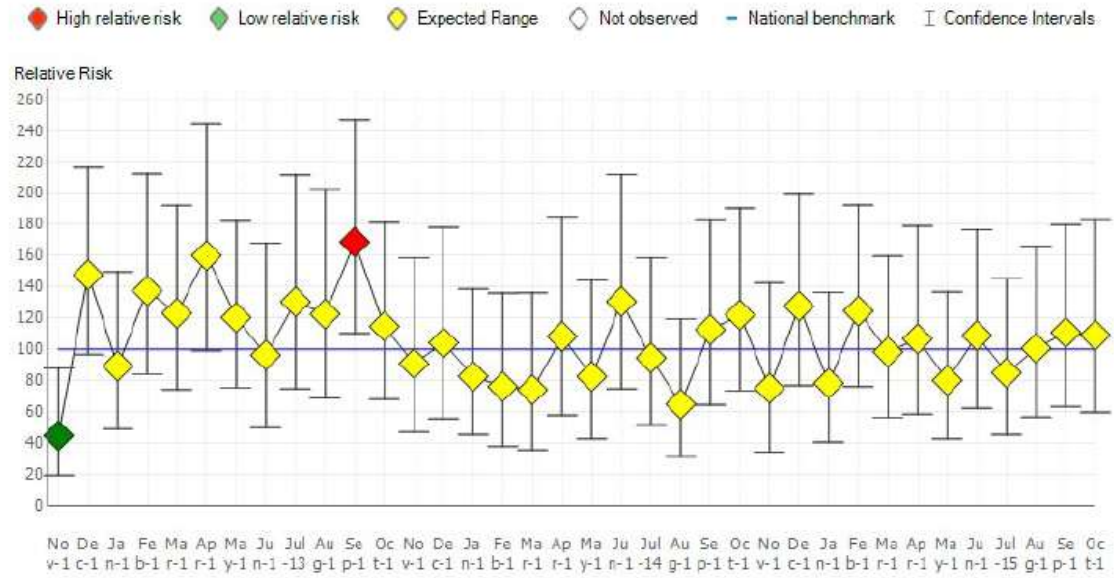
Liverpool Heart and Chest Hospital intends to take the following actions to continue to improve this rate and so the quality of its services by:

- Continuing to support the Patient Safety Group in reducing patient harm.
- Continuing to support the broadened remit of the mortality review group.

HSMR for all diagnoses



HSMR for 56-diagnosis groups as determined by Dr Foster Intelligence



Readmission within 28 days of Discharge

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

The percentage of readmissions refers to those coming back directly to our Trust. We have seen a very slight increase from last year and are slightly above target for the year-to-date to February 2016, although our rates are overall very low.

	Target 14/15	Performance 14/15	Target 15/16	Performance 15/16 YTD
Percentage of patients aged 16 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	0.97%	0.63%	0.70%	0.76%

NB. We monitor readmission rates up to 30 days post-discharge, not 28.

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

- introducing a direct line for patients following discharge.

Responsiveness to Personal Needs

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

Personal needs are 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 13/14	Performance 13/14	Target 14/15	Performance 14/15
Trust's responsiveness to the personal needs of its patients	none*	82.3%	none*	81.8%

Liverpool Heart and Chest Hospital 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

Liverpool Heart and Chest Hospital consider that this data is as described for the following reasons:

	Target 13/14	Performance 13/14	Target 14/15	Performance 14/15
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.	*90%	92%	*90%	92%

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%.

*the Trust had set up its own target of 90%, albeit there was no national target set for this. Taken from the 2014 National Staff Survey, the score of 92% of LHCH staff Recommending the Trust as a provider of care to their family or friends places the Trust 4th overall within the country.

The continued high levels of advocacy from staff highlight the on-going commitment to delivering safe, compassionate care to patients and their families.

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

- increasing communication of results through internal systems, such as directorate meetings, team briefs, listening events, and Executive walkabouts.

Venous Thromboembolism (VTE) Assessment

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

- Our rate of assessment of patients at admission has been consistently high this year and is an improvement on last year's performance. The data are taken directly from each patient's electronic record of care.

	Target 14/15	Performance 14/15	Target 15/16	Performance 15/16 YTD
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism	95.0%	94.3%	95.0%	95.9%

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

- establishing 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.

Clostridium Difficile Infection

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

Our infection rates are consistently low; the number of C.difficile cases due to lapses in care for 2015/16 was 3. This is the lowest level recorded since a robust data collection system has been in place.

	Target 14/15	Performance 14/15	Target 15/16	Performance 15/16
Rate per 100,000 bed days of cases of C.difficile infection (lapses in care) reported within the trust amongst patients aged 2 or over	<=7.5	1.9	<=7.5	6.4

NB. Data includes day case activity, as at end of February 2016.

Commissioner targets shown. Monitor de minimis target has been 12 for the last three years. The median is 16.9 CDI cases per 100,000 bed days taken from https://www.england.nhs.uk/wp-content/uploads/2015/07/cdClostridium-difficile-infection-objectives-for-NHS-organisations.pdf

Liverpool Heart and Chest Hospital 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

	Target 14/15	Performance 14/15	Target 15/16	Performance 15/16
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	1097 incidents 8.2 per 100 admissions (13335 admissions) 1 (0.09%) resulted in severe harm or death	None	**Data up to end February 16:** 1394 clinical incidents 11.2 per 100 admissions (12401 admissions) 1 (0.07%) resulted in severe harm or death

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

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

- implementing the Trust's vision for safety – Safe from Harm
- implementing the Speaking up Safely campaign
- developing the new Quality Strategy which is patient focused.

Please note that there is no national comparison, however the Trust receives a comparative report by the NRLS (National Reporting and Learning System).

Part 3: Other information

Performance Review

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2015/16.

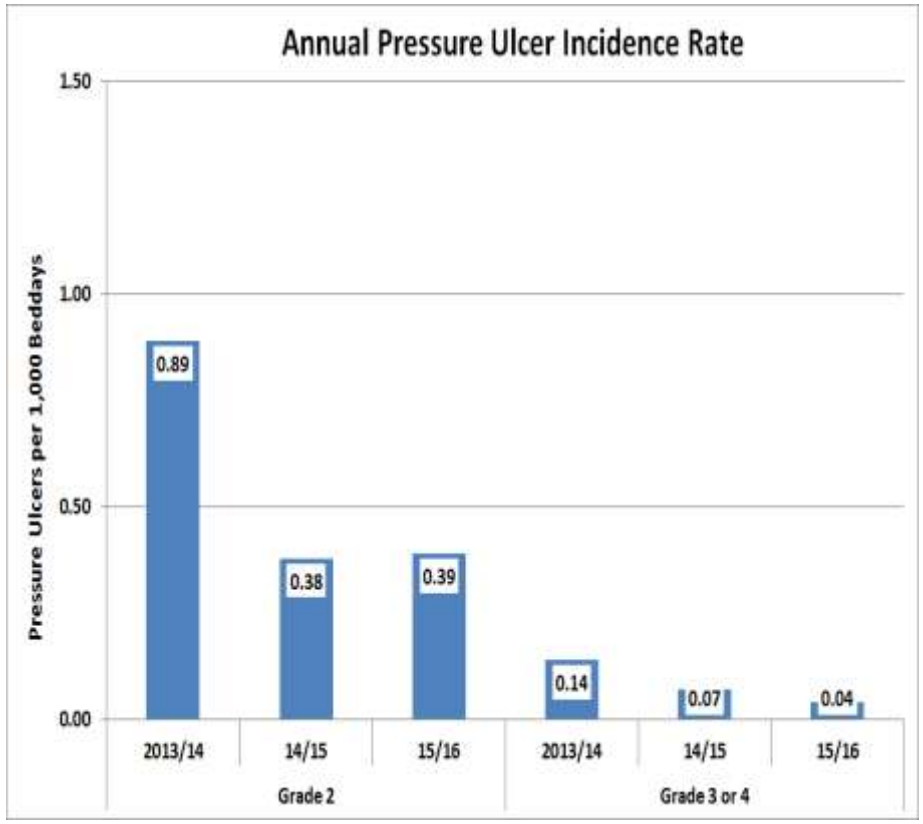
Presented are:

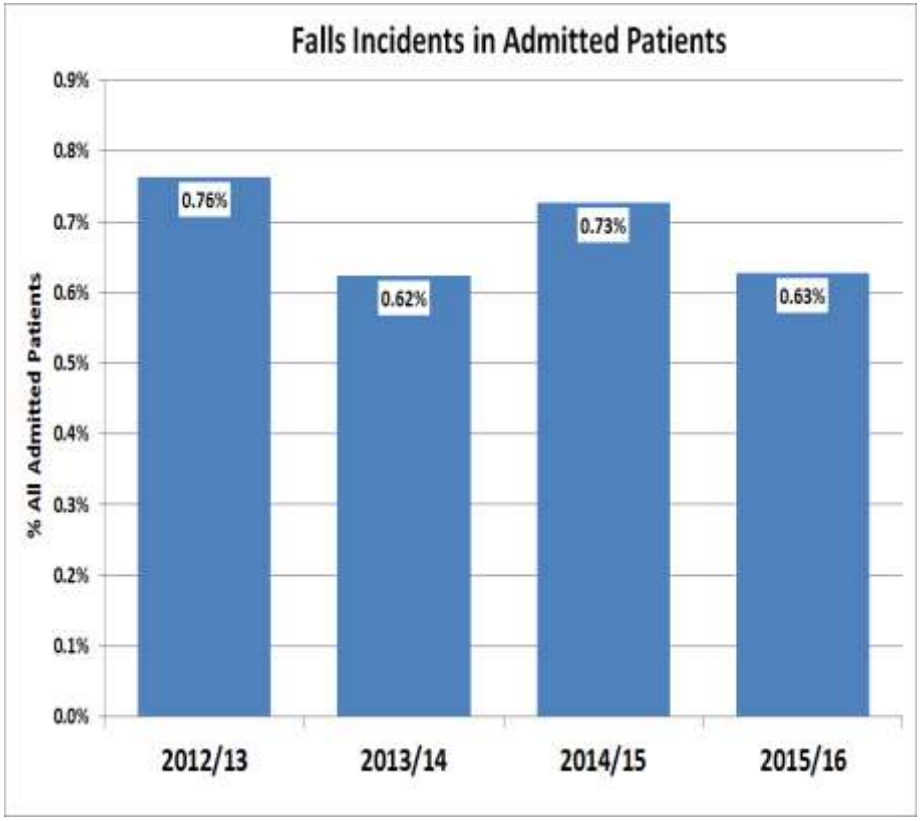
- Quantitative metrics, that is, aspects of safety, effectiveness and patient experience which we measure routinely to prove to ourselves the quality of care we provide.

Performance against relevant indicators from the Risk Assessment Framework

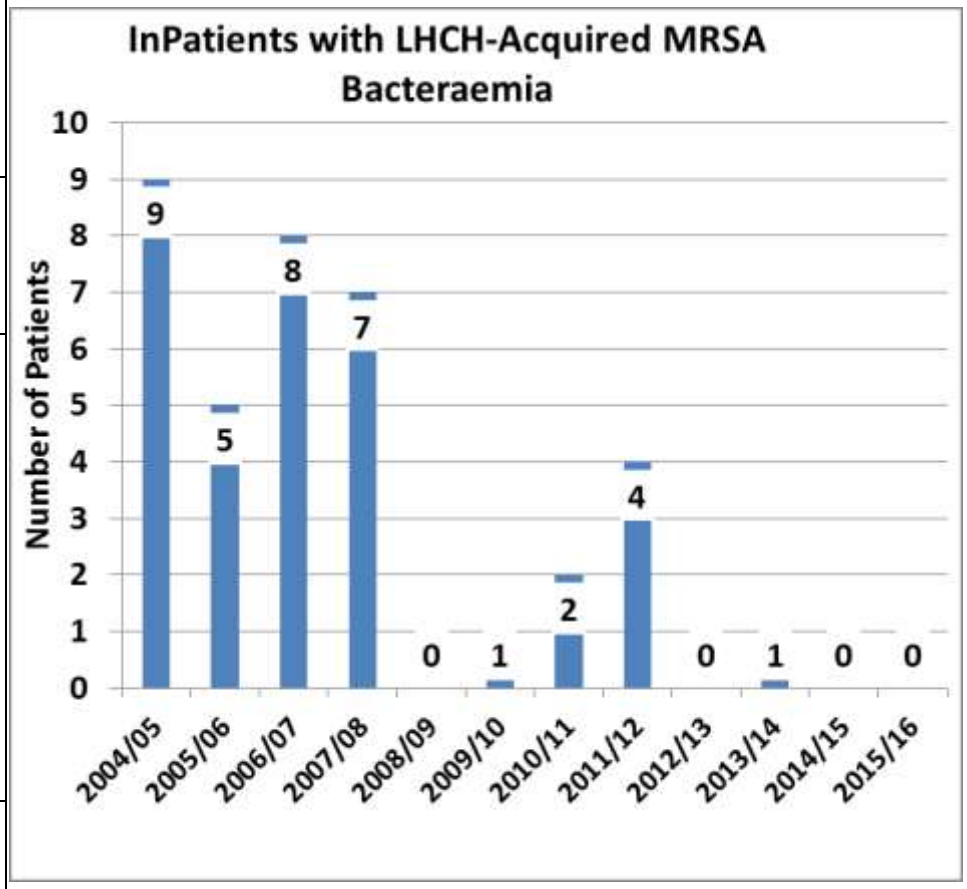
Quantitative Metrics

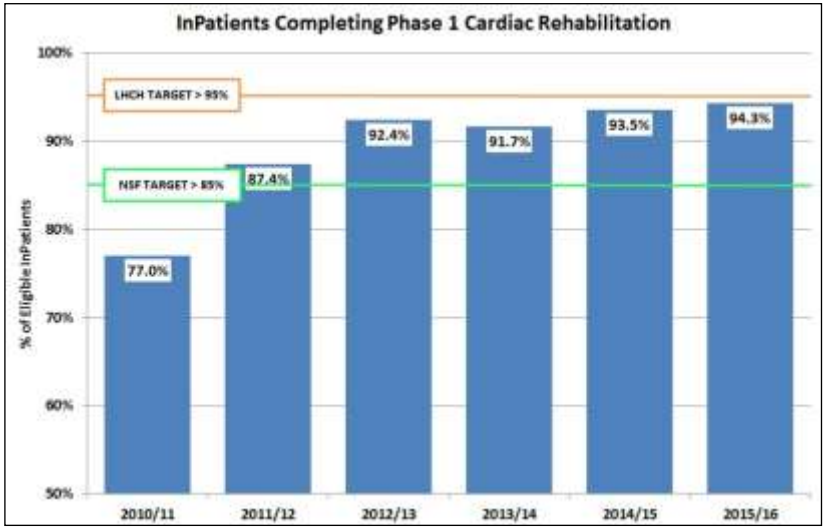
Safety			
Metric	Pressure ulcer incidence	**Organisation Wide or Service Specific**	Organisation Wide
Derived From	Referrals to the Tissue Viability Specialist Nurse	**Why metric chosen**	Pressure ulcers are painful for patients and contribute to a negative patient experience. Nursing high impact action
How is data collected	Staff who observe a pressure ulcer report this to the Trust's Tissue Viability Service for treatment	**Improvements planned**	1. Continued staff education 2. Establishment of the Pressure Ulcer Bundle with a focus on pressure ulcer prevention
LHCH Performance 2015/16	Grade 2 = 0.39 (< 2 ulcers per month) Grade 3+ = 0.04 (= 2 ulcers per year)	**LHCH Performance 2014/15**	Grade 2 = 0.38 (< 2 ulcers per month) Grade 3+ = 0.07 (= 4 ulcers per year)
Interpretation of Results	The large reduction in pressure ulcers occurring in our patients we saw last year has been maintained this year. The number of Grade 3 pressure ulcers was halved again this year and none of our patients have had a Grade 4 pressure ulcer since December 2011. The Tissue Viability Team have worked closely with all ward teams with the development of scoping meetings, changes to mechanical devices that previously had identified to be the causation of grade 2 pressure ulcers.		

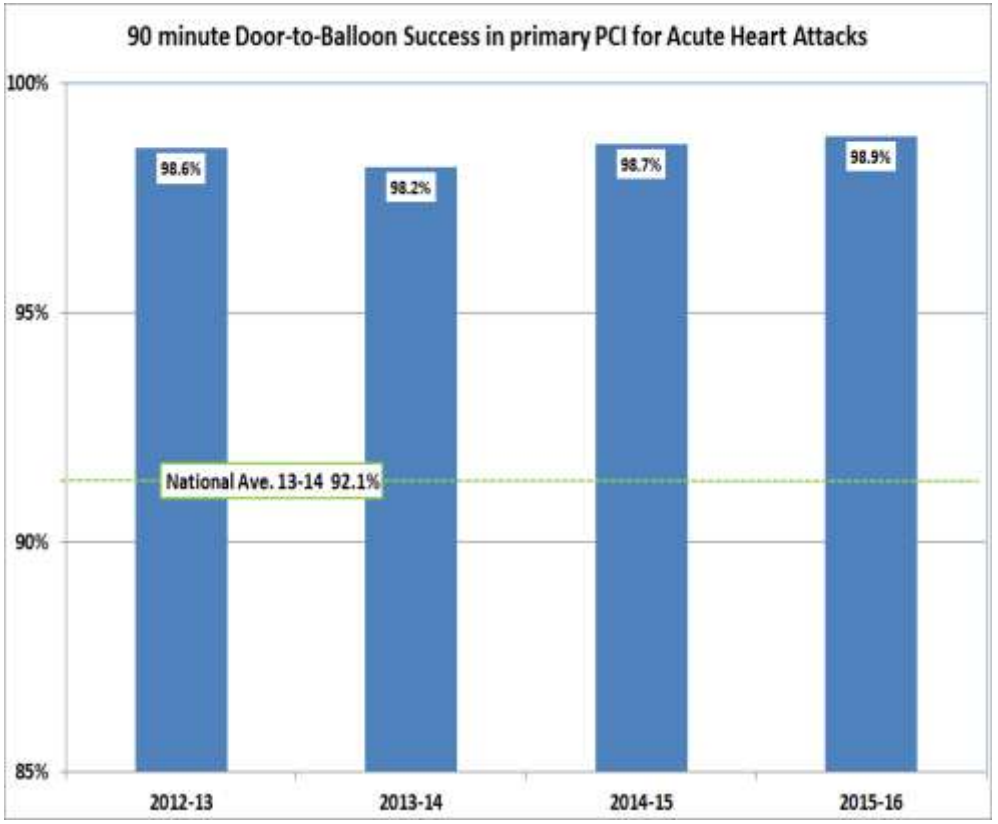


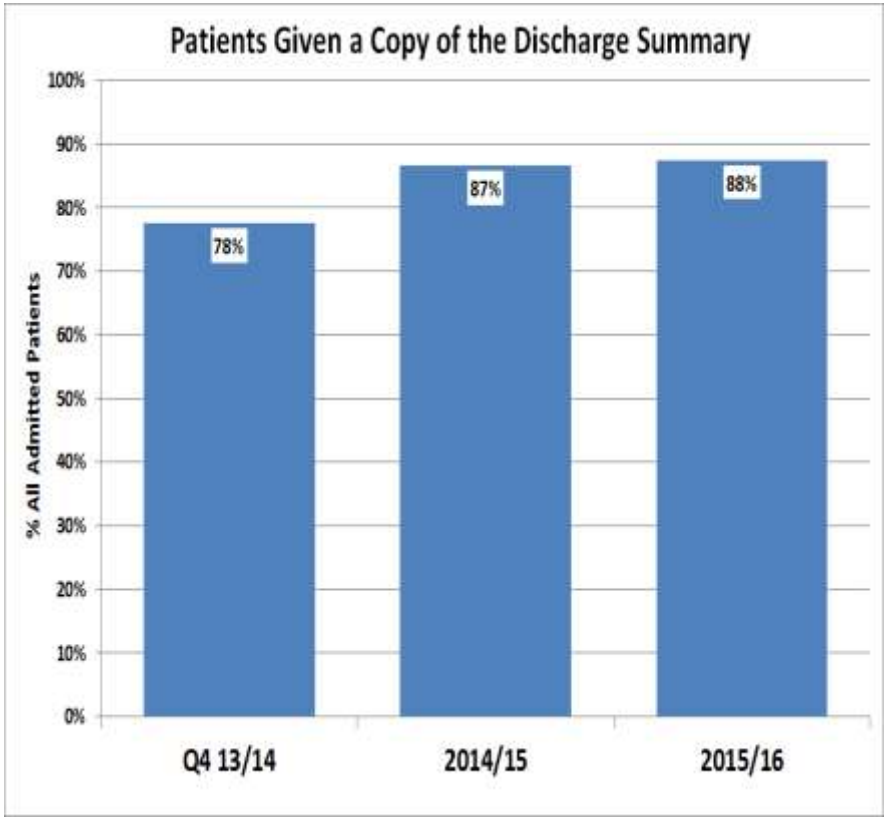
Safety				
Metric	No. patient falls	**Organisation Wide or Service Specific**	Organisation wide	
Derived From	Incident reporting	**Why metric chosen**	Falls have the potential to cause significant harm. Nursing high impact action	
How is data collected	Staff who witness or become aware of a fall report this via the Trust's risk management processes	**Improvements planned**	Embedding of Comfort Checks in wards- Call don't fall initiative, scoping meetings to prevent falls RCA for all sever harm falls-	
LHCH Performance 2015/16	0.63% (71 falls in 11,311 admissions)	**LHCH Performance 2014/15**	0.73% (97 falls in 13,335 admissions)	
Interpretation of Results	The rate of falls occurring in 2015/16 is slightly lower than last year. None of the falls resulted in anything more than minor harm. The risk profile of our inpatients continues to become more challenging. We will continue to strive to reduce the number of falls.			

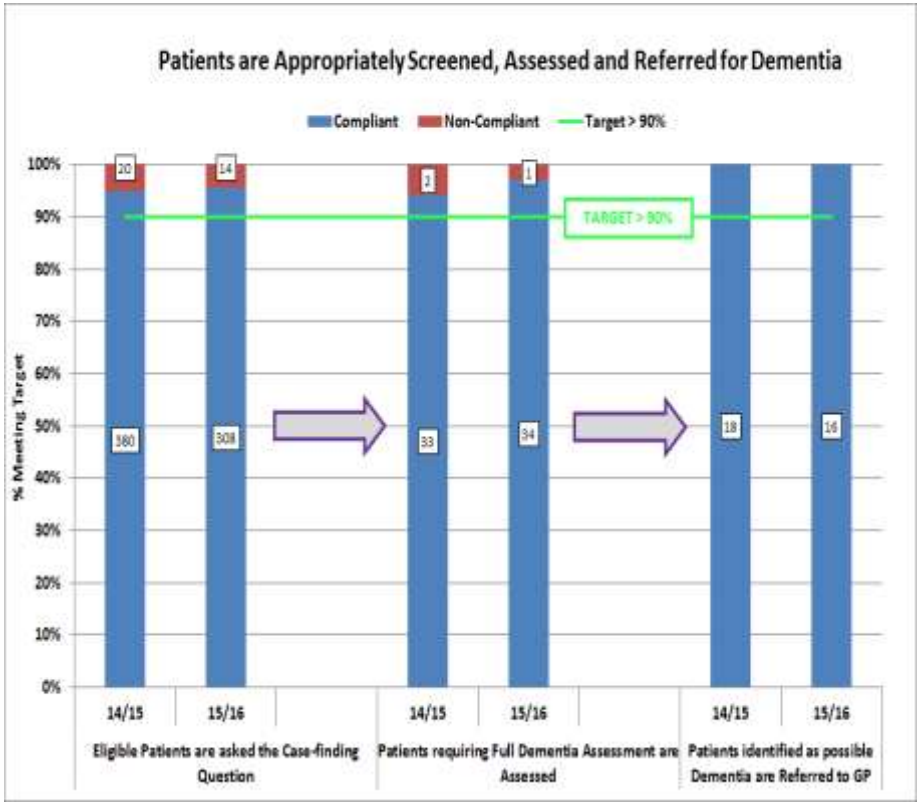
Safety			
Metric	Number of patients acquiring MRSA bacteraemia whilst in hospital	**Organisation Wide or Service Specific**	Organisation wide
Derived From	Infection prevention team	**Why metric chosen**	Major concern of patients; Department of Health priority
How is data collected	Monthly surveillance reported to health protection agency. National definitions of bacteraemia applied.	**Improvements planned**	We'll continue with the processes out in place last year: Surgical site infection check MRSA screening audits Central lines bundle
LHCH Performance 2015/16	0 patients	**LHCH Performance 2014/15**	0 patients
Interpretation of Results	The Trust has achieved an excellent result with no cases of MRSA in 2015/16.		

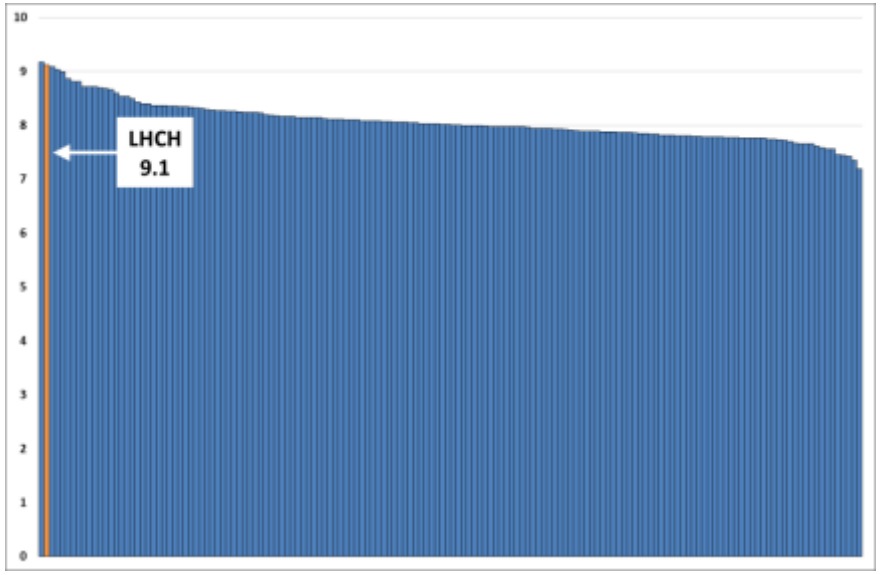


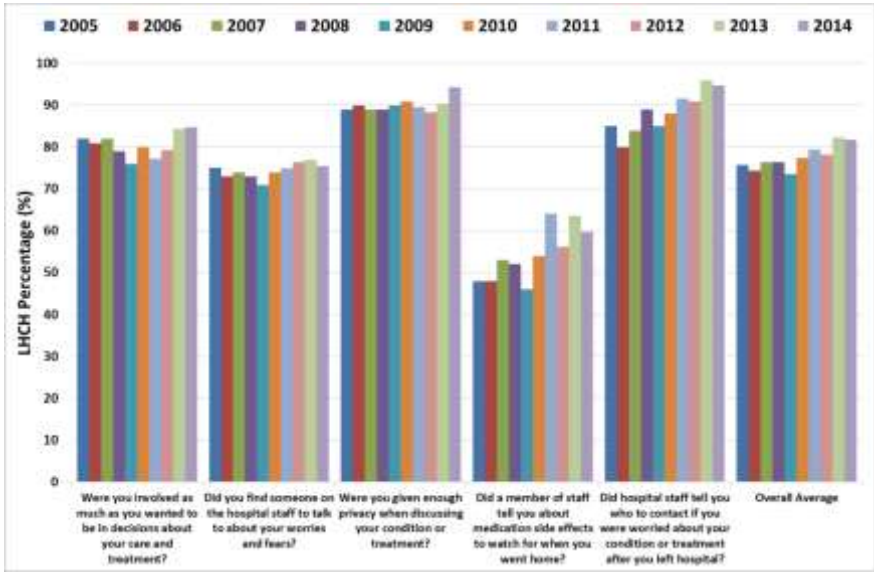
Effectiveness				
Metric	% patients completing phase one cardiac rehabilitation	**Organisation Wide or Service Specific**	Organisation wide – phase 1;	
Derived From	Local audit figures	**Why metric chosen**	Promotes lifestyle change and reduces future risk of cardiac events such as heart attacks	
How is data collected	When in hospital, Eligible patients for cardiac rehab receive a comprehensive educational session highlighting their personal lifestyle /medical risks and how they can make any changes to improve their health outcomes and prevent further disease and re-admissions to hospital This data is sent to the Clinical Quality	**Improvements planned**	Increase the number of staff with relevant competencies. Current training delivery methods by CR nurse and Knowsley CVD nurse ineffective due to increased competing initiatives for staff. Review and modify the competency tool agreed at CR steering group Jan 2016 that competencies will be delivered as E learning package. We are awaiting confirmation for mandatory status. This will form part of planned CR KPI for training /competency confirmed plans to redesign CR referral –start April 2016 have a PCB setting of service KPIs.	
LHCH Performance 2015/16	94.25%	**LHCH Performance 2014/15**	93.54%	
Interpretation of Results	We have exceeded the 2015/16 NSF target of 85%, set for this indicator, with a small increase from last year's percentage. We will continue the excellent service provided by having ward specific Cardiac Rehabilitation trainers with relevant competencies.			

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 2015/16	98.9%	**LHCH Performance 2014/15**	98.7%	
Interpretation of Results	The high standard set in previous years has been maintained this year. Our patients continue to benefit from this extremely efficient, gold-standard service.			

Effectiveness				
Metric	% 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 on-going 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.	**Improvements planned**	Our Electronic Patient Record (EPR) system includes a module for generating patient correspondence. Development of standard documentation across the health economy	
LHCH Performance 2015/16	88%	**LHCH Performance 2014/15**	87%	
Interpretation of Results	The EPR Discharge Checklist was introduced in December 2013. A steady improvement in the number of patients taking a copy of their summary has continued. We had hoped to see this rate increase to 95% over the course of this year, but we did fall slightly short of this. We will continue to monitor this in 2016/17 and hopefully make further improvement.			

Patient Experience				
Metric	Dementia screening, assessment and referral	**Organisation Wide or Service Specific**	Organisation wide	
Derived From	Data submitted to NHS England as part of national programme	**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 Electronic Patient Record	**Improvements planned**	Dementia awareness training	
LHCH 2015/16	307 of 322 Patients treated appropriately (95%)	**LHCH 2014/15**	378 of 400 patients treated appropriately (95%)	
Interpretation of Results	This process is now well embedded in the Trust. Patients with dementia and their carers can be assured that LHCH will help to ensure appropriate care is provided for this condition.			

<table>
<tr><th colspan="5">Patient Experience</th></tr>
<tr><td>Metric</td><td>Mean of ‘Overall patient experience’ question. Inpatient care rated 0-10</td><td>Organisation Wide or Service Specific</td><td>Organisation wide</td><td rowspan="4">National data not available until May 2016
2014/15 graph below:
 
</td></tr>
<tr><td>Derived From</td><td>National patient survey results</td><td>Why metric chosen</td><td>This question is an overall measure of the patients experience</td></tr>
<tr><td>How is data collected</td><td>850 LHCH patients are invited to complete a questionnaire about their in-patient stay. Results are benchmarked with other Trusts in England.</td><td>Improvements planned</td><td>Continuing the Implementation of the Patient and Family centred care plan</td></tr>
<tr><td>LHCH Performance 2015/16</td><td>Performance available in June 2016</td><td>LHCH Performance 2014/15</td><td>9.1 (91%)</td></tr>
<tr><td>Interpretation of Results</td><td colspan="4"></td></tr>
</table>

<table>
<tr><th colspan="5">Patient Experience</th></tr>
<tr><td>Metric</td><td>Responsiveness to patients needs</td><td>Organisation Wide or Service Specific</td><td>Organisation wide</td><td rowspan="3">National data not available until May 2016
2014/15 graph below:
 
</td></tr>
<tr><td>Derived From</td><td>Average of 5 key questions drawn from the national patient survey results</td><td>Why metric chosen</td><td>Summary of overall experience of care. National CQUIN indicator</td></tr>
<tr><td>How is data collected</td><td>850 LHCH patients are invited to complete a questionnaire about their in-patient stay. Results are benchmarked with other Trusts in England.</td><td>Improvements planned</td><td>Embedding Teach back, to make sure patients know exactly what their discharge summary means, and what to expect from their medication

Embed a generic discharge summary with clear instructions and information</td></tr>
<tr><td>LHCH Performance 2015/16</td><td>Performance available in June 2016</td><td>LHCH Performance 2014/15</td><td>81.8%</td><td></td></tr>
<tr><td>Interpretation of Results</td><td colspan="4"></td></tr>
</table>

Mandatory Indicators from Risk Assessment Framework to M12

Indicator	Target 2015/16	Performance 2014/15	Performance 2015/16
Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	92%	93.07%*	92.28%*
All cancers: 62 day wait for first treatment from: □ Urgent GP referral for suspected cancer □ NHS cancer screening service referral	85% 90%	91.12% N/A	91.57% N/A
All cancers: 31 day wait for second or subsequent treatment comprising: □ Surgery □ Anti-cancer drug treatments □ Radiotherapy	94% 98% 94%	100% N/A N/A	100% N/A N/A
All cancers: 31 day wait from diagnosis to first treatment	96%	99.49%	99.45%
Cancer: two week wait from referral to date first seen, comprising: □ All urgent referrals (cancer suspected)	93%	99.63%	100%
Data completeness: community services comprising: □ Referral to treatment information □ Referral information □ Treatment activity information	50% 50% 50%	N/A 100% 100%	N/A 99.99% 100%

***Average for the year**

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

Statement for the Liverpool Clinical Commissioning Group

(Not received)

Statements from Healthwatch

Healthwatch Liverpool is pleased to take this opportunity to comment on the 2015/016 Quality Account of Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH). This commentary relates to the contents of a draft Quality Account document that was made available to Healthwatch prior to publication. Given the level of details, this commentary can only focus on some of the areas featured.

The Quality Account sets out the key quality initiatives that LHCH is undertaking to ensure that it continues to provide the standard of service that patients and their families deserve. The document is relatively clear and easy to understand from the perspective of a layperson and provides useful information for on how well the organisation is serving its patients.

Healthwatch Liverpool notes that priority targets have been met for 2015/16 and as it stands, this Quality Account does evidence the commitment of LHCH to continuously improve the quality of its service.

Healthwatch Liverpool is pleased that LHCH has taken part in a number of clinical audits which demonstrate that it is contributing to a wider understanding of how the NHS is performing on important topics like cancer and national adult cardiac surgery consultant outcomes.

Healthwatch Liverpool is satisfied that LHCH has engaged with stakeholders in choosing the priorities set out in the Quality Account. Because Healthwatch strives to champion the patients' voice to improve health services, we are particularly pleased that LHCH has chosen 'Improve the patient experience in outpatient department for patients and patients' families', as Priority One. Healthwatch Liverpool is, however, supportive of all the priorities chosen in this Quality Account, and we are pleased to note the high relevance that Priorities Three and Four have in relation to appropriate discharge from hospital, also a key priority for Healthwatch Liverpool, and that LHCH has been keen to engage with us on.

LHCH has been generally proactive in its engagement with Healthwatch Liverpool over the last year. Healthwatch Liverpool was pleased to work jointly with LHCH to conduct a Listening Event in February 2016, when we heard from both inpatients and outpatients about their experiences. We were particularly pleased that patients demonstrated a high level of satisfaction and that so many singled out the positive impact that the Trust's championing of the "My name is.." initiative had on their experience of care with patients reporting feeling part of a team tackling their health issues together. This bodes well for the continued success of the Trust in delivering positive patient experiences (Priority One).

Looking at the potential future development of Quality Accounts at LHCH, Healthwatch Liverpool would like to see the links that exist between the quality of the service and equality of the service made more explicit to demonstrate how all patients receive the high quality service that is exemplified by this Quality Account.

Healthwatch Liverpool looks forward to further engagement and joint work with LHCH in the coming year, focusing mainly on its quality, equality and patient experience performance.

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

This Committee met throughout the year. We have reviewed the Quality Accounts for 2015/16 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 LHCH for the coming year.

We, as a group, are confident that this Hospital will respond, as it always has, in a very positive way, to the problems of the year ahead, 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

Annex 2 Statement of Directors Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

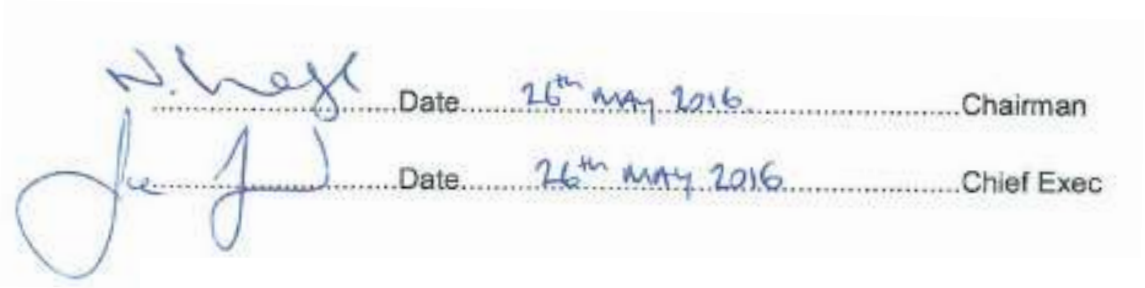
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2015 to March 2016
    - papers relating to Quality reported to the board over the period April 2015 to March 2016
- feedback from commissioners dated 18/04/2016
- feedback from governors dated 18//04/2016
- feedback from local Healthwatch organisation, dated 20/05/2016
- feedback from Overview and Scrutiny Committee (not received)
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/04/2016
- the [latest] national patient survey 09/04/2015 *(results for 2015 not released until June 2016)*
- the [latest] national staff survey 12/02/2016
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 05/04/2016
- CQC Intelligent Monitoring Report dated 21/04/2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

NB: sign and date in any colour ink except black



How to Provide Feedback on the Quality Account

Liverpool Heart and Chest Hospital NHS Foundation Trust would be pleased to either answer questions or receive feedback on how the content and layout of this quality account can be improved. Additionally, should you wish to make any suggestions on the content of future reports or priorities for improvement we may wish to consider, or should any reader require the Quality Account in any additional more accessible format then please contact:

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

PART 4: ACCOUNTS

Foreword to the accounts

Liverpool Heart and Chest NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by Liverpool Heart and Chest NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Name JANE TOMKINSON
Job title CHIEF EXECUTIVE
Date 26-May-16

Consolidated Statement of Comprehensive Income

	Note	Group 2015/16 £000	Group 2014/15 £000	Trust 2015/16 £000	Trust 2014/15 £000
Operating income from patient care activities	3	114,802	109,915	114,802	109,915
Other operating income	4	8,351	12,003	8,129	12,259
Total operating income from continuing operations		123,153	121,918	122,931	122,174
Operating expenses	5, 7	(122,491)	(117,282)	(122,029)	(116,877)
Operating surplus/(deficit) from continuing operations		662	4,636	902	5,297
Finance income	10	59	61	36	38
Finance expenses	11	(36)	(40)	(36)	(40)
PDC dividends payable		(2,193)	(2,095)	(2,193)	(2,095)
Net finance costs		(2,170)	(2,074)	(2,193)	(2,097)
Share of profit / (loss)	17	(6)	(32)	(6)	(32)
Surplus/(deficit) for the year from continuing operations		(1,514)	2,530	(1,297)	3,168
Surplus/(deficit) for the year		(1,514)	2,530	(1,297)	3,168
Other comprehensive income					
Revaluation gains/(losses) and impairment losses on property, plant and equipment	16	680	2,100	680	2,100
Fair value gains/(losses) on available-for-sale financial investments	17	(23)	48	0	0
Total comprehensive income/(expense) for the period		(857)	4,678	(617)	5,268
Surplus / (deficit) for the period attributable to:					
the Foundation Trust		(1,514)	2,530	(1,297)	3,168
Total comprehensive income / (expense) for the period attributable to:					
non-controlling interests; and		0	0	0	0
the Foundation Trust		(857)	4,678	(617)	5,268

Income and operating surplus are derived from the Group's continuing operations.

The notes on page 136 to 193 form part of these accounts.

The Trust revalued its estate on 31st March 2016, and as a consequence;
- Operating income includes a reversal of previous impairments of £27k
- Operating expenses includes an impairment of (£132k)
- Other comprehensive income includes an upward revaluation of £2,259k
- Other comprehensive income includes an impairment of (£1,579k)

There have been losses on disposal of assets of (£3k).

The normalised deficit position before these movements is (£1,406k).

Statement of Financial Position

	Note	Group 31 March 2016 £000	Group 31 March 2015 £000	Trust 31 March 2016 £000	Trust 31 March 2015 £000
Non-current assets					
Intangible assets	13	707	789	707	789
Property, plant and equipment	14	75,460	75,030	75,460	75,030
Investments in associates and joint ventures	17	18	24	18	24
Other investments	17	527	550	0	0
Total non-current assets		76,712	76,393	76,185	75,843
Current assets					
Inventories	20	3,004	2,381	3,004	2,380
Trade and other receivables	21	6,543	5,491	6,715	6,129
Other financial assets	22	0	0	0	0
Non-current assets for sale	23	37	6	37	6
Cash and cash equivalents	24	8,216	13,381	7,856	12,333
Total current assets		17,800	21,259	17,612	20,848
Current liabilities					
Trade and other payables	25	(16,134)	(16,977)	(16,117)	(16,954)
Other liabilities	26	(393)	(1,380)	(393)	(1,380)
Borrowings	27	(142)	(135)	(142)	(135)
Other financial liabilities	28	0	0	0	0
Provisions	30	(1,273)	(1,199)	(1,273)	(1,199)
Liabilities in disposal groups	23	0	0	0	0
Total current liabilities		(17,942)	(19,691)	(17,925)	(19,668)
Total assets less current liabilities		76,570	77,961	75,872	77,023
Non-current liabilities					
Trade and other payables	25	0	0	0	0
Other liabilities	26	(608)	(983)	(608)	(983)
Borrowings	27	(261)	(403)	(261)	(403)
Other financial liabilities	28	0	0	0	0
Provisions	30	(81)	(98)	(81)	(98)
Total non-current liabilities		(950)	(1,484)	(950)	(1,484)
Total assets employed		75,620	76,477	74,922	75,539
Financed by					
Public dividend capital		63,322	63,322	63,322	63,322
Revaluation reserve		14,497	13,886	14,497	13,886
Available for sale investments reserve		0	0	0	0
Other reserves		0	0	0	0
Merger reserve		0	0	0	0
Income and expenditure reserve		(2,897)	(1,669)	(2,897)	(1,669)
Non-controlling interest		0	0	0	0
Charitable fund reserves	18	698	938	0	0
Total taxpayers' and others' equity		75,620	76,477	74,922	75,539

The notes on page 136 to 193 form part of these accounts.

Name
Position CHIEF EXECUTIVE
Date **26-May-16**

Statement of Changes in Equity for the year ended 31 March 2016

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	NHS charitable funds reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**63,322**	**13,886**	**(1,669)**	**938**	**76,477**
Surplus/(deficit) for the year	0	0	(1,732)	218	(1,514)
Other transfers between reserves	0	(63)	63	0	0
Impairments	0	(1,579)	0	0	(1,579)
Revaluations	0	2,259	0	0	2,259
Revaluations and impairments- charitable funds	0	0	0	0	0
Transfer to retained earnings on disposal of assets	0	(6)	6	0	0
Fair value gains/(losses) on available-for-sale financial investments	0	0	0	(23)	(23)
Other reserve movements	0	0	435	(435)	0
Taxpayers' and others' equity at 31 March 2016	**63,322**	**14,497**	**(2,897)**	**698**	**75,620**

Statement of Changes in Equity for the year ended 31 March 2015

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	NHS charitable funds reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2014 - brought forward	62,799	11,836	(4,887)	1,528	71,276
Surplus/(deficit) for the year	0	0	2,202	328	2,530
Other transfers between reserves	0	(33)	33	0	0
Impairments	0	(191)	0	0	(191)
Revaluations	0	2,291	0	0	2,291
Revaluations and impairments - charitable fund assets	0	0	0	0	0
Transfer to retained earnings on disposal of assets	0	(17)	17	0	0
Fair value gains/(losses) on available-for-sale financial investments	0	0	0	48	48
Public dividend capital received	523	0	0	0	523
Other reserve movements	0	0	966	(966)	0
Taxpayers' and others' equity at 31 March 2015	63,322	13,886	(1,669)	938	76,477

Statement of Changes in Equity for the year ended 31 March 2016

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**63,322**	**13,886**	**(1,669)**	**75,539**
Surplus/(deficit) for the year	0	0	(1,297)	(1,297)
Impairments	0	(1,579)	0	(1,579)
Revaluations	0	2,259	0	2,259
Transfer to retained earnings on disposal of assets	0	(6)	6	0
Other reserve movements	0	(63)	63	0
Taxpayers' and others' equity at 31 March 2016	**63,322**	**14,497**	**(2,897)**	**74,922**

Statement of Changes in Equity for the year ended 31 March 2015

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2014 - brought forward	62,799	11,836	(4,887)	69,748
Surplus/(deficit) for the year	0	0	3,168	3,168
Impairments	0	(191)	0	(191)
Revaluations	0	2,291	0	2,291
Transfer to retained earnings on disposal of assets	0	(17)	17	0
Public dividend capital received	523	0	0	523
Other reserve movements	0	(33)	33	0
Taxpayers' and others' equity at 31 March 2015	63,322	13,886	(1,669)	75,539

Information on reserves

NHS charitable funds reserves
This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

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. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	Group 2015/16 £000	Group 2014/15 £000	Trust 2015/16 £000	Trust 2014/15 £000
Cash flows from operating activities					
Operating surplus/(deficit)		662	4,636	902	5,297
Non-cash income and expense:					
Depreciation and amortisation	5.1	5,125	5,039	5,125	5,039
Impairments and reversals of impairments	6	105	(3,502)	105	(3,502)
(Gain)/loss on disposal of non-current assets	5.1	3	0	3	0
(Increase)/decrease in receivables and other assets		(984)	(1,587)	(977)	(2,053)
(Increase)/decrease in inventories		(624)	161	(623)	161
Increase/(decrease) in payables and other liabilities		(630)	371	(165)	371
Increase/(decrease) in provisions		57	834	57	834
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		2	56	0	0
Net cash generated from/(used in) operating activities		3,716	6,008	4,427	6,147
Cash flows from investing activities					
Interest received		36	38	36	38
Purchase of intangible assets		(73)	(90)	(73)	(90)
Purchase of property, plant, equipment and investment property		(6,360)	(3,086)	(6,360)	(3,086)
Sales of property, plant, equipment and investment property		12	0	12	0
Investing cash flows of NHS charitable funds		23	23	0	0
Net cash generated from/(used in) investing activities		(6,362)	(3,115)	(6,385)	(3,138)
Cash flows from financing activities					
Public dividend capital received		0	523	0	523
Capital element of finance lease rental payments		(135)	(195)	(135)	(195)
Interest paid on finance lease liabilities		(36)	(37)	(36)	(37)
Other interest paid		0	(3)	0	(3)
PDC dividend paid		(2,348)	(1,870)	(2,348)	(1,870)
Net cash generated from/(used in) financing activities		(2,519)	(1,582)	(2,519)	(1,582)
Increase/(decrease) in cash and cash equivalents		(5,165)	1,311	(4,477)	1,427
Cash and cash equivalents at 1 April		13,381	12,070	12,333	10,906
Cash and cash equivalents at 31 March	24	8,216	13,381	7,856	12,333

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. 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 the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow 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.

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.

Going concern

These accounts have been prepared on a going concern basis.

The going concern basis of accounting is appropriate because there are no material uncertainties related to events or conditions that may cast significant doubt about the ability of the foundation trust to continue as a going concern

Note 1.1 Consolidation

NHS Charitable Fund
The NHS foundation trust is the corporate trustee to Liverpool Heart and Chest Hospital NHS charitable fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31st March in accordance with the UK Charities Statement of Recommended Practice (SORP) and are based on the FRSSE (Financial Reporting Standard for Smaller Entities). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Joint ventures
Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

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). Draft accounts of the company have been prepared for the year ended 31st March 2016 and the results are reflected in the accounts of the group in this financial year.

Note 1.2 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 trust is contracts with commissioners in respect of health care services.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.
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.

Note 1.3 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.4 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.

Note 1.5 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 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.
- collectively the 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement
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 location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value. Land and buildings used for the Foundation Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent 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 2016. This was undertaken on a desktop review basis.

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

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

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

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

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'.

Impairments
In accordance with the *FT ARM*, impairments that arise from a clear consumption of economic benefits or of 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 that arises from a clear consumption of economic benefit or of 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.

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 ie:

- 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.

Donated, government grant and other grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	n/a	n/a
Buildings Exc Dwellings	11	55
Dwellings	30	32
Assets under Construction & POA	1	2
Plant & machinery	7	10
Information technology	4	8
Furniture & fittings	7	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.6 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the 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 trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg 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, eg 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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 to IFRS 5.

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.

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Intangible assets - purchased		
Software	2	10
Licences & trademarks	2	10

Note 1.7 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners 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.

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured 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 inventories.

Note 1.9 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade date.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

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 trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

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

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

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

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices where possible otherwise by discounted cash flow analysis.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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 the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.10 Leases

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.

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.

Note 1.11 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 32.2 but is not recognised in the NHS foundation trust's accounts.

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 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.

Note 1.12 Contingencies

Contingent assets (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 in note 33 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 33, 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.

Note 1.13 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 Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 Value added tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Corporation tax

Liverpool Heart & Chest Hospital NHS Foundation Trust is a Health Service body within the meaning of the S519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the treasury to dis-apply the exemption in relation to the specified activities of a Foundation Trust (S159A (3) to (8) ICTA 1988). Accordingly, the trust is potentially within the scope of Corporation Tax, but there is no tax liability arising in respect of the current financial year.

Note 1.16 Foreign exchange

The functional and presentational currencies of the trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

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

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

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

Note 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 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 foundation 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 accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted
The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted.
IFRS 11 (amendment) acquisition of an interest in a joint operation - published by IASB May 2014; Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 38 (amendment) depreciation and amortisation - published by IASB May 2014; Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 41 (amendment) bearer plants - published by IASB June 2014; Expected to be effective from 2016/17.
IAS 27 (amendment) equity method in separate financial statements - Published by IASB August 2014; Expected to be effective from 2016/17.
IFRS 10 (amendment) and IAS 28 (amendment) Sale or contribution of assets - Published by IASB September 2014; Expected to be effective from 2016/17
IFRS 10 (amendment) and IAS 28 (amendment) Investment entities applying for consolidation exception - Published by IASB December 2014; Expected to be effective from 2016/17

IAS 1 (amendment) Disclosure initiative - Published by IASB December 2014; Expected to be effective from 2016/17
IFRS 15 Revenue from contracts with customers - Published by IASB December 2014; Expected to be effective from 2017/18

Annual improvements for IFRS; 2012 - 15 cycle - Published by IASB September 2014; Expected to be effective from 2017/18
IFRS 19 Financial Instruments - Published by IASB July 2014; Expected to be effective from 2018/19

The Trust has considered the above new standards, interpretations and amendments to the published standards that are not yet effective and concluded that they are not relevant to the Trust, or that they would not have a significant impact to the Trust's financial statements, apart from additional disclosures.

Note 1.21 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates of the underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical Judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Asset lives and residual values

Property, plant and equipment is depreciated over its useful life taking into account residual values, where appropriate. The actual lives of the assets and residual values are assessed annually and may vary depending on a number of factors. In reassessing asset lives, factors such as technological innovation and maintenance programmes are taken into account. Residual values assessments consider issues such as the remaining life of the asset and projected disposal value.

Impairment of Assets

At each balance sheet date, the 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. The impairment value recognised in the year ending 31st March 2016 is disclosed at note 6.

Recoverability of receivables

Provision for non-payment is made against all non-NHS receivables that are greater than 180 days old unless recoverability is certain. Provision is made against more recent receivables when there is some doubt concerning recoverability. The provision for impaired receivables at 31st March 2016 was £0.884m.

Short term employee benefits

The foundation trust calculated a provision for untaken holiday pay in 2012/13 which was based on a sample of circa 200 staff at a value of £275k. An updated exercise has been completed in 2015/16, which increases the value to £294k.

Provisions

The Trust regularly monitors the position regarding provisions, including legal claims and restructuring, to ensure that it accurately reflects at each balance sheet date the current position in providing for potential future costs from past events, including board resolutions. The total provision for liabilities and charges at 31st March 2016 was £1,354k

Key sources of estimation uncertainty

There are no key assumptions concerning the future, or other key sources of estimation uncertainty at the balance sheet date, that have significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial period.

Note 2 Operating Segments

The Group has one segment for the provision of healthcare which generated income of £123.150m.

	2015/16	2014/15
	£000	£000
The main sources of income received were:-		
North West Specialist Commissioning Team	73,032	68,363
Health Commission Wales	14,939	14,379
North West Secondary Contract	16,061	15,423

	Healthcare Segment	
	2015/16	**2014/15**
	£000	£000
Income	**123,153**	121,918
Surplus/(Deficit)	**(1,514)**	2,530
Net Assets	**75,620**	76,477

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	Group		Trust	
	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
Acute services				
Elective income	56,148	53,597	56,148	53,597
Non elective income	32,930	31,255	32,930	31,255
Outpatient income	12,861	10,648	12,861	10,648
Other NHS clinical income*	5,225	6,521	5,225	6,521
Community services				
Community services income from CCGs and NHS England	3,452	3,424	3,452	3,424
All services				
Private patient income	3,343	3,592	3,343	3,592
Other clinical income	843	878	843	878
Total income from activities	114,802	109,915	114,802	109,915

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

*Analysis of Other NHS clinical income Group & Trust	2015/16	2014/15
Cystic Fibrosis Inpatients	5,169	4,858
CQUIN	0	1,603
CCG Income - Non Contracted	56	60
	5,225	6,521

Note 3.2 Income from patient care activities (by source)

	Group		Trust	
Income from patient care activities received from:	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
CCGs and NHS England	93,242	88,108	93,242	88,108
NHS other	75	116	75	116
Non-NHS: private patients	3,343	3,592	3,343	3,592
Non-NHS: overseas patients (chargeable to patient)	15	38	15	38
Non NHS: other	18,127	18,061	18,127	18,061
Total income from activities	114,802	109,915	114,802	109,915
Of which:				
Related to continuing operations	114,802	109,915	114,802	109,915

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	Group		Trust	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Income recognised this year	**15**	38	**15**	38
Cash payments received in-year	**15**	38	**15**	38

Note 4 Other operating income

	Group		Trust	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Research and development	**1,195**	1,377	**1,250**	1,377
Education and training	**2,788**	2,622	**2,788**	2,622
Received from NHS charities : Receipt of grants / donations for capital acquisitions	**0**	0	**244**	777
Non-patient care services to other bodies	**185**	187	**185**	187
Reversal of impairments	**27**	3,529	**27**	3,529
Incoming resources received by NHS charitable funds	**521**	521	**0**	0
Other income*	**3,635**	3,767	**3,635**	3,767
Total other operating income	**8,351**	12,003	**8,129**	**12,259**
Of which:				
Related to continuing operations	**8,351**	12,003	**8,129**	12,259
Related to discontinued operations	-	-		

**Other Income is analysed in the note below*

***Analysis of Other Operating Income - Other Income - Group & Trust**	**2015/16**	**2014/15**
Clinical excellence awards	254	290
Staff contributions to employee benefit schemes	75	62
Estates recharges	31	31
IT recharges	17	18
Pharmacy sales	2	3
Other	3,256	3,363
	3,635	**3,767**

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group		Trust	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	111,006	104,943	111,006	104,943
Income from services not designated as commissioner requested services	3,796	4,972	3,796	4,972
Total	**114,802**	**109,915**	**114,802**	**109,915**

Note 4.2 Profits and losses on disposal of property, plant and equipment

Medical equipment assets used in the provision of commissioner requested services have been disposed of during the year.

This equipment, consisting of 11 Draeger Evita 4 ventilators, was reclassified as Assets Held For Sale during the year, prior to the disposal.

The Net Book Value of the equipment prior to disposal was £16k. Sales proceeds received on disposal via the Trust's agent Avensys Medical Ltd were £13k - resulting in a loss on disposal of (£3k).

The Trust will continue to meet its obligations to provide commissioner requested services through the replacement of the equipment disposed of. In March 2015 (2014/15 capital programme) the Trust purchased 16 Draeger Evita Infinity V500 ventilators in direct replacement.

Note 5.1 Operating expenses

	Group		Trust	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Services from NHS foundation trusts	0	5	0	5
Services from NHS trusts	11	85	11	85
Services from CCGs and NHS England	0	5	0	5
Employee expenses - executive directors	750	719	750	719
Remuneration of non-executive directors	115	113	115	113
Employee expenses - staff	64,879	62,539	64,743	62,444
Supplies and services - clinical	32,188	30,748	32,188	30,748
Supplies and services - general	2,851	2,664	2,851	2,664
Establishment	1,006	1,173	1,006	1,173
Research and development (Employee expenses)	890	827	890	827
Transport	361	384	361	384
Premises	3,986	3,671	3,986	3,671
Increase/(decrease) in provision for impairment of receivables	(336)	1,022	(336)	1,022
Increase/(decrease) in other provisions	307	0	307	0
Change in provisions discount rate(s)	(10)	4	(10)	4
Inventories consumed (Drugs)	7,465	6,167	7,465	6,167
Rentals under operating leases	58	63	58	63
Depreciation on property, plant and equipment	4,970	4,881	4,970	4,881
Amortisation on intangible assets	155	158	155	158
Impairments	132	27	132	27
audit services- statutory audit	62	63	61	61
other auditor remuneration (external auditor only)	7	0	7	0
Clinical negligence	722	465	722	465
Loss on disposal of non-current assets	3	0	3	0
Legal fees	53	80	53	80
Consultancy costs	566	493	566	493
Internal audit costs	80	2	80	2
Training, courses and conferences	205	281	205	281
Patient travel	14	15	14	15
Car parking & security	31	9	31	9
Insurance	135	124	135	124
Losses, ex gratia & special payments	43	(121)	43	(121)
Other resources expended by NHS charitable funds	325	214	0	0
Other	467	402	467	308
Total	122,491	117,282	122,029	116,877
Of which:				
Related to continuing operations	122,491	117,282	122,029	116,877
Related to discontinued operations	0	0	0	0

Note 5.2 Other auditor remuneration

	Group		Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
Other auditor remuneration paid to the external auditor:				
1. Audit of accounts of any associate of the trust	**0**	0	**0**	0
2. Audit-related assurance services	**7**	0	**7**	0
3. Taxation compliance services	**0**	0	**0**	0
4. All taxation advisory services not falling within item 3 above	**0**	0	**0**	0
5. Internal audit services	**0**	0	**0**	0
6. All assurance services not falling within items 1 to 5	**0**	0	**0**	0
7. Corporate finance transaction services not falling within items 1 to 6 above	**0**	0	**0**	0
8. Other non-audit services not falling within items 2 to 7 above	**0**	0	**0**	0
Total	**7**	0	**7**	0

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2014/15: £2m).

Note 6 Impairment of assets

	Group		Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
Net impairments charged to operating surplus / deficit resulting from:				
Changes in market price	**105**	(3,502)	**105**	(3,502)
Other	**0**	0	**-**	-
Total net impairments charged to operating surplus / deficit	**105**	(3,502)	**105**	(3,502)
Impairments charged to the revaluation reserve	**1,579**	191	**1,579**	191
Total net impairments	**1,684**	(3,311)	**1,684**	(3,311)

Note 7 Employee benefits

	Group				Trust			
	Permanent £000	Other £000	2015/16 Total £000	2014/15 Total £000	Permanent £000	Other £000	2015/16 Total £000	2014/15 Total £000
Salaries and wages	52,519	1,381	53,900	51,553	52,383	1,381	53,764	51,553
Social security costs	4,061	-	4,061	3,953	4,061	-	4,061	3,953
Employer's contributions to NHS pensions	5,505	-	5,505	5,158	5,505	-	5,505	5,158
Pension cost - other	-	-	-	-	-	-	-	-
Other post employment benefits	-	-	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-	-	-
Termination benefits	-	-	-	422	-	-	-	422
Agency/contract staff	-	3,407	3,407	3,240	-	3,407	3,407	3,240
Total gross staff costs	**62,085**	**4,788**	**66,873**	**64,326**	**61,949**	**4,788**	**66,737**	**64,326**
Recoveries in respect of seconded staff	(289)	-	(289)	(91)	(289)	-	(289)	(186)
Total staff costs	**61,796**	**4,788**	**66,584**	**64,235**	**61,660**	**4,788**	**66,448**	**64,140**
Of which								
Costs capitalised as part of assets	35	30	65	150	35	30	65	150

Note 7.1 Retirements due to ill-health

During 2015/16 there were 2 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £54k (£108k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	Group & Trust	
	2015/16 £000	2014/15 £000
Salary	762	701
Taxable benefits	21	2
Performance related bonuses	0	0
Employer's pension contributions	136	56
Total	**919**	**759**

Further details of directors' remuneration can be found in the remuneration report.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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:

Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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. 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 schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed 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.

Note 9 Operating leases

Note 9.1 Liverpool Heart and Chest NHS Foundation Trust as a lessor

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

Note 9.2 Liverpool Heart and Chest NHS Foundation Trust as a lessee

The Foundation Trust has vehicle leases on 2 cars covering 3 year agreements commencing from March 2012 (extended for a further 1 year from March 2015) and June 2012 respectively and a lease on a van which is not subject to a long term contractual commitment. The Foundation Trust has other leases for photocopiers under a 7 year agreement from 2013/14. The preceding 5 year lease term for photocopiers lapsed during 2013/14 but where the Trust has agreed to extend these leases there is no on-going contractual commitment.

	Group & Trust	
	2015/16	2014/15
	£000	£000
Operating lease expense		
Minimum lease payments	58	63
Contingent rents	-	-
Less sublease payments received	-	-
Total	**58**	**63**

	31 March 2016	31 March 2015
	£000	£000
Future minimum lease payments due:		
- not later than one year;	47	51
- later than one year and not later than five years;	131	165
- later than five years.	-	7
Total	**178**	**223**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	Group		Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
Interest on bank accounts	**36**	38	**36**	38
Investment income on NHS charitable funds financial assets	**23**	23	**-**	-
Total	**59**	61	**36**	38

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	Group		Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
Interest expense:				
Finance leases	**36**	37	**36**	37
Interest on late payment of commercial debt	**-**	3	**-**	3
Total interest expense	**36**	40	**36**	40
Other finance costs	**-**	-	**-**	-
Total	**36**	40	**36**	40

Note 11.2 The late payment of commercial debts (interest) Act 1998

	Group		Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
Amounts included within interest payable arising from claims made under this legislation	**-**	2	**-**	2
Compensation paid to cover debt recovery costs under this legislation	**-**	1	**-**	1

Note 12 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.

Note 13.1 Intangible assets - 2015/16

Group & Trust	Software licences	Intangible assets under construction	NHS charitable fund assets	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	1,396	0	0	1,396
Additions	73	0	0	73
Disposals / derecognition	(9)	0	0	(9)
Gross cost at 31 March 2016	1,460	-	-	1,460
Amortisation at 1 April 2015 - brought forward	607	0	0	607
Provided during the year	155	0	0	155
Disposals / derecognition	(9)	0	0	(9)
Amortisation at 31 March 2016	753	0	0	753
Net book value at 31 March 2016	707	0	0	707
Net book value at 1 April 2015	789	0	0	789

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.

Note 13.2 Intangible assets - 2014/15

Group & Trust	Software licences	Intangible assets under construction	NHS charitable fund assets	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	1,306	0	0	1,306
Additions	90	0	0	90
Disposals / derecognition	0	0	0	0
Valuation/gross cost at 31 March 2015	1,396	0	0	1,396
Amortisation at 1 April 2014 - as previously stated	449	0	0	449
Provided during the year	158	0	0	158
Disposals / derecognition	0	0	0	0
Amortisation at 31 March 2015	607	0	0	607
Net book value at 31 March 2015	789	0	0	789
Net book value at 1 April 2014	857	0	0	857

Note 14.1 Property, plant and equipment - 2015/16

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	3,300	53,665	1,026	1,912	23,523	0	13,948	2,413	0	99,787
Transfers by absorption	0	0	0	0	0	0	0	0	0	0
Additions	0	1,609	132	1,376	1,270	0	478	6	0	4,871
Impairments	(550)	(848)	(313)	0	0	0	0	0	0	(1,711)
Reversals of impairments	0	27	0	0	0	0	0	0	0	27
Reclassifications	0	435	236	(1,377)	486	0	201	19	0	0
Revaluations	0	611	(27)	0	0	0	0	0	0	584
Transfers to/ from assets held for sale	0	0	0	0	(607)	0	0	0	0	(607)
Disposals / derecognition	0	0	0	0	(118)	0	0	0	0	(118)
Valuation/gross cost at 31 March 2016	2,750	55,499	1,054	1,911	24,554	0	14,627	2,438	0	102,833
Accumulated depreciation at 1 April 2015 - brought forward	0	0	0	0	16,566	0	6,161	2,030	0	24,757
Transfers by absorption	0	0	0	0	0	0	0	0	0	0
Provided during the year	0	1,630	45	0	1,805	0	1,346	144	0	4,970
Impairments	0	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluations	0	(1,630)	(45)	0	0	0	0	0	0	(1,675)
Transfers to/ from assets held for sale	0	0	0	0	(561)	0	0	0	0	(561)
Disposals/ derecognition	0	0	0	0	(118)	0	0	0	0	(118)
Accumulated depreciation at 31 March 2016	0	0	0	0	17,692	0	7,507	2,174	0	27,373
Net book value at 31 March 2016	2,750	55,499	1,054	1,911	6,862	-	7,120	264	-	75,460
Net book value at 1 April 2015	3,300	53,665	1,026	1,912	6,957	-	7,787	383	-	75,030

Note 14.2 Property, plant and equipment - 2014/15

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	3,300	49,002	812	301	22,404	0	13,001	2,327	0	91,147
Transfers by absorption	0	0	0	0	0	0	0	0	0	0
Additions - purchased/ leased/ grants/ donations	0	729	10	1,912	1,526	0	698	94	0	4,969
Impairments	0	(218)	0	0	0	0	0	0	0	(218)
Reversals of impairments	0	3,521	8	0	0	0	0	0	0	3,529
Reclassifications	0	52	0	(301)	0	0	249	0	0	0
Revaluations	0	579	196	0	0	0	0	0	0	775
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(407)	0	0	(8)	0	(415)
Valuation/gross cost at 31 March 2015	3,300	53,665	1,026	1,912	23,523	0	13,948	2,413	0	99,787
Accumulated depreciation at 1 April 2014 - as previously stated	0	0	0	0	15,201	0	4,698	1,908	0	21,807
Transfers by absorption	0	0	0	0	0	0	0	0	0	0
Provided during the year	0	1,492	24	0	1,772	0	1,463	130	0	4,881
Impairments	0	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluations	0	(1,492)	(24)	0	0	0	0	0	0	(1,516)
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(407)	0	0	(8)	0	(415)
Accumulated depreciation at 31 March 2015	0	0	0	0	16,566	0	6,161	2,030	0	24,757
Net book value at 31 March 2015	3,300	53,665	1,026	1,912	6,957	0	7,787	383	0	75,030
Net book value at 1 April 2014	3,300	49,002	812	301	7,203	0	8,303	419	0	69,340

Note 14.3 Property, plant and equipment financing - 2015/16

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016										
Owned	2,750	55,499	1,054	1,911	6,404	0	7,120	264	0	75,002
Finance leased	0	0	0	0	458	0	0	0	0	458
On-SoFP PFI contracts and other service concession arrangements	0	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0	0
Government granted	0	0	0	0	0	0	0	0	0	0
Donated	0	0	0	0	0	0	0	0	0	0
NBV total at 31 March 2016	2,750	55,499	1,054	1,911	6,862	0	7,120	264	0	75,460

Note 14.4 Property, plant and equipment financing - 2014/15

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015										
Owned	3,300	53,665	1,026	1,912	6,329	0	7,787	383	0	74,402
Finance leased	0	0	0	0	628	0	0	0	0	628
On-SoFP PFI contracts and other service concession arrangements	0	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0	0
Government granted	0	0	0	0	0	0	0	0	0	0
Donated	0	0	0	0	0	0	0	0	0	0
NBV total at 31 March 2015	3,300	53,665	1,026	1,912	6,957	-	7,787	383	-	75,030

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

Note 15.1 Property, plant and equipment - 2015/16

Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2015 - brought forward	3,300	53,665	1,026	1,912	23,523	0	13,948	2,413	99,787
Valuation/gross cost at start of period for new FTs	0	0	0	0	0	0	0	0	0
Transfers by absorption	0	0	0	0	0	0	0	0	0
Additions purchased	0	1,552	0	1,331	1,270	0	468	6	4,627
Additions donated	0	57	132	45	0	0	10	0	244
Additions leased	0	0	0	0	0	0	0	0	0
Impairments charged to operating expenses	0	(57)	(75)	0	0	0	0	0	(132)
Impairments charged to the revaluation reserve	(550)	(791)	(238)	0	0	0	0	0	(1,579)
Reversals of impairments	0	27	0	0	0	0	0	0	27
Reclassifications	0	435	236	(1,377)	486	0	201	19	0
Revaluations	0	611	(27)	0	0	0	0	0	584
Transfers to/ from assets held for sale	0	0	0	0	(607)	0	0	0	(607)
Disposals / derecognition	0	0	0	0	(118)	0	0	0	(118)
Valuation/gross cost at 31 March 2016	2,750	55,499	1,054	1,911	24,554	-	14,627	2,438	102,833
Accumulated depreciation at 1 April 2015 - brought forward	0	0	0	0	16,566	0	6,161	2,030	24,757
Depreciation at start of period for new FTs	0	0	0	0	0	0	0	0	0
Transfers by absorption	0	0	0	0	0	0	0	0	0
Provided during the year	0	1,630	45	0	1,805	0	1,346	144	4,970
Impairments	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	(1,630)	(45)	0	0	0	0	0	(1,675)
Transfers to/ from assets held for sale	0	0	0	0	(561)	0	0	0	(561)
Disposals/ derecognition	0	0	0	0	(118)	0	0	0	(118)
Accumulated depreciation at 31 March 2016	-	-	-	-	17,692	-	7,507	2,174	27,373
Net book value at 31 March 2016	2,750	55,499	1,054	1,911	6,862	-	7,120	264	75,460
Net book value at 1 April 2015	3,300	53,665	1,026	1,912	6,957	-	7,787	383	75,030

Note 15.2 Property, plant and equipment - 2014/15

Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2014 - as previously stated	3,300	49,002	812	301	22,404	-	13,001	2,327	91,147
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 1 April 2014 - restated	3,300	49,002	812	301	22,404	-	13,001	2,327	91,147
Valuation/gross cost at start of period for new FTs	0	0	0	0	0	0	0	0	0
Transfers by absorption	0	0	0	0	0	0	0	0	0
Additions purchased	0	668	10	1,234	1,488	0	698	94	4,192
Additions donated	0	61	0	678	38	0	0	0	777
Additions leased	0	0	0	0	0	0	0	0	0
Impairments charged to operating expenses	0	(27)	0	0	0	0	0	0	(27)
Impairments charged to the revaluation reserve	0	(191)	0	0	0	0	0	0	(191)
Reversals of impairments	0	3,521	8	0	0	0	0	0	3,529
Reclassifications	0	52	0	(301)	0	0	249	0	0
Revaluations	0	579	196	0	0	0	0	0	775
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(407)	0	0	(8)	(415)
Valuation/gross cost at 31 March 2015	3,300	53,665	1,026	1,912	23,523	-	13,948	2,413	99,787
Accumulated depreciation at 1 April 2014 - as previously stated	-	-	-	-	15,201	-	4,698	1,908	21,807
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2014 - restated	-	-	-	-	15,201	-	4,698	1,908	21,807
Depreciation at start of period for new FTs	-	-	-	-	-	-	-	-	-
Transfers by absorption	0	0	0	0	0	0	0	0	0
Provided during the year	0	1,492	24	0	1,772	0	1,463	130	4,881
Impairments	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	(1,492)	(24)	0	0	0	0	0	(1,516)
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(407)	0	0	(8)	(415)
Accumulated depreciation at 31 March 2015	0	0	0	0	16,566	0	6,161	2,030	24,757
Net book value at 31 March 2015	3,300	53,665	1,026	1,912	6,957	-	7,787	383	75,030
Net book value at 1 April 2014	3,300	49,002	812	301	7,203	-	8,303	419	69,340

Note 15.3 Property, plant and equipment financing - 2015/16

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	2,750	54,666	601	1,866	6,270	-	7,111	244	73,508
Finance leased	-	-	-	-	458	-	-	-	458
Donated	-	833	453	45	134	-	9	20	1,494
NBV total at 31 March 2016	2,750	55,499	1,054	1,911	6,862	-	7,120	264	75,460

Note 15.4 Property, plant and equipment financing - 2014/15

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015									
Owned	3,300	53,001	591	1,234	6,147	-	7,787	379	72,439
Finance leased	-	-	-	-	628	-	-	-	628
Donated	-	664	435	678	182	-	-	4	1,963
NBV total at 31 March 2015	3,300	53,665	1,026	1,912	6,957	-	7,787	383	75,030

Note 15 Donations of property, plant and equipment

During the year there were donations of £244k in cash from the Liverpool Heart and Chest Hospital charity to fund the specific purchase of capital property, plant and equipment. This was spent as follows - £58k balance of Cherry Ward refurbishment, £131k to complete Robert Owen House refurbishment works, £10k for a Robot prototype, and £45k for Cedar Ward relatives area refurbishment.

Note 16 Revaluations of 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 2016.

Non-current assets held for sale include several items of medical equipment currently being marketed on behalf of the Trust by Avensys Medical Ltd.

All AHFS are held at the lower of their carrying value at the time of transfer, and their estimated realisable value. Depreciation is no longer charged following reclassification to AHFS.
The value of Non-Current Assets Held For Sale at 31st March 2016 is £37k.

Note 17.1 Investments - 2015/16

Group	Investment property	Investments in associates (and joint ventures)	Other investments
	£000	£000	£000
Carrying value at 1 April 2015	**-**	**24**	**550**
Share of profit/(loss)	-	(6)	-
Movement in fair value	-	-	(23)
Carrying value at 31 March 2016	**-**	**18**	**527**

Note 17.2 Investments - 2014/15

Group	Investment property	Investments in associates (and joint ventures)	Other investments
	£000	£000	£000
Carrying value at 1 April 2014	**-**	**6**	**502**
Acquisitions in year	-	50	-
Share of profit/(loss)	-	(32)	-
Movement in fair value	-	-	48
Carrying value at 31 March 2015	**-**	**24**	**550**

Note 17.3 Investments - 2015/16

Trust	Investment property	Investments in associates (and joint arrangements)	Other investments
	£000	£000	£000
Carrying value at 1 April 2015	**-**	**24**	**-**
Movement in fair value	-	(6)	-
Carrying value at 31 March 2016	**-**	**18**	**-**

Note 17.4 Investments - 2014/15

Trust	Investment property	Investments in associates (and joint arrangements)	Other investments
	£000	£000	£000
Carrying value at 1 April 2014	**-**	**6**	**-**
Acquisitions in year	-	50	-
Movement in fair value	-	(32)	-
Carrying value at 31 March 2015	**-**	**24**	**-**

Note 17.5 Investment property income and expenses

The foundation trust has no investment property

Note 18 Analysis of charitable fund reserves

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.

	31 March 2016 £000	31 March 2015 £000
Unrestricted funds:		
Unrestricted income funds	698	938
Revaluation reserve	-	-
Other reserves	-	-
Restricted funds:		
Restricted income funds	-	-
Permanent endowment funds	-	-
	698	**938**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 19 Disclosure of interests in other entities

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). Draft Accounts of the company have been prepared for the year ended 31st March 2016 and the results are reflected in the accounts of the group in this financial year.

Note 20 Inventories

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Drugs	538	459	538	459
Work In progress	-	-	-	-
Consumables	2,466	1,921	2,466	1,921
Energy	-	-	-	-
Inventories carried at fair value less costs to sell	-	-	-	-
Other	-	-	-	-
Inventories held by NHS charitable funds	-	1	-	-
Total inventories	**3,004**	**2,381**	**3,004**	**2,380**

Inventories recognised in expenses for the year were -£31,549k (2014/15: -£24,015k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: £0k).

Note 21.1 Trade receivables and other receivables

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Current				
Trade receivables due from NHS bodies	2,672	3,598	2,672	3,598
Receivables due from NHS charities	-	-	-	-
Other receivables due from related parties	1,947	1,527	2,165	2,218
Capital receivables	-	-	-	-
Provision for impaired receivables	(884)	(1,220)	(884)	(1,220)
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	536	425	536	425
PFI prepayments:				
Capital contributions	-	-	-	-
Lifecycle replacements	-	-	-	-
Accrued income	1,385	272	1,385	272
Interest receivable	-	-	-	-
Corporation tax receivable	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
PDC dividend receivable	75	-	75	-
VAT receivable	245	353	245	353
Other receivables	521	483	521	483
Trade and other receivables held by NHS charitable funds	46	53		-
Total current trade and other receivables	**6,543**	**5,491**	**6,715**	**6,129**

Non-current trade and other receivables are £nil (31st March 2015 - £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.

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.

Note 21.2 Provision for impairment of receivables

	Group		Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
At 1 April as previously stated	**1,220**	223	**1,220**	223
Transfers by absorption	**-**	-	**-**	-
Increase in provision	**207**	1,022	**207**	1,022
Amounts utilised	**-**	(25)	**-**	(25)
Unused amounts reversed	**(543)**	-	**(543)**	-
At 31 March	**884**	1,220	**884**	1,220

Debts with private patient companies over 180 days have been assessed for impairment and where there are pricing or contractual disputes these have been classed as impaired.

Note 21.3 Analysis of impaired receivables

Group	**31 March 2016**		**31 March 2015**	
	Trade receivables	**Other receivables**	**Trade receivables**	**Other receivables**
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	1	-	547	-
30-60 Days	3	-	-	-
60-90 days	12	-	18	-
90- 180 days	137	-	6	-
Over 180 days	732	-	649	-
Total	**885**	**-**	**1,220**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	770	-	696	-
30-60 Days	505	-	173	-
60-90 days	123	-	300	-
90- 180 days	955	-	622	-
Over 180 days	516	-	250	-
Total	**2,869**	**-**	**2,041**	**-**

Trust	31 March 2016		31 March 2015	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	1	-	547	-
30-60 Days	3	-	-	-
60-90 days	12	-	18	-
90- 180 days	137	-	6	-
Over 180 days	732	-	649	-
Total	**885**	**-**	**1,220**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	770	-	696	-
30-60 Days	505	-	173	-
60-90 days	123	-	300	-
90- 180 days	955	-	622	-
Over 180 days	516	-	250	-
Total	**2,869**	**-**	**2,041**	**-**

Note 22 Other assets

The Foundation Trust has no other Financial Assets.

Note 23.1 Non-current assets for sale and assets in disposal groups

	2015/16						2014/15
	Most recently held as:						
Group & Trust	**Intangible assets**	**Property, plant & equipment**	**Investments in associates & joint ventures**	**Investment properties**	**NHS charitable fund assets**	**Total**	**Total**
	£000	£000	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	0	6	0	0	0	6	6
Transfers by absorption	0	0	0	0	0	0	0
Plus assets classified as available for sale in the year	0	46	0	0	0	46	0
Less assets sold in year	0	(15)	0	0	0	(15)	0
Less impairment of assets held for sale	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0
NBV of non-current assets for sale and assets in disposal groups at 31 March	-	37	-	-	-	37	6

Non-current assets held for sale include several items of medical equipment currently being marketed on behalf of the Trust by Avensys Medical Ltd.
All AHFS are held at the lower of their carrying value at the time of transfer, and their estimated realisable value. Depreciation is no longer charged following reclassification to AHFS.
The value of Non-Current Assets Held For Sale at 31st March 2016 is £37k, as below -

Aquarius Haemofiltration machines x 6 - £20k
IE33 Echocardiograph machine x 1 - £6k
Vamos Anaesthetic Gas Monitors x 5 - £6k
Vision Non-Invasive ventilator x 1 - £5k

Note 23.2 Liabilities in disposal groups

The foundation trust has no liabilities in disposal groups

Note 24.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
At 1 April	**13,381**	12,070	**12,333**	10,906
Transfers by absorption	**0**	0	**0**	0
Net change in year	**(5,165)**	1,311	**(4,477)**	1,427
At 31 March	**8,216**	13,381	**7,856**	12,333
Broken down into:				
Cash at commercial banks and in hand	**2**	67	**2**	5
Cash with the Government Banking Service	**8,214**	13,314	**7,854**	12,328
Deposits with the National Loan Fund	**0**	0	**0**	0
Other current investments	**0**	0	**0**	0
Total cash and cash equivalents as in SoFP	**8,216**	13,381	**7,856**	12,333
Bank overdrafts (GBS and commercial banks)	**0**	0	**0**	0
Drawdown in committed facility	**0**	0	**0**	0
Total cash and cash equivalents as in SoCF	**8,216**	13,381	**7,856**	12,333

Note 24.2 Third party assets held by the NHS foundation trust

Liverpool Heart and Chest NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.
The value of cash and cash equivalents held at 31st March 2016 is £356 (31st March 2015 £48)

Note 25.1 Trade and other payables

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Current				
Receipts in advance	-	-	-	-
NHS trade payables	1,985	2,739	1,985	2,739
Amounts due to other related parties	779	727	779	727
Other trade payables	5,343	4,070	5,343	4,070
Capital payables	1,047	2,536	1,047	2,536
Social security costs	609	560	609	560
VAT payable	-	-	-	-
Other taxes payable	681	644	681	644
Other payables	100	92	100	92
Accruals	5,573	5,506	5,573	5,506
PDC dividend payable	-	80	-	80
Trade and other payables held by NHS charitable funds	17	23	-	-
Total current trade and other payables	**16,134**	**16,977**	**16,117**	**16,954**

Non-current trade and other payables are £nil (31st March 2015 - £nil).

Note 25.2 Early retirements in NHS payables above

The foundation trust has no early retirements included in NHS payables

Note 26 Other liabilities

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Current				
Deferred grants income	-	-	-	-
Deferred goods and services income	-	-	-	-
Deferred rent of land income	-	-	-	-
Other deferred income	393	1,380	393	1,380
Deferred PFI credits	-	-	-	-
Lease incentives	-	-	-	-
Other liabilities within NHS charitable funds	-	-	-	-
Total other current liabilities	**393**	**1,380**	**393**	**1,380**
Non-current				
Deferred grants income	-	-	-	-
Deferred goods and services income	-	-	-	-
Deferred rent of land income	-	-	-	-
Other deferred income	608	983	608	983
Deferred PFI credits	-	-	-	-
Lease incentives	-	-	-	-
Other liabilities within NHS charitable funds	-	-	-	-
Net pension scheme liability	-	-	-	-
Total other non-current liabilities	**608**	**983**	**608**	**983**

Note 27 Borrowings

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Current				
Bank overdrafts	-	-	-	-
Drawdown in committed facility	-	-	-	-
Loans from the Department of Health	-	-	-	-
Other loans	-	-	-	-
Obligations under finance leases	142	135	142	135
PFI lifecycle replacement received in advance	-	-	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	-	-	-	-
Other current borrowings within NHS charitable funds	-	-	-	-
Total current borrowings	**142**	**135**	**142**	**135**
Non-current				
Loans from the Department of Health	-	-	-	-
Other loans	-	-	-	-
Obligations under finance leases	261	403	261	403
Obligations under PFI, LIFT or other service concession contracts	-	-	-	-
Other non-current borrowings within NHS charitable funds	-	-	-	-
Total non-current borrowings	**261**	**403**	**261**	**403**

Note 28 Other financial liabilities

The foundation trust has no other financial liabilities

Note 29 Finance leases

Trust as a lessor

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

Trust as a lessee

Obligations under finance leases where Liverpool Heart and Chest NHS Foundation Trust is the lessee.

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Gross lease liabilities	**435**	**598**	**435**	**598**
of which liabilities are due:				
- not later than one year;	162	163	162	163
- later than one year and not later than five years;	273	435	273	435
- later than five years.	-	-	-	-
Finance charges allocated to future periods	(32)	(60)	(32)	(60)
Net lease liabilities	**403**	**538**	**403**	**538**
of which payable:				
- not later than one year;	142	135	142	135
- later than one year and not later than five years;	261	403	261	403
- later than five years.	-	-	-	-
Total of future minimum sublease payments to be received at the SoFP date	**-**	**-**	**-**	**-**
Contingent rent recognised as an expense in the period	-	-	-	-

In 2005/06 the Foundation Trust entered into lease arrangements, for a period of 5 to 7 years, for medical equipment associated with the Site Development. Upon expiry of the original term, the leased equipment was either returned to the lessor, purchased outright within the Capital Programme or was the subject of a new lease agreement. 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 to a good standard and they have to be returned to the lessor in a reasonable condition. This risk is managed by the Foundation Trust, through Insurance cover and Maintenance Contracts.

The difference between the future minimum lease payments and their present value is the interest rate implicit in the lease which is £32k at 31st March 2016.

Note 30.1 Provisions for liabilities and charges analysis

Group and Trust	Pensions - former directors	Pensions - other staff	Other legal claims	Agenda for change	Re-structurings	Continuing care	Equal pay	Redundancy	Other	NHS charitable fund provisions	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2015	-	-	56	-	-	-	-	-	1,241	-	1,297
Change in the discount rate	-	-	-	-	-	-	-	-	(10)	-	(10)
Arising during the year	-	-	-	-	-	-	-	-	1,184	-	1,184
Utilised during the year	-	-	(23)	-	-	-	-	-	(7)	-	(30)
Reversed unused	-	-	(7)	-	-	-	-	-	(1,080)	-	(1,087)
At 31 March 2016	-	-	26	-	-	-	-	-	1,328	-	1,354
Expected timing of cash flows:											
- not later than one year;	-	-	26	-	-	-	-	-	1,247	-	1,273
- later than one year and not later than five years;	-	-	-	-	-	-	-	-	27	-	27
- later than five years.	-	-	-	-	-	-	-	-	54	-	54
Total	-	-	26	-	-	-	-	-	1,328	-	1,354

The foundation trust has total provisions as at 31st March 2016 of £1,354k . Other provisions of £1,328k includes £122k provision for out of date stock; £338k for undercharge against lease of land; £314k potential repayment of funding; potential unfair dismissal costs £124k; potential employee claims under agenda for change £272; Legal advice provision £14k

Note 30.2 Clinical negligence liabilities

At 31 March 2016, £2,007k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Liverpool Heart and Chest NHS Foundation Trust (31 March 2015: £2,063k).

Note 31 Contingent assets and liabilities

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Value of contingent liabilities				
NHS Litigation Authority legal claims	(12)	(21)	(12)	(21)
Employment tribunal and other employee related litigation	-	-	-	-
Redundancy	-	-	-	-
Other	-	-	-	-
Gross value of contingent liabilities	**(12)**	**(21)**	**(12)**	**(21)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(12)**	**(21)**	**(12)**	**(21)**
Net value of contingent assets	**-**	**-**	**-**	**-**

Note 32 Contractual capital commitments

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	1,149	1,428	1,149	1,428
Intangible assets	-	-	-	-
Total	**1,149**	**1,428**	**1,149**	**1,428**

Note 33 Financial instruments

Note 33.1 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 2016 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.

Note 33.2 Financial assets

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	5,933	-	-	-	5,933
Other investments	18	-	-	-	18
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	7,856	-	-	-	7,856
Financial assets held in NHS charitable funds	406	527	-	-	933
Total at 31 March 2016	14,213	527	-	-	14,740

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	4,662	-	-	-	4,662
Other investments	24	-	-	-	24
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	12,333	-	-	-	12,333
Financial assets held in NHS charitable funds	1,101	550	-	-	1,651
Total at 31 March 2015	18,120	550	-	-	18,670

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives		-	-	-	-
Trade and other receivables excluding non financial assets	5,933	-	-	-	5,933
Other investments	18	-	-	-	18
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	7,856	-	-	-	7,856
Total at 31 March 2016	13,807	-	-	-	13,807

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Embedded derivatives		-	-	-	-
Trade and other receivables excluding non financial assets	4,662	-	-	-	4,662
Other investments	24	-	-	-	24
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	12,333	-	-	-	12,333
Total at 31 March 2015	17,019	-	-	-	17,019

Note 33.3 Financial liabilities

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	-	-	-
Obligations under finance leases	403	-	403
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non financial liabilities	13,870	-	13,870
Other financial liabilities	-	-	-
Provisions under contract	1,354	-	1,354
Financial liabilities held in NHS charitable funds	17	-	17
Total at 31 March 2016	15,644	-	15,644

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	-	-	-
Obligations under finance leases	538	-	538
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non financial liabilities	14,766	-	14,766
Other financial liabilities	-	-	-
Provisions under contract	1,297	-	1,297
Financial liabilities held in NHS charitable funds	23	-	23
Total at 31 March 2015	16,624	-	16,624

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	-	-	-
Obligations under finance leases	403	-	403
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non financial liabilities	13,870	-	13,870
Other financial liabilities	-	-	-
Provisions under contract	1,354	-	1,354
Total at 31 March 2016	15,627	-	15,627

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	-	-	-
Obligations under finance leases	538	-	538
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non financial liabilities	14,766	-	14,766
Other financial liabilities	-	-	-
Provisions under contract	1,297	-	1,297
Total at 31 March 2015	16,601	-	16,601

Note 33.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
In one year or less	15,302	16,124	15,285	16,101
In more than one year but not more than two years	153	148	153	148
In more than two years but not more than five years	135	282	135	282
In more than five years	54	70	54	70
Total	15,644	16,624	15,627	16,601

Note 33.5 Fair values of financial assets at 31 March 2016

	Group		Trust	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Non-current trade and other receivables excluding non financial assets	-	-	-	-
Other investments	18	18	18	18
Other	-	-	-	-
Non-current financial assets held in NHS charitable funds	527	527	-	-
Total	545	545	18	18

Note 33.6 Fair values of financial liabilities at 31 March 2016

	Group		Trust	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Non-current trade and other payables excluding non financial liabilities	-	-	-	-
Provisions under contract	81	81	81	81
Loans	-	-	-	-
Other	261	261	261	261
Non-current financial liabilities held in NHS charitable funds	-	-	-	-
Total	342	342	342	342

Note 34 Losses and special payments

	2015/16		2014/15	
Group and Trust	**Total number of cases Number**	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Cash losses	-	-	2	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	-	-	-	-
Total losses	**-**	**-**	**2**	**-**
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	-	-	-	-
Special severence payments	-	-	-	-
Ex-gratia payments	13	43	45	47
Total special payments	**13**	**43**	**45**	**47**
Total losses and special payments	**13**	**43**	**47**	**47**
Compensation payments received		-		-

Note 35 Prior period adjustments

There have been no prior period adjustments during the reporting period.

Note 36 Events after the reporting date

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

Note 37 Related parties

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 2016 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 Health Services NHS Foundation Trust (formerly Bridgewater Community HealthCare NHS Trust). The income from this Trust totals £14k for the year ended 31st March 2016. 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 number of significant transactions with the Department, and with other entities for which the Department is regarded as the parent Department. Where the value of these transactions is considered significant (where revenue, expenditure, receivables or payables is greater than £100k), these entities are listed below:

	Receivables		Payables	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Northumbria Healthcare NHS Foundation Trust	-	-	134	62
Warrington and Halton Hospitals NHS Foundation Trust	80	200	25	7
Wirral University Teaching Hospital NHS Foundation Trust	103	64	23	5
Mersey Care NHS Trust	1	12	162	82
Royal Liverpool and Broadgreen University Hospitals NHS Trust	1,906	1,188	1,619	2,356
St Helens and Knowsley Hospitals NHS Trust	69	76	155	-
University Hospitals of North Midlands NHS Trust	-	-	250	9
NHS Knowsley CCG	118	94	70	70
NHS Liverpool CCG	661	255	-	-
NHS Southport and Formby CCG	123	-	-	-
NHS St Helens CCG	138	4	-	-
NHS Warrington CCG	-	13	117	-
NHS West Lancashire CCG	-	3	195	-
NHS England - Cheshire and Merseyside Local Office	109	-	16	-
NHS England - Cheshire, Warrington & Wirral and Merseyside Area Team	-	763	-	-
Total	**3,308**	**2,672**	**2,766**	**2,591**

	Income		Expenditure	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Aintree University Hospital NHS Foundation Trust	41	27	216	135
University Hospital of South Manchester NHS Foundation Trust	1	0	217	0
Warrington and Halton Hospitals NHS Foundation Trust	332	364	41	8
Liverpool Community Health NHS Trust	224	220	14	0
Mersey Care NHS Trust	2	34	682	567
Royal Liverpool and Broadgreen University Hospitals NHS Trust	1,982	1,972	5,198	5,121
Southport and Ormskirk Hospital NHS Trust	99	144	4	7
St Helens and Knowsley Hospitals NHS Trust	165	109	149	55
University Hospitals of North Midlands NHS Trust	0	0	242	0
NHS Halton CCG	633	633	0	0
NHS Knowsley CCG	5,319	5,354	70	70
NHS Liverpool CCG	6,646	5,744	0	0
NHS South Sefton CCG	799	766	0	0
NHS Southport and Formby CCG	1,505	1,377	0	0
NHS St Helens CCG	1,007	882	0	0
NHS Warrington CCG	833	949	0	0
NHS West Cheshire CCG	1,106	1,133	0	0
NHS West Lancashire CCG	949	1,144	0	0

NHS Wirral CCG	1,340	1,485	0	0
Health Education England	2,782	2,597	0	0
NHS Litigation Authority	35	0	814	465
NHS England - Cheshire and Merseyside Local Office	324	0	0	0
NHS England - Cheshire, Warrington & Wirral and Merseyside Area Team	0	68,774	0	547
NHS England - North West Commisssioning Hub	72,963	0	0	0
	99,087	93,708	7,647	6,975

In addition, The Foundation Trust has had a number of significant transactions with other Government Departments and other Central and Local Government bodies. These entities are listed below:

	Receivables		Payables	
	2016	2015	2016	2015
	£000	£000	£000	£000
HM Revenue & Customs - VAT	245	353	-	-
HM Revenue & Customs - Other taxes and duties and NI contributions	-	0	1,290	1,204
NHS Pension Scheme	-	0	779	727
Welsh Health Bodies - Betsi Cadwaladr University Local Health Board	173	42	245	-
Total	**418**	**395**	**2,314**	**1,931**

	Income		Expenditure	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Liverpool City Council	-	-	93	413
HM Revenue & Customs - Other taxes and duties and NI contributions	-	-	4,061	3,819
NHS Pension Scheme	-	-	5,505	5,155
Welsh Health Bodies	14,988	14,228	-	-
Scottish Government	49	113	-	-
Total	15,037	14,341	9,659	9,387

Total

Note 38 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.

Summary Statement of Financial Activities	31st March 2016			31st March 2015		
	Amounts in Charity Accounts	Intra-Group eliminations	Amounts consolidated in Group Accounts	Amounts in Charity Accounts	Intra-Group eliminations	Amounts consolidated in Group Accounts
	£000	£000	£000	£000	£000	£000
Incoming resources:						
charitable activities	521	0	521	521	0	521
Resources expended:						
Employee resources expended with the Foundation Trust	(136)	136	0	(95)	95	0
Other resources expended with the Foundation Trust	(299)	299	0	(871)	871	0
Other resources expended external to the Foundation Trust	(326)	0	(326)	(216)	0	(216)
Total operating expenditure	(761)	435	(326)	(1,182)	966	(216)
Investment income and income on short term deposits	23	0	23	23	0	23
Net (outgoing) / incoming resources before other recognised gains and losses	(217)	435	218	(638)	966	328
Gains/(losses) on investment assets	(23)	0	(23)	48	0	48
Net movement in funds	(240)	435	195	(590)	966	376

Summary Balance Sheet	31st March 2016			31st March 2015		
	Amounts in Charity Accounts	Intra-Group eliminations	Amounts consolidated in Group Accounts	Amounts in Charity Accounts	Intra-Group eliminations	Amounts consolidated in Group Accounts
	£000	£000	£000	£000	£000	£000
Non-current assets						
Other investments	527	0	527	550	0	550
Total non-current assets	527	0	527	550	0	550
Current assets						
Inventories	0	0	0	1	0	1
Trade and other receivables	46	0	46	53	0	53
Cash and cash equivalents	360	0	360	1,048	0	1,048
Total current assets	406	0	406	1,102	0	1,102
Current liabilities						
Trade and other payables	(235)	218	(17)	(714)	691	(23)
Total current liabilities	(235)	218	(17)	(714)	691	(23)
Total non-current liabilities	0	0	0	0	0	0
Net Assets	698	218	916	938	691	1,629
Funds of the Charity*						
Unrestricted income funds**	698			938		
Total Charitable Funds	698			938		

*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.

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

Summarisation schedules numbers FTC01 to FTC40 and accompanying WGA sheets for ***2015/16*** 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 Annual Reporting Manual* ***2015/16*** 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
26th May *2016*

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
26th May *2016*

Grant Thornton

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated FTC1 to FTC38 (excluding FTC0, FTC8a and FTC8b) of Liverpool Heart and Chest Hospital NHS Foundation Trust for the year ended 31 March 2016, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the 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 and paragraph 4.2 of the Code of Audit Practice. Our work has been undertaken so that we might state to the Board of Directors those matters we are required to state to them in a consistency statement 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 and the Trust's Board of Directors as a body, for our audit work, for this statement, or for the opinions we have formed.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the audited financial statements which are also published in the consolidation schedules. Auditors are required to report on any differences over £250,000 between the audited financial statements and the consolidation schedules.

Unqualified audit opinion on the audited financial statements; no differences identified:

In our opinion the figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Grant Thornton UK LLP

Grant Thornton UK LLP

Liverpool
26 May 2016

Grant Thornton

Independent Practitioner's Limited Assurance Report to the Council of Governors of Liverpool Heart and Chest Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Liverpool Heart and Chest Hospital NHS Foundation Trust to perform an independent limited assurance engagement in respect of Liverpool Heart and Chest Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein against the criteria set out in Annex 2 to Chapter 7 of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' (the 'Criteria').

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to the limited assurance engagement consist of those national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the Council of Governors and Practitioner
The Council of Governors are responsible for the content and the preparation of the Quality Report covering the relevant indicators and in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2015/16' issued by Monitor and 'Detailed guidance for external assurance on quality reports 2015/16'.

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;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16'; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16, 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 1 April 2015 to 26 May 2016;
- Papers relating to quality reported to the Board over the period 1 April 2015 to 26 May 2016;
- Feedback from Commissioners dated18/4/2016;
- Feedback from Governors dated 18/4/2016;
- Feedback from local Healthwatch organisations dated 20/05/ 2016;
- Feedback from Overview and Scrutiny Committee – (not received)
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5 May 2016;
- The national patient survey dated 9/04/2015;
- The national staff survey dated 12/2/2016; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 05/04/ 2016.

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.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Ethics for Professional Accountants issued by the International Ethics Standards Board for Accountants, which is founded on the fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. 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 Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Liverpool Heart and Chest Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, 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 Hospital NHS Foundation Trust for our work or this report, except 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;
- analytical procedures;

- 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 2015/16' to the categories reported in the Quality Report; and
- reading the documents.

The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement and consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

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 affect 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 2015/16'.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Liverpool Heart and Chest Hospital NHS Foundation Trust.

Our audit work on the financial statements of Liverpool Heart and Chest Hospital NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Liverpool Heart and Chest Hospital NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Liverpool Heart and Chest Hospital NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006.

Our audit work is undertaken so that we might state to Liverpool Heart and Chest Hospital NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Liverpool Heart and Chest Hospital NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Liverpool Heart and Chest Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion
Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the Criteria;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16'; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Liverpool
26 May 2016

Grant Thornton

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

Our opinion on the financial statements is unmodified

In our opinion the financial statements of Liverpool Heart and Chest Hospital NHS Foundation Trust (the Trust):

- give a true and fair view of the state of the financial position of the Trust's affairs as at 31 March 2016 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with applicable law, the NHS Foundation Trust Annual Reporting Manual and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Who we are reporting to

This report is made solely to the Council of Governors of the 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 Council of Governors 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 and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Liverpool Heart and Chest Hospital NHS Foundation Trust for the year ended 31 March 2016 which comprise the consolidated statement of comprehensive income, the statements of financial position, the statement of cash flows, the statement of changes in equity and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and the NHS Foundation Trust Annual Reporting Manual (ARM) and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Overview of our audit approach

- Overall materiality: £2.5 million, which represents 2% of the Trust's gross operating costs 15/16;
- Key audit risks were identified as:
    - Occurrence and existence of healthcare income
    - Valuation of property, plant and equipment
    - Completeness of Expenditure on goods and services and
    - Completeness of employee remuneration

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit:

Audit risk	How we responded to the risk
Occurrence and existence of Healthcare and non-healthcare income Over 93% of the Trust's income is from contracts with NHS commissioners of healthcare services, with the remaining 7% arising from the provision of non-healthcare services. Income is recognised when the service has been performed. At the year-end income is accrued for services that have been performed but for which an invoice has not been issued. We therefore identified the occurrence and existence of healthcare and non-healthcare revenue as a significant risk requiring special audit consideration.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policies for revenue recognition of healthcare income for appropriateness and consistency with the prior year; • gaining an understanding of the Trust's system for accounting for health care income and the associated controls; • using the agreement of balances exercise which verifies the expenditure and receivables accounted for by the Trust with those recognised by other NHS bodies. This is provided by MONITOR to identify any significant differences in income and debtor balances with contracting bodies; • agreeing, on a sample basis, amounts recognised in income in the financial statements to signed contracts: and agreeing, on a sample basis, additional income to contract variations • agreeing, on a sample basis, non-contractual income adjustments to supporting documentation. The group's accounting policy on income recognition is shown in note 1.2 to the financial statements and related disclosures are included in note 3.
Valuation of property, plant and equipment The valuation of property, plant and equipment requires significant judgements and estimation and also represents 89% of the total asset value on the Trust's balance sheet. We therefore identified the valuation of property, plant and equipment as a significant risk requiring special audit attention.	Our audit work included, but was not restricted to: • obtaining management's assessment of the valuation of property, plant and equipment and understanding the valuation process including key controls and significant assumptions; • reviewing the reasonableness of any assumptions made by management in relation to o the valuation of property, plant and equipment, o the useful lives of property, plant and equipment; and o the amount of depreciation charged in the year. • review instructions to and competence of management's valuation experts and the scope of their work • test a sample of revaluations during the year to ensure they are correctly recorded in the asset register

Audit risk	How we responded to the risk
	The Trust's accounting policy on property, plant and equipment is shown in note 1.5 to the financial statements and related disclosures are included in notes 15 and 16.
Completeness of expenditure on goods and services Expenditure on goods and services represent 49% of the Trust's total expenditure. Management uses judgement to estimate accruals of expenditure for amounts un-invoiced at the year end. We therefore identified completeness of expenditure on goods and services as a risk requiring particular audit attention.	Our audit work included, but was not restricted to: • gaining an understanding of the systems used to recognise non-pay expenditure and year-end accruals, and the associated controls; • testing, on a sample basis, post year-end payments to confirm the completeness of accruals; • reviewing the reasonableness of accruals and provisions in the financial statements for completeness in reference to our understanding of the Trust from making enquiries of management and review of minutes. The Trust's accounting policy on expenditure on goods and services is shown in note 1.4 o the financial statements and related disclosures are included in note 5.1.
Completeness of employee remuneration Expenditure on employee remuneration represents the largest single area of expense for the Trust, at 51% of total expenditure. The Trust accrues at year end using estimates for employee related services. We therefore identified completeness of employee benefits as a risk requiring particular audit attention.	Our work included, but was not restricted to: • gaining an understanding of the systems used to recognise payroll expenditure and accruals, and the associated controls; • testing the reconciliation of employee remuneration expenditure in the financial statements to the general ledger and payroll systems; • performing a trend analysis of payroll costs and investigating unusual variations; and • review of post year end payments for cut off The Trust's accounting policy on employee benefits is shown in note 1.3 to the financial statements and related disclosures are included in note 7.

Our application of materiality and an overview of the scope of our audit

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the judgements of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

We determined materiality for the audit of the Trust's financial statements as a whole to be £2.33 million, which is 2% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the Trust's financial statements to be most interested in how it has expended its revenue and other funding.

The materiality benchmark percentage of 2% of Gross Revenue Expenditure for the current year is the same as in previous for the year ended 31 March 2015. We have not identified any additional audit risks as part of our of our interim visit or during the final audit. We have not identified any significant changes to the business risks, the control environment, key personnel or relevant financial systems.

We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality for the audit of the Trust's financial statements.

We also determined a lower level of specific materiality for certain areas such as cash and cash equivalents, senior managers salaries and allowances, auditors' remuneration and related party transactions.

We determined the threshold at which we would communicate misstatements to the Audit Committee to be £0.117 million and above.

Overview of the scope of our audit

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 Chief Executive as Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or 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.

We conducted our audit in accordance with ISAs (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based, and in particular included an interim visit to evaluate the Trust's internal control environment including its IT systems and controls over key financial systems.

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified

In our opinion:

- the part of the Directors' Remuneration Report subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual;
- the part of the Staff Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and
- the information given in the Strategic Report and Directors' Report for the financial year for which the financial statements are prepared is consistent with the Trust's financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that were communicated to the Audit Committee which we consider should have been disclosed.

Under the Code of Audit Practice we are required 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 ARM or is misleading or inconsistent with the information of which we are aware from our audit; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the above matters.

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:
As explained more fully in the Chief Executive's Responsibilities Statement, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Direction issued by Monitor and for being satisfied that they give a true and fair view.

What we are responsible for:
Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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 Code of Audit Practice issued by the Comptroller and Auditor General.

Jackie Bellard

Jackie Bellard
Director
For and on behalf of Grant Thornton UK LLP
4 Hardman Square, Spinningfields, Manchester, M3 3EB
25 May 2016