NHS
The Royal Liverpool and Broadgreen University Hospitals
NHS Trust

Annual Report
2017 - 2018

Where we all make a difference

Contents


Student
Physiotherapist

Feedback sheet

Please take a few minutes to tell us what you think about our services. Patient feedback is very important to us – it helps us make improvements to our services and the way people experience our care and our hospitals. We would be grateful if you would take a few minutes to fill in this questionnaire about your last visit to one of our hospitals.

Details about how to return it to us are available over the page.

1. When was the last time you visited one of our hospitals?

In the last month	☐	In the last three months	☐	In the last six months	☐
In the last year	☐	More than a year ago	☐		

2. Which hospital did you visit?

Royal Liverpool University Hospital	☐	Broadgreen Hospital	☐
Liverpool University Dental Hospital	☐		

3. Were you:

An outpatient (attending an outpatient appointment or diagnostic test e.g. x-ray)	☐	A day case patient (not staying overnight)	☐
An inpatient (staying overnight)	☐	A visitor	☐
Accompanying a patient to an appointment	☐	Other	☐

4. Overall, how would you rate the care and attention that you received?

Excellent	☐	Good	☐
Fair	☐	Poor	☐
Very poor	☐		

5. Were you given enough privacy when discussing your condition with staff?

Yes	☐	Not sure	☐	No	☐

6. Were you involved as much as you wanted to be in decisions about your care and treatment?

Yes	☐	No	☐

7. If no, how could you have been more involved in decisions about your care?

8. Did you have confidence in the staff looking after you?

Yes ☐ No ☐

9. Overall, did you feel you were treated with respect and dignity when you visited our hospitals?

Yes, always ☐ Yes, sometimes ☐ No ☐

10. Please tell us why you feel this way

11. How friendly and approachable did you find our staff during your visit?

Excellent ☐ Good ☐ Fair ☐

Poor ☐ Very poor ☐

12. Were staff quick to respond to the needs of you or your family/friends?

Yes ☐ No ☐

13. How would you rate the cleanliness of the hospital during your visit?

Excellent ☐ Good ☐ Fair ☐

Poor ☐ Very poor ☐

14. Did you see the staff you came into contact with wash their hands and/or use antiseptic hand gel?

Yes ☐ No ☐ Not applicable ☐

15. How well did staff meet your individual needs (e.g. assistance with mobility)?

Excellent ☐ Good ☐ Fair ☐

Poor ☐ Very poor ☐

16. How would you rate the quality of your last visit to our hospitals?

Excellent ☐ Good ☐ Fair ☐

Poor ☐ Very poor ☐

17. What would have improved your visit? (Tick more than one box if applicable).

Better signposting to help you find your way around ☐ Improved accessibility ☐

More facilities (e.g. coffee bars, rest areas etc) ☐ Shorter waiting times ☐

Better information (please tell us what type of information would have improved your experience in the box below)

18. Would you recommend this hospital to a relative / friend?

Yes ☐ No ☐

19. Would you be happy to return to this hospital for treatment?

Yes ☐ No ☐

20. Do you have any other comments you would like to make about your visit to our hospitals?

21. What do you think about this annual report?

We would like to know what you think about the subjects covered, the layout, design and the way it is written. We'd also like to know if there's anything you would like to see in next year's report. Please use the box below to tell us what you think.

Thank you for taking the time to complete this survey

Please return it to us by posting it to our freepost address (see below).

Freepost RRXJ-STLG-ELKY

Communications and Marketing Department
Royal Liverpool University Hospital
Prescot Street
Liverpool
L7 8XP


Dimensions
HOLOGIC
NHS

Our performance report

Where we all make a difference

Overview

Chief executive's summary

Aidan Kehoe,
Chief executive

It has been a challenging year and I am proud of the way staff across the Trust have risen to meet the many challenges we have faced. Their hard work, their dedication to providing the best possible patient care, their commitment to innovation and willingness to try new ways of working, has been immense and I want to thank them.

The NHS as a whole has been under significant pressure throughout the year and we all faced an extremely challenging winter. We continue to see increasing numbers of patients who have complex health problems. Over the last six years the numbers of patients in our emergency department aged 75 or older has increased by nearly 22%. These patients often require high levels of care both inside our hospitals and in the community when they are ready to leave hospital.

In addition, like other trusts, we are working in a very difficult financial climate where our running costs are higher than the income we receive to provide our services. We also faced the challenge of a global cyber attack that affected some NHS IT systems. Thankfully the Trust's IT infrastructure wasn't attacked, but our staff had to take urgent protective measures to ensure our systems remained secure and patient care was not affected.

Throughout these and the many more challenges we faced, our staff have shown great professionalism, dedication and compassion. Their desire to provide the best possible service is reflected in the number of comments and feedback from our patients and their families, praising staff for their hard work. Our staff have made a number of improvements within our hospitals and working with our partners across the North Mersey A&E Delivery Board to improve timely access to care whether in the community or in hospitals. The Trust has invested £1m on ward 11 at Broadgreen Hospital to be remodelled to support patients who are waiting to be discharged. We have adapted our emergency department to establish a clinical decisions unit for patients who are waiting for diagnostic tests, rather than admitting them to a hospital ward only to discharge them shortly after. Working with our partners in social and community care and other local hospitals in North Mersey, we've helped to create the Integrated Community Reablement and Assessment Service (ICRAS). By integrating and standardising pathways across Liverpool, Sefton and Knowsley, we are transferring patients more smoothly and swiftly. This is also increasing access to care aimed at avoiding the need for patients to go into hospital.

These measures and others have certainly helped to provide better access to urgent and emergency care this year. Despite one of the most challenging winters in memory, the percentage of patients seen in our emergency department in four hours or less was higher from November to March than the same months the previous winter.

However, the main issue remains transferring patients once they are fit enough to leave hospital. The numbers of patients who are ready for discharge or whose transfer or care has been delayed has increased this year and we are also seeing an increase in patients staying in hospital for longer periods. Throughout the year we have held regular meetings with senior colleagues in social and community care to address issues relating to the discharge of specific patients. We all share the same aims – to ensure that local people are provided with the best care and we will continue to work with our partners on system wide solutions to the issue of delays.

To help us fulfil these aspirations is our Global Digital Exemplar (GDE) programme. The GDE programme aims to create health systems across Liverpool to provide clinicians and patients with easier access to health information. In November 2017 we were awarded 'Best Global Digital Exemplar' by the e-Health Insider Awards in recognition of our progress so far. Our work includes introducing bedside e-observations, which have helped reduce cardiac arrests in our hospitals by 46% through early identification and intervention. In addition, we've developed our e-sepsis programme – a life-saving project that has increased the number of patients with early signs of sepsis getting antibiotics within one hour. E-sepsis has been recognised by the Secretary of State for Health and Social Care, as providing the blueprint for the rest of the NHS on treating sepsis.

The Trust has been named as part of a collaborative project to bring 5G broadband connectivity to socially and economically deprived parts of the city. The Liverpool 5G consortium, which includes Liverpool City Council, the

University of Liverpool, Liverpool John Moores University and Sensor City, will employ cutting edge technologies to improve patient monitoring and support, and communication between hospitals and the community. This project was one of six in the country to pilot the use of 5G technology and was awarded £3.5m by the Department for Digital, Culture, Media and Sports.

We are also proud to be involved in a number of pioneering clinical research studies that are putting Liverpool at the forefront of global life sciences. A collaborative project led by the University of Liverpool has been awarded £4.7m to develop a Zika virus vaccine and will involve first-in-human studies in our Clinical Research Unit.

Cancer Research UK has also awarded £1.5m for a University of Liverpool led study to help develop new treatments for pancreatic cancer. This six year programme will analyse tissue and blood samples from pancreatic cancer patients being treated at the Royal Liverpool and Aintree hospitals. Our researchers are also working on the HIV Pre-exposure Prophylaxis (PrEP) Impact study for Public Health England which aims to reduce the risk of acquiring HIV.

Another ground-breaking project that our staff worked on collaboratively with Warrington Hospital, the University of Liverpool and the Countess of Chester Hospital, has made anti-coagulation medication personalised to each patient by using their genotype to improve its effectiveness. This study won a Healthcare Pioneers award.

Marking a pivotal moment in the development of the Liverpool Health Campus, the Liverpool Life Sciences Accelerator was officially opened by Professor Sir Christopher Evans OBE, in March. This £25m joint project between the Trust and the Liverpool School of Tropical Medicine (LSTM) is a hi-tech business incubator and life science research facility and is the first building of the Health Campus to open. Our vision for the Health Campus is to have a mixture of leading hospitals, including the new Clatterbridge Cancer Centre, universities, the Liverpool School of Tropical Medicine, businesses and research all in one area, at the heart of the Knowledge Quarter of Liverpool. Nearby, the £1bn Paddington Village development will provide 1.8m square feet of land earmarked for science, technology, health and educational space. This exciting development will be home to the northern headquarters of the Royal College of Physicians in a purpose-built facility, due to open in 2020 as well as the Rutherford Cancer Centre North West, a £35m cancer centre which will offer life-saving proton beam therapy. With all this, Liverpool will provide one of the world's leading hubs for health and life sciences.

The liquidation of Carillion in January 2018, has meant that we will not be moving into the new Royal in summer 2018 as outlined in last year's Annual Report. Whilst this is hugely disappointing, we have been using the time to be as prepared as possible to ensure a safe and efficient move into the new Royal and we are looking forward to working in our world class new hospital.

We are continuing our work with Aintree University Hospital NHS Foundation Trust to achieve the proposed merger of the two trusts. Clinicians at both trusts are convinced they can deliver better clinical outcomes as one organisation. This would also make Liverpool an even more attractive prospect for research funding, helping to ensure that our patients have access to leading technologies and care.

We continue work on completing the business case and meet regularly with NHS Improvement to drive this forward. Clinical and non-clinical teams across the two organisations are continuing to work together on planning the integration of their services. The most advanced of these are the Trauma and Orthopaedic services, where the public consultation process has been completed and the business plan for the integration is expected to be completed by summer 2018.

In addition to meeting the numerous challenges this year, we have managed to make significant progress on a number of pivotal projects that will transform the health and wellbeing of future generations. None of this would have happened without staff across the Trust going the extra mile. We should all be extremely proud of what they have achieved.

Aidan Kehoe, chief executive

About us

Our Trust, which was established in 1995, manages three hospitals based on two sites: the Royal Liverpool University Hospital, Liverpool University Dental Hospital and Broadgreen Hospital. We are the major adult university teaching hospitals trust for Merseyside and Cheshire and our hospitals have often been at the forefront of medical breakthroughs.

We provide general hospital services to the adult population of Liverpool with one of the busiest emergency departments in the North West, where we provide care and treatment for patients who have life threatening injuries and serious illnesses such as strokes and heart attacks. We also provide care for patients with more routine illnesses and injuries, such as fractures.

We also provide a comprehensive range of specialist services to 750,000 people each year within a total catchment population of more than two million people in Merseyside, Cheshire, North Wales, the Isle of Man and beyond. In the past year, we provided emergency and urgent care for over 245,000 people, over 92,000 of whom were in our emergency department. We cared for over 114,000 day case and inpatients and provided over 600,000 outpatient appointments.

We are a major centre for the diagnosis, treatment, care and research of cancer. We provide a range of cancer services from our renowned Linda McCartney Centre. We are a regional cancer centre for pancreatic, urological, ocular (eye), testicular, anal, and oesophago-gastric cancers, specialist palliative care, specialist radiology and specialist pathology and chemotherapy cancer treatment services. We are a national centre for ocular oncology We also have excellent local cancer treatment services, including skin, breast and colorectal, head, neck and thyroid and lung cancer. We host a Macmillan Cancer Information and Support Service, with centres on both of our sites.

The Liverpool University Dental Hospital supports dental teaching and provides specialist dental services and emergency care for the local community.

As one of the largest employers in the city, we employ around 7,600 people and also provide services through outsourcing arrangements. Our annual budget is over £530 million.

Global Digital Exemplar

In September 2016, the Trust was named by the Department of Health as one of the first, 'Global Digital Exemplar' organisations. This means we are now working towards becoming internationally recognised for our use of digital technology and information in the way we provide care.

The aim of the Global Digital Exemplar (GDE) programme is to join up and digitise health systems to give clinicians more timely access to accurate information, patients better access to their records and support improvements between now and May 2020. As a GDE, the Trust will receive up to £10m of national funding to invest into technology and infrastructure to enhance staff training and digital technology.

The Trust has made a number of significant developments in digital technology over recent years. These include progress to ensure patient records are digitised, the work towards a joint electronic patient record with other partner trusts and our whiteboard system that was highlighted as outstanding in our 2016 Care Quality Commission report. This system provides staff with information to highlight which beds have been allocated to individual patients, what assessments have been completed, including Sepsis alerting and to also identify any vulnerable patients whilst they are in our care.

The Trust has begun to implement the GDE programme with projects such as:

- Enhancing electronic observations by using sensor technology to improve the way we monitor patients and reduce length of stay.
- Improved digital signage in the new Royal to enhance patient experience and access to information.
- Delivering an integrated electronic patient record across three local hospitals so that vital information can be shared wherever a patient is being treated. The Liverpool Electronic Patient Record system will allow patient information to be shared digitally between the Royal Liverpool, Broadgreen and Aintree and Liverpool Women's hospitals, ensuring wherever you are treated medical teams will have your information available.

Research and development

Our Trust has significant relationships with all the universities in Liverpool, but in particular the University of Liverpool's medical and clinical schools and Liverpool John Moores University, with regard to the training of nurses.

As well as being the host organisation for the North West Coast Comprehensive Research Network, we are also a centre for clinical research and lead teaching and training for a variety of health professions.

We have a dedicated Clinical Research Unit that is accredited by the Medicines and Healthcare products Regulatory Agency (MHRA) to perform first in human clinical trials. In collaboration with the University of Liverpool, we also have the only National Institute for Health Research (NIHR) funded Biomedical Research Unit in the UK, which is dedicated to research into pancreatic disease.

Our future

The Trust's long-term plan is for the Royal Liverpool University Hospital site to focus on emergency and complex care and Broadgreen Hospital site on non-emergency care, including specialist services for older people, elective surgical care and dermatology plus a range of outpatient services.

Three of the key developments within Liverpool's Knowledge Quarter are based on the Royal Liverpool University Hospital site. The aim here is to create a world leading hub for research and development in the city, creating thousands of jobs in the process

As part of this, we are building a new Royal Liverpool University Hospital on the same site as the existing Royal and Dental hospitals. A new Clatterbridge Cancer Centre is also being built alongside the new Royal. In March 2018 the Liverpool Life Sciences Accelerator, a collaboration between the Royal Liverpool and Broadgreen University Hospital Trust and Liverpool School of Tropical Medicine officially opened. The Accelerator brings together a range life science companies which support our research and development agenda and will allow our patients access to the latest healthcare innovations.

We are working together with Aintree University Hospital NHS Foundation Trust and with NHS Improvement, to achieve a proposed merger of the two trusts. Clinicians at both trusts believe that by working as one organisation, they can deliver better clinical outcomes for patients. A combined organisation would also make Liverpool an even more attractive prospect for research funding, helping to ensure that our patients have access to the latest technologies.

> Just felt the need to write this about the nursing staff on ward 3C in the Royal. I've had to attend on four different occasions and each time met by their friendly smiling faces who made me feel in safe hands every single time. They're the nicest, kindest nurses I've ever had the pleasure to meet.

How we manage our hospitals

The overall day-to-day management of all three of our hospitals and services is the responsibility of the team of executive directors, under the leadership of the chief executive and supported directly by other senior managers in various departments.

Following a major review of how we manage our clinical services we established a new department structure. This has meant combining some of our departments into care groups based on closely linked patient pathways. These clinically led care groups are managed as a triumvirate between the clinical director, general manager and matron. These in turn are managed by the Director of Operations who reports to the Chief Operating Officer.

In addition to these care groups we have a range of corporate services, which include communications, estates, finance, governance, human resources, information, organisational development, quality, new Royal redevelopment, research, development and innovation and service excellence and improvement.

We operate a board committee structure to ensure that we are well governed, managed effectively and scrutinised appropriately. The board of directors is responsible for the running of the Trust. Key committees include finance and performance, audit and assurance, quality governance and new hospital. We continually refine our governance arrangements, ensuring that they are suitable for the effective running of our hospitals. A formal escalation framework is in operation to ensure that key issues and concerns are escalated through the committee structure for board attention where appropriate.

> I recently took ill at Liverpool Airport. I would like you to thank all the people involved in my treatment. From the paramedics in the ambulance, to the staff in A&E especially Dr Mohammad and all his staff on AMU. Their professional care and treatment was first class.

Our strategic objectives

Our vision, values and objectives reflect our approach to providing excellent care for our patients, improving health for our population and investing in our staff.

Our vision

Delivering the highest quality of healthcare driven by world class research for the health and wellbeing of the population

Our values

Patient centred

Professional

Open and engaged

Collaborative

Creative

Our strategic themes for 2013-18

- To deliver an exceptional patient experience, making the Trust one of the most sought after places to be treated anywhere in the world
- To improve the quality of life for our patients by providing excellent, safe and accessible healthcare, which puts patient's wellbeing at the heart of all we do
- To develop a world-class workforce, recognised for its skills and level of engagement and founded on a culture of achievement, education, training and development
- To achieve international recognition for our research and innovation, bringing new therapies from the bench to the bedside
- To play a lead role in the development of a sustainable health system for the communities we serve

Corporate objectives for 2017-18

Our corporate objectives for this year are:

- Prepare a safe and successful move into the new hospital
- Deliver Quality, Efficiency and Productivity initiatives (QEPs) required to improve patient care, deliver best value and the financial plan
- Optimise patient flow to deliver safe, caring, responsive and effective care for all patients
- Deliver changes across the NHS that improve services for patients and attract further investment into research in Liverpool
- Continue to develop our workforce and ensure our staff feel motivated and empowered
- Deliver excellent digital services to enhance patient care

Risks to delivering our objectives

Like any organisation there are risks to the Trust's ability to deliver its objectives and ensuring patient safety. Defining these risks, analysing them and identifying how to mitigate against them is key to how the Trust manages risk. The most significant risks are reported to Board each month, along with actions to manage them and this information is available in the Trust's Board papers on its website. More detail is available in the Annual Governance Statement on page 41.

Going Concern

The Trust continues to adopt the going concern basis in preparing accounts following the Trust Board's assessment after making reasonable enquiries and consideration of supporting evidence.

We have assessed and considered key issues and risks about the reporting period and the future including twelve months from the date of signing the financial statements including:

- The overall financial position for the reporting year and underlying deficit
- Negative operating cash flows
- The level of support required to enable the Trust to meet its obligations as they become due
- Commissioner contracts
- Net assets and net current assets
- Trade creditors
- Major debt repayment
- Cash flows arising since the 2016-17 Statement of Financial Position
- Key Management arrangements
- Legal and statutory proceedings

From our assessment we identified the following material uncertainties:

Income & Expenditure Position

- The Trust's initial plan for 2017/18 was for a deficit of £4.6m, which was subsequently revised by the trust to a deficit of £14.4m;
- Alongside the planned position, NHS Improvement issued individual organisation level control totals. For this organisation the proposed control total was for a surplus of £5.3m;
- Delivery of this control total, together with other key operational objectives would attract strategic transformation funding of £9.3m;
- As a result of the financial challenges reflected in the deficit plan, the organisation signalled that it would not agree to the control total for 2017/18;
- The latest forecast income & expenditure position is the delivery of a deficit position of £24.88m;
- One of the main reasons for the over spend in 2017/18 was the shortfall in delivery of required efficiency savings, together with other operational pressures within the Trust and broader health economy pressures. The Trust introduced a recovery plan in the autumn and as a result there was a significant improvement in the financial position in the second half of the year.

Cash / Working Capital

- Each month, the Trust applies for working capital support and deficit funding in accordance with the Department of Health process which considers applications. Confirmation of support is provided after Department of Health consideration of each monthly application. Without external support the Trust would not be able to meet its obligations as they become due throughout 2017/18 and 2018/19. The Trust is in advanced discussions with NHS Improvement regarding the capital and revenue cash draw requirements for 2018/19. We are currently forecasting a requirement for cash support during 2017/18 of £66.3m (£23.6m in respect of prepayments for the construction of the new Royal and £42.7m revenue and capital cash support) and £51.0m in revenue obligations in 2018/19.

Other material uncertainties

- The Trust is falling short of the Better Payment Practice Code Targets. The Trust paid 37% of bills within the target of 30 days from the date of a valid invoice.
- Due to the liquidation of Carillion there is uncertainty over the timing of the completion of the new hospital, the Trust has no PFI liabilities in respect of the new PFI hospital in 2017/18. The Trust will also be required to make a payment to the University of Liverpool in respect of the University's interest in buildings on the Royal Liverpool Hospital site. The cash implications of the PFI and University of Liverpool payments are reflected in the Trust working capital support requirement.

Although these factors represent material uncertainties that may influence the going concern opinion, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Department of Health Group Accounting Manual, the Directors have prepared the financial statements on a going concern basis and have not included the adjustments that would result if it was unable to continue as a going concern.


SHN
NHS

Summary of our performance

Measuring access to treatment

Our commitment	National standard	2017-18 figure	Difference from 2016-17
Accident and emergency waiting times: Patients should be admitted, transferred or discharged with four hours of arrival.	95% or above	89.20%	+0.10%
Referral to treatment waiting times: Patients should start treatment within 18 weeks of referral	92% or above	81.78%	Nil
Cancer treatment waiting times:			
Maximum two week wait for first appointment for patients referred urgently for suspected cancer by a GP	93% or above	94%	-1%
Maximum two week wait for first appointment for patients referred urgently with breast cancer symptoms	93% or above	95%	+1%
Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	96% or above	95%	-2%
Maximum 31 day wait for subsequent surgical treatment	94% or above	96%	-2%
Maximum 31 day wait for subsequent treatment with anti-cancer drugs	98% or above	99%	-1%
Maximum 62 day wait from urgent GP referral to first treatment for cancer	85% or above	85%	-1%
Maximum 62 day wait for treatment for cancer following a consultant decision to upgrade their priority	85% or above	95%	Nil
*Maximum 62 day wait from referral from NHS screening service to first treatment for all cancers	90% or above	90%	-6%

*Not a national standard.

Measuring quality of care

Measure	National standard	2017-18 figure	Difference from 2016-17
Number of operations cancelled for non-clinical reasons	Less than 0.6% of all operations	0.89%, which is 458 cases	0.70%, which was 398 cases
Standardised Hospital Mortality Indicator (SHMI)	100	104 (based on deaths between Aug 16 – Sept 17)	103 (based on Q4 2016/17 figure
Patients admitted to hospital receiving a risk assessment for Venous Thrombo-Embolism	95%	88.5%	92.2%
Stroke patients spending 90% or more of their spell in hospital on the Stroke Unit	80%	72.8%	73.5%
Cases of C.difficile per 1,000 bed days	None	0.13	0.19
Patient falls per 1,000 bed days	None	6.35	5.84
Pressure ulcers per 1,000 bed days	None	0.32 hospital acquired	0.35 hospital acquired

Measuring patient feedback

	2017-18	2016-17
Patients who would recommend our outpatient department to friends and family	94%	94%
Inpatients who would recommend our service to friends and family	92%	92%
Patients who would recommend our emergency department to friends and family	82%	81%

> I found the Broadgreen Theatres Recovery and Post-Anaesthesia Care units to be exemplary in the after surgery care given to me by all the staff. Nothing was too much trouble and was delivered in an extremely professional and caring manner. The unit was spotlessly clean and quite frankly, a joy to be in. I cannot praise it highly enough. This model of excellence should be repeated in all hospitals. From entering the hospital everything was explained thoroughly and patiently explained to me throughout my time here. The term outstanding is often used but here it really lives up to its true meaning.

Our operational performance

Performance Analysis:

There are key performance measures that we are legally obliged to report upon both locally to our commissioners and nationally to other external bodies. These derive from the NHS England national standard contract, Commissioning for Quality and Innovation (CQUIN) and locally agreed measures with our local Clinical Commissioning Group (CCGs).

Key performance indicators (KPI) include performance against key areas including the following (not exhaustive) -

- Emergency department performance
- Undertaking assessments against specific diagnoses
- Healthcare associated infections
- Serious incidents and never events

To help us understand how well we are doing, the Trust measures its effectiveness in delivering its priorities by monitoring and reporting performance data in three areas:-

- National Quality Standards
- Local outcome measures
- Financial performance

The Trust's business intelligence function provides management information for performance reporting both internally and externally. Data is quality assured and validated before being shared. We hold bi-monthly Clinical Quality and Performance meetings with the local Clinical Commissioning Groups to discuss performance as above. Quarterly CQUIN performance is also discussed.

Performance data and analysis is reported through the Board's committee structure and ultimately to Board. Performance is managed through the Trust's operational management arrangements with assurance provided through the committees and exception reporting is provided to Board. Where required, risk management is applied to areas where the Trust is not meeting specific KPIs or outcomes and reported through the Trust's operational meetings through to the relevant committee and the Board, alongside risk reporting.

In order to understand the Trust's operational performance, first it is necessary to outline our activity.

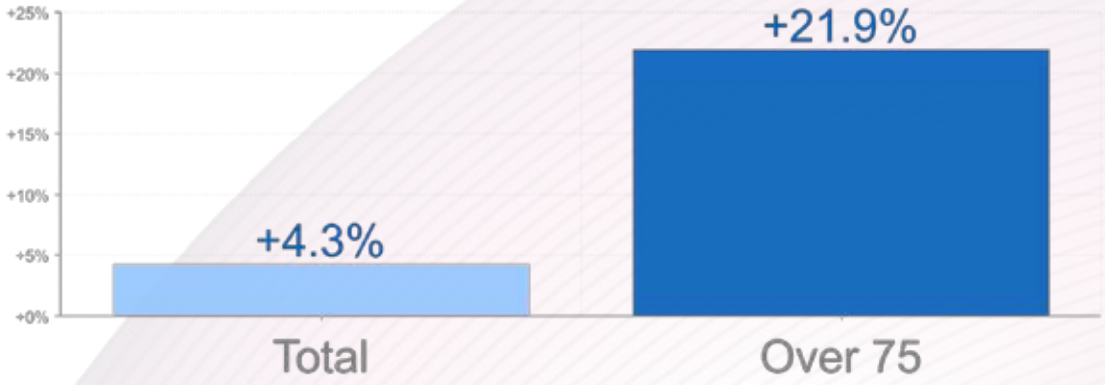
Activity

Activity	2016-17	2017-18	Increase/decrease %
Emergency and urgent attendances (all types)	235,781	245,657	+4.18%
Attendances at emergency department (type 1)	91,614	92,021	+0.44%
Attendances of patients age 75 or over	13,236	13,595	+2.71%
Admissions from A&E	28,168	30,273	+7.47%
Inpatients and day cases	116,682	114,122	-2.19%
Planned procedures	9,307	8,152	-12.4%
Unplanned procedures	36,173	40,007	+10.6%
Day case procedures	48,344	43,048	-11%
Outpatient appointments	638,719	607,309	-4.92%
All figures above are accurate at the time of reporting (April 2018). Some figures for 2016/17 have changed slightly from last year's Annual Report, due to validation of data after time of writing the 2016/17 report.			

As can be seen in the information above, the Trust has seen increased demands in emergency care. It also illustrates an increase in attendances of patients aged 75 and older.

In the last six years emergency department attendances have increased by over 4%. Within this time the number of patients aged 75 or over has increased by nearly 22% as the information below illustrates.

Increase in Emergency department attendances since 2012/13



Typically, these patients often have more acute, complex conditions and they require more diagnostic tests. Often these patients require longer stays in hospital and complex care packages when they are ready to be discharged.

This increase, along with the 10% increase in unplanned admissions and 7% increase in admissions from A&E, illustrate the increasingly complex nature of patients' conditions that we are managing. This has increased the demands both on hospital care and on the services of community and social care.

Unfortunately this often means that patients who are ready to leave the hospital to their next destination of care, are often delayed and they stay in hospital longer than they need to. For patients, particularly the elderly, staying in hospital after they are ready to be discharged can be very unsettling and their lack of movement can lead to considerable deterioration of their muscles, putting their recovery at risk.

Managing patient flow

Throughout the year, on average there have been around 150 patients each day who are waiting to be transferred to their next destination of care or to go home. This means that there are fewer beds available for patients who need to be admitted to them from the emergency department or who require a bed for recovery after their planned surgery. This has an impact on the Trust's ability to admit patients from the emergency department within four hours, in line with the national standard. It has also led to the Trust having to cancel operations, causing delays in patients waiting for surgery, which impacts on the Trust's ability to treat 92% patients within 18 weeks of referral in line with the national standard.

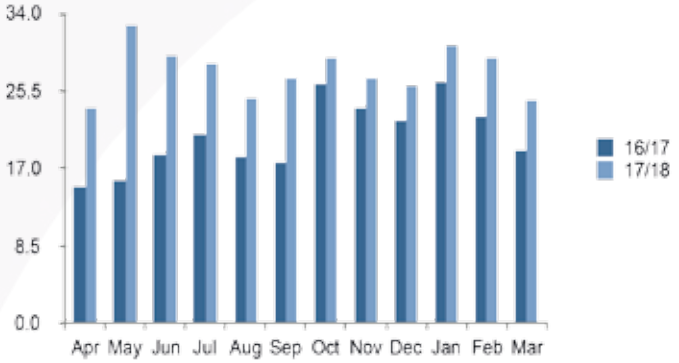
Patients who are medically fit yet unable to leave the hospital are reported in two ways. Delayed transfers of care refer to transfers from one care setting to another and are when a clinical decision has been made that the patient is ready for transfer, a multidisciplinary team has decided that the patient is ready for transfer, and the patient is safe to discharge/transfer. These delays can occur when patients are being discharged home or to a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

Patients who are 'ready for discharge' are defined as patients who are well enough to leave the hospital but have not yet been discharged. Delays for these types of patients include the above but also those patients who may still be awaiting a care placement or package outside the hospital to become available or agreed.

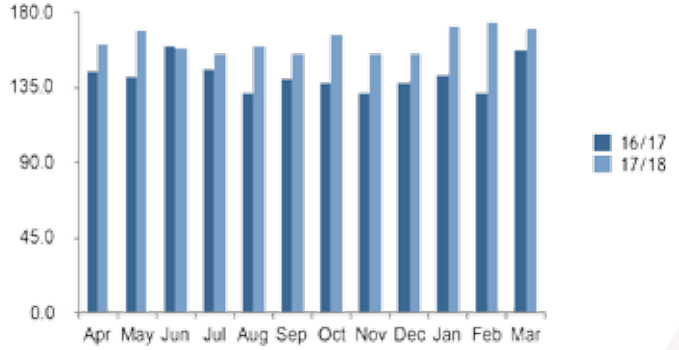
Using the daily average numbers of patients who are ready for discharge or whose transfer of care has been delayed, the graphs below show that on both measures, there have been increasing delays in transferring patients from hospital beds. In particular, from November to March, since last year, in each month there has been an increase in delays compared to the same month the previous year.

[At the time of writing the operational performance analysis, much of the data for March was unavailable. Therefore April to February data has been used to provide an indicative view of the year's performance. # Denotes where April to February data has been used.]

Daily average delayed transfer of care



Daily average ready for discharge patients



To help ease this pressure, the Trust invested around £1m to support patients who were awaiting discharge by opening 24 beds on a ward at Broadgreen Hospital. This created extra capacity at the Royal Liverpool University Hospital for those patients in need of specialist urgent care. From December to March, with additional winter funding from the Department of Health, the Trust was able to transform ward 2A at the Royal into a ward for patients who were ready for discharge, in collaboration with local community partners.

The Trust also implemented new protocols aimed at prioritising patients throughout the hospital, based on their care needs. This is so that when demand for beds are at their highest, patients whether in the emergency department or on a ward, who need a hospital bed most, are provided with one as quickly as possible. To support this, a Clinical Prioritisation Group (CPG) led by the medical director was established. The CPG has developed a standardised scoring system to measure the clinical and functional needs of each individual patient. This would enable it to make a Trust wide assessment of whose needs scored the highest and lowest and measure the risks of discharging a stable patient occupying a bed, against the risk keeping a patient in urgent need of a hospital bed waiting in the emergency department.

After testing the scoring system successfully via two table top exercises, the Clinical Prioritisation Protocol was implemented on 1 January. It was used during 16 of the busiest days at the Trust during January and February, with between 8 and 14 additional patients with urgent care needs being admitted to a hospital bed that was available due to discharges facilitated by the CPG. Further refinement of the protocol and work on communication and engagement is planned to support the further implementation of clinical prioritisation ahead of next winter.

The Trust is in the second year of a programme to reconfigure the emergency department to enable greater patient flow and support initiatives to treat patients in a timely fashion and where possible, without the need for them to be admitted into the hospital. This has included the development of Ambulatory Care and moving our Frailty Unit onto our emergency floor as reported in last year's Annual Report.

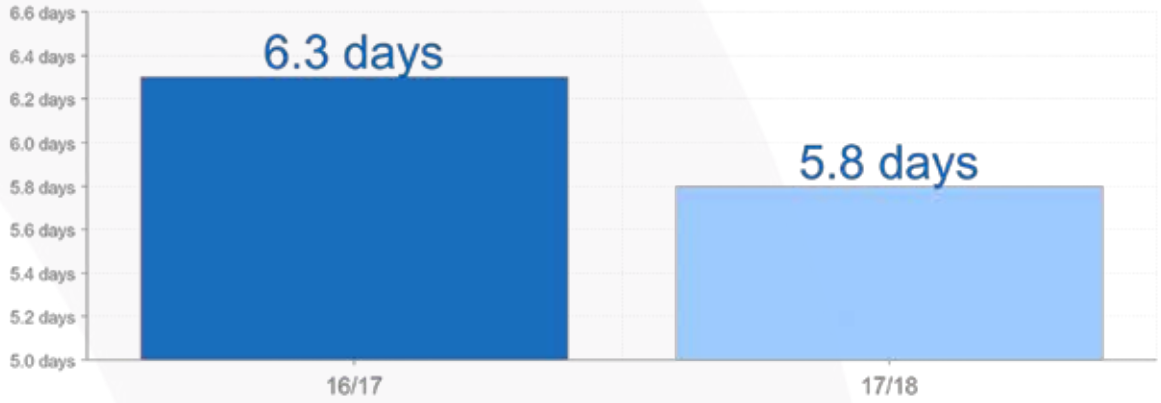
Around 40 patients a day have received ambulatory care in a designated area of our Acute Medical Unit, who would otherwise have been seen within the emergency department. This means their treatment can start sooner and in most cases they are able to leave the hospital on the same day, without needed to be admitted overnight.

The Frailty Unit aims to provide rapid assessment and treatment to frail elderly patients to get them medically fit as soon as possible to avoid staying in hospital any longer than necessary. Just over 600 patients were cared for and discharged from the Frailty Unit this year. 85% of those patients were discharged to their usual place of residence. The average length of stay on the unit was 4.6 days and patients leave the ward on average 6 hours after being assessed as ready for discharge.

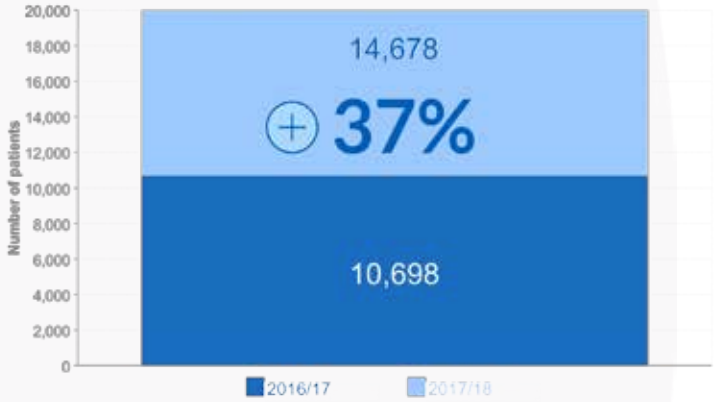
In June 2017, a new unit was created within the emergency department. The Clinical Decisions Unit (CDU) provided designated space for around 30 patients each day who would have previously been admitted to the wards in order to wait for diagnostic tests. Now they are no longer admitted when their clinical condition does not require it. These patients would receive a medical review within the emergency department within four hours and would then wait in the CDU, under close observation, until their results had returned. From June to February an average of around 945 patients a month were cared for in the CDU, with an average length of stay of six and a half hours and the overwhelming majority were able to leave without needing to be admitted to a hospital bed.

These measures have helped to reduce the average overall length of stay at the Trust from 6.3 days in 2016/17 to 5.8 days in 2017/18, by increasing the percentage of patients who were treated without the need for an overnight stay on a ward by 37%, as can be seen in the information below.

Analysis of average lengths of stay between 16/17 and 17/18



Patients who did not need to stay overnight in the last two years

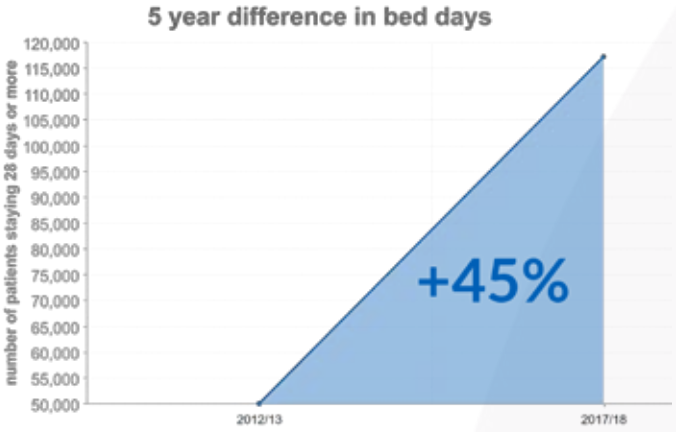


However whilst overall length of stay has been reduced, as the information below outlines, the number of patients staying at the Trust for long periods has increased significantly. Last year, patients staying 28 days or more in a hospital bed accounted for just 4.7% of our total inpatients, yet they accounted for 41% of the overall days patients spent in our hospital beds.

Comparative analysis of patients staying 28 days or more and percentage of bed days

In addition, for this 4.7% of inpatients, their stay is getting even longer as the number of days they remain in a hospital bed beyond 28 days has increased by 45% over the last 5 years.

Increase in patients staying 28 days or more



As described in last year's Annual Report, the Trust is continuing its work on implementing the SAFER practices across its wards and departments to improve patient flow and reduce length of stay. But we recognise there is more that we can do to ensure this is adopted consistently and are working with the Emergency Care Improvement Programme (ECIP) to establish SAFER exemplar wards.

The Trust has also been working closely with partners across the whole health system to develop new ways of working to reduce these delays to discharging patients.

There is a real need to speed up and simplify the processes related to transferring patient care between organisations. In response to this the Integrated Community Reablement and Assessment Service (ICRAS) was developed. The Trust has been heavily involved in this service which is improving access to community and social care services across Liverpool, Sefton and Knowsley (north Mersey), with health and social care organisations working as one.

SAFER stands for:

- **S** enior review of patients by 12pm
- **A** ll patients to be aware of their discharge plans
- **F** low of patients must start before 10am
- **E** arly discharge of medically fit patients before 12noon
- **R** eview of patients expected to stay over 14 days weekly

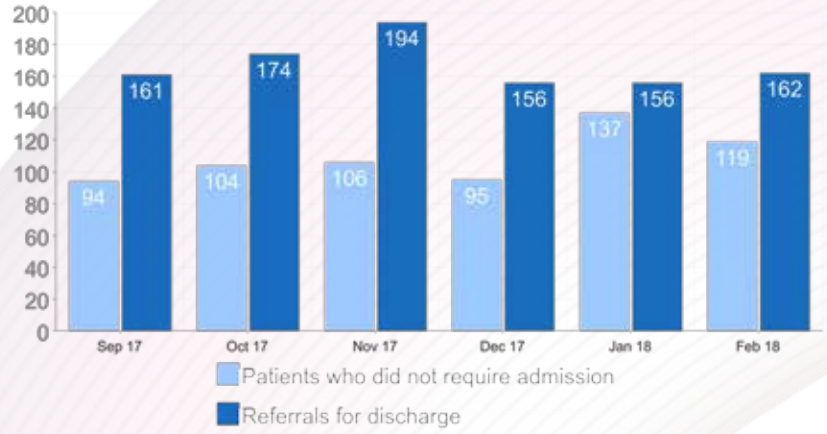
> Huge thank you to the fabulous team at the Liverpool University Dental Hospital. Not only were you amazing with such an anxious patient, you also taught me the difference between a catheter and a cannula!

By standardising pathways and streamlining services provided by local NHS and councils, the ICRAS is supporting greater continuity of care to enable as seamless an experience as possible, for patients and other service users. This helps to speed up discharges from hospitals to community and social care services, which helps to reduce hospital lengths of stay and support greater independence for patients and other service users. Supporting independence is also achieved by providing consistent services throughout the area for early interventions, to avoid the need for patients to have to go to A&E.

From October, when ICRAS was established, until February on average around 410 patients each month have been discharged from hospital through the service and 110 admissions to hospital have been avoided. Without ICRAS these figures would have been lower.

The information below illustrates the increased referrals to the ICRAS since it was established:

Referrals to the Integrated Community Reablement and Assessment Service (ICRAS)

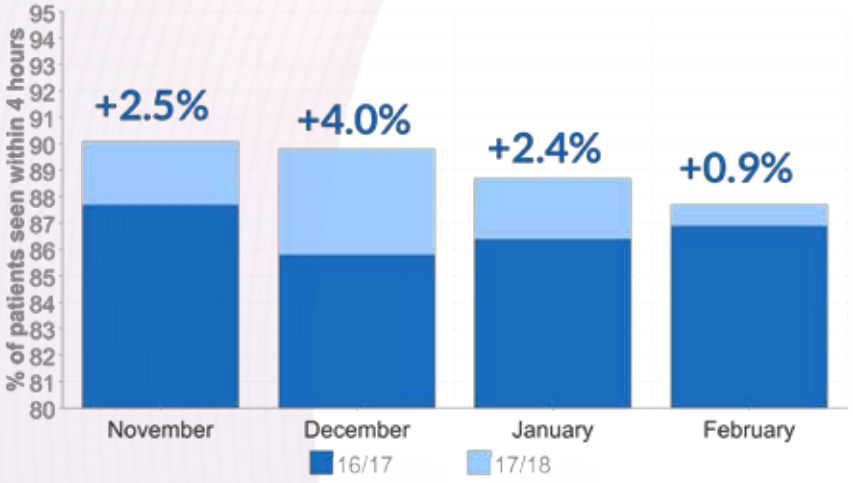


Improvements in emergency care

Whilst the majority of our patients were seen in our emergency department within four hours, the percentage who were, fell short of the national standard of 95%.

However throughout a winter of unprecedented pressure for urgent and emergency services nationally and with increased attendances at the Trust for urgent and emergency care, our performance against the 95% standard was better from November to February than the previous year.

Comparison of winter 2016/17 and 2017/18 performance against 4 hour standard in the emergency department



The safety of patients with serious or life threatening conditions will always take priority. During periods of high demand within the emergency department matrons keep a check on the health of those who are waiting to be seen and will escalate any serious deteriorations in their health so they can be seen more quickly.

The Trust has used a range of measures to reduce the time patients wait in the emergency department. These measures had been developed with the engagement of staff from across various departments and with the support of the Emergency Care Improvement Programme (ECIP).

These include:

- **Rapid assessment triage**
  Further improvements made to the triage system within the emergency department, enabling rapid assessment meant that on average around 90% of patients were triaged within 15 minutes of arrival in the department and the average wait for triage was under 8 minutes.

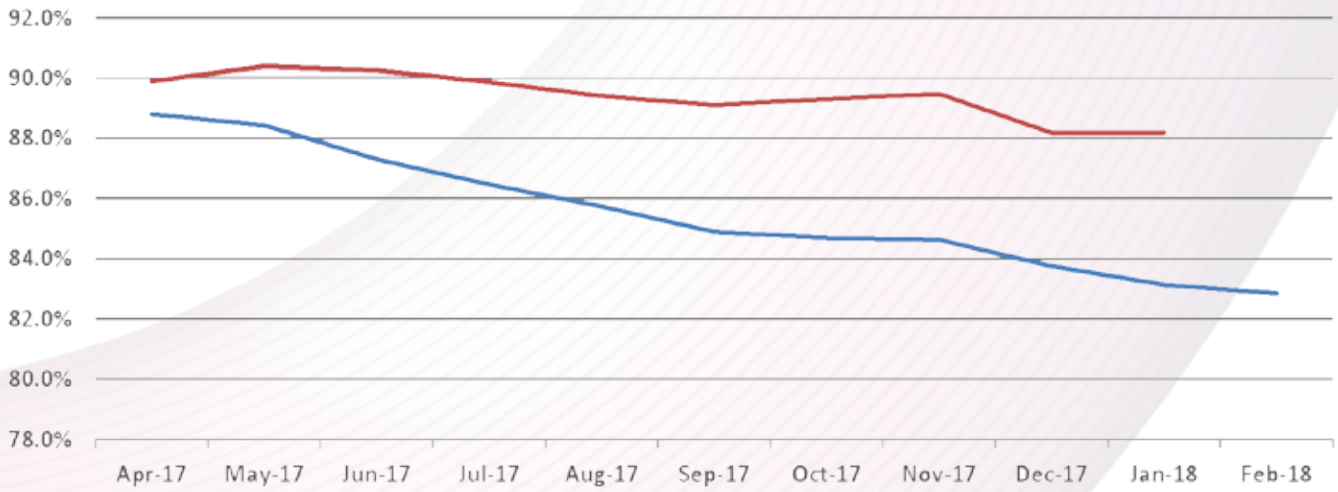
- **Primary care streaming**
  From October around 70 patients a week, who attended the emergency department but did not require the specialist skills of the emergency care team were directed to onsite primary care services to be seen by a primary care specialist.

Improvements to elective and diagnostic services

The national standard is that 92% of patients should be treated within 18 weeks of referral. Trying to reach this target has proved difficult throughout the NHS in England. In response to the pressures on emergency departments during winter, NHS England advised to hospital Trusts to cancel non-urgent elective procedures.

The Trust, in line with other trusts nationally hasn't met this standard, as the information from April to February below illustrates.

#Performance against 18 week referral to treatment standard (April to February)



National performance is based on treatment for patients resident in England only. In order to map the Trust's performance with the national (England) trend we have based data on patients resident in England only, although there is very little statistical difference with the Trust's overall performance (which includes patients resident in other parts of the UK)

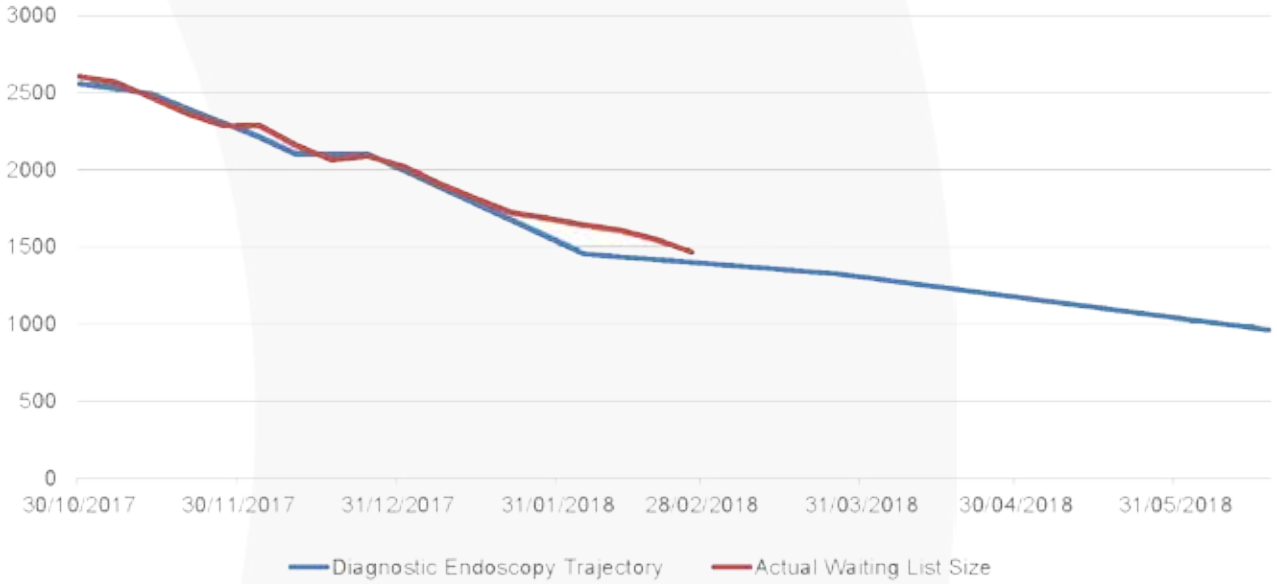
When high levels of pressure require the Trust to cancel procedures, the decision is made to cancel any non-urgent planned procedures first so that it can prioritise care for emergency and urgent procedures such as cancer cases. However during the late winter months, the Trust had to take the difficult decision to postpone some urgent procedures which included a small number of cancer cases. These patients were given a new appointment within seven days of their cancelled operation. Overall the Trust is performing well against the standards for cancer care, as the quarter 3 figures illustrate and has a consistent record of meeting the standards for cancer care.

Working with NHS Improvement's Elective Care Intensive Support Team (ECIST), the Trust has made significant progress on a range of improvement measures.

This year the Trust introduced a new two-way texting service for outpatients to help reduce the number of times patients did not attend (DNA) their appointment. This has helped to reduce the DNA rate for all outpatient appointment types as the graph below outlines. This means that services can be provided more efficiently.

Waiting times for other cases, mainly in endoscopy were below standard. In response to the difficulty with endoscopy appointments, the Trust has implemented an improvement programme with external support that has seen a 10% improvement in waiting times between November and February, despite the busy winter period.

Patients awaiting appointments for endoscopy (November to February) against trajectory



How patients perceive the care they receive

Results from the friends and family test, outlined in the performance summary, illustrate almost no change in the percentages of those who would recommend our services to their friends or family, with a slight increase in those who would recommend our emergency department.

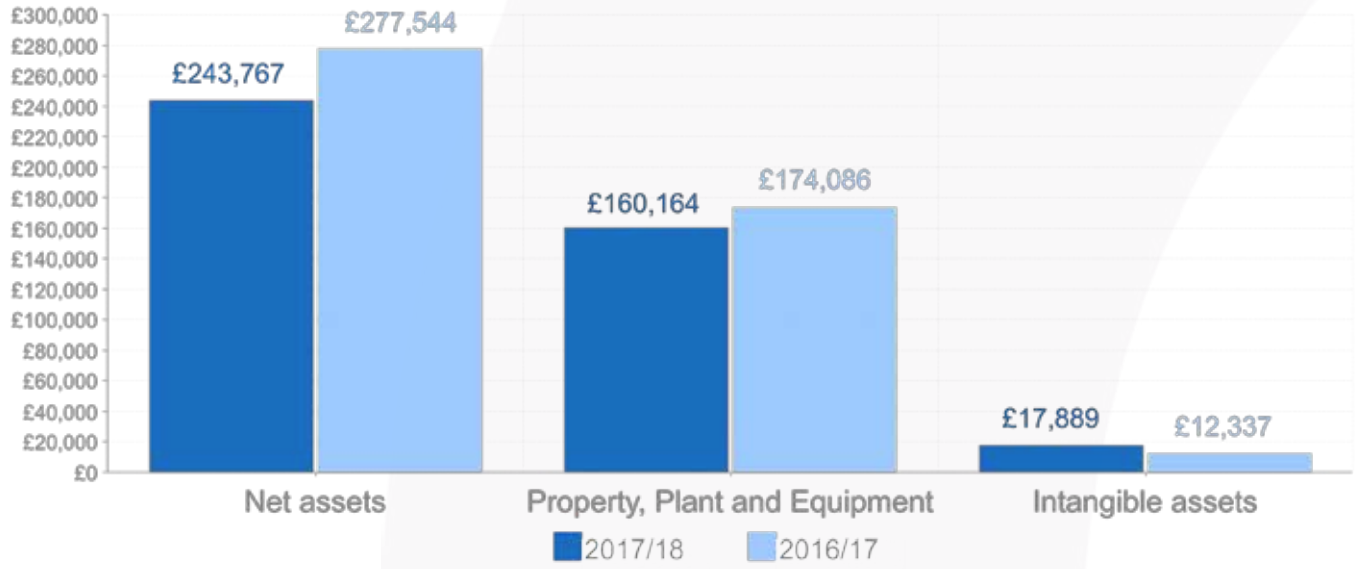
In conclusion, service pressures on the Trust have increased this year. The Trust is caring for larger numbers of patients who are sicker, with more complex health issues that require longer stays in hospital and complex care plans both within the hospital and to support their discharge from hospital. These pressures have also had an impact on patients waiting for planned operations. However a number of measures implemented by the Trust and with external partners are making a positive impact on patient flow, enabling a better service for patients. Had these measures not been in place it is likely that operational performance, particularly over the winter months, would not have been sustained.

Our financial performance

Measuring Trust's financial performance is achieved in a way that excludes the impacts of impairments and other technical adjustments.

The Trust's underlying deficit is £48m, however this is reduced through adjustments and one off transactions such as the sale of the staff car park at the Royal Liverpool University Hospital. The Trust is reporting an adjusted deficit position of £26.2m, although this excludes £1.4m of CQUIN income, which in 2017/18 is an unadjusted technical item, the deficit including this income is therefore £24.8m. This compares to last year's deficit of £1.3m (after adjusting for technical items).

The Trust received £5,150k Public Dividend Capital (PDC), mainly to support the Global Digital Exemplar (GDE) programme. The Trust's net assets at 31 March 2018 were £243,767k and these are broken down and compared to the previous year in the table below:



Non-current assets include £114,258k in respect of prepayments for the construction of the PFI of the new Royal, which reduces future contractual payments by £101,196k.

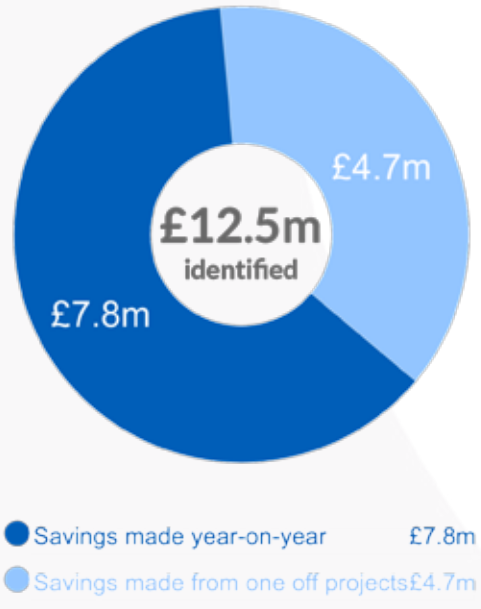
This includes £160,164k in respect of Property, Plant and Equipment assets, reflecting investment during the year in the completion of the Liverpool Life Sciences Accelerator and investments connected with the new Royal Liverpool University Hospital. Intangible assets have increased to £17,889k (£12,337k in 2016/17) reflecting the Trust's investment in information technology including the Electronic Patient Record.

Throughout the year, the Trust received loans from the Department of Health to support its cash position.

As part of the on-going Quality, Efficiency and Productivity (QEP) programme, staff throughout the Trust have identified lots of opportunities for improving quality, making savings and increasing income, by doing things right first time and avoiding duplication.

The QEP target for 2017/18 was £20.8m. During the year savings of £12.5m were identified. Of these savings, £7.8million can be made year-on-year, with £4.7milion from one off projects.

QEP savings 2017/18



Our social commitments

The Trust is proactive in safeguarding human rights from both a patient and staff perspective. We have a framework of policies that are designed to ensure the emotional and physical safety of patients, staff and volunteers.

Widening participation is a key aim of the Trust and over the past 12 months it has been presented with a number of awards for these in-house programmes of works:

- A Gold Standard Work Experience Quality Standard - a national award developed by Fair Train with support from the Department for Education, and other organisations. This demonstrates the high quality of our work experience placements and procedures, which help to ensure that all of the members of our local community who come into our hospitals have the best possible opportunity for learning to help them with their future employment opportunities.

- A Health Education England National Award for Work Exposure. This recognised the collaborative work between the Trust, Liverpool Clinical Laboratories, Wirral Metropolitan College and Liverpool in Work to develop and deliver a traineeship programme. The programme aims to prepare applicants for entry into healthcare scientist support roles, and is targeted at younger members of our local community (age 16-24) from less advantaged backgrounds.

- Liverpool and Sefton Chamber of Commerce Award for Empowering People. This award recognised the whole range of work experience programmes the Trust delivers which empower people in our local community by building their confidence, capturing their imagination, and helping them to gain valuable skills and experience.

When providing work experience programmes, we also try to target some of the more disadvantaged members of the community, and have provided programmes/events which support some of the following groups: Black and minority ethnic groups, people with learning disabilities, long term unemployed, people from low socio-economic groups, military veterans.

Human rights are respected in the organisation through effective management of safeguarding issues for patients and staff having access to a range of guidance and support, e.g. policy on bullying and harassment. There is an Equality and Diversity Sub Committee chaired by the Director of Workforce which oversees compliance with Human Rights issues. The Trust has recently contributed to the development of the impending Workplace Disability Equality Scheme.

In addition, our Modern Slavery Statement, is available on the Trust's website at https://www.rlbuht.nhs.uk/about-the-trust/trust-statements/

Anti-Corruption and Bribery

NHS providers are required to ensure that NHS resources are protected from fraud, bribery or corruption. The Trust's Anti-Fraud Specialist (AFS) continues to focus on the key areas of activity as outlined by NHS Fraud Authority (previously NHS Protect). This includes an assessment of compliance with the standards issued by NHS Fraud Authority which form a part of the Annual Report to the Audit & Assurance Committee by the AFS.

In 2017/18 the Trust revised its Standards of Personal and Business Conduct Policy. This was to comply with the model policy and guidance issued by NHS England for managing conflicts of interest and providing specific advice to staff and organisations about what to do in common situations in order to support good judgement about how conflicts should be approached and managed. The Trust has communicated the revised policy through a number of channels including senior management briefings cascaded to wider teams, staff bulletins and targeted messages to key staff. To support compliance, an online recording system for declarations of interest and recording of gifts and hospitality has been implemented. This has led to a significant increase in the number of staff completing declarations and will support improved oversight and reporting of compliance.

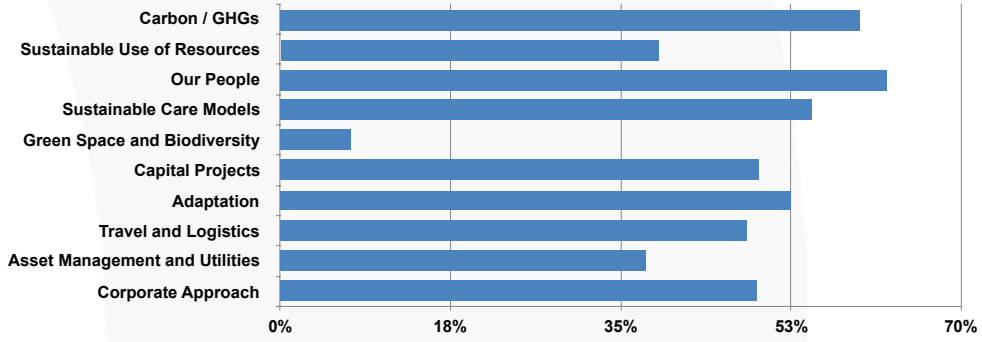
During 2017/18 the AFS has continued to raise the profile of anti-fraud message through the delivery of training, bespoke communication messages, proactive prevention exercises as well as undertaking investigations which have resulted in a number of disciplinary and criminal sanctions.

Sustainability report summary

The Sustainable Development Unit (SDU), NHS Improvement and Healthcare Financial Management Association again rated the Trust's sustainability reporting for 2016-17 as 'Excellent'. The overall score increased from 2015-16, and the Trust was rated the second highest of the 445 healthcare reports assessed. This is a great achievement, supported by the continued link to the annual Sustainability Plan, which provides a more detailed review. The Sustainability Plan 2018-19 can be accessed here: https://www.rlbuht.nhs.uk/about-the-trust/our-performance/annual-plan/

Sustainable Development Assessment Tool (SDAT)

SDAT is a new assessment developed by the SDU to monitor sustainabilityperformance. The Trust undertook its first assessment in January 2018. An overview is included below and all ten sections are included within the Sustainability Plan 2018-19.



SDAT links performance to the UN Sustainable Development Goals. The Trust's first assessment shows it is clearly contributing to the following goals, and starting to contribute to the majority of the seventeen goals.

CO_2 Emissions (tonnes CO_2e	201/12	2013/14	2014/15	2015/16	2016/17
Scope 1 (gas and oil use)	34,505	33,528	31,991	33,697	33,825
Scope 2 (electricity and imported heat)	-7,758	-7,027	-6,927	-7,644	-7,625
Scope 3 (including procurement, travel, waste and water)	58,189	60,887	59,461	71,403	87,534
Total	**84,936**	**87,389**	**84,526**	**97,457**	**113,734**

Carbon Emissions

As the full year information for carbon data reporting is not available at the time of writing the Annual Report, this information is reported a year behind. The total carbon footprint for 2016-17 has increased on the previous year. Scope 1 and 2 emissions have remained relatively stable. It is expected that the improved energy performance of the new Royal Liverpool University Hospital will contribute towards meeting the Trust's energy target for 2020, so a stable performance in the interim is welcome. Scope 3 emissions have increased by approximately 22.5%. This is mainly due to the inclusion – for the first time – of an estimate of emissions due to patient and visitor travel (more than 12,000 tonnes). Remaining Scope 3 emissions increased by only 5%. This includes an increase of 3,543 tonnes from procurement. Procurement emissions are calculated using a formula based on non-pay spend, which continues with increased demand on our services.

Adaptation

The Trust continues to work through its climate change adaptation action plan. Training has been devised and the Trust provided a case study for a report for Liverpool City Region Combined Authority: https://www.liverpoollep.org/wp-content/uploads/2015/06/Building-Climate-Resilience-in-Liverpool-City-Region-FINAL2017.pdf.

Accountability report

Where we all make a difference

Corporate Governance Report

Directors' report

The Trust Board consists of the chairman, plus five non-executive directors, two associate non-executive directors and five executive directors, including the chief executive as well as two executive directors, who are non-voting members. It is accountable for setting our strategic direction, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the local community.

NHS Improvement is responsible for appointing non-executive directors. The chief executive and executive directors are appointed through a competitive, open, recruitment and selection process by authority of the Trust Board. The purpose of the non-executive body is to ensure that we are governed effectively and hold the team of executive directors to account. Non-executive directors bring independent challenge within the Board to the actions proposed and being taken by the executive directors.

There have been a couple of changes to the Board this year. Debbie Herring joined the Trust in July 2017 as the Executive Director of Workforce. Debbie took over from Stella Clayton who had been acting Director of Human Resources and Organisational Development.

Chairman and non-executives

Bill Griffiths, Chairman

Bill has been chairman since January 2015. He is also currently chair of the Disclosure and Barring Service and has previously served as chairman of the Forensic Science Service.

After a career in finance and international business mainly with Unilever and latterly with ICI, he gained non-executive experience with several government departments including Defra, DFID and DWP. Bill is a qualified accountant (ACMA) with a BSc (Hons) in Mathematics.

As well as chairing the Trust Board, Bill also chairs the Nomination and Remuneration Committee and the Shadow Council of Governors meeting.

Neil Willcox, Non-Executive Director

Neil joined the Board in 2015 and is a chartered accountant. He began work in private industry before joining an international firm of chartered accountants as an audit senior and manager.

Neil is now the managing director of a software hosted services and infrastructure company which supports medium and large organisations in the private and public sector. Neil has both executive and non-executive experience, the latter gained in the health sector.

Neil is chair of the Audit and Assurance Committee and a member of the Finance and Performance Committee and the Nomination and Remuneration Committee.

Mike Eastwood, Non-Executive Director

Mike joined the Board in 2013. He is currently diocesan secretary (chief executive) of the Diocese of Liverpool as well as the director of operations at Liverpool Cathedral.

He has significant experience of working at director level in the third sector. He currently holds a number of voluntary positions supporting the church and local community development. He has a BA (Hons) in Modern History.

Mike is the chair of Finance and Performance Committee and also the Charitable Funds Committee and the Nomination and Remuneration Committee.

Geoff Stewart, Non-Executive Director

Geoff joined the Board in 2012. Geoff began his career in the chemical industry with extensive experience in sales, business development and marketing. Geoff then held a number of roles in public sector economic development and regeneration including joint ventures and maximising investment opportunities.

He has an established development and management consultancy whose principal activities include business review, strategic planning, corporate governance and project management.

Geoff is chair of the New Hospital Committee and a member of the Audit and Assurance Committee and the Nomination and Remuneration Committee.

Angela Phillips, Non-Executive Director

Angela joined the Board in 2016. She is a senior board member and finance professional with experience in both the public and private sector leading major change projects. Angela is a qualified chartered accountant. Most recently Angela was employed as the Director of Finance at the University of Bradford. Angela has worked in different roles in NHS commissioning as well as senior roles in a private hospital group.

Angela is the chair of the Workforce Committee and is also a member of the Audit and Assurance Committee and the Nomination and Remuneration Committee.

Professor Malcolm Jackson, Non-Executive Director

Malcolm joined the Board in 2016. He is a non-clinical biomedical scientist with a wide managerial experience. He completed a PhD in 1980, was awarded a DSc in 1994 and FRCPath in 1997. Malcolm is currently Associate Pro-Vice Chancellor for Research and Impact for the Faculty of Health and Life Sciences at the University of Liverpool. He is also the Director of the MRC-Arthritis Research UK Centre for Integrated Research into Musculoskeletal Ageing (CIMA).

Malcolm chairs the Quality Governance Committee and the Research, Development and Innovation Committee and the Nomination and Remuneration Committee.

Executive Directors

Aidan Kehoe, Chief Executive

Aidan is a Qualified Chartered Accountant having trained with KPMG in Birmingham. He started his career with the National Health Service as a Management Trainee and has over 20 years' experience as an NHS Manager, having worked in Trusts in Salisbury, Bournemouth, Birmingham, Salford and as Chief Executive of Blackpool Teaching Hospitals NHS Foundation Trust.

John Graham, Deputy Chief Executive and Director of Finance

John has around 30 years of NHS experience having worked for a variety of trusts including Greater Manchester West NHS Foundation Trust, a strategic health authority and the Department of Health. He joined the Trust as Director of Finance and Business Development in January 2011. John is a Chartered Institute of Management Accountants qualified accountant having gained his qualification in 1987.

Lisa Grant, Executive Chief Nurse and Chief Operating Officer

Lisa started at the Trust as Chief Nurse in March 2014. She was previously Director of Nursing and Modernisation at the Walton Centre from 2011 and has worked in various roles, gaining extensive experience, at Aintree University Hospital, Wirral Hospitals and the Christie Hospital. Lisa started her career as a staff nurse at the Royal in 1998. Lisa holds a Diploma in Nursing, Diploma in Management, a Masters in Management and Leadership and an MBA.

Dr Peter Williams, Medical Director

Peter held several junior doctor roles and worked as a kidney research fellow before becoming a senior registrar in nephrology at the Royal Liverpool University Hospital. With several years in Manchester as a consultant, he returned to Liverpool in 1997 as a consultant nephrologist. He has since remained at the Trust taking on a variety of roles including clinical director for general internal medicine, divisional medical director and most recently, medical director.

Debbie Herring, Executive Director of Workforce

Debbie joined the Trust in July 2017 from Alder Hey Children's Hospital where she was director of strategy and development.

Debbie has held various senior roles in the NHS including director of strategy, HR and organisational development at Liverpool Heart and Chest Hospital, director of HR and organisational development at Aintree University Hospital and director of HR and organisational development at Countess of Chester Hospital.

Debbie is also the vice chair of NHS Employer's Policy Board and chair of NHS Providers HR Directors Network.

Stella Clayton,
Acting Director of Human Resources and Organisational Development

Stella was acting Director of Human Resources and Organisational Development until the end of July 2017. Previous HR & OD experience includes Deputy and Associate Director roles in acute trusts and mental health services, together with project roles leading transformational change and restructure for an organisation in turnaround.

Non-voting board members

Dr James Kingsland, Associate Non-Executive Director

James joined the Board in 2016. He is a senior partner in general practice. He has significant experience of leading large primary care teams of clinicians, managers and administrators and has been a GP trainer and an undergraduate tutor for a number of medical schools.

James has held a wide range of senior leadership positions including National Practice Based Commissioning Clinical Network Lead, Vice Chair Wirral Health Authority, President National Association Primary Care as well as a number of roles with the Department of Health. He has previously served as a Non-Executive Director for six years in a specialist NHS FT.

James attends the Quality Governance Committee and the Research, Development and Innovation Committee.

Susan Young, Associate Non-Executive Director

Susan joined the Board in 2016. She is an experienced HR professional who has worked in both central and local government, and the NHS. Susan is a Chartered Fellow of the Chartered Institute of Personnel and Development with 16 years' experience in HR, OD and broader transformation and change in the public sector. Susan has significant board level experience in the public sector.

Susan attends the New Hospital Committee and Workforce Committee.

Helen Shaw, Director of Communications & Marketing

Helen has a degree in Business Studies and is a member of the Chartered Institute of Marketing. She has established and managed communication and marketing teams in a range of sectors including manufacturing, financial services, local authority, emergency services and has been at the Trust since 2008.

David Walliker, Chief Information Officer

David joined the Trust in July 2016 as Chief Information Officer. Prior to this he supported the Trust's information services under an agreement with Liverpool Women's Hospital NHS Foundation Trust, where he is also the Chief Information Officer. David has over 14 years' experience within the NHS including working in mental health and ambulance services. Within his current role David has accountability for Information Technology, Information Management and Patient Access Services and he is also the Senior Information Risk Officer (SIRO) for the Trust. David holds a MSc in Health Informatics.

Declarations of interest

The board of directors make annual declarations of interest regarding the detailass of company directorship and other significant interests, where those companies are likely to seek or do business with the NHS. These are provided in the Trust Board papers for May which are published on the Trust website here.

Each director confirms to the audit and assurance committee that they know of no information which would be relevant to the auditors for the purpose of their audit report, and of which the auditors are not aware, and; they have taken all necessary steps to make themselves aware of any such information and to establish that the auditors are aware of it.

Fit and Proper Person Regulation

In accordance with the requirements of the 'Fit and Proper Person Regulation (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5) the Trust undertakes an annual assessment of all directors to ensure that they continue to meet the requirements of the regulations. This is in addition to ensuring compliance during the selection process. The intention of the regulation is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

Keeping Information Secure

The Trust takes the confidentiality and security of information very seriously and continues to invest in technology to keep it safe. We ensure our devices are encrypted and our network is protected from viruses and other threats. Staff are trained regularly and there are regular audits to provide assurance. The Chief Information Office regularly reviews information risks and acts as the Trust Senior Information Risk Owner and the Information Governance Groups provides Trust oversight.

The Trust continues to maintain high standards for information governance. There are 45 standards within our Information Governance Toolkit (IGT), which have all been assessed as 'Satisfactory'. At the time of writing, we were on target to achieve 85%, the previous year we achieved 84%. The annual audit has given the IGT Significant Assurance Indicating that our self-assessment is robust.

The Trust received 646 Freedom of Information requests containing 6,039 questions. 92% were responded to within 20 days. Information is disclosed unless it is exempt under the terms of the Act, such as the protection of personal data.

There is a robust monitoring system for incidents. All of the information incidents reported this year are minor (57), a reduction of 9 from last year, with no incident being reported to the Information Commissioner.

> I was recently a patient on 8X at the Royal. I would like to express my gratitude to the staff that worked there during that time. The care I received from them was first class and they always had a smile and friendly word for me. I can't thank them enough for everything they done for me and I know what pressure and stress they are under so I would like to take the opportunity to once again say thank you so much and the staff need to know that they are doing a brilliant job.

Statement of the chief executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Aidan Kehoe **Date 29.05.18**

Chief Executive
Royal Liverpool and Broadgreen University Hospitals NHS Trust

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

Aidan Kehoe **Date: 29.05.18**
Chief Executive

John Graham **Date: 29.05.18**
Finance Director

Annual governance statement

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibility, through the Secretary of State for Health, to Parliament for the stewardship of the Trust's resources as set out in the NHS Trust Accountable Officer Memorandum.

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the management of the risks to the achievement of the aims and objectives of the Royal Liverpool and Broadgreen University Hospitals NHS 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 the Royal Liverpool and Broadgreen University Hospitals NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

3.1 As Chief Executive I have overall responsibility and accountability for all aspects of risk management which I discharge through the Executive Team ensuring that the organisational structure and resources are in place to deliver our objectives. I have delegated executive leadership for risk management to the Chief Nurse/Chief Operating Officer (COO), who also acts as the Trust's Chief Risk Officer. During 2017/18 the Chief Nurse/COO continued to provide oversight of the Trust's risk management arrangements in accordance with the Trust's Risk Management Policy.

3.2 Responsibility and leadership is delegated through directors in accordance with the Trust's Scheme of Reservation and Delegation with assurance provided to the Board and its committees. This covers all aspects of governance relating to our service delivery including quality governance, infection control, clinical care, Care Quality Commission (CQC) and other regulatory and statutory requirements, finance, information technology, health and safety, research and development.

3.3 Risk management training is provided to support the effective operation of the Trust's risk management arrangements. Managers receive root cause analysis training which also incorporates duty of candour arrangements. New managers receive one to one training including use of risk registers, incident and complaint management and the use of DATIX to support these functions.

4 The risk and control framework

4.1 Roles and responsibilities for managing and escalating risk are defined within the Trust's Risk Management Policy. The Policy is underpinned by a number of risk related policies and procedures which provide further information and guidance to staff in the management of risk.

4.2 The Trust's risk management framework provides a structure for the identification of risk, the coordination of the Trust's response and the provision of a safe environment for staff and patients to raise concerns. Risks are identified from many sources including risk assessments, incident reporting, audit data, complaints, legal claims, feedback from patients, members of the public, stakeholder/partnership feedback and internal/external assessments.

4.3 Levels of risk are determined by assessment within Trust policies and procedures. Risks are assessed using an impact versus likelihood 5 x 5 matrix which produces a red-amber-green (RAG) rating for the risk. Risks rated 8 - 12 are rated amber (moderate) and risks rated 15 and above are rated red (high).

4.4 All care groups and corporate functions are required to undertake risk assessments in accordance with the Trust's risk framework with regular reviews, the frequency dependant on the severity of the risk.

4.5 The Board Assurance Framework (BAF) provides assurance in relation to the principal risks to the delivery of the Trust's strategic objectives. The BAF is normally reviewed every quarter and considered by the Board's committees including the Audit & Assurance Committee, the executive team and the Board.

4.6 The principal risks to the delivery of the Trust's objectives are
- Inability to effectively manage demand
- Failure to maintain financial viability
- Failure to develop a sustainable local health system.

4.7 The Trust currently has a risk rating of 3 on NHSI's Single Oversight Framework meaning that the Trust receives mandated support from NHSI for significant areas of risk

4.8 The Trust was part of the North Mersey Local Delivery System (LDS) which fed into the wider Cheshire and Merseyside Partnership (previously Cheshire and Merseyside STP) actively working to deliver transformation across the health and social care system. I am the representative for acute Trusts on the System Management Board for the Cheshire and Merseyside Partnership. The objectives for the Partnership are to play a lead role in system management and to drive the development of place based care.

4.9 The Board is committed to the development of a city centre teaching campus bringing together health and academia on the Royal site to contribute to the development of sustainable hospital services to address unacceptable health outcomes for the population of Liverpool.

4.10 The Trust is working with commissioners, neighbouring hospital trusts and community care partners to shape the future of local healthcare provision. We continue to work with Aintree University NHS Foundation Trust to develop a comprehensive business case to demonstrate the benefits of creating a new single acute provider to deliver improved patient care and ensure sustainable services for the future. The vanguard of this is a proposal for improving orthopaedic services through the development of a city-wide Liverpool Orthopaedic and Trauma Service.

4.11 A 'provider alliance' has been established which is chaired by the Chief Executive of Mersey Care in which we are closely involved to set priorities for integrated working and support the design of clinical pathways.

4.12 The most significant clinical risks are caused by failure to:-
- treat patients in a timely manner as a result of demand exceeding available resources resulting in delays in treatment in A & E, the provision of diagnostic tests and referral to treatment.
- respond to serious incidents and never events in a timely way and ensure lessons are learnt across the Trust.
- maintain appropriate safe staffing levels with suitably skilled and experienced staff.
- follow best practice guidance.

4.13 Our priority is to provide high quality services for patients and to ensure that patients are protected from harm. To achieve this it is essential that we are systematic in our reporting, reviewing and learning from incidents throughout the organisation creating a culture of improvement. Sharing the learning from incidents, complaints and claims is an essential component to maintain an effective risk management culture within the Trust. Learning is shared through divisional governance structures and Trust wide forums such as the Quality Governance Committee. Learning is acquired from a variety of sources which include:
- Analysis of incidents, complaints, claims and investigations.
- External inspections.
- Internal and external audit reports.
- Clinical audits.
- Outcome of investigations and inspections from other organisations.

4.14 The Trust received 646 FOI requests containing 6039 questions during 2017/18. 92% were responded to within 20 days. Information is disclosed unless an exemption is applied.

4.15 The Trust has a comprehensive Equality and Diversity Plan to ensure progress with the delivery of its obligations under the Public Sector Equality Duty, aligned to the NHS Equality Delivery system. Progress is monitored by the Workforce Committee.

4.16 The Trust has an Anti- Fraud Specialist (AFS) whose primary role is to investigate all cases of fraud, bribery and corruption reported. To support this, a risk based annual Anti-Fraud work plan is overseen by the Audit & Assurance Committee. The Committee consider regular progress reports on anti-fraud activity, which includes work to establish a strong anti-fraud culture.

4.17 The Trust is required to comply with the Standards for Providers issued by the NHS Counter Fraud Authority. The Trust's AFS has completed a self-assessment against the standards under four headings with the number of standards assessed as green or amber listed below. No standards were assessed as red.

Standard	Green	Amber
Strategic governance	7	0
Inform and involve	3	1
Prevent and deter	5	1
Hold to account	5	1

4.18 Risks relating to data security are assessed through completion of the Department of Health's (DoH) Information Governance Toolkit. The Trust has assessed itself as securing a satisfactory status against all the standards (level 2 or above against every standard).

4.19 The Trust's Information Quality Assurance Strategy includes an objective to improve the quality of data through development of an information quality kite mark to demonstrate the level of assurance for data produced by the Trust with results reported to the Information Governance Group.

4.20 The requirement to ensure that national standards are adhered to across organisational boundaries is reflected in the Trust's Information Quality Strategy, reflecting the potential risk as data is shared with other providers and social care organisations.

4.21 The Trust has developed a matrix of externally published data. The matrix includes the quality assurance rating for each indicator, the standard operating procedure (SOP) which includes the responsibility for the data collation, assurance and publication.

4.22 The Trust has a Programme Management Office which provides an integrated programme management structure to support the delivery of the Trust's over-arching change programme. Progress with the delivery of the Trust's strategic projects within the overall change management programme is reported to the Trust Board on a monthly basis

4.23 The risk and control framework continued to be strengthened during 2017/18. An external review of the Trust's Risk Management Policy was undertaken in 2016/17. This led to a revised risk appetite statement which has been adopted by the Board, an updated Risk Management Policy and recommendations to further strengthen the Trust's risk management framework. Six of the ten recommendations have been completed with the remaining four 'in progress'. This includes work to strengthen and align the assessment of risk across the Trust's strategic change programmes and assess aggregate risk across all aspects of the Trust's activities to ensure the Board are fully sighted and appropriate mitigations are in place.

4.24 In addition to the audit of the Trust's risk management arrangements undertaken by internal audit which provided significant assurance, further assurance is provided by a monthly audit of a sample of the Trust's risk registers the output of which is reported to the Board as part of the integrated performance report.

4.25 The Trust is fully compliant with the registration requirement of the Care Quality Commission (CQC). The Quality Governance Committee has responsibility for monitoring compliance with the CQC registration requirements. The Trust has developed a quality monitoring system and assessment tool, mirroring CQC's inspection methodology to assess compliance with the CQC's Fundamental Standards. The safety and quality outcomes outlined by CQC continue to be met

4.26 The Trust was subject to a planned CQC inspection in March 2016 and the formal report was received in June 2016, which confirmed an overall rating of 'good'. Three regulatory actions formed part of the report, which the Trust has addressed.

4.27 In December 2016, CQC provided feedback that they were satisfied with the action taken by the Trust and progress made against the suggestions contained within the action plan. Progress against the CQC action plan has continued to be monitored by the Quality Governance Committee with the final report considered in November 2017.

4.28 Internal audit reviewed the systems and processes to ensure on-going compliance with CQC outcomes during 2017/18 and provided significant assurance based on the controls and their operation. Internal audit also reviewed the detailed action plan which was developed in response to the 2016 inspection. They reviewed evidence against 21 areas within the plan and met with key stakeholders. The review confirmed that the Trust had established systems and processes to ensure on-going compliance with CQC standards and effective arrangements were in place to provide on-going assurance up to the Board.

4.29 The CQC have changed the way they inspect provider organisations. The Trust uses the information from the CQC repository (Insight) to inform improvement activity. The Trust provides assurance to the CQC that areas of risk are being appropriately addressed during relationship meetings between the Chief Nurse and the CQC Inspector.

4.30 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 met. 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.

4.31 The 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. The Trust has a Sustainability Plan 2017/18 incorporating workstreams for Climate Change Adaptation, Environmental Management System, Social Value KPIs, Food, and Staff Engagement including long-term targets and objectives, aligned with external requirements and internal drivers.

5 Review of economy, efficiency and effectiveness of use of resources

5.1 Reflecting the significant challenge for the Trust in relation to its financial sustainability, the Trust has worked with external advisers to support the drive to achieve financial stability and improved sustainability. This has included strengthening the financial information reported to Finance and Performance Committee and the Board including improved clarity of the assumptions/sensitivities and the risks associated with them.

5.2 The Trust has also worked with external advisers to improve the effectiveness of the Trust's arrangements for delivering its quality and efficiency plans (QEP), with oversight of the plans provided through a weekly Financial Improvement Programme meeting, chaired by the Chief Executive or the Director of Finance, with reporting through to Finance and Performance Committee and the Board. The Trust is making use of service line reporting and patient level costing systems at divisional level to benchmark services and to identify opportunities for efficiencies.

6. Information governance

6.1 In 2017/18 there were 52 level one information security incidents reported by the Trust, a reduction of nine from 2016/17. There were no reportable incidents to the Information Commissioner's Office (ICO) and NHS Digital in 2017/18. In 2016/17 the Trust reported an external breach by a third party provider where personal information relating to current and previous radiology staff's radiation monitoring. The breach occurred at a national level. The Trust CIO wrote to individuals who were affected informing them of the breach. The national supplier took action to secure their processes

6.2 A number of NHS organisations were affected by a cyber-security attack in May 2017. The Trust was not directly affected but took steps to mitigate the risk, which included shutting down our network connectivity to the national NHS network. The Trust had already taken steps to reduce the risks posed by cyber-attacks and had become an early adopter of the Care Computing Emergency Response Team service provided through NHS Digital. The Trust has identified some vulnerability with its processes around patch management and penetration testing and these have been reviewed by internal audit by way of a Cyber Security Baseline Control Assessment.

6.3 All incidents are assessed by the Information Governance (IG) department with the outcome of the investigation and lessons learnt recorded. Anonymous examples are used in training sessions to highlight the issues that affect the Trust.

6.4 The Trust continues to maintain high standards for information governance. The 45 standards within the toolkit have all been assessed as 'satisfactory'. The Trust met 85% of the standards which is an improvement of 1% from 2016/17. Internal audit has reviewed the Trust's arrangements to determine the IG toolkit score and identify and potential risks. Internal audit reported that the Trust has a clear governance structure which appears to operate effectively, with key roles in place. The audit provided significant assurance.

6.5 IG training forms part of the core skills and induction training programme. IG training programmes have been delivered to various departments and staff groups supported by e-learning programmes. The Information Governance toolkit assessment shows level 2 (satisfactory) compliance rating.

6.6 The Trust takes the confidentiality and security of information seriously and continues to invest in technology to maintain security. Devices are encrypted and the Trust network is protected from viruses and other threats. Staff are trained regularly with regular audits to provide assurance.

6.7 The role of Senior Information Risk Officer (SIRO) is undertaken by the Trust's Chief Information Officer (CIO). The CIO regularly reviews information risks. Oversight is provided by the Information Governance Group which reports to Clinical and Cost Effectiveness Sub Committee and Quality Governance Committee.

7 Annual Quality Account

7.1 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. In preparing the Quality Account directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account 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 Account 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 national guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

7.2 The following steps are in place to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data.

7.3 The Chief Nurse/COO is responsible for the Quality Account. The Board receives a monthly integrated performance report which reports progress against the quality objectives with a more detailed quality performance report considered by the Quality Governance Committee with assurance provided to the Board through the Committee Assurance Report.

7.4 The Trust has fully engaged with its CCGs, Healthwatch and local stakeholders to ensure that its key quality priorities fit with local and national priorities. The Trust has also engaged with other stakeholders to ensure that its quality priorities as outlined in its Quality Account have been considered and agreed. Each of the key quality priorities can be mapped back to the NHS definition of quality, i.e. patient experience, clinical outcomes and patient safety.

7.5 The CIO provides executive leadership for data quality. The Trust undertakes an annual data quality audit which forms part of the Information Governance Toolkit. Risks associated with data quality are included in the Trust risk register.

7.6 The Quality Account includes information on both good performance and areas for improvement which provides a balanced picture of the Trust's performance.

7.7 The Trust has policies and procedures to ensure the provision of high quality data. These documents are subject to audit to ensure compliance. The policies and procedures that relate to the quality of the data in the Quality Account are:

- Risk management policy
- Information quality assurance policy
- Incident reporting policy
- Clinical coding procedure

- Records management policy
- Data protection guidance
- Information security policy
- Information quality assurance policy.

7.8 All Trust policies and procedures are reviewed periodically and updated in accordance with the Trust's policy management arrangements.

7.9 Staff are informed of all policy changes via a weekly In Touch email communication and further supported by other methods including a weekly Patient Safety Bulletin, monthly team brief with significant policy changes supported by targeted and bespoke communication.

7.10 There are systems and processes in place for the collection, recording, analysis and reporting of data which are focused on securing data which is accurate, valid, reliable, timely, relevant and complete. Data which is reported to external bodies is supported by a standard operating procedure (SOP) which is subject to audit and review. The Trust is assured on the quality and accuracy of the elective waiting time data through application of a robust SOP and audit.

7.11 The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust business continuity management and emergency preparedness arrangements in place. Both of these are tested with an annual report provided to the Board.

7.12 Roles and responsibilities in relation to data quality are defined and incorporated, where appropriate, into job descriptions.

7.13 The Trust delivers training to staff to ensure they have the skills for the effective collection, recording, analysis and reporting of data. Data quality standards are subject to regular audit with the results reported to the Information Governance Group.

7.14 The clinical audit programme is overseen by the Clinical and Cost Effectiveness Sub Committee through to the Quality Governance Committee. The clinical audit programme integrates national mandatory audits, audits of the Trust's mortality and morbidity alerts and audits of aspects of clinical care which relate to the Trust's strategic aims.

7.15 During 2017/18, there were 43 national clinical audits and four national confidential enquiries into patient outcomes related to NHS services the Trust provides. During this period, the Trust participated in 98% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. The Trust was unable to submit to one audit owing to a national digital issue but which has subsequently been addressed.

7.16 Of the 33 national audits published during 2017/18, 20 have been reviewed. No actions were required for eight, action plans have been submitted for ten and with two outstanding. Summary reports and action plans are underway for a further 13.

7.17 Audit returns for all mandatory audits are reviewed by the Associate Medical Director for Clinical Audit and assigned an assurance rating taking in to consideration outcomes, emergent risk, number of audit cycles and quality of the action plan.

8 Review of effectiveness

8.1 As Accountable 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 and risk management is informed by the work of the internal and external auditors, clinical audit, executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee as well as other Board Committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

8.2 The Trust Board has met 13 times in 2017/18. The Trust Board consists of a Non-Executive Chair, five Non-Executive Directors and five Executive Directors (including the Chief Executive). The Board is routinely attended by a number of additional directors, including both associate non executives and directors, who bring additional capability and capacity to the Board. Further details about Board members and changes to Board membership during the year can be found in the Directors' Report and the Remuneration Report.

8.3 The Trust undertakes an annual assessment of all directors to ensure that they continue to meet the requirement of the fit and proper person's regulation1. The outcome of the assessment is reported to the Nomination and Remuneration Committee. This is in addition to the checks undertaken during the selection process.

8.4 The governance structure aligns the Trust's quality, risk and performance management arrangements. The committees, sub committees, groups and individuals have defined responsibility to ensure delivery of the Trust's strategic goals and objectives, via compliance with performance and quality indicators and monitoring of associated risks.

8.5 The Board is supported by eight committees:-

- Audit and Assurance
- Nomination and Remuneration
- Research, Development and Innovation.
- Quality Governance
- Finance and Performance
- Workforce
- Charitable Funds
- New Hospital

8.6 The Audit & Assurance Committee has overarching responsibility for ensuring that risk is managed effectively within the organisation including the evaluation of the effectiveness of the risk management and control systems. This is further supported by the Board's committees that oversee risks relevant to their role. The risk management framework provides for the effective management of risk across the Trust, including escalation from the ward to the Board through the performance management framework. 'Perfect ward' meetings address issues at ward level with visibility through to the Board via the monthly ward quality dashboard and safe staffing reports.

8.7 The Audit and Assurance Committee provides the Board with an independent and objective view on its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS. The focus of the Committee is upon the establishment and maintenance of an effective system of integrated governance, risk management and internal control.

8.8 The Nomination and Remuneration Committee decides and keeps under review the terms and conditions of office of the Trust's executive directors and senior managers on local pay including all aspects of salary, provision of other benefits and arrangements for termination of employment and other contractual terms in accordance with national guidance.

8.9 The Quality Governance Committee provides assurance to the Board that high quality care is provided and that appropriate governance arrangements are in place to promote safety and excellence in patient care. The Committee oversees the prioritisation and management of risk arising from clinical care, ensuring effective and efficient use of resources through adoption of evidence based clinical practice and promotion of wellbeing for patients.

8.10 The Finance and Performance Committee provides assurance to the Board in relation to the financial and corporate performance of the Trust, monitoring delivery against targets and objectives. A quarterly report is provided to the Trust Board to provide assurance in relation to compliance with the Trust's health and safety obligations and delivery of its objectives and identification of any significant risks.

8.11 The Workforce Committee provides assurance to the Board on the delivery of the workforce strategy and ensuring compliance with statutory requirements and legislation relating to the employment of staff. The Committee also oversees delivery of plans to ensure that the Trust's workforce has the capacity and capability to deliver the Trust's objectives through effective management, leadership and development, workforce planning and organisation development.

8.12 The Research, Development and Innovation Committee provides direction and oversight of research, development and innovation to advance the effective care and management of patients.

8.13 The Charitable Funds Committee oversees the management, investment, and effective use of charitable funds, on behalf of the Board in accordance with its delegated powers, statutory requirements and best practice as required by the Charity Commission.

8.14 The New Hospital Committee continues to oversee the Trust's plans, service transformation and redesign projects directly linked to the effective transition to the new hospital. The liquidation of Carillion in January 2018 has created significant uncertainty and further delay regarding completion of the new hospital. The Committee is closely scrutinising the position in relation to both the construction of the new hospital and arrangements for the continuation of facilities management services which were also provided by Carillion.

8.15 The Trust monitors attendance of members and regular attenders at each Board and Committee meeting and also reviews attendance as part of the annual review of the Board and its committees.

	Attendance 2017/18 (target 75%)
Trust Board	77%
Audit and Assurance	76%
Quality Governance	64%
Finance and Performance	78%
Research Development and Innovation	67%
Nomination & Remuneration	71%
Charitable Funds	93%
New Hospital	63%
Workforce	83%

8.16 The Trust's corporate governance framework is defined by its Standing Orders (SO), Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD). These were last reviewed and approved by the Board in November 2017.

8.17 The responsibilities of Directors are reviewed through individual performance appraisal and as part of the assessment of the skills and experience of the Board.

8.18 An annual audit plan is prepared by the Trust's internal audit provider for discussion and approval by the Audit and Assurance Committee. A summary of internal audit reports is considered by the Audit & Assurance Committee and support the Director of Internal Audit's Opinion. Substantial assurance was provided by the Head of Internal Audit for 2017/18 which means that there is a generally sound system of internal control designed to meet the Trust's objectives, and that controls are generally being applied consistently. During 2017/18 the Trust received four internal audits which provided limited assurance. These related to IM &T Critical Applications – PENS and PFHR, Ward Quality Spot checks for wards 3A, 4A and 5X, Doctor's annual leave and IM & T: EPR Project Management.

8.19 Action plans in response to limited assurance audits are overseen by the Audit and Assurance Committee with independent assurance provided by way of a follow up audit by internal audit. The above audits identified weaknesses in design and/or operation of control with no significant internal control issues or gaps in control identified. Action plans have been completed in respect of the above audits.

8.20 The following internal audit reports provided significant or high assurance: :

- Global Digital Exemplar Milestone
- Financial ledger
- Accounts receivable
- Accounts payable
- Treasury management
- Asset management

- Budgetary Reporting
- ESR/Payroll interface
- IM & T : Information Governance Toolkit
- Risk Management
- NMC Revalidation
- Ward Quality Spot Checks
- CQC action plan
- Patient safety alerts
- Safeguarding
- Nurse Rostering
- Mandatory Training
- Clinical Audit Validation – Consent Audit

8.21 The Trust has participated in the national Financial Improvement Programme (FIP). During 2017/18 the Trust operated an internal turnaround programme supported by external advisers with additional leadership provided by an interim Turnaround Advisor to support the Trust's drive to achieve financial stability and improved financial sustainability. This process has supported the Board's pursuit of a financial improvement strategy informed by productive opportunities. .

8.22 The Patient Safety Sub Committee monitors the completion of the investigation and the action plan in response to never events, serious incidents and high level investigations ensuring actions are complete.

8.23 The Trust Board considers the Annual Report on Serious Incidents and Never Events which identifies trends and lessons learnt.

8.24 The Trust has been challenged in year to maintain required performance levels for A & E waiting times and the 18 week RTT pathways standard Detailed improvement plans are in place to ensure that required improvements in performance are achieved including both internally driven improvements as well as actions required by commissioners and other providers. The Trust continues to work with the Emergency Care Improvement Programme (ECIP) to optimise the use of the SAFER care bundle within the Trust.

8.25 The Trust has a consistent record of meeting the national standards for cancer waiting times. However, this year it narrowly missed the target on one of these national standards. Improvement actions have been put into place and the Trust is working with the Cheshire and Merseyside Cancer Network to further improve care.

8.26 In 2017/18 the Trust reported 30 serious incidents (3 others were stood down). There were 3 never events. All serious incidents are subject to a root cause analysis (RCA) with lessons learnt shared across the Trust. 80 local RCAs were requested following moderate/high harms and are reviewed through the weekly Patient Safety meeting. The Trust has completed 77% of moderate to high harm RCAs to date in this financial year.

8.27 The National Reporting System demonstrates that the Trust is in the top 25% for reporting incidents and the Trust reports more no harm incidents than the average, which is evidence of a positive reporting culture.

8.28 The governance framework provides assurance that arrangements are in place for the effective discharge of the Trust's statutory functions and that the Trust is compliant with its statutory responsibilities.

9. Significant Issues

9.1 Through 2017/18 the Trust has continued to be challenged by the significant number of patients who are ready for discharge from hospital but with no onward package of care available. Given the challenges with regard to wider urgent care system resilience, delivery of effective patient flow, the A&E target remains a key challenge and priority, delivery of which requires a whole system focus and joint working. The Trust continues to work to improve patient flow both internally within the hospital and externally across the system through the A & E Delivery Board which I chair. This includes work to ensure sustainability of the SAFER model and further development of ambulatory care.

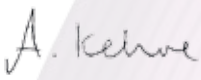
9.2 The Trust recognises that delivery of the Trust's financial plan is increasingly challenging, which is reflected nationally across the NHS provider sector. The Trust has strengthened both its financial reporting arrangements and governance structure to drive the achievement of the unprecedented saving challenge which is predicated on improved quality to ensure efficiency. We continue to explore every opportunity to improve the financial sustainability of the organisation. The Trust has operated an internal turnaround programme during 2017/18 supported by external advisers. This process has enabled the Board to pursue a financial improvement strategy informed by productive opportunities.

9.3 As a consequence of the financial challenge the Trust has been in receipt of cash support and has been in regular dialogue with NHSI and the DoH regarding the need for continued working capital support during 2017/18. In 2017/18 this amounted to c£66m. The Trust is forecasting an on-going requirement for cash support from DoH in 2018/19 which is driven by the underlying revenue deficit and the Trust will continue regular dialogue with NHSI and DoH regarding this support. The capital programme required to complete the new Royal Hospital project and related schemes is significant in 18/19 and will require cash support to complete as outlined below.

9.4 The new £335m Royal hospital was originally planned to open in 2017 but following the liquidation of Carillion, completion of the new build is uncertain. The Trust is working closely with the New Hospital Company (Liverpool) and key stakeholders to expedite completion of the construction. Plans are well developed for the transition to the new hospital with commissioning teams for each speciality ensuring staff are prepared. The implications of the continued delay and on-going uncertainty are closely monitored by the Board with a view to mitigating the impact.

Conclusion

My overall opinion is that, taking account of the items referred to above and the mitigations put in place, that there is an adequate system of internal control designed to meet the Trust's objectives and that controls are generally being applied consistently. I can confirm that the system of internal control has been in place for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.



Aidan Kehoe
Chief Executive
Royal Liverpool and Broadgreen University Hospitals NHS Trus

Date 29 May 2018

> Thanks for the second time this year to A&E staff last night. Every staff member was friendly, caring, reassuring and model professionals. The receptionist, healthcare assistants, nurses, cleaners and everyone else involved, are all a credit to the Trust and the NHS.

Remuneration report

Remuneration policy

The Trust has a Nomination and Remuneration Committee which is established by the Board of Directors whose purpose is to oversee the development of the policy of Executive terms and conditions and to apply and monitor its application. The aim is to ensure that there is a transparent process for determining pay for the Chief Executive, Executive Directors and senior staff on Trust terms and conditions as there is no national framework which applies to executives (VSMs). The remit covers salary, benefits and contracted terms of employment. The Trust's policy is based on a wide consideration of local/national market rates and benchmarking with comparable trusts. The last benchmarking exercise led by an independent expert was undertaken in 2014. The ranges were set at 90% to 110% of the public sector/not for profit benchmarking data with a view to attracting and retaining high calibre executive directors through the provision of a competitive salary comparable with comparable organisations in terms of size and complexity.

The level of remuneration paid to the chair and non-executive directors is set by the Secretary of State for Health.

Executive team changes

Debbie Herring joined the Trust as Executive Director of Workforce on 31 July 2017. The Chairman, Chief Executive and two non-executives (Angela Phillips and Susan Young) were involved in the appointment process. Remuneration was based on consideration of market rates and salary package comparisons within the agreed salary range for the role (2014).

Following the departure of the Director of Operations and the failure to recruit a substantive replacement, the functions were distributed to other members of the Executive team. Lisa Grant continued in the dual role as Chief Nurse/Chief Operating Officer on an interim basis. The Medical Director assumed responsibility for the move to the new hospital, with the Director of Finance assumed responsibility for leading on the contractual aspects of the new hospital build and health and safety.

Executive Performance and Remuneration.

The Nomination and Remuneration Committee considered a report at its meeting in July 2017 which set out the principles underpinning executive pay. The Committee confirmed that the principles were valid and would continue to be applied to executive pay.

All executive directors participate in the annual appraisal process which incorporates assessment of performance against agreed objectives, demonstration of behaviours in line with the Trust's values and the agreement of any development needs.

The chairman is responsible for agreeing the personal objectives of the Chief Executive and undertaking the annual appraisal, the outcome of which is reported to the Nomination and Remuneration Committee.

VSM remuneration policy

- Director pay is determined according to job size, market rates and performance. All director roles have been evaluated independently and benchmarked to NHS Improvement approved salary range. The Committee approves the salary range for each post with the actual point on the salary range is agreed by the Chief Executive and the director upon appointment.
- Director job roles are reviewed and evaluated on an on-going basis. The last time this was done was 2014 with new roles evaluated prior to recruitment. .
- Progression through the pay scale is not automatic but pay should be reviewed annually with regard to national guidance. Performance for directors will be assessed upon their appraisal and achievement of their objectives.
- Director pay awards should as far as possible mirror existing practices for the pay of other non-medical staff across the NHS paid within the nationally agreed Agenda for Change framework.

Nomination and Remuneration Committee

The Nomination and Remuneration Committee operates in accordance with its terms of reference. It is chaired by Bill Griffiths, Chair of the Trust and consists of all the non – executives. The Chief Executive is invited to attend the Committee in relation to discussions about Board succession planning and remuneration of Executive Directors. The Chief Executive is not present during discussions relating to his own performance, remuneration and terms of service. The Executive Director of Workforce provides advice and guidance to the Committee and withdraws from the meeting when discussions about her own remuneration and terms of service are held. The Trust's Associate Director of Corporate Affairs/Trust Secretary acts as secretary to the Committee.

The following tables and fair play multiple, which are subject to external audit, show Directors' remuneration for the year.

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 member's 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. Where an employee has held a post with the Trust for part of the year, the real increase in CETV is calculated on a pro rata basis.

Directors' remuneration

The table below records the remuneration, pay and benefits in kind of Trust directors for the year 2017/18, pro-rated for each director. The aspects of the remuneration report subject to audit are:

- Benefits of senior managers (and related narrative notes), the table of salaries and allowances of senior managers (and related narrative notes)
- The table of pensions

Salary and allowance table for the year ended 31 March 2018 Name & Title	Salary (Bands of £5,000)	Taxable expenses including the provision of cars (see Note b) to nearest £100	Performance pay and bonuses (Bands of £5000)	All pension related benefits (Bands of £2,500)	Total (bands of £5,000)
Executive Directors:					
A Kehoe Chief Executive	200-205	4,600		0	205-210
J Graham Director of Finance	135-140	11,900		0-2.5	150-155
D Herring Director of Workforce (from 31 July 2017)	75-80	1,400		7.5-10	85-90
S Clayton Acting Director of Workforce (to 30 July 2017)	35-40			5-7.5	40-50
L Grant Chief Nurse and Operating Officer	130-135	10,000			140-145
P Williams Medical Director	140-145				140-145
D Walliker (see Note A) Chief information officer	70-75	5,800			75-80
D McLaughlin Director of Operations (to 2 April 2017)	0-5			0-2.5	0-5
H Shaw (see Note A) Director of Communications	60-65			20-22.5	85-90
Chairman & Non-executive Directors:					
B Griffiths Chairman	40-45				40-45
M Eastwood Non-executive Director	5-10				5-10
M Jackson Non-executive Director	5-10				5-10
G Stewart Non-executive Director	5-10				5-10
S Young Non-executive Director	5-10				5-10
J Kingsland Non-executive Director	5-10				5-10
N Willcox Non-executive Director	5-10				5-10
A Phillips Non-executive Director	5-10				5-10

Note A – where senior managers have undertaken work for another organisation and salary is recharged, the recharged amount is excluded from the table

Note B – where a senior manager has a salary sacrifice scheme (i.e. for leased cars), the amount sacrificed is reported under the taxable benefits column than salary

From April 2018, all leased cars for senior managers are under the Salary Sacrifice Scheme.

Salary and allowance table for the year ended 31 March 2017 Name & Title	Salary (Bands of £5,000)	Taxable expenses include the provision of cars (see Note B) to the nearest £100	Performance pay and bonuses (Bands of £5000)	All pension related benefits (Bands of £2,500)	Total (bands of £5,000)
Executive Directors:					
A Kehoe Chief Executive	200-205	8,400		2.5-5.0	210-215
J Graham Director of Finance	135-140	9,500		15.0-17.5	160-165
R Edwards Director of Human Resources (to 30th April 2016)	5-10	500		0-2.5	10-15
S Clayton Acting Director of Human Resources (from 1 May 2016)	95-100			40-42.5	140-145
L Grant Chief Nurse (and Chief Operating Officer from 1 November 2016	125-130	10,500			135-140
P Williams Medical Director (from 1 May 2016)	130-135				130-135
J Hobbs Medical Director (1 April -30 April 2016)	10-15		0-5	0-2.5	15-20
D Walliker (see Note A) Chief information officer (from 1 July 2016)	50-55	1,700		35-37.5	90-95
D McLaughlin Director of Operations (to 2 April 2017)	125-130	4,300		27.5-30	155-160
H Shaw (see Note A) Director of Communications	60-65			15-17.5	75-80
Chairman & Non-executive Directors:					
B Griffiths Chairman	40-45	500			40-45
M Eastwood Non-executive Director	5-10				5-10
D Kilworth Non-executive Director (to 31 August 2016)	0-5	1,000			5-10
G Stewart Non-executive Director	5-10	2,300			5-10
B Burgoyne Non-executive Director (Until 31 August 2016)	0-5				0-5
N Willcox Non-executive Director	5-10				5-10
A Phillips Non-executive Director (from 2 September 2016)	0-5	600			0-5
M Jackson Non-executive Director (from 1 September 2016)	0-5				0-5
S Young Non-executive Director (from 1 October 2016)	0-5				0-5
J Kingsland Non-executive Director (from 1 October 2016)	0-5				0-5

Note A where senior managers have undertaken work for another organisation and salary is recharged, the recharged amount is excluded from the table

Note B where a senior manager has a salary sacrifice scheme (i.e. for leased cars), the amount sacrificed is reported under the taxable benefits column rather than salary.

*Performance related pay for medical staff includes local and national clinical excellence awards. National Clinical Excellence awards are funded by the Department of Health.

Salaries are reviewed on an annual basis, and for 2017/18 a 1% uplift of the average Director salary was applied to each Director salary which followed national guidance on director salaries. New and revised job descriptions are externally evaluated on an on-going basis using the Hay Group job evaluation methodology and the salary range approved by the Nominations and Remuneration Committee.

Pension table for the year ended 31 March 2018 Name & title	Real increase in pension at retirement age Banding £2500	Real increase in lump sum at retirement age related to real increase in pension Banding £2500	Total accrued pension at retirement age at 31 March 2018 Banding £5000	Lump sum at retirement age related to accrued pension at 31 March 2018 Banding £5000	Cash equivalent transfer value at 31 March 2017 £000s	Real increase in cash equivalent transfer value £000s	Cash equivalent transfer value at 31 March 2018 £000s	Employers contribution to stakeholders pension £000s
A Kehoe Chief Executive								
J Graham Director of Finance	0-2.5	2.5-5	20-25	65-70	428	43	475	0
D Herring Director of Workforce (from 30 July 2017)	0-2.5	0-2.5	35-40	95-100	628	33	684	0
S Clayton Acting Director of Workforce (to 30 July 2017)	0-2.5	2.5-5	45-50	140-145	993	79	1081	0
H Shaw Director of Communication	0-2.5	N/A	15-20	N/A	189	32	222	0
D Walliker Chief Information Officer (not in pension scheme)								
L Grant Chief Nurse (not in pension scheme)								
P Williams Medical Director (not in pension scheme)								

Pension table for the year ended 31 March 2017 Name & title	Real increase in pension at retirement age	Real increase in lump sum at retirement age related to real increase in pension	Total accrued pension at retirement age at 31 March 2017	Lump sum at retirement age related to accrued pension at 31 March 2017	Cash Equivalent transfer value at 31 March 2017	Cash Equivalent transfer value at 31 March 2016	Real increase in cash equivalent transfer value	Employers contribution to stakeholders pension
	Banding £2500	Banding £2500	Banding £5000	Banding £5000	£000s	£000s	£000s	£000s
A Kehoe Chief Executive	0-2.5	0-2.5	65-70	195-200	1292	1248	44	0
J Graham Director of Finance	0-2.5	2.5-5	20-25	60-65	428	385	42	0
R Edwards Director of Human Resources to 30 April 2016	2.0-2.5	0	15-20	0	256	216	40	0
S Clayton Acting Director of Human Resources from 1 May 2016	2.5-5.0	10-12.5	45-50	135-140	993	919	74	0
J Hobbs Medical Director from 1 April to 30 April 2016	0-2.5	10-12.5	0-5	10-15	70	25	44	0
H Shaw Director of Communications	0-2.5	N/A	10-15	N/A	189	160	29	0
D Walliker Chief Information Officer (from 1 July 2016)	0-2.5	0-2.5	15-20	40-45	221	207	11	0
D McLaughlin Director of Operations	0-2.5	0	30-35	85-90	450	414	32	0
L Grant Chief Nurse (not in pension scheme)								
P Williams Medical Director (not in pension scheme)								

Fair pay disclosure

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 2017-18 was £200-205k (2016-17: £210-15k). This was 8 times (2016-17, 8 times), the median remuneration of the workforce, which was £26,565 (2016-17: £26,350).

In 2017-18, 1 employees (2016-17: 3) received remuneration in excess of the highest-paid director. Remuneration ranged from £15,404 to £213,057 (2016-17: £15,251 to £236,159).

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

	Group 2017-18	Group 2016-17
Band of highest paid directors total remuneration	200-205	210-215
Median total remuneration	£26,565	£26,350
Ratio	8	8

Staff numbers

Average Staff Numbers	2017-18 Total Number	2016-17 Total Number	2017-18 Total Costs £000s	2016-17 Total Costs £000s
Medical and dental	865	856	89,310	86,377
Ambulance Staff		0	84	144
Administration and estates	1,849	1,835	68,473	67,216
Healthcare assistants and other support staff	802	752	27,355	27,582
Nursing, midwifery and health visiting staff	1,938	1,980	83,066	81,922
Scientific, therapeutic and technical staff	1,411	1,317	39,428	35,879
TOTAL	**6,865**	**6,740**	**307,716**	**299,120**

Thank you to consultant ophthalmologist Mark Batterbury from the family of a patient having surgery at St Paul's:

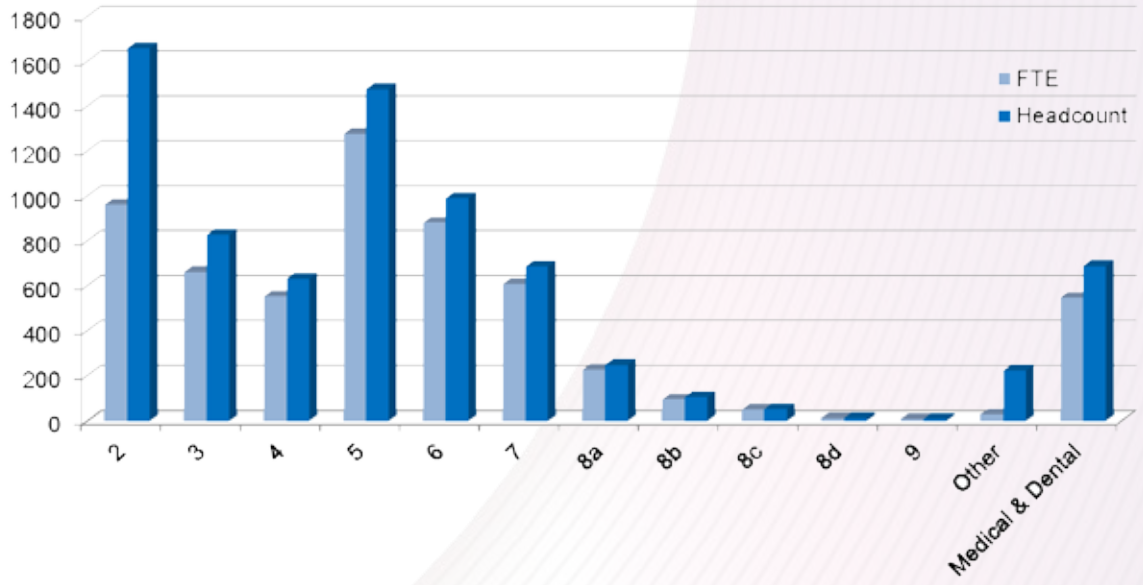
"Everyday what you do changes lives for the better. My son's world was getting darker and darker. It was obvious surgery would be extremely difficult but you were willing to try. You did an amazing job and you and your team took excellent care of him with wonderful results. He has been rediscovering the world, seeing things he hasn't seen in a long time. His world is brighter and clearer. We will be forever grateful to you and your team."

Staff report

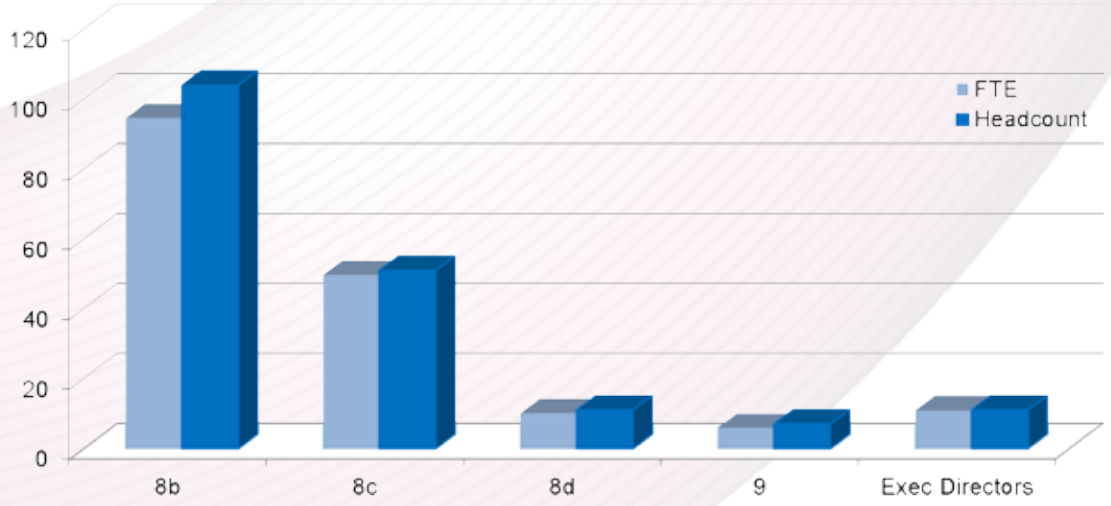
Staff composition

The Trust currently employs 7,600 people and in addition has temporary bank staff (internal temporary agency) workers, all supporting our services. The following charts provide a breakdown of our workforce based on the number of people employed, referred to as headcount and the contracted hours referred to as full time equivalent.

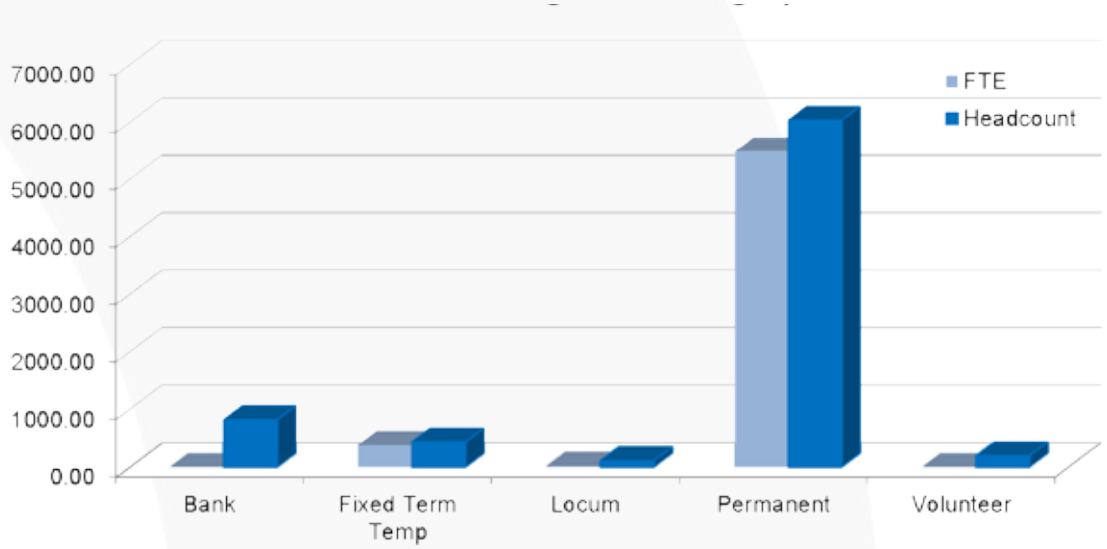
Our overall workforce numbers by banding are illustrated below. As the graph shows the largest staff group is qualified staff at band 5, which is the qualified entry grade for clinical staff such as a trained nurse and support staff at band 2:



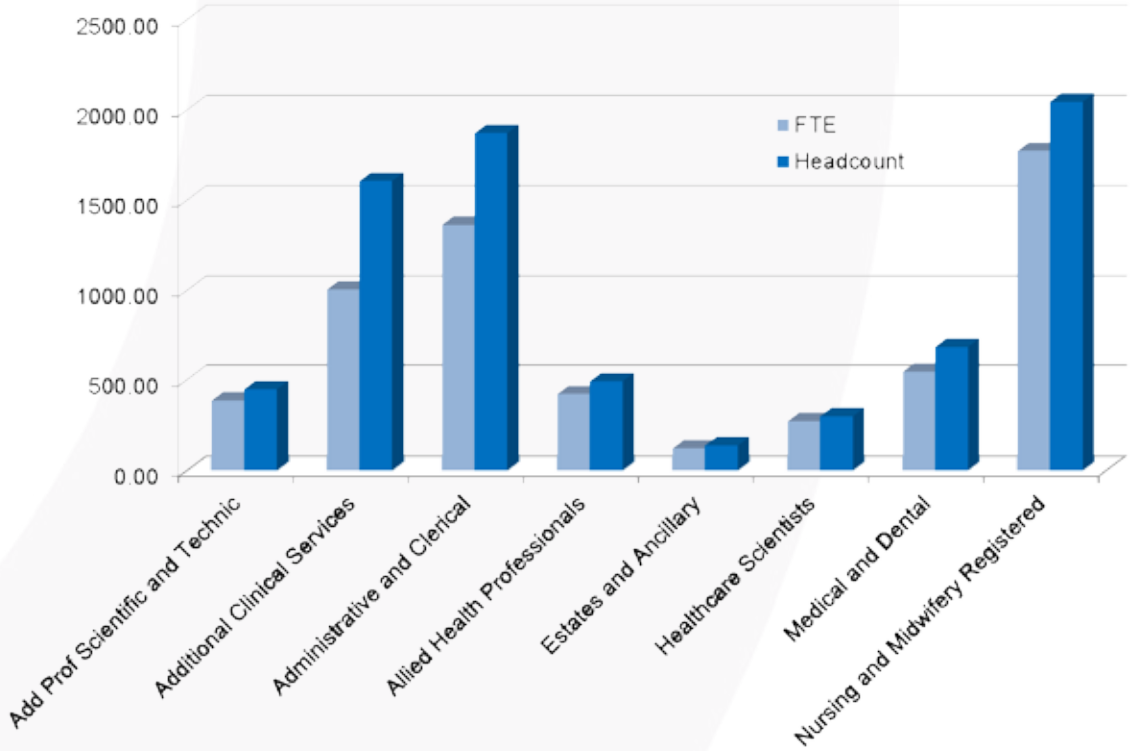
Among our staff, the Trust employs around 180 senior managers (in roles 8b or above). The number of senior managers within the organisation by band is illustrated below:



Looking at how staff are assigned to roles the graph below outlining the employment status of our workforce shows the overwhelming majority are on permanent contracts:

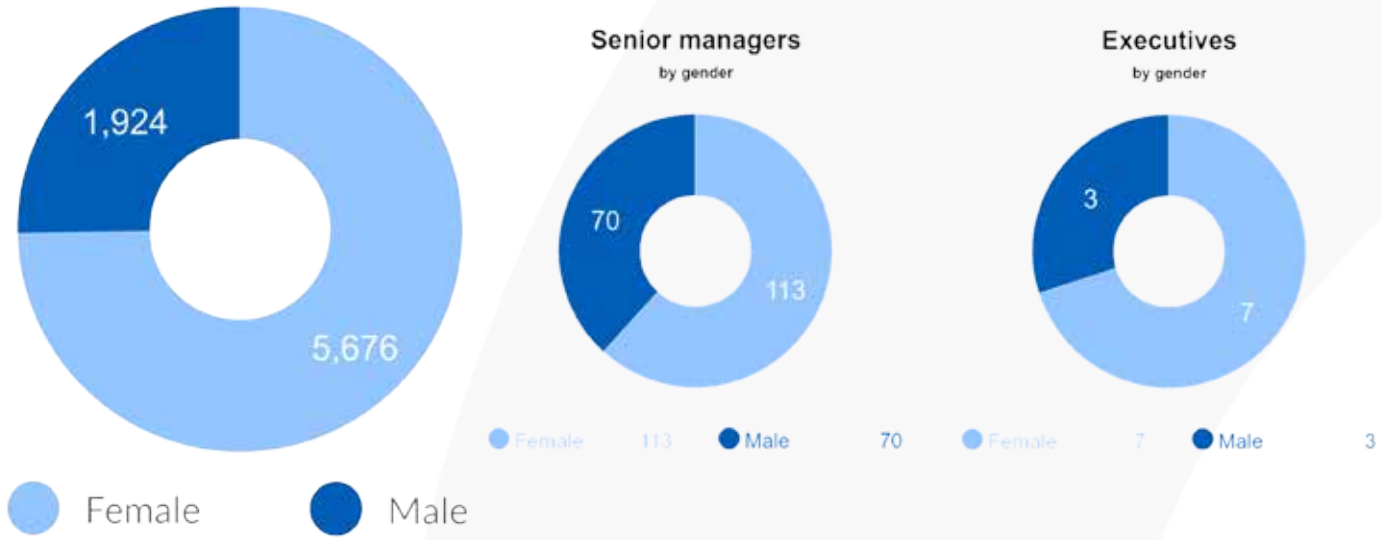


Looking at the type of roles that our staff have, the chart below outlines the workforce by staff group (staff group is derived using the NHS Digitals NHS Occupational Code Manual). This shows that the majority of our staff are in nursing roles.

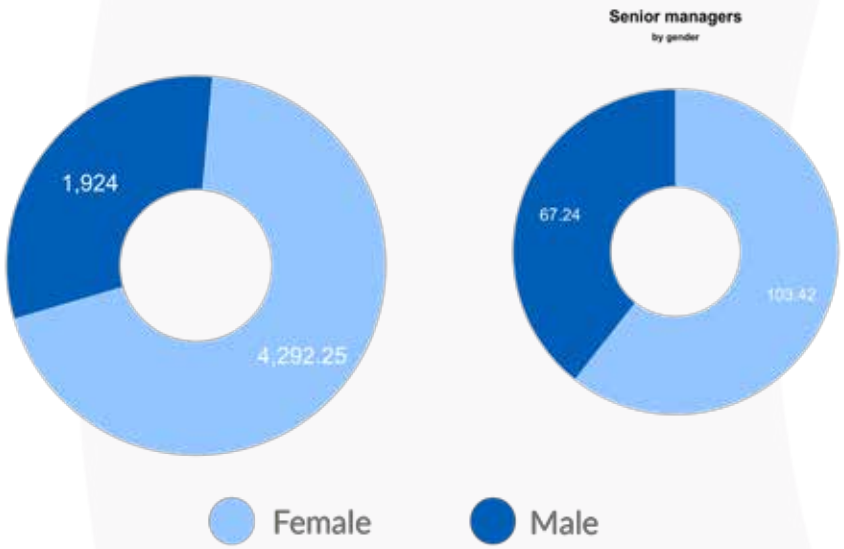


The vast majority of staff at the Trust are female, around 73%. How gender is split across seniority is illustrated below. Around 40% more senior managers are female than male.

Gender split by headcount:



Gender split by full-time equivalent



The Trust has reported a gender pay gap of approximately 25% which is consistent with other comparable NHS organisations. The gap can largely be accounted for by additional payments, or "bonus payments" which at the Trust relates to clinical excellence awards. The pay gap has fluctuated slightly and reduced over the last 12 months. A number of steps are planned to better understand the gap and put measures in place to begin to address it. This includes the development of an action plan in partnership with union and staff representatives, a review of our approach to talent management and career progression and further investigation of the balance of male and female employees at different levels in the Trust.

Social demographics

The Trust has undertaken extensive analysis of its workforce equality data as part of the Workforce Equality Standard 2017. The following outlines the findings from this analysis.

The 2011 Census put Liverpool's Black and Minority Ethnic (BME) Population at 13.7% (which excludes white Irish). The proportion of BME staff in the Trust as at April 2017 was 10.87% which was a decrease on the previous year from 11.28%. 11.0% of the clinical workforce is BME. BME representation has increased in bands 2, 3, 6, 8b and 8c grades in the last year and decreased in band 4, 5, and 7, further work will need to be undertaken to identify if these changes are positive and linked to career progression and promotion. Representation has reduced across many clinical grades in the last year and this may be the reason that the BME workforce overall has reduced slightly over the last year.

There is a significant difference in diversity between the Board voting membership and the Trust's overall workforce. Positive action has been undertaken for recruitment to Board posts with positive action statements in adverts and the adverts being shared widely in the community. All of the actions agreed for improving equal opportunities in career progression apply to Board recruitment.

White people were 1.84 times more likely to be appointed from shortlisting across all posts. Several actions have been taken to address this including recommendations around management training and encouraging under-represented groups to apply for roles. The outcome of the EU referendum could account for some of these challenges as the impact has included an increase in hate crime for some people in society who may identify as BME. A BME mentoring scheme has been piloted this year. Through the BME focus group it has been agreed that training will be provided to BME staff on how to complete NHS jobs application forms, interview techniques and presentation skills to support the selection process.
The likelihood of BME staff entering disciplinary procedures has reduced from 1.26 times last year to 0.88 and means that BME staff are less likely to enter disciplinary processes than white staff.
There has been a decrease in the number of both BME and white British staff reporting experiencing harassment, bullying or abuse from patients, relatives and public in the last 12 months. This is a positive change, however BME staff are still reporting a higher level of harassment, bullying and abuse than white staff (White: 23.49 % & BME: 26.41% respectively. However both have reduced from last year (White: 25.81% and BME: 27.18 %). The reduction is positive considering evidence of an increase in the number of race hate crimes both locally and nationally following the EU referendum. However, BME staff have reported higher levels of harassment, bullying or abuse from colleagues compared to last year and this will be addressed through the Trust's Staff Survey Action Plan for 2018.

Significant progress has been made on developing race equality over the past 12 months. However, the Trust still has some way to go in terms of achieving its goal of being representative of the local community for BME across all staff groups, and banding structures, by 2020. Furthermore, there is an immediate and long term challenge around addressing a range of cultural and organisational factors which culminate in BME people experiencing poorer employment prospects and experiences than their white counterparts in the Trust.

Sickness absence

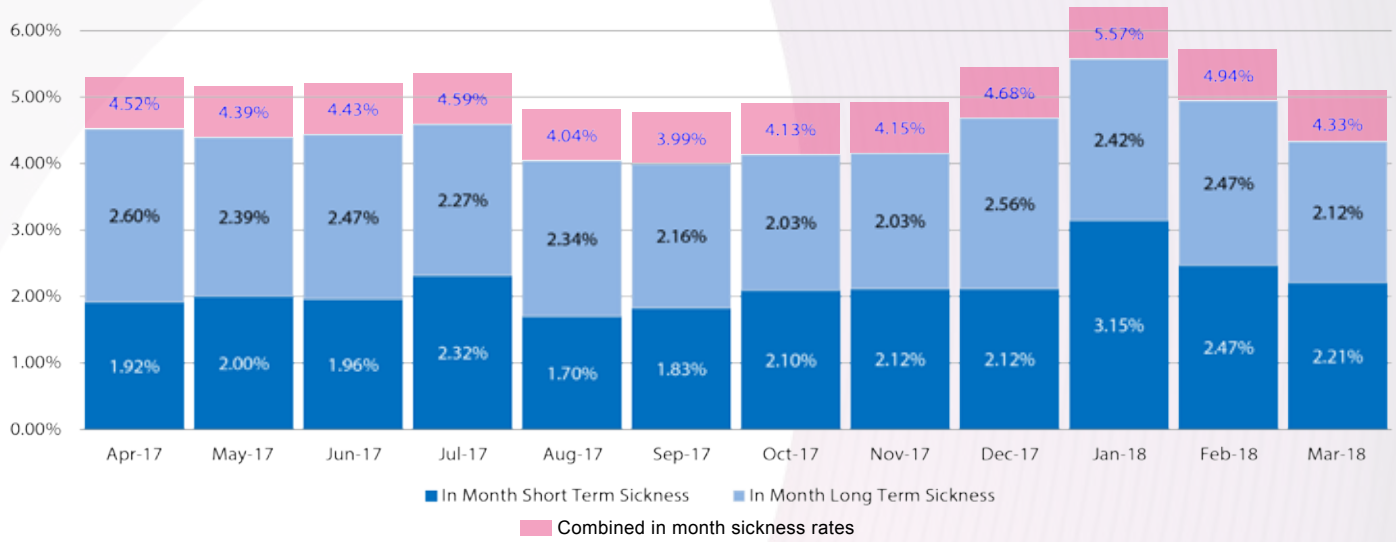
Trusts are also required to report on staff sickness. The information below reflects a full year of recorded sickness.

Over the last year the Trust has revised its Sickness Absence Policy to make it consistent with neighbouring trusts and to improve support for the effective and consistent management of sickness.

The Trust now has a dedicated sickness absence support team in place that is working with both managers and individuals to understand particular issues and trends and support staff through their sickness to have a healthy return to work.

There is also a broad spectrum of health and wellbeing initiatives for staff. These include physical activity sessions, weight loss challenges, mental health support, health awareness and grievance support. The Trust also has a staff therapy service with staff able to self-refer to a Physiotherapist or Occupational Therapist on a fast-track basis which complements the existing Occupational Health Service. There is also a confidential Staff Support Service providing a free counselling service for staff, which is available 24/7.

Trust sickness absence rates



Staff policies

The Trust has a range of policies which our staff have access to via the Trust intranet and also the Trust induction programme. The Trust also has training for managers in the application of employment policies. The policies include Equality and Diversity in Employment, including a Reasonable Adjustments Policy. The Trust has an active trade union membership and has a Partnership Agreement which sets out how we work with trade union colleagues and the underpinning arrangements for employee relations within the Trust. This agreement also describes how we recognise trade unions and what facility time is available for accredited representatives. The health, and safety of our employees is really important to us and arrangements are developed in partnership with the trade unions and overseen by the Health and Safety Sub Committee. The Board receives quarterly reports on health and safety matters. The pay, terms and conditions for our non-medical staff are determined nationally although there are small elements of local pay for example on-call payments.

Around 2% of staff at the Trust have declared a disability. The Trust continues to support the Two Ticks standard of guaranteeing an interview to any disabled applicant who meets the minimum requirement of the person specification, making reasonable adjustments available on request. The right to request adjustments is made clear in recruitment documentation. Where staff acquire a disability whilst in employment, the Trust provides guidance and support to these individuals with expert input from our Occupational Health Service, our Staff Support Service and our Staff Therapies Service, including specific Occupational Therapy advice which can identify necessary adjustments. All steps are taken to make any required reasonable adjustment, including access to training, development and temporary or permanent redeployment were required. The Trust analyses its employment data such as staff survey results, to take account of differences in experience by staff from different minority groups and develops plans to address any discrepancies.

We value our staff and have an annual appraisal process which applies to all non-medical staff and a specific medical appraisal process is also in place.

Expenditure on consultancy

The table below details the Trust's expenditure on consultancy services

	Number of Cases	2017-18 £000s
Costs relating to Business Cases approved by NHS Improvement	3	922
Costs relating to Business Cases awaiting approval by NHS Improvement		
Costs exempt from approval by NHS Improvement (below £50,000 or prior to 2 June 2015)	12	106
Costs exempt from approval by NHS (Other)		
TOTAL	**15**	**1,028**

Off payroll engagements

Off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

Number in place on 31 March 2017	**11**
Of which,	
Number that have existed for less than one year at time of reporting.	2
Number that have existed for between one & two years at time of reporting.	3
Number that have existed for between two and three years at time of reporting.	1
Number that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	5

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, or those that reached six months in duration during the year, for more than £245 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	**11**
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	11
Number engaged directly (via PSC contracted to the entity) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review	

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed 'board members, and/or senior officers with significant responsibility during the financial year'. This figure includes both off-payroll and on-payroll engagements	0

All off-payroll arrangements are in respect of Mersey Internal Audit Agency which is hosted by the Trust.
Exit packages

The Trust has operated a Mutually Agreed Leavers Scheme during this year. 10 individuals left the Trust under the Scheme from band 7 to band 8d. The total value of the packages across all ten staff was £483,750.

In addition, the Trust made 3 compulsory redundancies with packages totalling £45,478. All applications are considered by an exec panel and reported to the Nomination and Remuneration Committee for assurance.

Exit Packages Note: Table 1

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	1	8,473	1	8,473	0	0
£10,001 - £25,000	3	45,478	0	0	3	45,478	0	0
£25,001 - £50,000	0	0	3	97,259	3	97,259	0	0
£50,001 - £100,000	0	0	6	378,018	6	378,018	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	3	45,478	10	**483,750 Agrees to A below**	13	529,228	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the Mutually Agreed Leavers Scheme. Exit costs in this note are accounted for, in full, in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Exit Packages Note: Table 2

	Agreements Number	Total Value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	10	483,750
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
	10	**483,750 A – agrees to total in Table 1**


PHILIPS

Audit Report

Independent auditor's report to the Directors of Royal Liverpool and Broadgreen University Hospitals NHS Trust Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Royal Liverpool and Broadgreen University Hospitals NHS Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including the significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2018 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.6.1 in the financial statements, which indicates that the Trust incurred a deficit of £26.2 million during the year ended 31 March 2018. The Trust has not agreed a control

total for 2018/19 with NHS Improvement, and the first draft of its 2018/19 Operational Plan includes a planned deficit of £40 million, which assumes £31 million of efficiencies are delivered. The Trust is planning on the basis of receiving significant cash support in 2018/19 totalling £65.9 million, comprising £43 million to support revenue expenditure and £22.9 million to support capital expenditure. As stated in note 1.6.1, NHSI has not, at the date of our report, formally confirmed acceptance of the Trust's 2018/19 financial plan. These events or conditions, along with the other matters explained in note 1.6.1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the group and Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the group or the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the group or the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matter described in the basis for qualified conclusion section, we are satisfied that, in all significant respects, Royal Liverpool and Broadgreen University Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- the Trust incurred a deficit of £26.2 million for the year ended 31 March 2018;
- the Trust is forecasting a further £40 million deficit for the year ending 31 March 2019, assuming delivery of a total of £31 million of efficiencies;
- the Trust is reliant on receiving £65.9 million of cash support to support revenue and capital expenditure in 2018/19.

These matters are evidence of weaknesses in the proper arrangements for setting a sustainable budget under the current service configuration, with sufficient capacity to absorb emerging cost pressures.

These matters are evidence of weaknesses in the proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November

2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Royal Liverpool and Broadgreen University Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

John Farrar

John Farrar
Associate Director
for and on behalf of Grant Thornton UK LLP

4 Hardman Square Spinningfields Manchester M3 3EB
29 May 2018

Annual accounts for the year ended 31 March 2018

Where we all make a difference

Annual accounts

Statement of Comprehensive Income

	Note	Group 2017/18 £000	Group 2016/17 £000	Trust 2017/18 £000	Trust 2016/17 £000
Operating income from patient care activities	3	382,385	402,000	382,385	402,000
Other operating income	4	133,508	128,099	132,987	126,959
Operating expenses	6, 8	(554,573)	(517,465)	(553,668)	(516,265)
Operating surplus/(deficit) from continuing operations		**(38,680)**	**12,634**	**(38,296)**	**12,694**
Finance income	11	308	390	51	90
Finance expenses	12	(2,638)	(1,280)	(2,638)	(1,280)
PDC dividends payable		(8,183)	(7,398)	(8,183)	(7,398)
Net finance costs		**(10,513)**	**(8,288)**	**(10,770)**	**(8,588)**
Other gains / (losses)	13	8,800	1,337	8,705	185
Share of profit / (losses) of associates / joint arrangements	23	-	-	-	-
Gains / (losses) arising from transfers by absorption		1,129	-	1,129	-
Corporation tax expense		-	-	-	-
Surplus / (deficit) for the year from continuing operations		**(39,264)**	**5,683**	**(39,232)**	**4,291**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-	-	-
Surplus / (deficit) for the year		**(39,264)**	**5,683**	**(39,232)**	**4,291**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	(1,315)	-	(1,315)	-
Revaluations	21	1,620	5,618	1,620	5,618
May be reclassified to income and expenditure when certain conditions are met:					
investments	13	-	-	-	-
Recycling gains / (losses) on available-for-sale financial	13	-	-	-	-
Foreign exchange gains / (losses) recognised directly in SOCI	13	-	-	-	-
Total comprehensive income / (expense) for the period		**(38,959)**	**11,301**	**(38,927)**	**9,909**
Surplus/ (deficit) for the period attributable to:					
non-controlling interest, and		-	-	-	-
Royal Liverpool and Broadgreen University Hospitals NHS Trust		(39,264)	5,683	(39,232)	4,291
TOTAL		**(39,264)**	**5,683**	**(39,232)**	**4,291**
Total comprehensive income/ (expense) for the period attributable to:					
non-controlling interest, and		-	-	-	-
Royal Liverpool and Broadgreen University Hospitals NHS Trust		(38,959)	11,301	(38,927)	9,909
TOTAL		**(38,959)**	**11,301**	**(38,927)**	**9,909**

Adjusted financial performance		
Surplus/(deficit) for the period (before consolidation of charity)	(39,232)	4,291
Add all I & E Impairments/reversals (excluding IFRIC 12 impairments)	15,367	(4,916)
IFRIC 12 adjustment (including IFRIC 12 impairments)		1,751
Adjust (gains)/losses on transfers by absorption	(1,129)	
Remove capital donations/grants I & E impact	185	203
CQUIN Risk Reserve - 16/17 adjustment	(1,400)	
Adjusted financial performance surplus/(deficit)	**(26,209)**	**1,329**

The Trust's reported NHS financial performance position is derived from its retained surplus/(deficit), but adjusted for the following:

Reporting Standards (IFRS) accounting in 2009/10) - NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue and expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical during accounting periods up to 2016/17.

b) Impairment and reversal of impairments to non-current asset which is not considered part of the Trust's operating

c) The impact of donated asset and associated depreciation

The notes on pages 78 to 125 form part of this account

Statement of Financial Position

	Note	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Non-current assets					
Intangible assets	16	17,889	12,337	17,889	12,337
Property, plant and equipment	18	160,164	174,086	160,164	174,086
Investment property	22	-	-		
Investments in associates (and joint ventures)	23	-	-		
Other investments / financial assets	24	8,947	9,155		
Trade and other receivables	28	124,825	2,364	124,825	2,364
Other assets	29	-	-		
Total non-current assets		**311,825**	**197,942**	**302,878**	**188,787**
Current assets					
Inventories	27	8,626	8,096	8,617	8,087
Trade and other receivables	28	64,806	157,369	64,744	156,821
Other investments / financial assets	24	-	-		
Other assets	29	-	-		
Non-current assets for sale and assets in disposal groups	30	-	-		
Cash and cash equivalents	31	21,809	25,280	20,406	24,457
Total current assets		**95,241**	**190,745**	**93,767**	**189,365**
Current liabilities					
Trade and other payables	32	(47,123)	(51,912)	(46,740)	(51,447)
Borrowings	35	(7,406)	(1,252)	(7,406)	(1,252)
Other financial liabilities	33	-	-		
Provisions	37	(682)	(616)	(682)	(616)
Other liabilities	34	(1,003)	(10,031)	(1,003)	(10,031)
Liabilities in disposal groups	30	-	-		
Total current liabilities		**(56,214)**	**(63,811)**	**(55,831)**	**(63,346)**
Total assets less current liabilities		**350,852**	**324,876**	**340,814**	**314,806**
Non-current liabilities					
Trade and other payables	32	-	-		
Borrowings	35	(94,574)	(33,783)	(94,574)	(33,783)
Other financial liabilities	33	-	-		
Provisions	37	(2,473)	(2,668)	(2,473)	(2,668)
Other liabilities	34	-	(811)		(811)
Total non-current liabilities		**(97,047)**	**(37,262)**	**(97,047)**	**(37,262)**
Total assets employed		**253,805**	**287,614**	**243,767**	**277,544**
Financed by					
Public dividend capital		246,936	241,786	246,936	241,786
Revaluation reserve		45,225	44,392	45,225	44,392
Available for sale investments reserve		-	-		
Other reserves		-	-		
Merger reserve		-	-		
Income and expenditure reserve		(48,394)	(8,634)	(48,394)	(8,634)
Non-controlling Interest		-	-		
Charitable fund reserves	26	10,038	10,070	-	
Total taxpayers' equity		**253,805**	**287,614**	**243,767**	**277,544**

The notes on pages 78 to 125 form part of these accounts.

A. Kehoe

Aidan Kehoe

Chief executive

29 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves (Note 26) £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**241,786**	**44,392**	**(8,634)**	**10,070**	**287,614**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	(39,368)	104	**(39,264)**
Transfers by absorption: transfers between reserves	-	528	(528)	-	**-**
Impairments	-	(1,315)	-	-	**(1,315)**
Revaluations	-	1,620	-	-	**1,620**
Public dividend capital received	5,150	-	-	-	**5,150**
Other reserve movements	-	-	136	(136)	**-**
Transfer to FT upon authorisation	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2018	**246,936**	**45,225**	**(48,394)**	**10,038**	**253,805**

Statement of Changes in Equity for the year ended 31 March 2017

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves (Note 26) £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**206,654**	**38,774**	**(12,925)**	**8,678**	**241,181**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	4,191	1,492	**5,683**
Revaluations	-	5,618	-	-	**5,618**
Public dividend capital received	35,132	-	-	-	**35,132**
Other reserve movements			100	(100)	**-**
Transfer to FT upon authorisation	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2017	**241,786**	**44,392**	**(8,634)**	**10,070**	**287,614**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**241,786**	**44,392**	**(8,634)**	**277,544**
At start of period for new FTs				**-**
Surplus/(deficit) for the year			(39,368)	**(39,368)**
Transfers by absorption: transfers between reserves		528	(528)	**-**
Impairments		(1,315)		**(1,315)**
Revaluations		1,620		**1,620**
Public dividend capital received	5,150			**5,150**
Other reserve movements			136	**136**
Transfer to FT upon authorisation				**-**
Taxpayers' and others' equity at 31 March 2018	**246,936**	**45,225**	**(48,394)**	**243,767**

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**206,654**	**38,774**	**(12,925)**	**232,503**
Prior period adjustment				**-**
Taxpayers' and others' equity at 1 April 2016 - restated	**206,654**	**38,774**	**(12,925)**	**232,503**
At start of period for new FTs				**-**
Surplus/(deficit) for the year			4,291	**4,291**
Revaluations		5,618		**5,618**
Public dividend capital received	35,132			**35,132**
Transfer to FT upon authorisation				**-**
Taxpayers' and others' equity at 31 March 2017	**241,786**	**44,392**	**(8,634)**	**277,544**

Information on reserves

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 organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the 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.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

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

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in Note 26

Statement of Cash Flows

	Note	Group 2017/18 £000	Group 2016/17 £000	Trust 2017/18 £000	Trust 2016/17 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(38,680)	12,634	(38,296)	12,694
Non-cash income and expense:					
Depreciation and amortisation	6.1	13,769	12,382	13,769	12,382
Net impairments	7	15,367	(4,916)	15,367	(4,916)
Income recognised in respect of capital donations	4	-	-	-	(100)
Amortisation of PFI deferred credit		(26)	-	(26)	-
Non-cash movements in on-SoFP pension liability		-	-	-	-
(Increase)/decrease in receivables and other assets		(23,132)	(32,950)	(23,178)	(32,950)
(Increase)/decrease in inventories		(530)	(273)	(530)	(273)
Increase/(decrease) in payables and other liabilities		(13,067)	25	(13,065)	25
Increase/(decrease) in provisions		(131)	(13)	(131)	(13)
Movements in charitable fund working capital		337	(634)	-	-
Tax (paid)/received		-	-	-	-
Operating cash flows from discontinued operations		-	-	-	-
Other movements in operating cash flows		583	878	-	-
Net cash flows from / (used in) operating activities		**(45,510)**	**(12,867)**	**(46,090)**	**(13,151)**
Cash flows from investing activities					
Interest received		51	90	51	90
(Purchase)/sale of financial assets / investments		-	-	-	-
Purchase of intangible assets		(2,777)	(6,356)	(2,777)	(6,356)
Sales of intangible assets		-	-		
Purchase of PPE and investment property		(26,939)	(27,406)	(26,939)	(27,406)
Sales of PPE and investment property		14,515	185	14,515	185
Receipt of cash donations to purchase assets		(136)	-	(136)	-
Prepayment of PFI capital contributions		-	-	-	-
Net cash flows from charitable fund investing activities		-	-	-	-
Investing cash flows from discontinued operations		-	-	-	-
Cash from acquisitions/disposals of subsidiaries		-	-	-	-
Net cash flows from / (used in) investing activities		**(15,286)**	**(33,487)**	**(15,286)**	**(33,487)**
Cash flows from financing activities					
Public dividend capital received		5,150	35,132	5,150	35,132
Public dividend capital repaid		-	-	-	-
Movement on loans from DHSC		66,269	15,371	66,269	15,371
Movement on other loans		-	38	-	38
Other capital receipts		-	-	-	-
Capital element of finance lease rental payments		(4,829)	(1,193)	(4,829)	(1,193)
Capital element of PFI, LIFT and other service concession payments		(665)	(737)	(665)	(737)
Interest paid on finance lease liabilities		(154)	(108)	(154)	(108)
Interest paid on PFI, LIFT and other service concession obligations		(953)	(1,009)	(953)	(1,009)
Other interest paid		(732)	(42)	(732)	(42)
PDC dividend (paid) / refunded		(6,761)	(7,716)	(6,761)	(7,716)
Financing cash flows of discontinued operations		-	-	-	-
Net cash flows from charitable fund financing activities		-	-	-	-
Cash flows from (used in) other financing activities		-	-	-	-
Net cash flows from / (used in) financing activities		**57,325**	**39,736**	**57,325**	**39,736**
Increase / (decrease) in cash and cash equivalents		**(3,471)**	**(6,618)**	**(4,051)**	**(6,902)**
Cash and cash equivalents at 1 April - b/f		**25,280**	**31,898**	**24,457**	**31,359**
Prior period adjustments			-		
Cash and cash equivalents at 1 April - restated		**25,280**	**31,898**	**24,457**	**31,359**
Cash and cash equivalents transferred under absorption accounting	47	-	-	-	-
Unrealised gains / (losses) on foreign exchange		-	-	-	-
Cash and cash equivalents at 31 March	31	**21,809**	**25,280**	**20,406**	**24,457**

Notes to the Accounts

Note 1 Accounting policies and other information

1 Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2017-18 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

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

1.3 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DH Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM required the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

1.5 Pooled Budgets

The trust has not entered into any pooled budgets.

1.6 Critical accounting judgements and key sources of estimation uncertainty

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

1.6.1 Critical judgements in applying accounting policies

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

Going Concern

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The Trust continues to adopt the going concern basis in preparing accounts following the Trust Board's assessment after making reasonable enquiries and consideration of supporting evidence.

The Trust's assessment process considered key issues and risks about the reporting period and the future including twelve months from the date of signing the financial statements including:

- The overall financial position for the reporting year and underlying deficit
- Negative operating cash flows
- The level of support required to enable the Trust to meet its obligations as they become due
- Commissioner contracts
- Net assets and net current assets
- Trade creditors
- Major debt repayment
- Cash flows arising since the 2016-17 Statement of Financial Position
- Key Management
- Legal and statutory proceedings

The assessment identified the following material uncertainties that may cast a significant doubt:

- The Trust's initial plan for 2017/18 was a £4.6m deficit and the 2017/18 retained NHS adjusted deficit was £26.2m on a control total basis. The Trust has not agreed the 2018/19 initial control total set by NHSI and is in ongoing discussion with NHSI around financial turnaround. A turnaround advisor has been working with the Trust since October 2017 and KPMG have been working with the Trust to support the financial recovery process.
- The Trust submitted the first draft of the 2018/19 Operational Plan, which includes a planned deficit of £40m (which assumes the delivery of a total of £31m efficiencies). NHS Improvement has not formally confirmed acceptance of the Trust's 2018/19 financial plan. In addition, and in common with other areas, there are affordability issues within the Cheshire and Merseyside health economy to consider.
- The Trust Board has approved the submission of an Outline Business Case relating to a transaction with Aintree University Hospitals NHS Foundation Trust.
- The Trust is planning on the basis of receiving significant cash support in 2018/19 (£65.9m which incorporates £22.9m capital and £43m revenue).
- The Trust is falling short of the Better Payment Practice Code Targets but does not anticipate difficulties with creditors if cash support requested from DH is secured.
- Due to the liquidation of Carillion, the Trust's PFI liability in respect of the new hospital has been delayed. Following handover, the annual liability including interest and capital repayment will be £17m.

Although these factors represent material uncertainties that may cast a significant doubt on the going concern opinion, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Department of Health Group Accounting Manual the Directors have prepared these financial statements on a going concern basis and have not included the adjustments that would result if it was unable to continue as a going concern.

Leases

In applying the classification of leases in IAS 17, management may consider leases as being either a finance lease arrangement or an operating lease. In some cases, the lease transaction is not always conclusive, and management uses judgement in determining whether the lease is a finance lease arrangement that transfers substantially all the risks and rewards incidental to ownership.

The University of Liverpool has interests in both the Royal Liverpool Hospital and the Liverpool Dental Hospital under long-standing long term lease arrangements. The methodology used to calculate the University of Liverpool's interest in these buildings is based on the proportion of the relevant occupation of the building covered by the lease.

Inventories

The valuation of inventories is considered at each balance sheet date and a judgement is exercised as to the likelihood of obsolescence occurring. The estimated amount is then written down to the income statement.

Useful asset lives

The charge in respect of depreciation is derived after determining an estimate of an asset's expected useful life and the expected residual value at the end of its life. Increasing an asset's expected life or its residual value would result in a reduced depreciation charge in the consolidated statement of comprehensive income. The useful lives and residual values of the Trust's assets are determined by management at the time the asset is acquired and reviewed annually for appropriateness. The lives are based on historical experience with similar assets as well as anticipation of future events which may impact their life such as changes in technology.

Impact of PFI on asset valuations

The Trust plans to demolish buildings on the Royal site once the construction of the New Royal is completed. Buildings that will be demolished have been impaired on a straight line basis by the amount represented by their remaining useful life beyond 30th June 2019 (this date is being used as a working assumption but is subject to confirmation) This amount is based on the valuation of the buildings on 31st March 2018 provided by the District Valuer.

Consolidation of joint operations

The Trust has reviewed its interest in partnership arrangements in respect of Liverpool Clinical Laboratories (LCL) and the Liverpool Vascular and Endovascular Service (LiVES). LCL is a partnership arrangement between the Trust and Aintree University Hospitals NHS Foundation Trust to operate a biomedical hub providing high quality clinical laboratory services in the North West region of the UK. LiVES is a partnership arrangement between the Trust and Aintree University Hospitals NHS Foundation Trust and Southport and Ormskirk NHS Trust to provide a vascular and endovascular service. The Trust has concluded that these do not meet the criteria for consolidation. The Trust has accounted for its own share of revenue and expenses in respect of these services.

Partially completed spells

The Trust accounts for income relating to patient care spells that are part-completed at the year-end by apportioning the income according to the length of stay at the end of the reporting period compared to the expected length of stay. Income relating to part- completed spells is included within Note 3 – Revenue from patient care activities, with the corresponding receivable reported in Note 28.1 - Trade and other receivables as NHS receivables.

Deferred income

During 2017/18 the Trust reviewed deferred income balances to ensure that any balances recognised at the year-end fulfilled the criteria for continued recognition as a liability. Where there was insufficient evidence to support the retention of deferred income these have been written back to income.

Recognition of payments relating to the New Royal PFI

The Trust continued to make payments to the PFI operator during 2017/18 in respect of capital contributions during the construction phase of the New Royal. These payments have been recognised as non-current prepayments which will be released to write down the long term liability when the asset comes into use. The amount recorded under non-current receivables includes an accrued income amount at the financial year-end with the corresponding liability recognised as a non-NHS capital payable.

1.6.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

When preparing the financial statements, management undertakes a number of judgements, estimates and assumptions about recognition and measurements of assets, liabilities, income and expenses. The actual results may differ from the judgements, estimates and assumptions made by management.

Information about significant judgements, estimates and assumptions that have the most significant effect on recognition and measurement of assets, liabilities, income and expenses are discussed below.

Valuation of Land and Buildings

The valuation of Land and buildings is based upon the views of an independent professional valuer. Where indices, which are estimates of land and property values, are used as advised by the valuer, this may result in changes to valuations when a full revaluation is carried out. The Trust based the valuation of Land and Buildings in 2017/18 on the views of the Valuation Office Agency which includes the use of national building indices and location factor indices. VAT has been excluded from the valuation of assets that will be re-provided by the New Royal on the basis that VAT would be eligible for recovery under HMRC Contracting Out Services rules.

Provisions

For the purposes of calculating provisions balances, estimates are made based upon information supplied by third parties such as the NHS Litigation Authority and the NHS Pensions Agency. Inflation and discount rates are notified to the Trust. The probability and timing of settlements are also estimated, based upon previous experience and robust estimation techniques. Provisions in respect of payments to the NHS Pensions Agency are calculated based on actuarial tables covering life expectancy and are regularly reviewed.

Salaries and wages

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Annual leave untaken is accrued for and charged to the appropriate financial year. The annual leave accrual is calculated on a sample basis and recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following year

New Royal PFI

The Trust has impaired building assets on the Royal Liverpool Hospital site to reflect the Trust's demolition plans once the New Royal is completed. The calculation of the impairment is based on achievement of the latest anticipated completion date of 30th June 2019 (this date is being used as a working assumption but is subject to confirmation). The Trust closely monitors progress on the New Royal and delay to the construction programme means that the New Royal is expected to be handed over to the Trust at 30th June 2019. The handover date of 30th June 2019 is subject to contractual confirmation.

1.7 Revenue

Revenue 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 revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

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.

1.8 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 leave 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.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.1 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to the NHS trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or

• collectively, a number of items have a total 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.
The Trust's Global Digital Excellence accreditation and the move and preparation for the New Royal Hospital will be considerations when capitalising expenditure.
Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost 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.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Valuations will be influenced by residual values and will be reviewed each year end, with the effect of any changes recognised on a prospective basis. Revaluations of property, plant and equipment 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.

Current values in existing use are determined as follows:

• Land and non-specialised buildings – market value for existing use.
• Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust has valued assets on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is

1.11 Intangible assets

Recognition

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

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

Measurement

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluation and impairments are treated in the same manner as for property, plant and equipment.

1.12 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non- current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives, unless the trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non- current assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.13 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS trust as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

Other assets contributed by the NHS trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set againt the carrying value of the liability.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS trust through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.18 Inventories and stockpiled goods
Inventories are valued at the lower of cost and net realisable value using the first-in first-out formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Strategic goods held for use in national emergencies (stockpiled goods) are held as non-current assets within property, plant and equipment. These stocks are maintained at minimum capability levels by replenishment to offset write-offs and so are not depreciated, as agreed with HM Treasury. Stockpiled goods are held at current value in existing use.

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.20 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016-17: positive 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A short term rate of negative 2.42% (2016-17: negative 2.7%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.85% (2016-17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.56% (2016-17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 37.3

1.22 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS 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 as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emission that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation. Allowances acquired under the scheme are recognised as intangible assets.

1.24 Contingencies

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non- occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

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

1.25 Financial assets

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

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

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Impairment

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

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de- recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets* ; and
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Value Added Tax

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

1.28 Foreign currencies

The NHS trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 36 to the accounts (note reference to be confirmed).

1.30 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning on IAS 32.

At any time the Secretary of State can issue new PDC to, and require repayment of PDC from the trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as public dividend capital dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the trust.

Relevant net asset are calculated as the value of all assets less liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances with the Government Banking Service) and National Loans Fund (NLF) deposits, excluding cash cash balances held in GBS accounts that relate to a short term working capital facility
- any PDC dividend balance receivable or payable.

The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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. The PDC Dividend calculation is based upon the trust's group accounts (i.e. including relevant joint arrangements), but excluding consolidated charitable funds.

1.31 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 the NHS trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

From 1st April 2014, the trust has consolidated the results of The Royal Liverpool and Broadgreen University Hospitals NHS Trust Charitable Fund over which it considers it has power to exercise control in accordance with IFRS10 requirements.

1.33 Associates

Material entities over which the NHS trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.34 Joint arrangements

Material entities over which the NHS trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Trust is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts. The Trust works in partnership with Aintree University Hospitals NHS Foundation Trust and established Liverpool Clinical Laboratories to provide a biomedical hub in Liverpool as the regional leader for the provision of high quality clinical laboratory services. The Trust has a contractual arrangement with Aintree University Hospitals NHS Foundation Trust and accounts for the arrangement as a joint operation. The Trust accounts for the assets it controls, liabilities and expenses incurred and its share of income from the activities of the joint operation.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.35 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.36 Accounting Standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019

The impact of the above accounting standards is not expected to be material.

1.37 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.38 Investments

Investments held as part of the Trust's Charitable Fund, are measured at fair value in accordance with IFRS 13. Fair value is an estimate of the price at which an orderly transaction to sell the asset would take place between market participants at the measurement date. The majority of the Trust's charity fund investments are quoted equity instruments and valuations are prepared by the Trust's investment managers.

Note 2 Operating Segments

The Chief Operating Decision maker (the Trust's Chief Executive) considers there is one operating segment which is healthcare, as reported in the main financial statements and the notes to the accounts, and the Trust does not therefore report on separate segmented accounts.

The majority of the Trust's £515,372,000 (2016/17: £528,959,000) income relates to the provision of healthcare.

Income from the largest external customer was income from Clinical Commissioning Groups and NHS England of £368,499,000 (2016/17: £386,479,000) for the provision of healthcare. Clinical Commissioning Groups are considered to be under common control and regarded as a single customer for the purpose of this disclosure.

Note 3 Operating income from patient care activities (Group)

Note 3.1 Income from patient care activities (by nature)	Group * 2017/18 £000	2016/17 £000
Acute services		
Elective income	66,042	65,658
Non elective income	79,385	77,968
First outpatient income	32,549	33,498
Follow up outpatient income	42,053	52,134
A & E income	13,764	12,481
High cost drugs income from commissioners (excluding pass-through costs)	44,546	46,645
Other NHS clinical income	104,046	113,616
Mental health services		
Cost and volume contract income	-	-
Block contract income	-	-
Clinical partnerships providing mandatory services (including S75 agreements)	-	-
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	-	-
Ambulance services		
A & E income	-	-
Patient transport services income	-	-
Other income	-	-
Community services		
Community services income from CCGs and NHS England	-	-
Income from other sources (e.g. local authorities)	-	-
All services		
Private patient income	-	-
Other clinical income	-	-
Total income from activities	**382,385**	**402,000**

Note 3.2 Income from patient care activities (by source)	Group *	
	2017/18	2016/17
Income from patient care activities received from:	**£000**	**£000**
NHS England	97,319	98,472
Clinical commissioning groups	271,180	288,007
Department of Health and Social Care	27	-
Other NHS providers	-	-
NHS other	-	-
Local authorities	1,595	1,607
Non-NHS: private patients	511	351
Non-NHS: overseas patients (chargeable to patient)	179	98
NHS injury scheme	984	1,622
Non NHS: other	10,590	11,843
Total income from activities	**382,385**	**402,000**
Of which:		
Related to continuing operations	382,385	402,000
Related to discontinued operations	-	-

* Group - where there is no difference between the Group and Trust disclosures, only the Group transactions are disclosed.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	Group	
	2017/18	2016/17
	£000	£000
Income recognised this year	179	98
Cash payments received in-year	75	57
Amounts added to provision for impairment of receivables	23	117
Amounts written off in-year	21	-

Note 4 Other operating income (Group)	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Research and development	17,481	19,272	17,481	19,272
Education and training	32,354	34,907	32,354	34,907
Receipt of capital grants and donations	-	-	-	-
Charitable and other contributions to expenditure	-	100	136	100
Non-patient care services to other bodies	75,386	65,033	75,386	65,033
Support from the Department of Health and Social Care for mergers	-	-	-	-
Sustainability and transformation fund income	-	4,850	-	4,850
Rental revenue from operating leases	260	992	260	992
Rental revenue from finance leases	-	-	-	-
Income in respect of staff costs where accounted on gross basis	-	-	-	-
Charitable fund incoming resources	657	1,240		
Other income	7,370	1,805	7,370	1,805
Total other operating income	**133,508**	**128,199**	**132,987**	**126,959**
Of which:				
Related to continuing operations	133,508	128,199	132,987	126,959
Related to discontinued operations	-	-		

Note 6.1 Operating expenses (Group)	Group		Trust	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	16,690	11,134	16,690	11,134
Purchase of healthcare from non-NHS and non-DHSC bodies	3,808	3,767	3,808	3,767
Purchase of social care	-	-	-	-
Staff and executive directors costs	307,716	299,120	307,716	299,120
Remuneration of non-executive directors	88	84	88	84
Supplies and services - clinical (excluding drugs costs)	69,998	67,158	69,998	67,158
Supplies and services - general	16,337	16,566	16,337	16,566
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	61,177	62,329	61,177	62,329
Inventories written down	38	59	38	59
Consultancy costs	1,028	1,533	1,028	1,533
Establishment	6,732	5,434	6,732	5,434
Premises	17,361	12,467	17,361	12,467
Transport (including patient travel)	1,753	1,752	1,753	1,752
Depreciation on property, plant and equipment	12,790	11,772	12,790	11,772
Amortisation on intangible assets	979	610	979	610
Net impairments	15,367	(4,916)	15,367	(4,916)
Increase/(decrease) in provision for impairment of receivables	-	1,798	-	1,798
Increase/(decrease) in other provisions	-	-	-	-
Change in provisions discount rate(s)	21	150	21	150
Audit fees payable to the external auditor				
audit services- statutory audit	69	69	64	64
other auditor remuneration (external auditor only)	12	12	12	12
Internal audit costs	-	-	-	-
Clinical negligence	5,161	3,690	5,161	3,690
Legal fees	234	90	234	90
Insurance	438	433	438	433
Research and development	176	1,948	176	1,948
Education and training	1,371	1,548	1,371	1,548
Rentals under operating leases	2,737	3,368	2,737	3,368
Early retirements	-	-	-	-
Redundancy	45	-	45	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	9,812	10,490	9,812	10,490
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-	-	-	-
Car parking & security	83	-	83	-
Hospitality	7	11	7	11
Losses, ex gratia & special payments	180	-	180	-
Grossing up consortium arrangements	-	-	-	-
Other services	-	-	-	-
Other NHS charitable fund resources expended	900	1,195	-	
Other	1,465	3,794	1,465	3,794
Total	**554,573**	**517,465**	**553,668**	**516,265**
Of which:				
Related to continuing operations	554,573	517,465	553,668	516,265
Related to discontinued operations	-	-	-	-

Audit fees payable to the external auditor include non-recoverable VAT.

The Trust hosts Mersey Internal Audit Agency (MIAA). Internal audit fees of £63,438 (2016/17: £99.569) were accounted for as an internal transfer of costs by the Trust.

Services from NHS bodies does not include expenditure which falls into a category below:

Supplies and Services - Clinical
Supplies and Services - General
Clinical Negligence
NHS Resolution Property Expenses Scheme (PES) and Liabilities to Third Parties Scheme (LTPS)

Note 6.2 Other auditor remuneration (Group)

	Group 2017/18 £000	Group 2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	12	12
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**12**	**12**

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m (2016/17: £0m).

Note 7 Impairment of assets (Group)

	Group 2017/18 £000	Group 2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	-	-
Impairments of charitable fund assets	-	-
Other	15,367	(4,916)
Total net impairments charged to operating surplus / deficit	**15,367**	**(4,916)**
Impairments charged to the revaluation reserve	1,315	-
Total net impairments	**16,682**	**(4,916)**

The Trust adopts a Modern Equivalent Asset basis for the valuation of Land and Buildings, which permits an alternative site basis and optimisation. The Trust has used an alternative site for valuation during 2017/18 which has given rise impairment and reversal of impairments of assets.

Note 8 Employee benefits (Group)

	Group	
	2017/18 Total £000	2016/17 Total £000
Salaries and wages	255,684	243,643
Social security costs	20,574	21,872
Apprenticeship levy	1,131	-
Employer's contributions to NHS pensions	26,834	25,681
Pension cost - other	13	14
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	501	384
Temporary staff (including agency)	6,544	10,975
NHS charitable funds staff	-	-
Total gross staff costs	**311,281**	**302,569**
Recoveries in respect of seconded staff	-	-
Total staff costs	**311,281**	**302,569**
Of which		
Costs capitalised as part of assets	3,565	3,449

Note 8.1 Retirements due to ill-health (Group)

During 2017/18 there were 2 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £94k (£223k in 2016/17).

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

Note 9 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:

a) 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. 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 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 employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The Pensions Act 2008 introduced new duties on employers to provide access to a workplace pension scheme that meets certain legal requirements. As from 1st April 2013 the Trust chose the National Employment Trust (NEST) to fulfil this role for employees who are unable to join the NHS Pensions Scheme due to its restrictions. There are currently 84 (2016/17: 74) employees in the NEST scheme which is a defined contribution pension scheme. A defined contribution pension scheme is where the retirement income a member gets depends on how much has been contributed, investment returns and the amount of charges over time.

Note 10 Operating leases (Group)

This note discloses income generated in operating lease agreements where Royal

The Trust has brought the Accelerator building into use during 2017/18 and agreed a number of tenancies with non-NHS organisations including the Liverpool School of Tropical Medicine.

	Group	
	2017/18	**2016/17**
	£000	**£000**
Operating lease revenue		
Minimum lease receipts	260	992
Contingent rent	-	-
Other	-	-
Total	**260**	**992**

	31 March 2018	**31 March 2017**
	£000	**£000**
Future minimum lease receipts due:		
- not later than one year;	492	-
- later than one year and not later than five years;	1,826	-
- later than five years.	8,011	-
Total	**10,329**	**-**

This note discloses costs and commitments incurred in operating lease

	Group	
	2017/18	**2016/17**
	£000	**£000**
Operating lease expense		
Minimum lease payments	2,737	3,368
Contingent rents	-	-
Less sublease payments received	-	-
Total	**2,737**	**3,368**

	31 March 2018	**31 March 2017**
	£000	**£000**
Future minimum lease payments due:		
- not later than one year;	2,566	3,104
- later than one year and not later than five years;	3,605	5,038
- later than five years.	3,317	3,603
Total	**9,488**	**11,745**
Future minimum sublease payments to be received	-	-

Note 11 Finance income (Group)

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

	Group		Trust	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Interest on bank accounts	51	90	51	90
Interest on impaired financial assets	-	-	-	-
Interest income on finance leases	-	-	-	-
Interest on other investments / financial assets	-	-	-	-
NHS charitable fund investment income	257	300	-	-
Other finance income	-	-	-	-
Total	**308**	**390**	**51**	**90**

Note 12.1 Finance expenditure (Group)

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

	Group	
	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,406	20
Other loans	121	120
Overdrafts	-	-
Finance leases	154	108
Interest on late payment of commercial debt	2	-
Main finance costs on PFI and LIFT schemes obligations	444	500
Contingent finance costs on PFI and LIFT scheme obligations	509	509
Total interest expense	**2,636**	**1,257**
Unwinding of discount on provisions	2	23
Other finance costs	-	-
Total finance costs	**2,638**	**1,280**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18 £000	2016/17 £000
Total liability accruing in year under this legislation as a result of	-	
Amounts included within interest payable arising from claims made under this legislation	2	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses) (Group)

	Group		Trust	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Gains on disposal of assets	8,705	185	8,705	185
Losses on disposal of assets	-	-	-	-
Gains / losses on disposal of charitable fund assets	-	-	-	-
Total gains / (losses) on disposal of assets	8,705	185	8,705	185
Gains / (losses) on foreign exchange	-	-	-	-
Fair value gains / (losses) on investment properties	-	-	-	-
Fair value gains / (losses) on financial assets / investments	-	-	-	-
Fair value gains/(losses) on charitable fund investments & investment properties	95	1,152	-	-
Fair value gains / (losses) on financial liabilities	-	-	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-	-	-
Total other gains / (losses)	**8,800**	**1,337**	**8,705**	**185**

During 2017/18 the Trust disposed of the Multi Storey Car Park on the Royal Liverpool Hospital and the transaction was completed before the 31st March 2018.

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's surplus/(defict) for the period was (£41.1) million (2016/17: £4.3 million). The trust's total comprehensive income/(expense) for the period was (£38.9) million (2016/17: £9.9 million).

Note 16.1 Intangible assets - 2017/18

Group	Group: Internally generated information technology	Group: Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	6,822	6,456	13,278
Valuation / gross cost at start of period for new FTs	-	-	-
Transfers by absorption	-	-	-
Additions	6,531	-	6,531
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	6,456	(6,456)	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Transfer to FT upon authorisation	-	-	-
Valuation / gross cost at 31 March 2018	19,809	-	19,809
Amortisation at 1 April 2017 - brought forward	941	-	941
Amortisation at start of period for new FTs	-	-	-
Transfers by absorption	-	-	-
Provided during the year	979	-	979
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to / from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Transfer to FT upon authorisation	-	-	-
Amortisation at 31 March 2018	1,920	-	1,920
Net book value at 31 March 2018	17,889	-	17,889
Net book value at 1 April 2017	5,881	6,456	12,337

Note 16.2 Intangible assets - 2016/17

Group	Group: Internally generated information technology	Group: Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	4,253	-	4,253
Prior period adjustments	-	-	-
Valuation / gross cost at 1 April 2016 - restated	4,253	-	4,253
Gross cost at start of period for new FTs	-	-	-
Transfers by absorption	-	-	-
Additions	2,569	3,787	6,356
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	2,669	2,669
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Transfer to FT upon authorisation	-	-	-
Valuation / gross cost at 31 March 2017	6,822	6,456	13,278
Amortisation at 1 April 2016 - as previously stated	331	-	331
Prior period adjustments	-	-	-
Amortisation at 1 April 2016 - restated	331	-	331
Amortisation at start of period for new FTs	-	-	-
Transfers by absorption	-	-	-
Provided during the year	610	-	610
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Transfer to FT upon authorisation	-	-	-
Amortisation at 31 March 2017	941	-	941
Net book value at 31 March 2017	5,881	6,456	12,337
Net book value at 1 April 2016	3,922	-	3,922

Note 18.1 Property, plant and equipment - 2017/18 **Group**

Group	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 2017 - brought forward	26,715	90,310	1,000	24,606	98,092	176	20,550	7,538	268,987
Transfers by absorption	60	699	-	-	370	-	-	-	1,129
Additions	-	8,273	-	5,051	945	-	3,813	529	18,611
Impairments charged to operating expenses	-	(17,695)	(1,000)						(18,695)
Impairments charged to the revaluation reserve	(1,315)								(1,315)
Reversal of impairments charged to operating expenses	-	(1,985)							(1,985)
Revaluations	-	906		-	-	-	-	-	906
Reclassifications	-	21,442	-	(21,442)	-	-	-	-	-
Disposals / derecognition	-	(5,875)	-	-	-	-	-	-	(5,875)
Valuation/gross cost at 31 March 2018	25,460	96,075	-	8,215	99,407	176	24,363	8,067	261,763
Accumulated depreciation at 1 April 2017 - brought forward	-	-	-	-	71,366	170	16,848	6,517	94,901
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	6,028	64	-	4,872	3	1,522	301	12,790
Reversal of impairments credited to operating expenditure		(5,249)	(64)						(5,313)
Revaluations		(714)							(714)
Disposals / derecognition	-	(65)	-	-	-	-	-	-	(65)
Accumulated depreciation at 31 March 2018	-	-	-	-	76,238	173	18,370	6,818	101,599
Net book value at 31 March 2018	25,460	96,075	-	8,215	23,169	3	5,993	1,249	160,164
Net book value at 1 April 2017	26,715	90,310	1,000	24,606	26,726	6	3,702	1,021	174,086

Note 18.2 Property, plant and equipment - 2016/17 Restated * **Group**

Group	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 2016 - as previously stated	26,975	164,318	1,219	8,613	95,668	170	20,011	7,342	324,316
Prior period adjustments	-	(80,328)	(219)	-	-	-	-	-	(80,547)
Valuation / gross cost at 1 April 2016 - restated	26,975	83,990	1,000	8,613	95,668	170	20,011	7,342	243,769
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	1,121	-	18,920	2,620	6	577	197	23,441
Reversal of impairments credited to operating expenses		1,465							1,465
Revaluations		3,731							3,731
Reclassifications		258		(2,927)					(2,669)
Disposals/derecognition	(260)	(255)			(196)		(38)	(1)	(750)
Valuation/gross cost at 31 March 2017	26,715	90,310	1,000	24,606	98,092	176	20,550	7,538	268,987
Accumulated depreciation at 1 April 2016 - as previously stated	-	80,328	219	-	66,684	170	15,685	6,163	169,249
Prior period adjustments	-	(80,328)	(219)	-	-	-	-	-	(80,547)
Accumulated depreciation at 1 April 2016 - restated	-	-	-	-	66,684	170	15,685	6,163	88,702
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	5,274	64	-	4,878	-	1,201	355	11,772
Reversal of impairments charged to operating expenses	-	(3,451)							(3,451)
Revaluations	-	(1,823)	(64)						(1,887)
Disposals/ derecognition	-	-	-	-	(196)	-	(38)	(1)	(235)
Accumulated depreciation at 31 March 2017	-	-	-	-	71,366	170	16,848	6,517	94,901
Net book value at 31 March 2017	26,715	90,310	1,000	24,606	26,726	6	3,702	1,021	174,086
Net book value at 1 April 2016	26,975	83,990	1,000	8,613	28,984	-	4,326	1,179	155,067

*The 2016/17 Property, Plant and Equipment note has been restated to reflect the requirement to write out accumulated depreciation to the Valuation/Gross cost section of the note, following formal revaluation.

Note 18.3 Property, plant and equipment financing - 2017/18

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Charitable fund PPE assets £000	Total £000
Net book value at 31 March 2018										
Owned - purchased	25,460	90,380	-	8,215	18,510	3	4,047	1,249	-	**147,864**
Finance leased	-	582	-	-	609	-	1,946	-	-	**3,137**
On-SoFP PFI contracts and other service concession arrangements	-	402	-	-	3,341	-	-	-	-	**3,743**
PFI residual interests	-	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	4,711	-	-	709	-	-	-	-	**5,420**
NBV total at 31 March 2018	**25,460**	**96,075**	**-**	**8,215**	**23,169**	**3**	**5,993**	**1,249**	**-**	**160,164**

Note 18.4 Property, plant and equipment financing - 2016/17

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Charitable fund PPE assets £000	Total £000
Net book value at 31 March 2017										
Owned - purchased	26,715	83,898	1,000	24,606	26,042	6	3,697	1,021	-	**166,985**
Finance leased	-	1,639	-	-	-	-	-	-	-	**1,639**
On-SoFP PFI contracts and other service concession arrangements	-	423	-	-	-	-	-	-	-	**423**
PFI residual interests	-	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	12	-	-	-	-	**12**
Owned - donated	-	4,350	-	-	672	-	5	-	-	**5,027**
NBV total at 31 March 2017	**26,715**	**90,310**	**1,000**	**24,606**	**26,726**	**6**	**3,702**	**1,021**	**-**	**174,086**

Note 20 Donations of property, plant and equipment

The Trust received £136k from The Royal Liverpool and Broadgreen University Hospitals NHS Trust Charitable Fund for the purchase of equipment assets.

Note 21 Revaluations of property, plant and equipment

In accordance with the Department of Health and Social Care Group Accounting Manual the Land and Building assets of the Trust have been revalued since 1st April 2009 on a modern equivalent asset basis, using an alternative site. The valuation was carried out by the District Valuation Service (DVS), the commercial arm of the Valuation Office Agency.

The modern equivalent asset basis uses depreciated replacement cost as the principle valuation methodology.

In accordance with the Trust's policy, these assets are revalued on an annual basis at the balance sheet date, in order that the closing carrying value is the most up to date value available in accordance with best practice under International Financial Reporting Standards (IFRS).

Under this Policy the Trust's assets were revalued with an effective date of 31st March 2018.

Impairment to reflect planned demolition

Final approval for the building of the 'New Royal' was received during 2013/14 and the PFI contract was signed on 13th December 2013. Consequently, the Trust's buildings were impaired in 2013/14 to reflect planned demolition.

The methodology used to calculate the asset impairment is based on the asset value at 31st March 2018 and the estimated remaining useful life provided by the District Valuer. The impairment represents the difference between the value of the buildings at 31st March 2018 where the buildings are to be demolished, and the depreciated value of the buildings based on 30 June 2019, which is the date used as an indication of a completion date for the purposes of this calculation only. A confirmed contractual completion date is awaited.

The amount charged to the revaluation reserve in respect of the revaluation of land and buildings was £1,315k and the amount added to the revaluation reserve was £1,620k.

The economic lives of non-current assets currently in existence for different categories of assets are:

	Group	
	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings, excluding Dwellings	50	90
Dwellings	20	26
Plant and Machinery	5	20
Transport Equipment	7	7
Information Technology	2	10
Furniture and Fittings	5	15

Note 22.1 Investment Property

The Trust had no Investment property during 2017/18.

Note 22.2 Investment property income and expenses (Group)

The Trust did not have any investment property income and expenses during 2017/18.

Note 23 Investments in associates and joint ventures

The Trust did not have any investments in associates and joint ventures during 2017/18.

Note 24 Other investments / financial assets (non-current)

All of the investment assets are held by The Royal Liverpool and Broadgreen University Hospitals NHS Trust Charitable Funds

	Group		Trust	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Carrying value at 1 April - brought forward	**9,155**	8,711	-	-
Prior period adjustments		-	-	-
Carrying value at 1 April - restated	**9,155**	8,711	-	-
At start of period for new FTs	-	-		
Transfers by absorption	-	-	-	-
Acquisitions in year	6,096	571	-	-
Movement in fair value	95	1,152	-	-
Net impairments	-	-	-	-
Transfers to / from assets held for sale and assets in disposal groups	-	-	-	-
Amortisation at the effective interest rate (assets held at amortised cost only where applicable)	-	-	-	-
Current portion of loans receivable transferred to current financial assets	-	-	-	-
Disposals	(6,399)	(1,279)	-	-
Transfer to FT upon authorisation	-	-		
Carrying value at 31 March	**8,947**	**9,155**	-	-

Note 26 Analysis of charitable fund reserves

The Royal Liverpool and Broadgreen University Hospitals NHS Trust Charitable Funds have been consolidated with the Trust.

	Group	
	31 March 2018 £000	31 March 2017 £000
Unrestricted funds:		
Unrestricted income funds	-	-
Revaluation reserve	-	-
Other reserves	-	-
Restricted funds:		
Endowment funds	82	85
Other restricted income funds	9,956	9,985
	10,038	**10,070**

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 27 Inventories

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Drugs	2,468	2,072	2,468	2,072
Work In progress	-	-		
Consumables	6,149	6,015	6,140	6,014
Energy	-	-		
Other	-	-		
Charitable fund inventory	9	9		
Total inventories	**8,626**	**8,096**	**8,608**	**8,086**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £116,250k (2016/17: £93,155k). Write-down of inventories recognised as expenses for the year were £38k (2016/17: £59k).

Note 28.1 Trade receivables and other receivables

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade receivables	55,279	49,642	55,279	49,642
Capital receivables (including accrued capital related income)	-	102		102
Accrued income	-	-		
Provision for impaired receivables	(512)	(2,527)	(512)	(2,527)
Deposits and advances	-	-		
Prepayments (non-PFI)	8,769	105,476	8,769	
PFI prepayments - capital contributions	-	-		105,476
PFI lifecycle prepayments	-	-		
Interest receivable	-	-		
Finance lease receivables	-	-		
PDC dividend receivable	-	692		692
VAT receivable	-	1,493		1,493
Corporation and other taxes receivable	-	-		
Other receivables	1,162	1,943	1,208	1,943
NHS charitable funds: trade and other receivables	108	548		
Total current trade and other receivable	**64,806**	**157,369**	**64,744**	**156,821**
Non-current				
Trade receivables	-	-		
Capital receivables (including accrued capital related income)	-	-		
Accrued income	-	-		
Provision for impaired receivables	(181)	(289)	(181)	(289)
Deposits and advances	-	-		
Prepayments (non-PFI)	8,000	-	8,000	
PFI prepayments - capital contributions	114,258	-	114,258	
PFI lifecycle prepayments	-	-		
Interest receivable	-	-		
Finance lease receivables	-	-		
VAT receivable	-	-		
Corporation and other taxes receivable	-	-		
Other receivables	2,748	2,653	2,748	2,653
NHS charitable funds: trade and other receivables	-	-		
Total non-current trade and other receivables	**124,825**	**2,364**	**124,825**	**2,364**
Of which receivables from NHS and DHSC group bodies:				
Current	40,024	33,748	40,024	33,748
Non-current	-	-	-	-

Note 28.2 Provision for impairment of receivables

	Group		Trust	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
At 1 April as previously stated	**2,816**	**1,116**	**2,816**	**1,116**
Prior period adjustments		-		
At 1 April - restated	**2,816**	**1,116**	**2,816**	**1,116**
At start of period for new FTs	**-**	**-**		
Transfers by absorption	-	-		
Increase in provision	-	161		161
Amounts utilised	(2,123)	(98)	(2,123)	(98)
Unused amounts reversed	-	1,637		1,637
Transfer to FT upon authorisation	-	-		
At 31 March	**693**	**2,816**	**693**	**2,816**

Note 28.3 Credit quality of financial assets

Group	31 March 2018		31 March 2017	
Ageing of impaired financial assets	**Trade and other receivables £000**	**Investments & Other financial assets £000**	**Trade and other receivables £000**	**Investments & Other financial assets £000**
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	36	-
Over 180 days	100	-	2,090	-
Total	**100**	**-**	**2,126**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	6,726	-	13,799	-
90- 180 days	-	-	1,315	-
Over 180 days	10,552	-	17,386	-
Total	**17,278**	**-**	**32,500**	**-**

Note 29 Other assets

The Trust did not have any other assets at 31st March 2018.

Note 30.1 Non-current assets held for sale and assets in disposal groups

The Trust did not have any Non-current assets held for sale or assets in disposal groups at 31st March 2018.

Note 31.1 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	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April	**25,280**	**31,898**	**24,457**	**31,359**
Prior period adjustments		-		
At 1 April (restated)	**25,280**	**31,898**	**24,457**	**31,359**
At start of period for new FTs	**-**	**-**		
Transfers by absorption	-	-		
Net change in year	(3,471)	(6,618)	(4,051)	(6,902)
Transfer to FT upon authorisation	-	-		
At 31 March	**21,809**	**25,280**	**20,406**	**24,457**
Broken down into:				
Cash at commercial banks and in hand	1,418	841	15	18
Cash with the Government Banking Service	20,391	24,439	20,391	24,439
Deposits with the National Loan Fund	-	-		
Other current investments	-	-		
Total cash and cash equivalents as in SoFP	**21,809**	**25,280**	**20,406**	**24,457**
Bank overdrafts (GBS and commercial banks)	-	-		
Drawdown in committed facility	-	-		
Total cash and cash equivalents as in SoCF	**21,809**	**25,280**	**20,406**	**24,457**

Note 31.2 Third party assets held by the trust

Royal Liverpool and Broadgreen University Hospitals NHS 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.

	Group and Trust	
	31 March 2018	31 March 2017
	£000	£000
Bank balances	6	15
Monies on deposit	-	-
Total third party assets	**6**	**15**

Note 32.1 Trade and other payables

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade payables	19,369	25,949	19,369	25,949
Capital payables	4,580	7,562	4,580	7,562
Accruals	9,411	8,233	9,411	8,233
Receipts in advance (including payments on account)	4	94	4	94
Social security costs	3,340	3,314	3,340	3,314
VAT payables	1,965	-	1,965	
Other taxes payable	2,605	2,774	2,605	2,774
PDC dividend payable	730	-	730	
Accrued interest on loans	817	20	817	20
Other payables	3,917	3,501	3,919	3,501
NHS charitable funds: trade and other payables	385	465		
Total current trade and other payables	**47,123**	**51,912**	**46,740**	**51,447**
Non-current				
Trade payables	-	-	-	-
Capital payables	-	-	-	-
Accruals	-	-	-	-
Receipts in advance (including payments on account)	-	-	-	-
VAT payables	-	-	-	-
Other taxes payable	-	-	-	-
Other payables	-	-	-	-
NHS charitable funds: trade and other payables	-	-	-	-
Total non-current trade and other payables	**-**	**-**	**-**	**-**
Of which payables from NHS and DHSC group bodies:				
Current	8,351	14,888		
Non-current	-	-		

Note 32.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	3,727		3,590	

Note 34 Other liabilities

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Deferred income	977	10,000	977	10,000
Deferred grants	-	-		
Deferred PFI credits / income	26	31	26	31
Lease incentives	-	-		
NHS charitable funds: other liabilities	-	-		
Total other current liabilities	**1,003**	**10,031**	**1,003**	**10,031**
Non-current				
Deferred income	-	-		
Deferred grants	-	-		
Deferred PFI credits / income	-	811		811
Lease incentives	-	-		
NHS charitable funds: other liabilities	-	-		
Net pension scheme liability	-	-		
Total other non-current liabilities	**-**	**811**	**-**	**811**

Note 35 Borrowings

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Bank overdrafts	-	-		
Drawdown in committed facility	-	-		
Loans from DHSC	4,870	-	4,870	
Other loans	328	-	328	
Obligations under finance leases	1,531	587	1,531	587
PFI lifecycle replacement received in advance	-	-		
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	677	665	677	665
NHS charitable funds: other current borrowings	-	-		
Total current borrowings	**7,406**	**1,252**	**7,406**	**1,252**
Non-current				
Loans from DHSC	76,770	15,371	76,770	15,371
Other loans	11,252	11,580	11,252	11,580
Obligations under finance leases	1,543	1,275	1,543	1,275
PFI lifecycle replacement received in advance	-	-		
Obligations under PFI, LIFT or other service concession contracts	5,009	5,557	5,009	5,557
NHS charitable funds: other current borrowings	-	-		
Total non-current borrowings	**94,574**	**33,783**	**94,574**	**33,783**

Note 35.1 Borrowings/Loans - repayment of principal falling due in:

	Group 31st March 2018			Group 31st March 2017		
	DH	Other	Total	DH	Other	Total
0-1 years	4,870	2,536	7,406	-	1,252	1,252
1-2 years	8,342	2,146	10,488	-	1,144	1,144
2-5 years	66,578	14,247	80,825	15,371	15,257	30,628
Over 5 years	1,850	1,411	3,261	-	2,011	2,011
Total	**81,640**	**20,340**	**101,980**	**15,371**	**19,664**	**35,035**

Note 36 Finance leases

Royal Liverpool University Hospitals NHS Trust as a lessee
Obligations under finance leases where the trust is the lessee.

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**3,261**	**2,003**	**3,261**	**2,003**
of which liabilities are due:				
- not later than one year;	1,644	660	1,644	660
- later than one year and not later than five years;	1,617	1,343	1,617	1,343
- later than five years.	-	-		
Finance charges allocated to future periods	(187)	(141)	(187)	(141)
Net lease liabilities	**3,074**	**1,862**	**3,074**	**1,862**
of which payable:				
- not later than one year;	1,531	587	1,531	587
- later than one year and not later than five years;	1,499	1,275	1,499	1,275
- later than five years.	44	-	44	
Total of future minimum sublease payments to be received at the reporting date	**3,074**	**1,862**	**3,074**	**1,862**
Contingent rent recognised as an expense in the period	509	509	509	509

Note 37.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,875**	**280**	**1,129**	**3,284**
Transfers by absorption	-	-	-	**-**
Change in the discount rate	21	-	-	**21**
Arising during the year	63	203	63	**329**
Utilised during the year	(333)	(54)	-	**(387)**
Reclassified to liabilities held in disposal groups	-	-	-	**-**
Reversed unused	(16)	(78)	-	**(94)**
Unwinding of discount	2	-	-	**2**
Movement in charitable fund provisions	-	-	-	**-**
Transfer to FT upon authorisation	-	-	-	**-**
At 31 March 2018	**1,612**	**351**	**1,192**	**3,155**
Expected timing of cash flows:				
- not later than one year;	331	351	-	**682**
- later than one year and not later than five years;	920	-	1,192	**2,112**
- later than five years.	361	-	-	**361**
Total	**1,612**	**351**	**1,192**	**3,155**

Note 37.3 Clinical negligence liabilities

At 31 March 2018, £17,960k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal Liverpool and Broadgreen University Hospitals NHS Trust (31 March 2017: £18,901k).

Note 38 Contingent assets and

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities				
NHS Resolution legal claims	(37)	(100)	(37)	(100)
Employment tribunal and other employee related litigation	-	-		
Redundancy	-	-		
Other	-	-		
Gross value of contingent liabilities	**(37)**	**(100)**	**(37)**	**(100)**
Amounts recoverable against liabilities	-	-		
Net value of contingent liabilities	**(37)**	**(100)**	**(37)**	**(100)**
Net value of contingent assets	**-**	**-**		

Contingent liabilities relate to public and employer's liability. A contingent liability quantifies the possible additional risk to the Trust upon an uncertain likelihood that claims may be successful. The Trust is involved in a number of disputes with contractors who have provided services to the Trust. The outcome of these contractual matters cannot be determined with any certainty at this time.

Note 39 Contractual capital

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	6,257	5,794	6,257	5,794
Intangible assets	-	-		
Total	**6,257**	**5,794**	**6,257**	**5,794**

Note 41 On-SoFP PFI, LIFT or other service concession arrangements

The trust has arrangements to enable it to provide dialysis services to patients in the Merseyside area and beyond.

Warrington Dialysis Unit

Contract Start date:	29/01/1996
Contract End date:	08/04/2021

Broadgreen Dialysis Unit

Contract Start date:	19/05/1999
Contract End date:	08/04/2023

The contract is for a period of 25 years reviewable at 7 and 14 years.
Under the terms of the arrangements for the service at Broadgreen the building will become a Trust asset at the end of the contract.

Veolia (previously Dalkia) Energy contract:

The Trust has a contract with Veolia for the provision of energy to the Trust.
The energy centre at Broadgreen will become a Trust asset at the end of the contract.

Contract Start date:	01/06/2005
Contract End date:	31/03/2026

Retail Development:

The Trust has entered into an agreement with a private contractor for the provision of a retail facility at the site.
This will result in the Trust gaining an asset in terms of an extension to the front entrance at the end of the contract.
There are no contractual payments to be made by the Trust to the contractor during the provision of this facility.

Broadgreen Car Park

The Trust accepted a settlement in respect of the contract with Indigo Park Services during 2017/18. A new contract was agreed for the provision of car parking for 19 years.

Contract Start date:	01/04/2018
Contract End date:	31/03/2037

A contract for the development of the new hospital was signed by the Trust and its PFI partner (The Hospital Company Liverpool Limited) on 13 December 2013. The scheme will deliver a new Royal Liverpool University hospital. This will be a modern, state-of-the art acute hospital facility on the RLUH site which was expected to be handed over to the Trust in February 2018.

The ownership of The Hospital Company Liverpool Limited is as follows:
Carillion Private Finance (50%)
Scottish Widows Investment Partnership (50%)

The contracted value of the new hospital is £330m (of which £280m related to construction costs and £50m to fees and finance costs to be incurred prior to construction completion).

During the year, the construction company (Carillion) entered liquidation and the contract for the provision of the New Royal is currently under review.
The contract will run for thirty years from the date of handover. The date of handover is currently under review and for the purposes of a working date for the preparation of accounts and related assumptions, the 30th June 2019 has been used as the anticipated date or handover. The consortium will manage the facility and the Trust will make payments to the consortium (the Unitary Payment). The first year's Unitary Payment is assessed at £19.1m at a 2013-14 price base. The Trust will be committed to the full Unitary Payment until the contract expires, at which time the building will revert to the Trust at no additional cost. The Unitary Payment will be subject to change based on annual movements in the Retail Price Index.

The Trust will make 'Bullet Payments' totalling £118m, of which £94m will be funded through PDC. The bullet payments will reduce the Trust's overall liabilities over the life of the PFI scheme.

Note 41 On-SoFP PFI, LIFT or other service concession arrangements

Note 41.1 Imputed finance lease

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**7,246**	**8,227**	**7,246**	**8,227**
Of which liabilities are due				
- not later than one year;	1,109	1,109	1,109	1,109
- later than one year and not later than	4,822	4,768	4,822	4,768
- later than five years.	1,315	2,350	1,315	2,350
Finance charges allocated to future	(1,560)	(2,005)	(1,560)	(2,005)
Net PFI, LIFT or other service concession arrangement obligation	**5,686**	**6,222**	**5,686**	**6,222**
- not later than one year;	677	665	677	665
- later than one year and not later than five years;	3,642	3,546	3,642	3,546
- later than five years.	1,367	2,011	1,367	2,011
	5,686	**6,222**	**5,686**	**6,222**

Note 41.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	75,104	85,584	75,104	85,584
Of which liabilities are due:				
- not later than one year;	11,200	10,490	11,200	10,490
- later than one year and not later than five years;	41,754	43,041	41,754	43,041
- later than five years.	22,150	32,053	22,150	32,053
	75,104	**85,584**	**75,104**	**85,584**

Note 41.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	11,430	12,164	11,430	12,164
Consisting of:				
- Interest charge	444	500	444	500
- Repayment of finance lease liability	665	665	665	665
- Service element and other charges to operating expenditure	9,812	10,490	9,812	10,490
- Capital lifecycle maintenance	-	-	-	-
- Revenue lifecycle maintenance	-	-	-	-
- Contingent rent	509	509	509	509
- Addition to lifecycle prepayment	-	-	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-	-	-
Total amount paid to service concession operator	**11,430**	**12,164**	**11,430**	**12,164**

Note 42 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust did not have any Off-SoFP PFI, LIFT and other service concession arrangements during 2017/18

Note 43 Financial instruments

Note 43.1 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 Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the 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 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 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 activity is subject to review by the Trust's 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. However, the trust is the lead organisation for a EU Research Framework Programme (FP7) which involves the receipt of funding from the European Commission. This funding is received in Euros and converted to sterling by the Government Banking Service (GBS). Payments to partner organisations in Europe are made using the GBS. These payments are susceptible to some currency risk and this is managed by making onward payments to partner organisations as soon as possible after receipt of funding from the European Commission.

Investments

A range of investments are held as part of the Trust's Charitable Funds. All investments are subject to the Trust's investment policy which is provided to the Trust's investment managers. The object of the Trust's investment policy is to maximise returns by investing in a diversified portfolio of equities, fixed interest, cash and alternative investments which may include commodities, property, private equity and hedge funds, to comply with the Trust's investment powers as interpreted by the Trust. No direct investments may be made in companies which derive most of their earnings from tobacco. individual investments cannot exceed 10% except for government securities or pooled investments. The Trust's Charitable Funds committee monitors the performance of the Trust's investments at each committee meeting.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust places short term deposits with the National Loans Fund, fixed at the time of agreeing the amount and length of the deposit. The Trust's operating cash balances held in the Trust's Government Banking Service (GBS) account also attracts interest which is subject to minimal fluctuation. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because 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 31 March 2018 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 Clinical Commissioning Groups and Specialist Commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internal sources, Public Dividend Capital and finance leases where appropriate. The Trust monitors adherence to the prompt settlement of amounts due from commissioners under the terms of the NHS Standard Contract and other significant receivables, and their impact on the Trust's liquidity. The NHS generally and the Trust has experienced an increasingly challenging financial environment and the Trust's liquidity position has reflected this. The Trust monitors its liquidity through the Finance and Performance Committee and also the Trust Board. The Trust would seek access to a working capital facility if significant liquidity risks were identified within forecasts.

Note 43.2 Carrying values of financial assets

Group	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	54,875	-	-	-	**54,875**
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents	21,809	-	-	-	**21,809**
Consolidated NHS Charitable fund financial assets	-	10,458	-	-	**10,458**
Total at 31 March 2018	**76,684**	**10,458**	**-**	**-**	**87,142**

Group	Loans and receivables £000	Assets at fair value £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	47,765	-	-	-	**47,765**
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents	25,280	-	-	-	**25,280**
Consolidated NHS Charitable fund financial assets	-	10,526	-	-	**10,526**
Total at 31 March 2017	**73,045**	**10,526**	**-**	**-**	**83,571**

Trust	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives					-
Trade and other receivables excluding non financial assets	54,767				**54,767**
Other investments / financial assets					-
Cash and cash equivalents	20,406				**20,406**
Total at 31 March 2018	**75,173**	**-**	**-**	**-**	**75,173**

Trust	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives					-
Trade and other receivables excluding non financial assets	47,217				**47,217**
Other investments / financial assets					-
Cash and cash equivalents	24,457				**24,457**
Total at 31 March 2017	**71,674**	**-**	**-**	**-**	**71,674**

Note 43.3 Carrying values of financial liabilities

Group	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	93,220	-	93,220
Obligations under finance leases	3,074	-	3,074
Obligations under PFI, LIFT and other service concession	5,686	-	5,686
Trade and other payables excluding non financial liabilities	34,188	-	34,188
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Consolidated NHS charitable fund financial liabilities	-	-	-
Total at 31 March 2018	136,168	-	136,168

Group	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	26,951	-	26,951
Obligations under finance leases	1,862	-	1,862
Obligations under PFI, LIFT and other service concession	6,222	-	6,222
Trade and other payables excluding non financial liabilities	43,916	-	43,916
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Consolidated NHS charitable fund financial liabilities	-	-	-
Total at 31 March 2017	78,951	-	78,951

Trust	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives			-
Borrowings excluding finance lease and PFI liabilities	93,220	-	93,220
Obligations under finance leases	3,074	-	3,074
Obligations under PFI, LIFT and other service concession	5,686	-	5,686
Trade and other payables excluding non financial liabilities	33,803	-	33,803
Other financial liabilities			-
Provisions under contract			-
Total at 31 March 2018	135,783	-	135,783

Trust	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives			-
Borrowings excluding finance lease and PFI liabilities	26,951	-	26,951
Obligations under finance leases	1,862	-	1,862
Obligations under PFI, LIFT and other service concession	6,222	-	6,222
Trade and other payables excluding non financial liabilities	43,531	-	43,531
Other financial liabilities			-
Provisions under contract			-
Total at 31 March 2017	78,566	-	78,566

Note 44 Losses and special payments

Group and trust	2017/18 Total number of cases	2017/18 Total value of cases	2016/17 Total number of cases	2016/17 Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	55	57	7	4
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	550	89	289	94
Stores losses and damage to property	-	-	-	-
Total losses	**605**	**146**	**296**	**98**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	41	64	44	175
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**41**	**64**	**44**	**175**
Total losses and special payments	**646**	**210**	**340**	**273**
Compensation payments received		-		-

Note 45 Gifts

The Trust did not receive gifts exceeding £300k during 2017/18.

Note 43.4 Fair values of financial assets and liabilities

The table below analyses financial instruments carried at fair value, by the levels in the fair value hierarchy. The
Level 1 : quoted prices (unadjusted) in active markets for identical assets or liabilities
Level 2: inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either
Level 3: inputs for the asset or liability that are not based on observable market data (unobservable inputs)

	Group 31st March 2018 Level 1 £000s	Level 2 £000s	Level 3 £000s	Total £000s
Equity securities designated as at fair value through profit or	2,597	-	-	2,597

	Group 31st March 2017 Level 1 £000s	Level 2 £000s	Level 3 £000s	Total £000s
Equity securities designated as at fair value through profit or	8,830	-	-	8,830

Note 43.5 Maturity of financial liabilities

	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
In one year or less	41,594	45,168	41,209	44,783
In more than one year but not more than two	10,488	1,144	10,488	1,144
In more than two years but not more than five	80,825	30,628	80,825	30,628
In more than five years	3261	2,011	3,261	2,011
Total	**136,168**	**78,951**	**135,783**	**78,566**

Note 46 Related parties

Royal Liverpool and Broadgreen University Hospitals NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year, none of the Board Members or members of the key management or staff or parties related to them has undertaken any material transactions with Royal Liverpool and Broadgreen University Hospitals NHS Trust. The Trust ensures that all members of staff, including Executive and Non-Executive Directors and senior managers, are aware of the Trust's policies around Standards of Personal and Business Conduct, standards for public office and relevant professional standards. Declarations around these requirements are updated on an annual basis.

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

	Income from Related Party £000s	Expenditure with Related Party £000s	Receivable with Related Party £000s	Payable with Related Party £000s
NHS Liverpool CCG	202,616	-	26	-
NHS England	107,185	3	7,810	4
Health Education England	32,002	8	-	156
NHS Knowsley CCG	19,782	-	2	159
Department of Health and Social Care	16,789	6	65	-
NHS South Sefton	10,014	-	404	-
NHS Wirral CCG	6,793	-	416	-
NHS St Helens CCG	6,610	-	461	189
NHS Southport and Formby CCG	5,503	-	72	-
NHS Warrington CCG	4,801	-	307	-
NHS Halton CCG	4,222	-	-	-
NHS West Cheshire CCG	3,143	-	185	-
NHS West Lancashire CCG	2,538	-	64	-
NHS Wigan Borough CCG	1,332	-	15	-
The Clatterbridge Cancer Centre NHS Foundation Trust	16,697	1,376	9,308	500
Aintree University Hospitals NHS Foundation Trust	16,443	5,811	5,836	896
Liverpool Heart and Chest Hospital NHS Foundation Trust	5,391	1,932	1,703	1,044
Liverpool Women's NHS Foundation Trust	2,921	1,054	691	200
The Walton Centre NHS Foundation Trust	1,640	527	306	137
St Helens and Knowsley Hospital Services NHS Trust	1,398	1,197	366	388
HM Revenue and Customs	-	22,155	-	5,945
NHS Pension Scheme	-	26,834	-	3,727
HM Revenue and Customs - VAT	-	-	-	1,965
NHS Resolution	-	5,542	87	108

Professor Malcolm Jackson, a Non-executive member of the Trust Board is also an employee of the University of Liverpool.

The Trust is involved in numerous transactions with the University of Liverpool, involving staff recharges and sharing common facilities costs. The Trust received payments from the University totalling £5,746,669 during 2017/18 (2016/17: £4,508,525) and made payments totalling £19,661,960 (2016/17: 7,748,308. At 31st March 2018 the Trust owed the University £1,135.497 (2016/17: 5,521,989) and the University owed the Trust £416,499 (2016/17: £4,508,978.

A number of the Trust's senior management are Directors of Liverpool Health Partners. During 2017/18 the Trust made payments of £80,000 (2016/17: £80,000) and received £175,599 (2016/17: £59,697) from Liverpool Health partners. The Trust was owed £37,437 (2016/17: £42,940) at 31st March 2018.

The Trust has also received revenue and capital payments from a number of charitable funds and certain of the Trustees of these funds are also members of the NHS Trust Board. Total income received from the Royal Liverpool and Broadgreen University Hospitals NHS Trust Charitable Funds was £136,000 (2016/17: £100,000) and at 31st March 2018 the amount owed to the Trust by the charity was £46,000 2016/17: £146,000) and the Trust owed the Charity £2,000 (2016/17: £11,000).

A number of the Trust's consultants have been paid by Trust suppliers in a consultancy or speaker teaching role. It has been confirmed that in this capacity no decisions are taken that could influence business with the Trust. Trust employees abstain from decisions where a conflict of interest could arise.

Mr. David Walliker is Chief information Officer at Liverpool Women's NHS Foundation Trust.

Note 47 Transfers by absorption

Assets and members of staff transferred from Liverpool Community Health NHS Trust to the Royal Liverpool and Broadgreen University Hospitals NHS Trust on 1st June 2017. The Trust recognised a gain on absorption of £1,128, 873 and corresponding assets and liabilities. The transfer of functions was accounted for as a 'transfer by absorption' as these are classified as 'machinery of government change'.

Note 50 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	122,788	279,211	112,766	273,542
Total non-NHS trade invoices paid within target	46,252	142,048	88,353	216,600
Percentage of non-NHS trade invoices paid within target	37.67%	50.87%	78.35%	79.18%
NHS Payables				
Total NHS trade invoices paid in the year	4,627	67,482	3,858	60,805
Total NHS trade invoices paid within target	1,390	45,133	2,405	50,639
Percentage of NHS trade invoices paid within target	30.04%	66.88%	62.34%	83.28%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 51 External financing

The trust is given an external financing limit against which it is permitted to underspend

	2017/18 £000	2016/17 £000
Cash flow financing	69,976	55,513
Finance leases taken out in year	-	3,787
Other capital receipts		-
External financing requirement	69,976	59,300
External financing limit (EFL)	91,443	74,789
Under / (over) spend against EFL	21,467	15,489

Note 52 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	25,142	29,797
Less: Disposals	(5,810)	(515)
Less: Donated and granted capital additions	(136)	(100)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	19,196	29,182
Capital Resource Limit	21,992	32,319
Under / (over) spend against CRL	2,796	3,137

Note 53 Breakeven duty financial performance

	2017/18 £000	2016/17 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(26,209)	4,291
Remove impairments scoring to Departmental Expenditure Limit	-	(4,916)
Add back income for impact of 2016/17 post-accounts STF reallocation	-	-
Adjustments for donated assets		203
CQUIN Risk Reserve - 16/17 adjustment	1,400	
Add back non-cash element of On-SoFP pension scheme charges	-	-
IFRIC 12 breakeven adjustment	464	1,751
Breakeven duty financial performance surplus / (deficit)	**(24,345)**	**1,329**

Note 54 Breakeven duty rolling assessment

	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance		4,021	4,238	5,472	7,420	11,025	11,225	24,543	1,329	(24,345)
Breakeven duty cumulative position	5,215	9,236	13,474	18,946	26,366	37,391	48,616	73,159	74,488	50,143
Operating income		401,461	422,274	424,633	440,705	457,382	483,175	534,415	528,959	515,372
Cumulative breakeven position as a percentage of operating income		2.30%	3.19%	4.46%	5.98%	8.18%	10.06%	13.69%	14.08%	9.7%

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