NHS
The Royal Liverpool and Broadgreen University Hospitals
NHS Trust

Annual report
2018 - 2019

Where we all make a difference

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Dr Peter Williams, interim chief executive

As we celebrated 70 years of the National Health Service this year, the nation proudly reflected on what an amazing, innovative, unique and cherished institution the NHS is. The NHS has faced many challenges and changes over the years. As the nation moves towards transformational times, the NHS will continue to meet its challenges with the same spirit of compassion and care that embodies the very best of the service.

The Trust also celebrated 40 years of service for the Royal Liverpool Hospital. Similarly, as the Trust moves forward with its own programme of transformation and progress, we have met the many challenges and changes we have faced with that same spirit.

Our chairman, Bill Griffiths' term of office came to an end this year and our previous chief executive, Aidan Kehoe, finance director John Graham and chief nurse and chief operating officer Lisa Grant have all moved on. We offer them all our best wishes in their next endeavours.

Given our plans and the process for a proposed merger with Aintree University Hospitals NHS Foundation Trust, we have made a number of interim board appointments, including my own.

I have worked at the Royal and the Trust for many years, including serving as medical director since 2008. I am acutely aware of the healthcare needs of the local population. My colleagues on the Board and I, are committed to working with our partners in the local health economy to provide the improvements needed across the system, to ensure the people of Merseyside receive the best healthcare in the world.

One of our objectives towards achieving this is the development of the new Royal and the Liverpool Health Campus. Whilst the new Royal has been delayed, due to the liquidation of Carillion in January 2018, work has restarted following the appointment of Laing O'Rourke as management contractor in November 2018. At the time of writing, Laing O'Rourke were working on a new timetable for completing construction.

In the meantime we continue to invest in and carry out essential maintenance to the current Royal to ensure we have a safe environment for our patients, visitors and staff. This year we have invested over £1m into the maintenance of the current Royal. We have carried out detailed assessments on the current estate to ensure

that we are aware of the potential issues. From this, we have developed robust contingency plans, purchased equipment and spare parts and are tackling potential maintenance issues proactively, to reduce the risk of them occurring.

The challenges the Trust faced following the liquidation of Carillion and in managing numerous issues with the infrastructure of the current Royal were featured in the excellent BBC Two Hospital documentary series. But as well as the problems, the documentary also featured the amazing dedication and hard work of our staff and those who work in facilities management in ensuring patient safety. The positive response of viewers towards those that work here, praising their diligence and compassion was truly touching.

Despite the set-back with the new Royal, we have been using this additional time positively, to ensure we are as prepared as possible for when we move. We have begun to use the new stock of beds and mattresses and various items of equipment for the new Royal in our current hospital, replacing equipment that was nearing the end of its life.

In February, we opened our new state of the art Clinical Sterile Services Department in purpose built premises at Broadgreen Hospital and moved the service from their deteriorating environment in the lower ground floor of the current Royal.

Another of our major objectives is the proposed merger with Aintree University Hospitals NHS Foundation Trust. Clinicians across both organisations believe this will help to deliver better services and greater outcomes for our patients.

Huge progress has been made on examining opportunities for teams to come together to share best practice and consider how they can work differently to deliver improvements. This has enabled us to identify what the benefits to patients could be and develop our clinical recommendation. We remain on track to merge in 2019/20. Throughout the year we have been engaging with staff across both trusts to understand the benefits integrating services will bring for patients. We have established a programme to understand the culture of both organisations, identifying where the similarities and differences are so that the two organisations can come together as seamlessly as possible. The Trauma and Orthopaedic teams whose proposals to deliver emergency and urgent services at Aintree Hospital and planned procedures at Broadgreen Hospital, will be the first such integration.

Further work this year has included the development of a patients' benefits case and a draft business case to be presented to NHS Improvement. We have also been preparing for public engagement activities to begin in May 2019. This will be an opportunity for patients, the public and wider health partners to hear more about our merger proposal and what our trusts could achieve by working together. We will ask people to share their views on how we improve the services we have and make them work better for all our patients. The outputs from this engagement will inform future proposals for how we integrate our services.

Like most of the NHS, the Trust continues to face significant increases in demands for its services that pose tough challenges for both our financial and operational performance.

Our staff continue to find innovative ways to improve quality, efficiency and productivity, saving around £20m this year, whilst maintaining patient safety. We continue to work closely with our colleagues in neighbouring trusts and local authorities across Liverpool, Sefton and Knowsley as part of the North Mersey A&E Delivery Board. The aim of the Delivery Board is to ensure that organisations support one another effectively when spikes in demand create challenges to the delivery of emergency and urgent care. The Delivery Board has initiated a number of joint workstreams to improve emergency services, facilitate patient flow and reduce delays to discharging patients. It has been encouraging to see staff across each organisation focusing on the common goal of improving the lives of patients in delivering changes to their services.

Our Global Digital Exemplar (GDE) programme continues to develop innovative technologies to support patient care across Liverpool. This year we launched the first digital testing space of its kind in the NHS to test this latest digital technology. The 'Livernerds Lab', located in the Life Sciences Accelerator consists of two specialised areas a 'Smart Room', which simulates a hospital bedroom, and a 'Smart House', which simulates a patient's home. Both spaces are specifically adapted and fitted with the latest digital equipment including sensor technology, virtual reality, telehealth and health care. This technology is all enabled by high speed 5G connectivity as part of the £3.5 million Liverpool 5G Health and Social Care pilot. Some of this technology is already being tested by the Trust, with telehealth being used to support appropriate respiratory and cardiology patients at home. This technology allows health care staff to monitor key daily observations, records ad hoc episodes that may be of concern, and triggers support within the patient's home. It also empowers patients to manage their conditions better with access videos and advice on their condition. The Trust is also piloting the use of virtual reality as a distraction technique for pain management in palliative care and critical care.

Towards the end of the year, the Trust was inspected by the Care Quality Commission as part of its routine programme and their findings will be published during 2019-20. In their initial feedback, inspectors acknowledged the period of change for the Trust and observed that morale was good across the organisation and staff were passionate about patient care. These positive comments were reflective of the overwhelmingly positive feedback that we have received regarding our staff during the NHS 70 celebrations and throughout the broadcast of BBC Two's Hospital.

We are all incredibly proud of the spirit of our staff and their dedication to providing patients with the best possible care, despite the many challenges we have faced. I'd like to thank all our staff for their hard work and I'd also like to thank our patients and the people of Liverpool for the inspirational support and praise they have given us this year.

Dr Peter Williams, Interim Chief Executive

About the Trust

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

As one of the largest employers in the city, we employ around 8,300 people and our annual budget is over £530 million.

The Trust provides a comprehensive range of specialist services to over 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 to an estimate of over 255,000 people, over 95,000 of whom attended our emergency department. We cared for an estimated 117,000 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, specialist pathology and chemotherapy cancer treatment services, as well as a national centre for ocular oncology. We also have excellent local cancer treatment services, including skin, breast, colorectal, head, neck and thyroid and lung cancer. We host a Macmillan Cancer Information and Support Service, with centres on both of our sites.

We also 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.

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

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 working to become 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, give patients better access to their records and support improvements between now and May 2020. As a GDE, the Trust will receive up to £10 million 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 ensuring patient records are digitised
- Our whiteboard system that provides staff with information on which beds have been allocated to which patients and what assessments they have had to help manage their care more effectively. This was highlighted as outstanding in our 2016 Care Quality Commission report.
- Enhancing electronic observations by using sensor technology to improve the way we monitor patients and reduce length of stay
- Our nationally recognised eSepsis programme for the screening and early recognition of sepsis. As well as saving up to 200 lives a year at the Trust, eSepsis was adopted as one of the GDE Blueprint programmes, included in the NHS Long Term Plan.

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 nurse training.

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.

In recent years the Trust has been involved in a variety of ground-breaking research projects including:

- Pioneering clinical research studies to develop a Zika virus vaccine
- Numerous studies at the forefront of pancreatic cancer research
- Developing the use of personalised medicine
- Using big health data intelligently, drawing on masses of information, to transform the understanding of and treatment for rare genetic disorders, through involvement in the Rare Diseases Sprint Exemplar Innovation Project

Our future

We are working together with Aintree University Hospital NHS Foundation Trust and with NHS Improvement, to achieve a proposed merger of the two trusts in the next financial year. 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 attractive prospect for research funding, helping to ensure that our patients have access to the latest technologies and treatments.

The Trust's long-term plan is for the new Royal Liverpool University Hospital to provide state of the art emergency and complex care, as part of a health campus with access to some of the latest innovations in Life Sciences. Broadgreen Hospital would focus on providing the best non-emergency care, including specialist services for older people, elective surgical care and dermatology plus a range of outpatient services.

The aim is to create a world leading hub for research and development in the city, creating thousands of jobs in the process.

Three of the key developments within Liverpool's Knowledge Quarter are based on the Royal Liverpool University Hospital site; the new Royal Liverpool University Hospital, the new Clatterbridge Cancer Centre being built alongside the new Royal and the Liverpool Life Sciences Accelerator, a collaboration between the Trust and Liverpool School of Tropical Medicine. 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.

Our strategy and objectives

The Royal Liverpool Hospital and the Trust has been central to providing innovative care to the people of Liverpool for decades. The Trust is acutely aware of the challenging health issues that are a legacy of social deprivation in the city, but also the city's rich academic and pioneering heritage in healthcare.

We recognise the strong link between this social deprivation and poor health, and the reverse; the opportunity to improve health through economic prosperity.

We therefore are determined to use our role and assets to contribute to the regeneration of Liverpool.

We also recognise that the Liverpool NHS system has a large number of individual organisations none of which alone is big enough to fully compete on the national stage. It also leaves us struggling to collaborate sufficiently to deliver the critical mass to attract the resources we need.

Our strategy puts the people of Liverpool and our patients at the heart of our future plans. That strategy is outlined below:

- See the completion of a state of the art new Royal Liverpool University Hospital, which will provide the world class environment to greatly improve services and make way for the redevelopment of the rest of the site.
- Redevelop the Royal Liverpool site as a health campus which will provide a comprehensive range of healthcare services, bringing together services that are currently fragmented. Its position next to the universities, the Royal College of Physicians' northern HQ and within the heart of the Knowledge Quarter provides easy access to the academic expertise and research capability needed to develop new treatments and innovations. The economic boost to the city that this will provide, will improve the prosperity and health of its people.
- Reduce local competition in favour of collaboration in the interests of improving clinical services for the benefit of patients. This is the motivation behind our proposals to merge with Aintree University Hospital NHS Foundation Trust, along with our collaborations with Clatterbridge Cancer Centre to create a comprehensive cancer centre beside the new Royal and the Liverpool Women's NHS Foundation Trust on their proposals to operate from the new Royal site.
- Amidst all this change the Trust is also determined to remain focused on its core purpose - to continue striving to deliver the best possible treatment and care. We believe the key to doing this is to innovate and to find new ways to deliver quality services, in collaboration with local partners where necessary.
- Liverpool has some of the highest incidences of disease in the country. This makes it vital to invest in research to identify new treatments, to provide our patients now with access to clinical trials, and our future patients with new, more effective treatments. The Trust will continue to focus on maximising its use of resources through research, innovation and improvement activities to

become more efficient and effective. It will also help us to develop the innovations we need to transform service delivery for the future. A key part of this is our commitment to digital transformation.

Our vision statement summarises what we stand for, believe and strive for. We have a passionate belief that, in the face of an extremely challenging environment, and to some extent because of it, our role is to focus on our patients, and doing all we can to improve their outcomes.

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 corporate objectives 2018-19 are:

- Deliver high quality care to all patients by improving the way we admit and discharge our patients
- Deliver our financial plan and ensure we are as efficient as possible
- Complete the proposed merger with Aintree University Hospital and continue to work with our partners to improve care
- Change the way we work to ensure we are ready for a successful move into the new Royal

Enabled by:

- Creating a great place to work for the benefit of staff and patients
- Deliver excellent digital services to improve 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 44.

The most recent reporting period at the time of production of this Annual Report was February 2019. The most significant risks reported to the Board at this time and mitigations against them, are detailed on the risk register in our board papers (pages 46 to 59), which are available online.

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.

Our operational structure combines some of our clinical departments into care groups based on closely linked patient pathways. Each clinically led care group has a management team comprising a clinical director, general manager and matron. These in turn are managed by a director of operations who reports to the chief operating officer.

Care groups are supported by 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 formulating strategy, ensuring accountability and shaping a healthy culture. We operate a board committee structure. 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.

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 2017-18 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 2018/19 was for a £40m deficit and the 2018/19 retained NHS adjusted deficit was £39.7m on a control total basis. The draft income and expenditure position shows a deficit of £55.5m, this position is subject to external audit.

- The Trust has made significant progress during the year in stabilising the financial position and this will be further supported by the appointment of a turnaround director in March to support the financial recovery process. The key driver of the adverse financial position in 2018/19 relates to a shortfall in the delivery of the Quality Efficiency and Productivity programme, together with operational pressures.

Cash / Working Capital

- The Trust has worked closely with NHS Improvement and the Department of Health and Social Care during 2018/19 in agreeing the cash support requirements for the year. In practical terms, each month, the Trust applies for working capital support and deficit funding in accordance with the Department's process which considers applications. Confirmation of support is provided after the Department's consideration of each monthly application.

Without external support the Trust would not be able to meet its obligations as they become due throughout 2018/19 and 2019/20. The Trust is in advanced discussions with NHS Improvement regarding the capital and revenue cash draw requirements for 2019/20. We are currently forecasting a requirement for cash support during 2019/20 of £30.1m in revenue cash support. The draw on cash in 2019/20 is a combination of the projected in-year deficit of £22.8m, together with cash support in advance of receiving Provider Sustainability Funding and Financial Recovery Funding.

- The Trust has a proposed capital spend of around £169m in 2019/20. The majority of this expenditure is required to complete the construction and associated projects on the new Royal hospital site. Construction costs to complete amount to £131m, which is assumed to be funded by Public Dividend Capital (PDC). £5.2m PDC is also expected to support project team costs, backlog maintenance on the existing hospital, and implications of the new Clatterbridge Cancer Centre beside the new Royal. A further £0.8m of PDC funding has been included in respect of IT Health System Led Investment. Internally generated resources are assumed to fund the rest of the capital programme.

Other material uncertainties

- 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 falling short of the Better Payment Practice Code targets but does not anticipate difficulties with creditors if cash support requested from the Department is secured.

- The PFI contract supporting the construction of the new Royal was terminated during 2018/19. At the time of writing, the Trust was progressing a business case with NHSI to finalise the funding required to complete the construction. The Trust is assuming that full funding in the form of PDC will be provided.

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.

Our operational performance

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. With a few exceptions, 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 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 with exception reporting through the operational meetings, through to the committees and the Board.

Performance summary:

Measuring access to treatment

Data included below is from latest published position at the time of writing. To enable comparison the corresponding data from the previous year is included and detailed in the table below:

Our commitment	**National standard**	**2017-18 Full year figure**	**April 17 to Jan 18**	**April 18 to Jan 19**	**Difference from April to Jan**
Accident and emergency waiting times (all types): Patients should be admitted, transferred or discharged within four hours of arrival.	95% or above	89.20%	89.56%	88.17%	-1.39%
# ***RTT -*** *Most recent reporting period at time of writing was January 2018 so month on month comparison is provided*		**Figure reported in last year's Annual Report (March 2018)**	**Jan-17**	**Jan-18**	**Difference from Jan to Jan**
Referral to treatment waiting times: Patients should start treatment within 18 weeks of referral	92% or above	81.78%	83.20%	80.58%	-2.62%
# *Cancer waits – Most recent reporting*					

period was April to December					
Cancer treatment waiting times:			**April 17 to Dec 17**	**April 18 to Dec 18**	**Difference from April to Dec 2017 and 2018**
Maximum two week wait for first appointment for patients referred urgently for suspected cancer by a GP	93% or above	94.47%	94.24%	91.55%	-2.69%
Maximum two week wait for first appointment for patients referred urgently with breast cancer symptoms	93% or above	95.60%	95.71%	97.13%	+1.42%
Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	96% or above	94.75%	96.99%	92.49%	-4.50%
Maximum 31 day wait for subsequent surgical treatment	94% or above	96%	96.67%	90.68%	-5.99%
Maximum 31 day wait for subsequent treatment with anti-cancer drugs	98% or above	99%	100%	100%	-0.21%
Maximum 62 day wait from urgent GP referral to first treatment for	85% or above	85%	86.05%	76.74%	-9.31%

cancer					
* Maximum 62 day wait for treatment for cancer following a consultant decision to upgrade their priority	85% or above	94.51%	94.27%	93.10%	-.1.17%
Maximum 62 day wait from referral from NHS screening service to first treatment for all cancers	90% or above	89.33%	90.59%	87.83%	-2.76%

***Not a national standard*

Measuring quality of care

Measure	**National standard**	**2017-18 Full year figure**	**April 17 to Jan 18**	**April 18 to Jan 19**	**Difference from April to Jan**
Number of operations cancelled for non-clinical reasons	Less than 0.6% of all operations	0.89%, which is 458 cases	0.77% (327 cancelled ops)	1.04% (455 cancelled ops)	-0.27%
Patients admitted to hospital receiving a risk assessment for Venous Thrombo-Embolism	95%	88.5%	87.87%	93.57%	+5.70%
Stroke patients spending 90% or more of their spell in hospital on the Stroke	80%	72.8%	70%	78.90%	+8.90%

Unit					
Cases of C.difficile per 1,000 bed days	None	0.13	0.13	0.13	-0.01
Patient falls per 1,000 bed days	None	6.35	6.30	5.6	-0.67
Pressure ulcers per 1,000 bed days (hospital acquired)	None	0.32	0.36	0.39	+0.03
# Most recent reported SHMI for 2018/19 was October-September					
Measure	**National standard**	**2017-18 Full year figure**	**Oct 17 – Sept 17**	**Oct 18 – Sept 18**	**Difference Oct/Sept 2017 & 2018**
Standardised Hospital Mortality Indicator (SHMI)	100	105.02	104.12	104 .44	+0.32

Measuring patient feedback

Measuring patient feedback	**2017/18**	**April 17 to Jan 18**	**April 18 to Jan 19**	**Difference from 2017/18 (Apr-Jan)**
Patients who would recommend our outpatient department to friends and family	93.23%	92.98%	94.25%	+1.27%
Inpatients who would recommend our service to friends and family	92.48%	92.59%	92.26%	-0.33%
Patients who would recommend our emergency department to friends and family	82.41%	83.34%	80.87%	-2.47%

Performance Analysis

Like the majority of trusts, increased demands have presented a significant challenge with performance falling below the national standard on a number of measures. However, staff strive to provide the best care possible and in the vast majority of cases, patients receive timely care.

In order to understand the challenges facing the Trust's operational performance, first it is necessary to outline our activity and understand the levels of acuity and complexity of the patients we care for.

Activity

At the time of writing, financial year data had been collated up to January 2019. Therefore to enable a fair comparison with the previous year we have extrapolated same year to date data.

Activity	**Full year 2017-18**	**April 17 to Jan 18**	**April 18 to Jan 19**	**Difference from April to Jan**
Emergency and urgent attendances (all types)	245,627	204,185	215,326	+ 5.46% (11,141)
Attendances at emergency department (type 1)	92,021	77,113	81,725*	+ 5.98% (4,612)
Attendances of patients age 75 or over	13,594	11,325	11,394	+ 0.61% (69)
Admissions from A&E	29,173	24,512	25,481	+ 3.95% (969)
Inpatients and day cases	114,165	95,123	98,272	+ 3.31% (3,149)
Planned admissions	8,051	6,781	6,516	- 3.91% (265)
Unplanned admissions	40,025	33,271	35,761	+ 7.48% (2,490)
Day case procedures	43,173	35,752	37,284	+ 4.29% (1,533)
Outpatient	609,911	509,745	504,225	- 1.08% (5,520)

appointments				

***** *In November the St Paul's Eye Unit Emergency Department (where attendances were recorded as type 2) was reconfigured so that the reception and booking-in area was combined with the Royal's main Emergency Department. Therefore 3,275 emergency attendances at the St Paul's Unit were included in Type 1 figures. These figures are reflected in the table above.*

As can be seen from the activity table above the Trust has again seen increased demands on its services. In particular, emergency and urgent attendances increased by over 5% on the same period the previous year, similarly unplanned admissions increasing by over 7% with admissions from A%E rising by almost 4%.

Throughout the last year the Trust also experienced significant issues with the Royal Liverpool University Hospital estate. This building is scheduled for demolition and the Trust had expected to move into the new Royal last year. However the liquidation of construction company Carillion who had been leading the project, meant an ongoing delay in completion and a longer than planned stay in the current Royal. During the year, a number of issues with the estate had a detrimental impact on our ability to provide care, in line with timely performance measures. These include:

- A leak in the roof water reservoir that caused flooding in theatres resulting in the brief cancellation of the elective programme.
- Relocation of ward areas due to numerous floods and plumbing issues
- Failing water supply leading to the brief cancellation of endoscopy lists
- Electrical faults in theatres leading to a number of cancelled operations.

Thanks to robust business continuity plans and the sheer determination and commitment of staff, patient safety was maintained and delays and cancellations were kept to a minimum. However, the experience for patients affected by these issues was poor and it undoubtedly added to the challenges to performance, faced by our teams.

The Department of Health and Social Services has provided additional capital funding to maintain patient safety and ensure the Trust can continue to provide services in the existing Royal and we have spent over a million pounds this year on modernising the lifts, increasing maintenance for essential equipment and systems and on ensuring we have vital spare parts on-site for systems such as heating and ventilation. Our teams are also ready to respond quickly to any issues to make sure that disruption to patients is kept to a minimum.

Patient flow: Supporting patients in the emergency department

Patients in the emergency department are triaged according to how urgent their illness or injury is. Those in the most urgent need of care are seen first.

The Trust continues to work as part of the wider health system to redirect those patients in the emergency department whose needs are not urgent to more appropriate services in the community. For some patients, following triage, they may

be directed to the appropriate primary care services co-located within the emergency department or in the community.

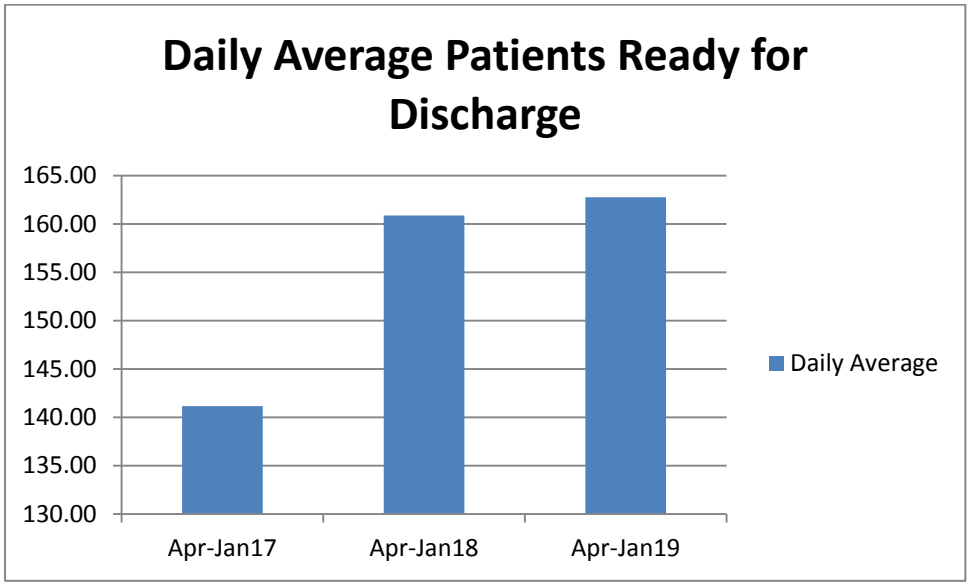
In addition the ambulatory care service has been expanded. This service is supporting patients in the emergency department to be seen quicker and in a more appropriate setting. Often these patients can be seen without the need for them to be admitted to hospital, with any necessary follows ups in a clinic or even over the phone at home. Up to 30 patients a day are benefiting from this advanced service with an additional 25 patients a day being supported at home. This service has been enabled through enhancements to our Patient Dashboard tracking technology allowing clinicians in ambulatory care to access test results and patient details more efficiently. These clinicians can then contact the patient to inform them over the phone without them needing to come back into the hospital and a letter detailing the outcome is sent to their GP.

The Frailty Unit located beside the emergency department provides rapid assessment and treatment for frail elderly patients. This is aimed at enabling these patients to be medically fit as soon as possible to avoid staying in hospital any longer than necessary. These patients are then discharged with the support of an integrated frailty team, consisting of staff from the Trust, Liverpool Local Authority and Mersey Care NHS Trust.

Almost 750 patients were cared for and discharged from the Frailty Unit this year, an increase of around 150 patients. 90% of those patients were discharged to their usual place of residence, an increase of 5%. The average length of stay on the unit was 5.6 days, a slight increase of 1 day.

Patient flow: Supporting patients' discharge

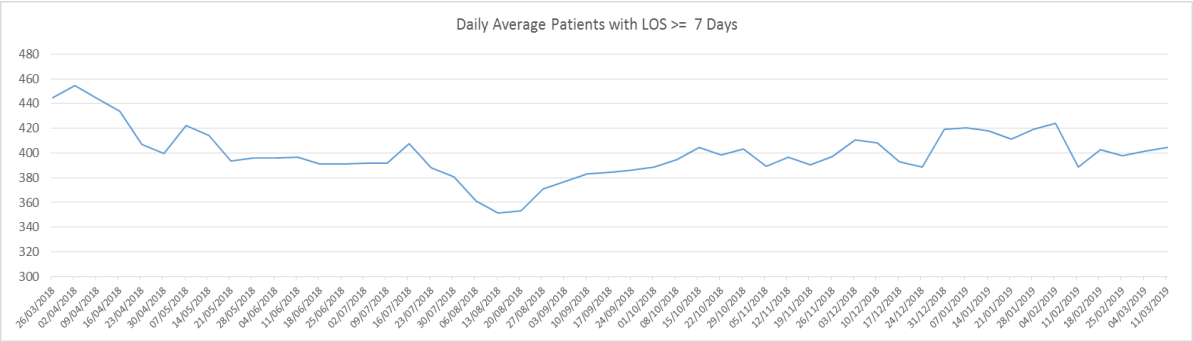
The numbers of patients who remain in a hospital bed, yet are ready to be discharged remains high. Patients who are 'ready to be discharged' are defined as patients who are well enough to leave the hospital but have not yet been discharged. These delays may be due to awaiting a care placement or package of care to be agreed or become available. The daily average number of patients who are ready to be discharged has been steadily increasing in recent years. Between April and January this year the average number of patients ready for discharge was 162 a day, which represents a significant portion of inpatient beds.

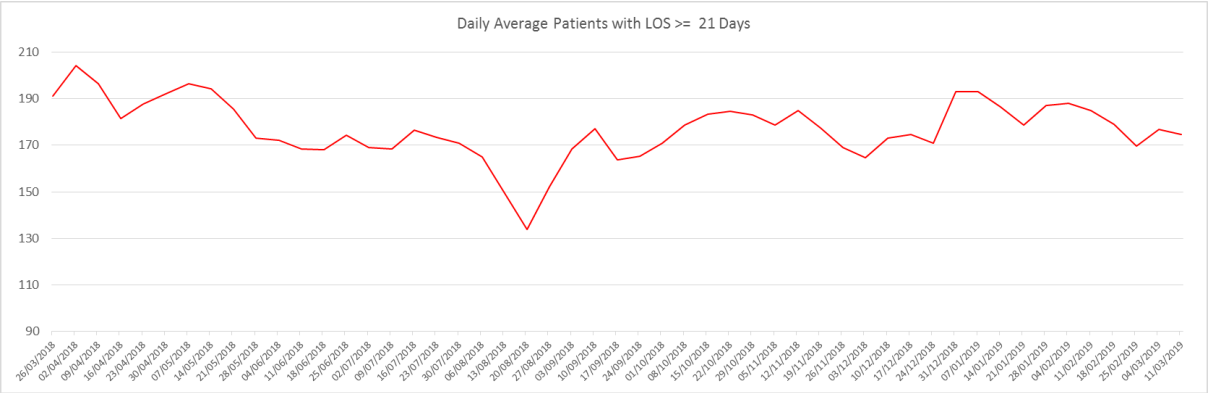


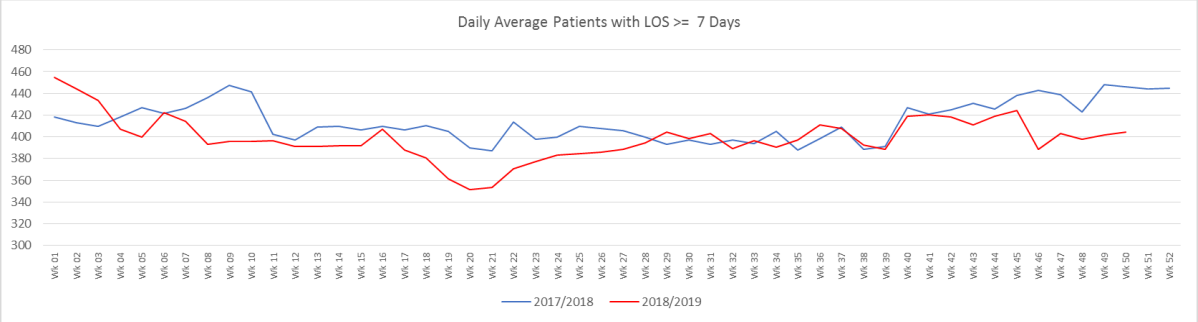
The Trust continues to work alongside colleagues in social services and community care across Liverpool, Sefton and Knowsley as part of the North Mersey A&E Delivery Board, to reduce delays to discharge, and improve access to services in the community. This work includes the establishment of the Integrated Community Reablement and Assessment Service (ICRAS).

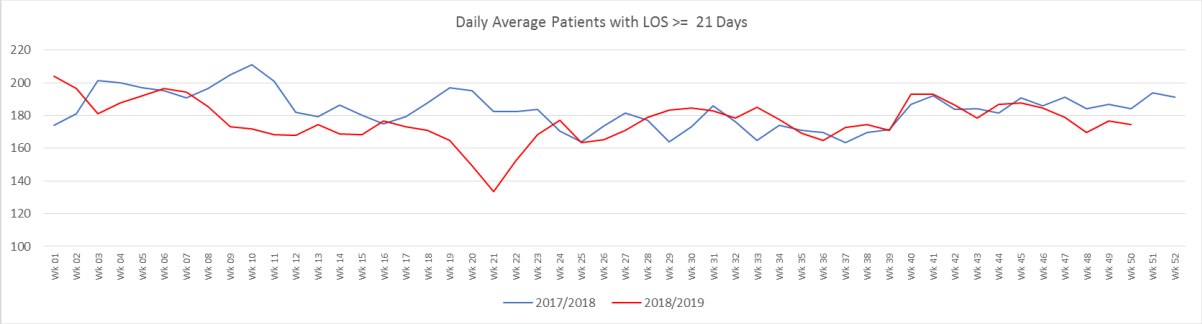
ICRAS has been one of the schemes that has helped the Trust to reduce the length of stay for patients who have been in the Trust for seven days or more and 21 days or more. This year the Trust has implemented a process to robustly assess and review these long stay patients to understand their care plan and progress to the next stage of the plan as quickly as possible. The Trust works closely with the local authority and Mersey Care with the aim to support safe and effective discharge. In addition 'Trusted Assessors' have been appointed to support patients and families in assessing which care home placement would best suit the needs of the patient. The Trust can also use 'Home First' which allows patients to be discharged earlier and have on-going assessments completed outside the hospital with support from the community services and the local authority.

The reduction in these long stay patients can be seen in the graphs below and have been compared with the previous year:









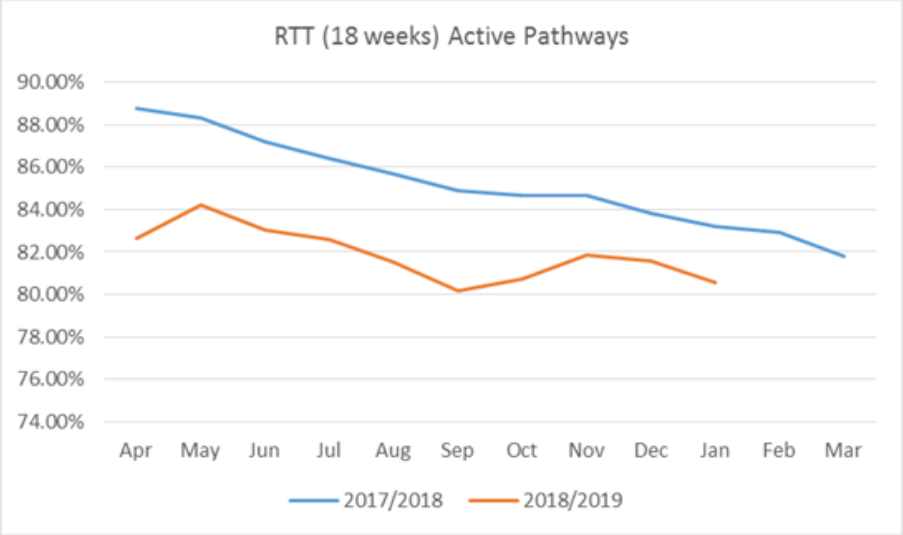
During the year the Trust produced a comprehensive communications campaign for the North Mersey Delivery Board. The aims of the campaign were to make patients and carers aware of the importance of not delaying discharge and how they can support swifter discharges. It was also aimed at changing the behaviour and attitude of some staff to ensure they understand that prioritising discharges is acting in the patients' best interests. These aims were informed through detailed research with patients and staff across the three adult acute Trusts within the delivery board. The campaign messages were delivered through comprehensive social media marketing, working proactively with local media outlets, a patient information booklet about the discharge process and through consistent internal communications to staff.

Access to treatment

In response to the pressures on emergency departments last winter, NHS England advised all hospital Trusts to cancel non-urgent planned procedures. This had an inevitable impact on the Trust's ability to meet the national standard that over 92% of patients should be treated within 18 weeks of referral. The impact of this continued during 2018/19 with a backlog of routine procedures and has therefore increased waiting times this year.

Throughout winter, despite continuing to face increasing demand for urgent, unplanned procedures, every effort was made to ensure as many procedures went ahead as possible. It is anticipated that this will help to avoid a continued growth in the backlog of procedures in the next financial year.

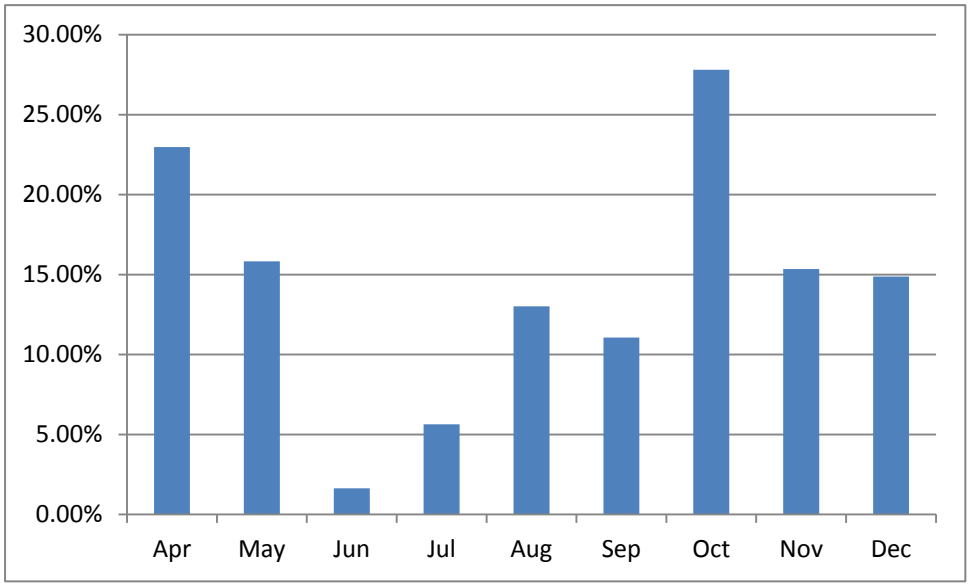
The graph below outlines the Trust's performance against the 18 week referral to treatment standard over the last two years:



From April to January, the Trust carried out over 1,200 more operations than the same period the previous year. The data in the performance summary reports an increase of 128 cancelled operations from April to January on the same period the previous year. In some cases the Trust has cancelled procedures due to issues with the infrastructure of the existing Royal Liverpool Hospital.

From April to December, the Trust has over 1,500 more patients being referred for appointments on suspected cancer pathways, which is an increase of nearly 14%. Unfortunately this has contributed to extended waiting times. The chart below shows the increases in patients with suspected cancer being seen within two weeks compared to the same months the previous year.

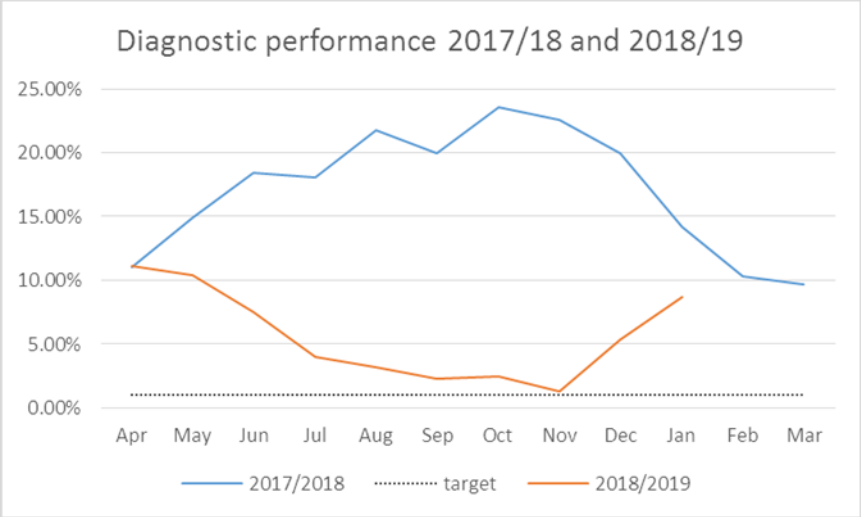
Percentage month on month increase between 2017/18 and 2018/19 for total patients seen on two week wait cancer list:

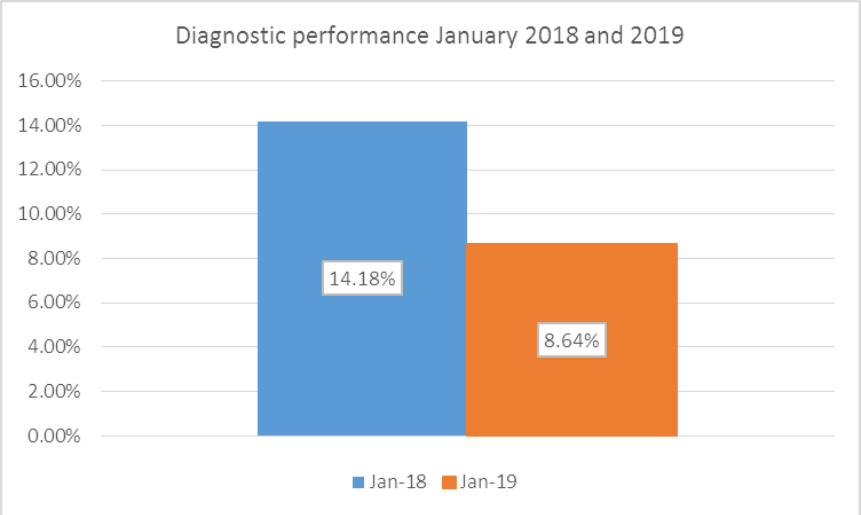


Improvement work is underway to ensure the standards for cancer care are met consistently over the coming year. This work includes reviews of all patient pathways, faster access to diagnostic testing and additional clinic appointments. We are working closely with our colleagues in primary care to ensure general practitioners have the ability to speak to consultant teams for advice before referring a patient.

Access to diagnostics

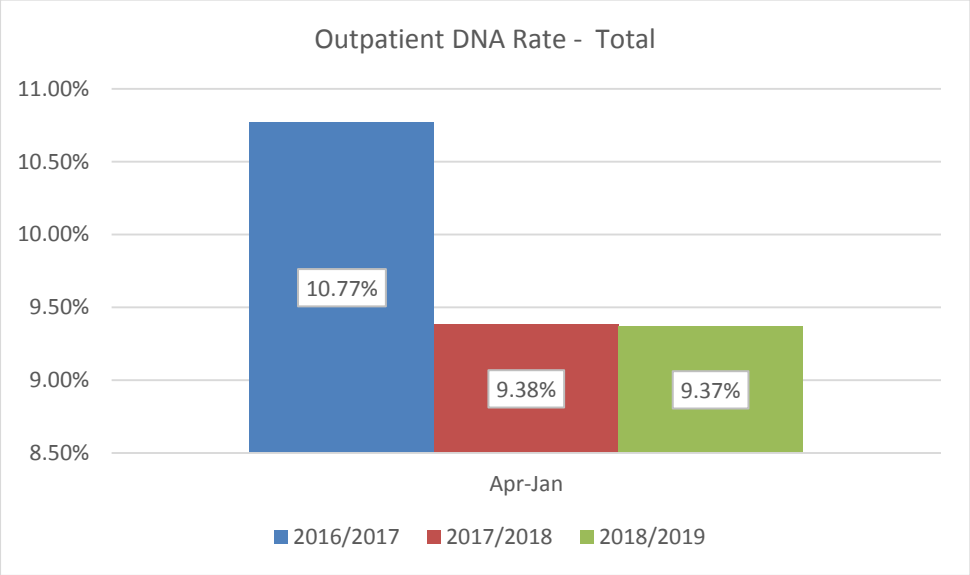
Less patients have waited more than 6 weeks for diagnostic tests this year as the charts below outline:





The Trust has undertaken an improvement programme with the aim that no more than 1% of patients should wait more than 6 weeks for a diagnostic test. The Trust managed a steady reduction throughout the year reporting a position of 1.3% in November 2018, however this position deteriorated and at February 2019 was just below the year's starting position at 8.6%. This deterioration was due to challenges around the national shortages of qualified echophysiologists for echocardiology and also the fact that in December and January, the company brought in to support waiting times in endoscopy reduced its capacity by over 50%. We have worked hard to ensure these patients are seen.

The Trust has seen a sustained reduction in the number of times patients did not attend (DNA) their appointment. This means that services can be provided more efficiently. Last year the Trust introduced a new two-way texting service for outpatients to help reduce the DNA rate. This texting service along with improvements in written communication to patients and also evening and weekend clinics has helped to maintain this reduction as the graph below outlines:



Patients' views on the care they receive

As outlined in the performance summary, there are small variances in the percentages of patients who would recommend our services to friends and family, with a small increase for outpatient services and a small decrease for the emergency department.

From data collected by our Patient Advice and Liaison Service (PALS) the main themes that patient's had complained about this year were:

- Patient care
- Access to treatment or medication
- Communication
- Values and behaviours
- Admissions and discharges

Conclusion

In conclusion, the Trust's performance has been impacted by a number of challenges this year. These include continued increasing demand on services, particularly in emergency, non-urgent care and in cancer care, and despite the best efforts of staff to maintain services, numerous issues with the failing infrastructure of the existing Royal Liverpool Hospital (that is scheduled for demolition), have also had an impact on performance.

Our financial performance

The Trust faced a difficult financial climate and worked extremely hard to stabilise its financial position this year.

The Trust's income and expenditure position shows an adjusted deficit of £55.5m. This position is adjusted for technical items relating to the accounting treatment of the new hospital being brought onto the balance sheet of the Trust. Specifically this involves adjustments to recognise the transfer of assets (shown as donated income of £108m) and impairments (of £92.8m) to provide an updated assessment of current value. Additional information regarding this matter can be found in Note 1.1b Additional Directions, Note1.6.1(New Royal), Note1.10 (Measurement), Note1.13 (Donated assets), Note 4 (Other operating income), Note 7 (Impairment of assets), Note 15.3 and 15.5 (Property, Plant and Equipment). This position compares to last year's deficit of £26.2m (after adjusting for technical items). The Trust received £80,784k Public Dividend Capital (PDC), mainly to support the costs to complete the new Royal.

The Trust's net assets at 31 March 2019 were £289,429k.

Non-current assets include £405,119k in respect of property, plant and equipment assets, reflecting investment during the year in the new Royal Liverpool University Hospital.

Intangible assets have increased to £21,246k from £17,889k last year, reflecting the Trust's investment in information technology including the Electronic Patient Record and investment as a Global Digital Exemplar.

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

Improving quality, efficiency and productivity

The Trust has a duty to ensure value for money for the taxpayer, whilst also ensuring that patients are provided with a high quality service. To do this the Trust has established a Quality, Efficiency and Productivity (QEP) programme aimed at doing things right first time and identifying opportunities for improving quality, avoiding duplication, making savings and/or increasing income. The QEP programme is aimed at working with staff to support the improvements that in most cases, they have identified.

This year the Trust originally had a target of £31.4m to save. This was revised with agreement from NHS Improvement to £21m, in recognition of practical considerations relating to some areas, such as the requirement for system wide change. At the time of writing the Trust had saved almost £20.5m. Of these savings, £10.2million can be made year-on-year, with £10.2 million from one off projects.

The following are among the QEP schemes established this year, that have helped to deliver significant savings:

- The Pharmacy team continually deliver savings from carefully managing the prescribing drugs and exploring new opportunities where the Trust may change a supplier to reduce costs. This approach saved over £400,000 this year, and this saving is recurrent.

- Better management and control of external agency staff usage and maximising the use of internal bank staff delivered £700,000 of savings this year. Using staff from the bank, is not only more cost effective, it improves safety as these staff are already familiar with the Trust's values and policies and standards of care.

- Standardisation of shifts in clinical areas to ensure that variations are minimal has achieved consistency and fairness in allocating shifts. This has also improved staff satisfaction and experience, which is essential in delivering improved patient care. The project has delivered £650,000 of recurrent savings this year.

Our commitments

Patient safety and duty of candour

The Trust encourages an open reporting and learning culture to identify trends in incidents and implement preventative action. Staff should have confidence in the investigation process and understand the value of reporting and learning from incidents.

Research shows that trusts with higher levels of incident reporting are more likely to demonstrate other features of a stronger safety culture and commitment to patients to inform them when incidents have occurred. Incident reporting supports clinicians to learn about why patient safety incidents happen within their own service, and what they can do to keep their patients safe from avoidable harm.

The ‘degree of harm’ for patient safety incidents is defined by:

> **No harm:** any patient safety incident that had the potential to cause harm but was prevented.
>
> **Low harm:** any patient safety incident that required extra observation or minor treatment and caused minimal harm
>
> **Moderate harm:** any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm
>
> **Severe harm:** the patient has been permanently harmed as a result of the patient safety incident
>
> **Death:** the patient safety incident has resulted in the death of the patient.

The Trust reviews all patient safety incidents at a weekly patient safety meeting. Incidents of moderate harm, severe harm and death will result in a formal Root Cause Analysis Investigation (RCA).

The Trust will apply the Serious Incident and Never Event Framework and report more serious incidents or incidents where there is greater learning, to the Clinical Commissioning Group (CCG).

All incidents at these levels will be shared with the patient and/or family in accordance with the Trust’s Duty of Candour Policy. This is a moral, ethical and legal requirement to act in an open and transparent way with patients and families.

Duty of candour reporting requirements state that as soon as reasonably practicable, after becoming aware of a notifiable patient safety incident the health professional or Trust must:

- Notify the patient (or someone lawfully acting on their behalf) that the incident has occurred.
- Provide reasonable support to the patient following the incident

The notification must:

- Be conducted verbally; by a representative of the Trust, typically the senior doctor or senior nurse responsible for the patient at the time of the incident; with the patient (or someone lawfully acting on their behalf). If the patient is still an inpatient this should occur in the clinical environment, if the patient is no longer an inpatient then a telephone conversation should be made.
- Provide a truthful account of all the facts that the Trust knows about the incident at the time of the notification.
- Advise and, if appropriate, agree with the patient (or someone lawfully acting on their behalf) what further enquiries into the incident are appropriate, from both the patient's and Trust's perspective (informing the terms of reference for the investigation).
- Include an apology.

Incidents can relate to moderate, severe harm or death.
The Trust has a policy in place that specifies the process by which the Trust must adhere to national requirements.

The Trust reporting requirements and compliance are monitored through the Trust governance process, and various audits have been carried out to understand our compliance with this.

The tables below outline the number and rate of incidents at the Trust resulting in varying degrees of harm from none to death, for the two most recent reporting periods.

Between 1 April and 30 September 2018 the Trust reported 7098 incidents to the National Reporting and Learning System (NRLS), which is a rate of 56.58 per 1,000 bed days

Degree of Harm 01.4.18 – 30.9.18

None	**Low**	**Moderate**	**Severe**	**Death**
6185	734	171	6	2
%	%	%	%	%
87.1	10.3	2.4	0.1	0

In the previous reporting period, 1 October 2017 to 31 March 2018, the Trust reported 5335 incidents (rate of 41.09) incidents per 1,000 bed days during this period.

Degree of Harm 01.10.17 – 31.3.18

None	**Low**	**Moderate**	**Severe**	**Death**
4440	730	152	12	1
%	**%**	**%**	**%**	**%**
83.2	13.7	2.9	0.2	0

The Trust has taken the following actions to improve the rates of reporting and improve the quality of the investigation.

- Undertaking comprehensive investigations following moderate and severe incidents in order to learn lessons and improve practice.

- Providing staff training in relation to risk and incident management, root cause analysis and Duty of Candour.

- Ensuring rigorous reporting of key performance indicators in relation to incidents at the monthly Patient Safety sub-committee and Perfect Ward meetings with ward managers to ensure lessons are learned, learning is shared across the organisation and appropriate actions are implemented.

- A human factors training programme has been implemented to enhance team working in clinical areas. The human factors course raises awareness with staff of how the way in which they react to different situations, may contribute to improving quality and safety of patient care. This reinforces the importance of leadership, communication and an open culture of learning.

- Monitor and audit compliance against the Duty of Candour and report to appropriate committees.

Never events

Never events are described by NHS England as serious incidents that are wholly preventable. Each never event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a never event.

For the period 2018/19, the Trust reported three never events.

The Trust has taken the following actions to mitigate the risk of reoccurrence of never events.

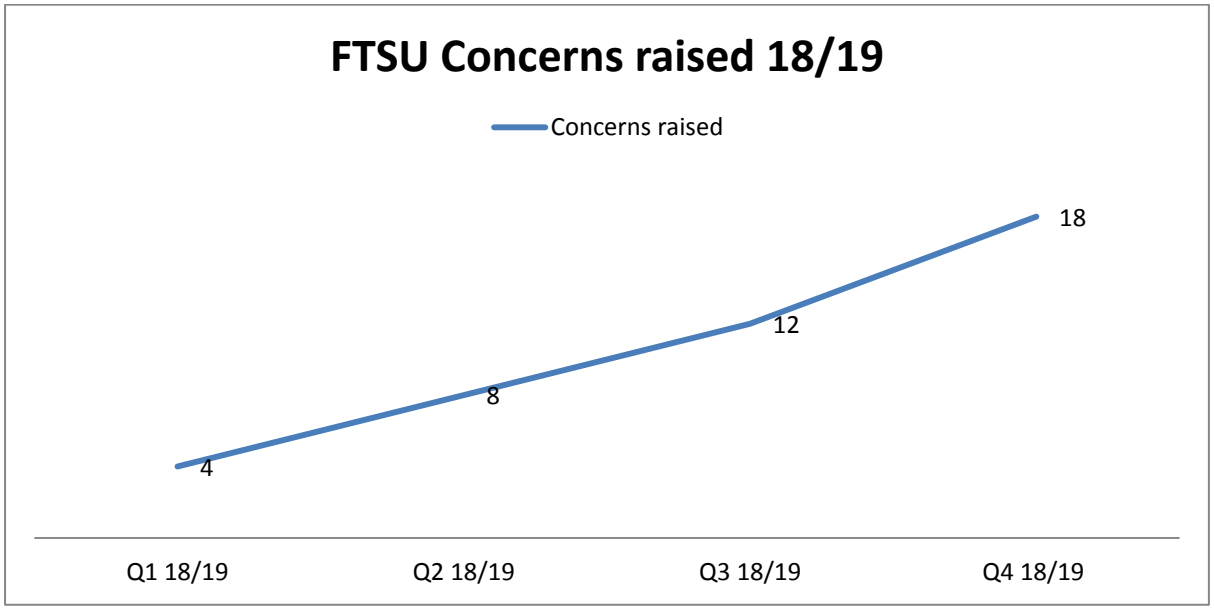
- Improved surgery safety checklists.
- Human factors training course and rolled out for theatre staff alongside the introduction of Local Safety Standards for Invasive Procedures (LocSSIPs).
- Staff empowered to challenge areas of concern.
- Regular communication to staff through a weekly Patient Safety Bulletin to share lessons learned, trend analysis and share areas of good practice.

The Trust is committed to using Root Cause Analysis (RCA) to investigate adverse events, including never events. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and encourage feedback in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.

Freedom to Speak Up

The Trust is committed to ensuring an open and honest culture where staff feel able to speak up about any concerns they have, particularly regarding patient safety. In line with the findings of Sir Robert Francis in the Freedom to Speak up Review (2015), trusts are required to evidence that they have robust arrangements in place to handle concerns including the appointment of a Freedom to Speak Up (FTSU) Guardian. The Trust appointed the Assistant Director of Patient Safety and Human Factors to the role of FTSU Guardian in June 2017, and also appointed five FTSU champions from various professional and ethnic backgrounds to enhance the approachability and accessibility of the FTSU team.

During 2018/19, the Trust has seen significant improvements in both the awareness and confidence of staff to raise concerns via the FTSU guardian as depicted in the below graph:



Each concern is actively managed by the FTSU guardian until the Trust has provided adequate assurance to the concern raiser that their issues have been adequately

addressed. Since the start of this process a total of 50 concerns have been raised of which 31 have been addressed in full and closed.

Of the 42 concerns raised this year, 7 related to patient safety concerns with the remaining 35 related to the treatment and/or behaviour of staff. This has resulted in a number of cultural transformation work streams to improve local cultures and staff working lives. These include the gradual introduction of a behavioural standards framework to more effectively manage inappropriate behaviours within the workplace.

Complaints

Patient safety is our priority and we are committed to ensuring all of our patients have a positive experience. However, we recognise that we do not always get it right first time. If our service has not been as good as it should be we will make sure we learn lessons and share them across the organisation.

During the year, we have worked to improve the way we respond to and learn from complaints.

Informal complaints are complaints or concerns that are raised at ward or departmental level. This year, we received 2,082 informal complaints. This compares to 1,742 the previous year, an increase of 16%.

The increase has occurred due to our referral system through online media applications and due to our goal to attempt to address as many complaints or concerns as possible at source.

All of these informal complaints were dealt with by Patient Advice and Liaison Service within the response target of five working days.

This year we addressed 331 formal complaints in line with our target of 25, 35 or 60 working days with a similar number the previous year. At the time of writing, we met our response time standard in 76% of cases.

Safeguarding human rights

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

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 2018/19 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 HFMA rated our sustainability reporting for 2017-18 as 'Excellent', for the third year in a row. The Trust hosted a workshop in January 2019 to share best practice on sustainability reporting with other Liverpool City Region NHS trusts. Our Sustainability Plan 2019-20 can be accessed here:

https://www.rlbuht.nhs.uk/about-the-trust/our-performance/annual-plan/

Sustainable Development Assessment Tool (SDAT)

The Trust uses SDAT to monitor our sustainability performance. We undertook our second assessment in January 2019, showing an increase in scores across nine sections. The increase in Adaptation was due to our continued work with the Local Resilience Forum and the creation of training for staff. The increase in Capital Projects was supported by the recent developments of the new Clinical Sterile Services Department at Broadgreen Hospital and the Life Sciences Accelerator on the Royal site.

Our scores are in the table below and all ten SDAT sections are included within the Sustainability Plan 2019-20. In addition, SDAT shows us which UN Sustainable Development Goals (SDGs) the Trust is supporting. The SGDs were approved in 2015 and the Trust has evidence that it is working towards all seventeen goals. The Trust submitted a case study to the UK Government in 2019, as part of their SDG Voluntary National Submission to the UN in July 2019.

SDAT section	2019 score	2018 score	SDGs supported
Corporate Approach	61.01%	49.06%	Goals 1,4, 7,8, 9, 12, 13
Asset Management & Utilities	43.48%	37.68%	Goals 6, 7, 8
Travel & Logistics	64.58%	47.92%	Goals 7, 11, 12, 13, 17
Adaptation	75.64%	52.56%	Goals 3, 12, 13, 17
Capital Projects	82.54%	49.21%	Goals 7, 12, 13, 15, 17
Green Space & Biodiversity	17.39%	7.25%	Goal 14
Sustainable Care Models	62.67%	54.67%	Goals 3, 4, 10, 12, 16
Our People	66.67%	62.37%	Goals 2, 3, 5, 8, 9, 16,
Sustainable Use of Resources	50.00%	39.89%	Goals 2, 6, 11, 12
Carbon / GHGs	47.75%	49.55%	Goals 6, 7, 8

Carbon emissions

We report our carbon data a year behind, as the full information for 2018-19 is not collated before our annual report sign-off. Our total carbon footprint for 2017-18 has decreased slightly on the previous year. Scope 1 (gas and oil) and 2 (electricity and imported heat) emissions have remained relatively stable, although our electricity exports have decreased which has resulted in smaller negative scope 2 emissions. It is expected that the improved energy performance of the new Royal hospital will contribute towards meeting our energy targets in the future.

Scope 3 emissions (including procurement, travel, waste and water) have decreased. Procurement emissions are calculated based on non-pay and capital spend.

Other scope 3 emissions include from staff and patient travel, from water use and the waste that we produce. 2016/17 and 2017/18 scope 3 emissions are larger than

CO_2 Emissions (tCO_2e)	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total	84,936	87,389	84,526	97,457	113,734	110,721
Scope 1 (gas and oil use)	34,505	33,528	31,991	33,697	33,825	34,517
Scope 2 (electricity & imported heat)	-7,758	-7,027	-6,927	-7,644	-7,625	-6,662
Scope 3 (including procurement, travel, waste and water)	58,189	60,887	59,461	71,403	87,534	82,866

in previous years, as we are now able to include an estimate of emissions from patient and visitor travel.

Accountability Report

Corporate Governance Report

Director's 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 number of changes to the Board and the executive team this year and a number of interim appointments have been made to provide continuity of leadership, whilst being cognisant of the proposed merger with Aintree University Hospital NHS Foundation Trust.

Interim appointments include Interim Chief Executive, following the departure of Aidan Kehoe, an interim director of finance, an Interim Chief Nurse and an Interim Chief Operating Officer. The latter two follow the departure of Lisa Grant who had held the combined position of Chief Nurse and Chief Operating Officer and the new posts commence on 1 April 2019 (details of these will therefore be including in next year's Annual Report). The Trust has also appointed an Interim Medical Director due to the existing Medical Director taking up the position of Interim Chief Executive.

At the end of the financial year, chairman Bill Griffiths' term of office ended and Mike Eastwood has been appointed interim chairman.

Chairman and non-executives

Bill Griffiths, Chairman

Bill has been chairman since January 2015. 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. Bill's term of office ended on 31 March 2019.

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 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. Mike has been vice chair and was appointed interim chairman in April 2019. He is currently diocesan secretary (chief executive) of the Diocese of Liverpool as well as chief officer 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, 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 variety of 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 joined the Trust as chief executive in 2012, having previously been chief executive at Blackpool Teaching Hospitals NHS Foundation Trust. 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. Aidan left the Trust in March 2019.

John Graham, Deputy Chief Executive and Director of Finance

John joined the trust as director of finance and business development in January 2011. He has around 30 years of NHS experience having worked for a variety of Trusts including, a strategic health authority and the Department of Health. John left the Trust in November 2018.

Lisa Grant, Executive Chief Nurse and Chief Operating Officer

Lisa started her career as a staff nurse at the Royal in 1998 and returned to 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 left the Trust in March 2019.

Dr Peter Williams, Medical Director and Interim Chief Executive

Peter has worked at the Royal and the Trust for many years, first as a research fellow and senior registrar between 1984 and 1992. With several years in Manchester as a consultant, he returned to Liverpool in 1997 as a consultant nephrologist. Peter has undertaken many roles at the Trust including clinical director for general internal medicine, divisional medical director and served as medical director since 2008. Recently Peter's roles have included programme director for the proposed merger with Aintree University Hospitals and overseeing the planning of the move into the new Royal. Peter was appointed interim chief executive in March 2019, providing continuity to the executive team.

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.

Paul Bradshaw, Interim Director of Finance

Paul has around 28 years NHS experience in financial management roles, with 20 years operating in board and deputy level roles in a number of NHS Trusts in the North West. He joined the Trust in 2014 as deputy director of finance from North West Ambulance Service, where he held the same position. Paul was appointed interim director of finance in 2018. Paul is a Chartered Institute of Management Accountants qualified accountant.

Dr Andrew Loughney, Interim Medical Director

Andrew was appointed interim medical director in March 2019 on secondment from Liverpool Women's NHS Foundation Trust, where he had been medical director and deputy chief executive. Andrew retains clinical commitments at Liverpool Women's Hospital, where he joined in 2016 having previously worked in Sunderland as consultant and associate medical director for clinical governance. Andrew has been practising in obstetrics and gynaecology since 1990. His first consultant post was at

Newcastle upon Tyne where he was lead clinician for the delivery suite between 2000 and 2008 and he has practiced in maternal medicine up until 2012.

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 Foundation Trust.

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 worked in a wide range of sectors including manufacturing and financial services and has established and managed communication and marketing teams in local authorities, 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. 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 details 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. (include link in electronic version)

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 officer regularly reviews information risks and acts as the Trust Senior Information Risk Owner (SIRO) and the Information Governance Group provides Trust oversight.

The Trust continues to maintain high standards for information governance. There are 10 sections within the new Data Security and Protection Toolkit (DSPT) which is submitted at the end of March each year. An audit has been conducted and has received 'substantial assurance' as a result.

The Trust received 695 Freedom of Information requests containing 6,897 questions. 88% 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 information security incidents. The information incidents reported this year are minor (77), with one incident being reported to the Information Commissioner, with no further actions for the Trust.

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.

Signed.....P S Williams.....Chief Executive

Date.....11/6/2019.....

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

11/6/2019 Date ..... Chief Executive

11/6/2019 Date ..... Finance Director

Annual governance statement

1. Scope of responsibility

1.1 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 responsibilities as set out in the 'NHS Trust Accountable Officer Memorandum'.

2. The purpose of the system of internal control

2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2019 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Describe the key ways in which:

- leadership is given to the risk management process; and
- staff are trained or equipped to manage risk in a way appropriate to their authority and duties. Include comment on guidance provided to them and ways in which you seek to learn from good practice

3.1 As Chief Executive I have overall responsibility for ensuring arrangements are in place for the effective management of risk. The Trust Board recognises that risk management is an integral part of good management practice and is responsible for reviewing the effectiveness of internal

controls. The responsibility for leading the management of risk throughout the organisation is delegated to the Executive Directors to ensure that the organisational structure and resources are in place to deliver our objectives.

3.2 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 2018/19 the Chief Nurse/COO continued to provide oversight of the Trust's risk management arrangements in accordance with the Trust's Risk Management Policy.

3.3 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.

3.4 Risk reporting through the Committee structure has been strengthened throughout the year with an enhanced bespoke risk report being provided to the Finance and Performance, Workforce and the Quality Governance Committees. The aim of the reports is to provide assurance to Committee members with regards to the identification and control of risk. The report includes the current position of relevant risks with a rating of 12 and above to enable Committee to seek further assurance if required. The New Hospital Committee has also received a quarterly risk management report produced by the Redevelopment Team.

3.5 The Board receives a regular Committee Assurance Report which outlines the key risks, negative assurances and positive assurances from the meetings held. The minutes of the standing Committees are also made available to Board members. A risk register outlining risks with a rating of 15 and above is also reported to the Board through the standing Integrated Performance Report item. The Audit and Assurance Committee oversees the systems of internal control and overall assurance process associated with managing risk.

3.6 **Risk Management Training**

3.7 Risk management training is provided to staff appropriate to their level. New employees are trained through an induction programme and specific training is targeted for individual roles appropriate to their responsibilities. The Trust's mandatory training programme reflects essential training needs and includes risk management processes such as health and safety, clinical risk management, fire safety, conflict resolution, resuscitation, moving and handling, safeguarding patients, infection prevention, information governance and equality and diversity. Each of these is included within an

e-learning programme available to staff.

3.8 Risk management training is provided to support the effective operation of the Trust's risk management arrangements. Relevant staff and managers receive root cause analysis training which also incorporates duty of candour arrangements. Staff who require access to DATIX receive one to one training. Refresher training is also provided. The Risk team provides a telephone help line to assist staff and managers with risk and DATIX related queries.

4. The Risk and Control Framework

Describe the key elements of the risk management strategy, including the way in which risk (or change in risk) is identified, evaluated, and controlled. Include mention of how risk appetites are determined. Explicitly describe the key elements of the quality governance arrangements, including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with CQC registration requirements. Explicitly include how risks to data security are being managed and controlled as part of this process.

Include a brief description of the organisation's major risks, including significant clinical risks, separately identifying in-year and future risks, how they are/will be managed and mitigated and how outcomes are/will be assessed. Work performed to assess whether services are well-led under NHS Improvement's well-led framework will assist with this assessment and the trust should refer to well-led reviews as appropriate.

Describe key ways in which risk management is embedded in the activity of the organisation. For example, set out the ways in which equality impact assessments are integrated into core trust business or how incident reporting is openly encouraged and handled across the trust.]

4.1 The Trust's 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. Central to this aim is the Trust's governance framework and this is supported by a risk management system that aims to deliver continuous improvements in safety and quality, and maximises opportunity for growth and development.

4.2 The Risk Management Policy applies to all Trust employees, contractors or volunteers working at the Trust with specific roles and responsibilities for managing and escalating risk are defined within the 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.

4.3 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

4.4 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).

4.5 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.

4.6 **Strategic Risks**

4.7 The principal risks to the delivery of the Trust's strategic objectives are

- Inability to effectively manage demand
- Failure to maintain financial viability
- Failure to develop a sustainable local health system.

4.8 The Board Assurance Framework (BAF) provides assurance in relation to the principal risks to the delivery of the Trust's strategic objectives (on page 9). 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.

4.9 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

4.10 The Board considered a review of the Trust's risk management processes in March 2018. The review focussed on how the Trust could enhance the assessment and control of strategic risks and specifically those attached to strategic change programmes.

4.11 A number of recommendations were accepted by the Board with a view to improving the way risks are managed, strengthening existing controls and providing greater assurance. This included the introduction of a Collaborative Risk Management working group and delivery of portfolio risk management training for all project and programme teams; operational and corporate senior managers.

4.12 The Collaborative Risk Management working group has reviewed the reporting of risks to committees and identified a number of risks to be

realigned to a different committee. Work is continuing with lead officers to improve the reporting of risks and this has resulted in the changes outlined in paragraph 3.4.

4.13 The Board has recognised that there are key areas of focus that independently carry risk with many interdependencies between them. It is the aggregation of these risks that can have an impact on the Trust's ability to deliver its corporate objectives and strategic aims. In response to this, the Trust has developed an aggregated risk report which considers the timings and interdependencies of highest scoring organisational risks.

4.14 Matters relating to strategic developments are highlighted to the Board in the Chief Executive Summary of the Integrated Performance Report. Updates are provided on the progress being made in relation to the Cheshire and Merseyside Partnership ('Partnership' – previously known as Cheshire and Merseyside STP). My predecessor was the representative for acute trusts on the System Management Board for the Partnership (until March 2019). The objectives of the Partnership are to play a lead role in system management and to drive the development of place based care. A report was received in February 2019 which provided an overview to the Board on the governance of the Partnership, the achievements made to date and the future plans. Action is planned to ensure that the Trust continues to have a role to play in the Partnership.

4.15 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. The Trust also recognises its role in improving the broader regeneration, employment and education opportunities in the city. The Trust has representation on key strategic bodies such as the Knowledge Quarter, Science Park and Health and Life Sciences Boards. The Trust is a founder member of the Northern Health Science Alliance and has Board representatives on the AHSN (Innovation Agency) and Liverpool Health Partners. The Trust also hosts the North West Coast Clinical Research Network.

4.16 The Trust is working with commissioners, neighbouring hospital trusts and community care partners to shape the future of local healthcare provision. We have worked 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. This is scheduled to be submitted to NHSI in the summer of 2019. The vanguard of the proposed merger is a proposal for improving orthopaedic services through the development of a city-wide Liverpool Orthopaedic and Trauma Service. This service is scheduled to be combined from September 2019.

4.17 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.

4.18 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

4.19 **Risk Appetite**

4.20 An updated risk appetite statement was agreed at the October 2016 Board and its relevance was discussed and reaffirmed at a Board development session in December 2018. It was confirmed that the Trust places an absolute priority on patient safety. The Trust has a low appetite for risk on patient safety and this principle overrides all other considerations at all times.

4.21 Further work is planned in 2019/20 to enhance the relationship between different risk reports and how the risk appetite statement to support effective discussion and decision-making.

4.22 **Clinical Risks**

4.23 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.

4.24 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.
- Internal and external audit reports.
- Clinical audits.
- Best practice / benchmarking reports.

4.25 The Trust also produces a ‘Patient Safety Newsletter’ which is circulated to all staff. This highlights pertinent patient safety issues and also outlines the key learning points from incident reporting.

4.26 The Board has recognised the deteriorating building fabric of the Royal Liverpool Hospital as carrying a risk of impacting the quality of care. During 2018/19 the Trust experienced significant flooding and electrical disruption. Valuable lessons were identified and communication was an area where it was noted that improvements could be made. In order to address this, the Trust has purchased radios for critical areas to provide backup support to telephony and electronic communications which will enable incident managers to communicate more effectively.

4.27 Additionally, some staff reported not being aware of what actions they should take whilst waiting for power to be restored. The Trust has provided opportunities for staff to familiarise themselves with emergency plans including departmental business continuity arrangements. It is expected that this will continue to be an area of challenge and risk into 2019/20.

4.28 Governance arrangements for health and safety have been revised with a view to strengthening reporting through to the Workforce Committee with items escalated to the Board through the Committee Report as necessary. The Board will also receive an annual report on progress against the identified health and safety objectives.

4.29 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 assurance report provided to the Board.

4.30 One of the key benefits of the proposed merger is the potential to reduce risks to patients. The development of better integrated city-wide services will simplify and improve patient pathways and provide the opportunity to develop new services in the future (e.g. liver transplantation).

4.31 **Data Quality Risks**

4.32 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.

4.33 Roles and responsibilities in relation to data quality are defined and incorporated, where appropriate, into job descriptions. The Chief Information Officer (CIO) provides executive leadership for data quality. The Trust undertakes an annual data quality audit which forms part of the Data Protection and Security Audit. Risks associated with data quality are included in the Trust risk register.

4.34 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.

4.35 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. The initial results of this work have been reported to the Board through the monthly Integrated Performance Report. The performance dashboard section includes a rating of data quality.

4.36 **Staff Risks**

[New for 2018/19] Describe the key ways in which the trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective. Describe how your trust complies with the 'Developing Workforce Safeguards' recommendations.

4.37 The Board approved a Workforce Strategy 2018-21 in November 2018 which outlines the future vision and priorities for our workforce to ensure that we attract and retain the best healthcare workers. It also seeks to respond to the national and regional context emphasising service reconfiguration, the imperative for new and efficient ways of working, technological and demographic change and delivers the best value use of our future healthcare resources. It is aligned to the priorities outlined in the Trust corporate objectives and the National Health and Care Workforce Strategy. The strategy is underpinned by a delivery plan with key performance indicators, which are submitted to Workforce Committee for on-going monitoring.

4.38 The Workforce Strategy provides a long term strategic framework under which a number of more detailed projects address specific challenges and emerging priorities. The Trust manages medium term staffing risks and priorities through a workforce plan. The workforce plan was approved by the Board in February 2018 with an update provided to the Workforce Committee In November 2018. Assurance was provided that workforce modelling had taken place to determine safe staffing for the new hospital, together with a financial analysis to establish where further workforce efficiencies could be made, subject to quality impact assessments. An update on the workforce plan is scheduled for consideration by the Board in Quarter 1 2019/20.

4.39 A monthly report is received by the Board on safe staffing levels which responds to the requirements of the National Quality Board (NQB) recommendations for publishing safe staffing figures. Assurance is provided on staffing levels and fill rates by the Chief Nurse and any potential risks

associated with nurse staffing are highlighted. The report provides an assessment of the resilience of the Trust's safe staffing processes and notes any performance exceptions.

4.40 Using the Association of UK University Hospitals (AUKUH) 'Safer Nursing Care Tool' (SNCT), the Trust measures the acuity and dependency of all inpatients over a four week period, twice each year, during a winter and summer period. During each study the data is collected Monday-Friday to allow for the capture of data during periods of increased surgical activity. This information informs safe staffing establishment numbers and is reported to the Board on a bi-annual basis (April and October during 2018).

4.41 The proposed merger of the Trust and Aintree University Hospital NHS Foundation Trust will represent a period of significant organisational change. Typically such programmes of change lead to feelings of uncertainty for employees. Accordingly, one of the key priorities has been to ensure that all staff are supported through the organisational workforce change process and that there is no impact to the service and level of care delivered to patients. In particular plans have been developed to address key workforce implications relating to the proposed merger, including:

- The development of a single positive culture
- An Organisational Development (OD) plan to support the new merged Trust to become a consistently high-performing organisation
- The approach to workforce transition, including organisational restructuring and the TUPE transfer of staff into the new merged Trust
- The creation of a consistent Education and Training offer to support the development of staff across the merged Trust.

4.42 **CQC Registration Requirements**

4.43 The Trust is fully compliant with the registration requirement of the Care Quality Commission (CQC).

4.44 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.

4.45 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.

4.46 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.

4.47 Internal audit reviewed the systems and processes to ensure ongoing 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 ongoing compliance with CQC standards and effective arrangements were in place to provide ongoing assurance up to the Board.

4.48 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.

4.49 The Trust was subject to a CQC inspection during January and February 2019. The final report is expected in Quarter 1 2019/20.

4.50 **Well-Led**

4.51 As part of NHSI's support and assurance processes an independent review of governance and leadership at the Trust was commissioned. The review was undertaken by Deloitte LLP during August and September 2018 and focussed on the following key lines of enquiry from the Well-Led Framework:

- Board leadership capacity and capability;
- Board effectiveness;
- Information and reporting;
- Interaction with operational leadership and governance structures;
- Improving financial performance at pace;
- Driving large-scale transformation; and
- Stakeholder engagement.

4.52 The review reported positively on the way that the Trust was handling a number of the challenges whilst also recognising a number of areas for improvement. The Improvement Action Plan contains 35 recommendations. with seven key recommendations.

4.53 Lead officers have been agreed for each recommendation. Progress against the actions is reported to the Board on a monthly basis. Progress with the

improvement action is also monitored by NHSI at monthly performance meetings.

4.54 The Integrated Performance Report received by the Board on a monthly basis includes a summary of the Trust's performance against the well-led domain. This includes detailed finance and workforce sections, a high level risk register and case studies of service improvement and innovation work.

4.55 Throughout 2018/19 The Trust has continued to develop and strengthen the Freedom to Speak Up function. The Trust's Freedom to Speak Up Guardian reports to the Board on a bi-annual basis to provide specific examples of concerns raised by staff during the reporting period and actions taken to effectively mitigate the risks associated with the concerns raised. The Trust has also provided training to staff on the human factors approach which will influence procurement processes and system design.

4.56 **Validity of Corporate Governance Statement**

[Include a description of the principal risks to compliance with the NHS provider licence , condition 4 and actions identified to mitigate these risks, particularly in relation to:

- the effectiveness of governance structures,
- the responsibilities of directors and subcommittees;
- reporting lines and accountabilities between the board, its subcommittees and the executive team;
- the submission of timely and accurate information to assess risks to compliance with the conditions of the licence; and
- the degree and rigour of oversight the board has over the trust's performance.]

4.57 In making its corporate governance statement for 2018/19, the Trust will have assured itself of the validity of the statement through identification of the information and evidence available to support each part of the statement.

4.58 The Board, through the established governance assurance processes of the organisation, maintains on-going oversight of compliance with those principles, systems and standards of good corporate governance which would be reasonably regarded as appropriate for a supplier of health care services to the NHS.

4.59 In determining ongoing compliance the Board has, through its Audit & Assurance Committee, continued to review the effectiveness of its internal control systems. As a result of the controls in place, the Trust has not identified any significant risks to compliance with the NHS FT condition 4 (FT Governance).

4.60 **Register of Interests**

4.61 The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. This is published on the following link: https://www.rlbuht.nhs.uk/about-the-trust/our-performance/trust-registers-of-interest/

4.62 **NHS Pension Scheme**

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

4.64 **Equality and Diversity**

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

4.66 The Equality and Diversity sub-committee has oversight of the Workforce Race Equality Standard (WRES). Bi-annual reports on WRES action reports are provided to the Workforce Committee for assurance and scrutiny purposes. The 2018 report concluded that progress has been made in developing race equality over the past 12 months. However, the Trust has further work to do to achieve its goal of being representative of the local community for BME across all staff groups, and banding structures, by 2020.

4.67 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.

4.68 The following next steps have been identified for 2019:

- The results of the WRES 2018 report to be discussed with the BME staff focus group and will be shared with all staff. Managers will provided with training by HR to support changing behaviours. .
- A pool of BME staff / lay people will be trained to participate in interview panels for large scale recruitment.
- Monitoring of diversity of recruitment panels will take place to ensure inclusion of BME staff

4.66 The Board has identified an Equality and Diversity Champion (Non-Executive Director) who ensures that Equality and Diversity issues are considered and

are embedded in the decision-making of the Board. A particular focus has been to ensure that policies and service changes being presented to the Board have an Equality Impact Assessment included.

4.67 Sustainable Development

4.68 The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

4.69 The Trust has a Sustainability Plan 2018/19 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 the use of resources

Describe the key process that has been applied to ensure that resources are used economically, efficiently and effectively, including some comment on the role of the board, internal audit and any other review or assurance mechanisms.

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 an Executive Director 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 to benchmark services and to identify opportunities for efficiencies. The Trust has worked closely with the NHSI Operational Productivity team throughout 2018/19 to ensure transparency in financial reporting and the improvements being made.

5.3 The Trust is also participating in the 'Getting it Right First Time' (GIRFT) programme. A steering group has been established to monitor implementation plans. Support is provided by the Service Improvement team who liaise with the North West hub on timelines for specific projects. Work is ongoing to review litigation and clinical coding within the organisation as both are

recurring themes that have been identified from the GIRFT reviews undertaken.

5.4 The Audit and Assurance Committee receives a report on losses and special payments throughout the year and assurance is sought that action is being taken to minimise these costs. Additional reports have been received through 2018/19 on the effectiveness of the Trust's mechanisms to reclaim costs from overseas visitors. The Audit & Assurance Committee also receives assurance in relation to the mechanism and processes in place for the approval of tender waivers.

6 Information governance

Describe any serious incidents relating to information governance including data loss or confidentiality breach. As a minimum this should include details of any incidents classified as Level 2 in the Information Governance Incident Reporting Tool. For these cases the trust should also disclose whether these cases have been reported to the Information Commissioner's Office (ICO) and detail any action taken by the ICO.

6.1 In 2018/19 there were 63 level one information security incidents reported by the Trust, a slight increase from 2017/18 (52). There was one reportable incident to the Information Commissioner's Office (ICO) and NHS Digital (via the toolkit) in 2018/19, but no further action was taken against the Trust.

6.2 The Trust receives regular communications from NHS Digital which supports notification of potential information security incidents and has previously taken steps to reduce the risks posed by cyber-attacks. The Trust has identified vulnerabilities following a penetration test and work continues to address all of these issues with action plans and review through the governance structure.

6.3 All incidents are reviewed by the Information Governance (IG) team and liaison with the handlers to identify outcomes 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. Completion of the new Data Security and Protection Toolkit (DSPT) was completed this year, and the Trust continued to maintain high standards for information governance and information security. The 10 assertions are based on the National Data Guardian's data security standards, and there are 100 mandatory and 49 non-mandatory sub-assertions. In its first year of operation, the Trust has been focused on completing the mandatory (sub) assertions, although a couple of the non-mandatory sub-assertions have also been completed. The Trust has consistently achieved compliance and the DSPT score for the year was assured as 'substantial' by MIAA for the 4 assertions audited. The assessment was submitted on time.

6.5 IG training is delivered electronically with an expectation that 95% of staff are trained in year up to 31st March 2019. There were additional face-to-face training sessions at the end of the year to encourage more staff to complete their training. The Trust declared a 94.32% compliance level for delivery of IG training in year.

6.6 The Trust takes the confidentiality and security of information seriously and continues to invest in technology to maintain security. Mobile 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.

6.8 25th May 2018 saw the implementation of the new General Data Protection Regulations and the UK's Data Protection Act 2018. The Trust appointed a Data Protection Officer (DPO) through MIAA, who is active in the governance process, overseeing Data Protection Impact Assessments and giving lawful advice and guidance in issues associated with the eight rights of access. The DPO acts as the point of contact with the ICO. There have been no issues raised to the ICO.

7 Annual Quality Account

Brief description of steps which have been put 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 data In particular this should explain how the trust assures the quality and accuracy of elective waiting time data, and the risks to the quality and accuracy of this data

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.

7.2 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.

7.3 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.

7.4 The Chief Nurse is responsible for the Quality Account. The Board receives a monthly integrated performance report which reports progress on the metrics which support the quality objectives. A more detailed quality performance report is considered by the Quality Governance Committee with assurance provided to the Board through the Committee Assurance Report.

7.5 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.

7.6 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. 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.

8 Review of effectiveness

Describe the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including some comment on the role and conclusions of:

- the board
- the audit committee
- if relevant, the risk/ clinical governance/ quality committee/risk managers/risk improvement manager
- clinical audit
- internal audit and
- other explicit review/assurance mechanisms.

Include an outline of the actions taken, or proposed to deal with any significant internal control issues and gaps in control, if applicable

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 is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS 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 & 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 10 times in 2018/19. 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 regulation. 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 & 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.

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. A quarterly report is received by the Committee to provide assurance in relation to compliance with the Trust's H & S obligations and delivery of its objectives and identification of any significant risks.

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 reviewing the governance arrangements of the continued management of the new hospital construction process following the termination of the PFI contract in October 2018.

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.

Meeting	Attendance 2018/19 (target 75%)
Trust Board	84%
Audit & Assurance	88%
Quality Governance	73%
Finance and Performance	74%
Research Development & Innovation	59%
Nomination & Remuneration	87%
Charitable Funds	75%
New Hospital	83%

Workforce	53%

8.16 The Board reviewed the performance and effectiveness of the Board and its committees in January 2019. The review concluded that the Committees were effectively discharging their role with a series of minor recommendations made. These included the strengthening of reporting to provide enhanced focus on the 'so what' question, improved clarity of risk reporting and a consistent approach to administration (templates, action trackers etc.) A detailed action plan for each Committee has been developed and this will be discussed in meetings with the respective Chairs and Lead Executives to inform practice for 2019/20.

8.17 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 October 2018.

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

8.19 Internal Audit

8.20 An annual audit plan is prepared by the Trust's internal audit provider for discussion and approval by the Audit & 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 2018/19 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.

8.21 During 2018/19 the Trust received one internal audit which provided limited assurance. This related to the Ward Quality Assessment process. 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 audit identified weaknesses in design and/or operation of control with no significant internal control issues or gaps in control identified. An action plans has been prepared in respect of the above audit.

8.22 The following internal audit reports provided moderate assurance:

- Establishment Reporting
- Mandatory Training Reporting

- Quality Spot Checks (1 ward)
- EPR Project Management
- Cyber Security

The Committee received follow up reports for these areas and evidence that actions plans were in place.

8.23 The following internal audit reports provided substantial assurance:

- Duty of Candour
- Complaints & Incidents (Lessons Learnt)
- Quality Spot Checks (7 wards)
- Activity Data Capture (62 day Cancer)
- General Ledger
- Accounts Payable
- Accounts Receivable
- Treasury Management
- Asset Management
- Budgetary Control
- Data Protection & Security

8.24 Clinical Audit

8.25 The clinical audit programme is overseen by the Clinical and Cost Effectiveness Sub Committee which reports 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.

8.26 During 2018/19, 54 National Clinical Audits (NCAs) and Clinical Outcome Review Programmes and other quality improvement projects covered NHS services that the Royal Liverpool and Broadgreen University Hospitals NHS Trust provides. During this period, the Trust participated in 96% of national clinical audits and 100% of outcome review programmes which it was eligible to participate in. During the year, two reports were published that omitted Trust level data; the National Inpatient Diabetes Audit (NaDIA) and the National Ophthalmology Database (NOD) Cataract audit. Subsequent investigation revealed submission to NaDIA had been made however a corrupted file had prevented inclusion in the final report. In regards to NOD, a continued IT issue prevented submission, however during 2018/19 this issue was resolved, all clinicians eligible are now registered to submit data on the database and, as at March 2019 in excess of 1,700 records have been created for validation.

8.27 The Trust has reviewed our internal arrangements. In addition to capturing confirmation of submission digitally, a member of the central team now telephones the national body to request assurance they have received all data. This contact is captured on the audit database.

8.28 Forty four national audits reports were reviewed during 2018/19; 35 of which required actions plan, 100% of which have been received.

8.29 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.

8.30 Incident Reporting and Access Targets

8.31 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.

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

8.33 In 2018/19 the Trust reported 16 serious incidents (with one 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. 79 local RCAs and 198 Post Infection Reviews (PIRs) were requested following moderate/high harms which were reviewed through the weekly Patient Safety meeting. The Trust has completed 86% of all RCAs and 97% of all PIRs and where appropriate has undertaken its duty of candour responsibilities with sharing learning with our patients and families. The remainder of our investigations are on-going.

8.34 The Trust has been challenged in year to maintain required performance levels for A & E waiting times, the 18 week RTT pathways standard and the Cancer 62 days Urgent GP Referrals target. 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.

8.35 Summary

8.36 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. In addition the framework helps to ensure that the Trust's strategic objectives continue to be met and risks of not achieving the objectives are closed, mitigated or controlled.

9 Significant Issues

9.1 Through 2018/19 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. This includes work to ensure sustainability of the SAFER model and further development of ambulatory care.

9.2 An impact of this work has been to reduce the length of stay with fewer patients staying in the Trust for seven days or more and 21 days or more. This year the Trust has implemented a process to review these long stay patients to ensure they are assessed in order to understand what their care plan is and what is next on that plan, to speed up the process. Alongside these reviews the Trust works closely with the local authority and Mersey Care NHSFT with the aim to support safe and effective discharge.

9.3 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.

9.4 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 Department of Health and Social Care (DHSC) regarding the need for continued working capital support during 2018/19. In 2018/19 this amounted to c£44m for revenue (c£36m net) and c£14m for capital (c£12m net). The Trust is forecasting an on-going requirement for cash support from DHSC in 2019/20 which is driven by the underlying revenue deficit and the Trust will continue regular dialogue with NHSI and DHSC regarding this support.

9.5 The Trust has submitted a financial plan for 2019/20 which accepts the control total set for it by NHSI. This reflects the stabilisation of the underlying financial position of the Trust during 2018/19.

9.6 The capital programme required to complete the new Royal Hospital project and related schemes is significant and the Trust is developing a detailed business case with the costs outlined for submission to the DHSC in 2019/20.

9.7 Whilst the new Royal has been delayed, due to the liquidation of Carillion in January 2018, work has restarted following the appointment of Laing

O'Rourke as management contractor in November 2018. At the time of writing, Laing O'Rourke is working on a new timetable for completing construction, though we expect to move into the new Royal in 2021.

9.8 In the meantime we continue to invest in and carry out essential maintenance to the current Royal to ensure we have a safe environment for our patients, visitors and staff. This year we have invested over £1m into the maintenance of the current Royal. We have carried out detailed assessments on the current estate to ensure that we are aware of the potential issues. From this, we have developed robust contingency plans, purchased equipment and spare parts and are tackling potential maintenance issues proactively, to reduce the risk of them occurring.

9.9 There were a number of changes to the Board, Executive and Senior Management Team during 2018/19. Aidan Kehoe (Chief Executive) and Lisa Grant (Chief Nurse / Chief Operating Officer) both left the Trust in March 2019. In addition, the Chairman Bill Griffith's term of office ended on 31st March 2019.

9.10 Given our plans and the process for a proposed merger with Aintree University Hospitals NHS Foundation Trust, we have made a number of interim executive director appointments, including my own. For my previous role of medical director, we have appointed Dr Andrew Loughney, medical director and deputy CEO of the Liverpool Women's NHS Foundation Trust, as interim medical director on secondment.

9.11 In addition, following the departure of Lisa Grant, we have appointed our director of nursing/deputy chief nurse Colin Hont as interim chief nurse and Dr Paul Fitzsimmons, deputy medical director has been appointed interim chief operating officer. From 1 April 2019, Mike Eastwood, vice chair of the Trust will act as interim chair for the immediate future.

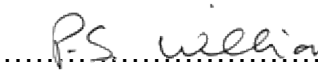
9.12 The risks of managing a challenging agenda with a number of changes at Board level is acknowledged and regularly discussed by the Board. There is confidence that the Trust has an experienced team with the right mixture of expertise suited to guiding the Trust towards achieving its objectives.

10 **Conclusion**

State either that no significant internal control issues have been identified or make specific reference to those significant internal control issues which have been identified in the body of the AGS above

10.1 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 2019 and up to the date of approval of the annual report and accounts.



…… 11.06.19

Peter Williams Date

Interim Chief Executive

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Remuneration and Staff 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, benefit 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, banded in accordance with the turnover of the Trust.

Executive team changes

There have been a number of changes to the Executive Team. The Chief Nurse/ Chief Operating Officer, Lisa Grant left the Trust on 31st March 2019. The Chief Executive, Aidan Kehoe left on the 21st March 2019. The Trust's Executive Director of Finance, John Graham, left the Trust on 30th November 2018.

Peter Williams was previously the Trust's Medical Director until his appointment to the role of interim Chief Executive on 22nd March 2019. Dr Andrew Loughney was appointed to the role of interim Medical Director from 22nd March 2019. Paul Bradshaw was acting as the Director of Finance to cover a period of absence and was formally appointed in an interim capacity from 1 December 2018.

The Trust's Chairman, Bill Griffiths, term of office expired on 31st March 2019.

Executive Performance and Remuneration.

The Nomination & 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 agreed by the Chief Executive or in the case of the Chief Executive, determined by the Chairman.

- Director job roles were last independently reviewed and evaluated in 2014. New roles that have been created since have been subject to independent audit.

- 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.

When reviewing salary the Committee will also consider national remuneration benchmarking data, as a reference point only and will take into account the above factors as well as individual circumstances.

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 his/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
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.

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Directors' remuneration

The table below records the remuneration, pay and benefits in kind of Trust directors for the year 2018/19, 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 2019 **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 (to 21st March 2019)	200-205	800			200-205
P Williams Medical Director (to 21st March 2019) Interim Chief Executive (from 22nd March 2019)	110-115	0			110-115
J Graham **(see Note C)** Director of Finance (to 30th November 2018)	185-190	5,100		2.5-5	195-200
P Bradshaw **(see Note C)** Interim Director of Finance (from 7th June 2018)	100-105			95-97.5	195-200
D Herring Director of Workforce	125-130	4,000		157.5-160	285-290
L Grant Chief Nurse and Chief Operating Officer (to 31st March 2019)	135-140	300			135-140
D Walliker **(see Note A)** Chief Information Officer	65-70	7,200		17.5-20	95-100
A Loughney Interim Medical Director (from 22nd March 2019)	0-5				0-5
H Shaw Director of Communications	95-100			20-22.5	115-120
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. Salary before recharges would be in the band £120k-£125k

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

Note C – Paul Bradshaw acted as Director of Finance from 7th June 2018 to cover absence. The salary for John Graham includes payment for accrued annual leave and payment in lieu of notice.

Salary and allowance table for the year ended 31 March 2018 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	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 31st July 2017	75-80	1,400		7.5-10	85-90
S Clayton Acting Director of Workforce (to 30th July 2017)	35-40			5-7.5	40-50
L Grant Chief Nurse and Chief 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 2nd 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. Salary before recharges would be in the band £120k-£125k for D Walliker and in the band £90k-£95k for H Shaw.
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
From April 2018, all leased cars for senior managers are under the Salary Sacrifice Scheme.

*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 2018/19 a 2.06% increase was applied to each director's salary which followed national guidance on director salaries.
In addition during 2018/19 the Nomination and Remuneration Committee supported an increase in remuneration for the Executive Director of Workforce to reflect the postholder's performance and additional responsibilities undertaken.

Pension table for the year ended 31 March 2019 **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 2019**	**Lump sum at retirement age related to accrued pension at 31 March 2019**	**Cash Equivalent transfer value at 31 March 2018**	**Real increase in Cash Equivalent Transfer Value**	**Cash Equivalent transfer value at 31 March 2019**	**Employers contribution to stakeholders pension£000**
	Banding £2500	Banding £2500	Banding £5000	Banding £5000	£000s	£000s	£000s	£000s
J Graham – Director of Finance	0-2.5	0-2.5	20-25	70-75	475	60	549	0
D Herring – Director of Workforce	7.5-10	15-17.5	40-45	115-120	684	233	938	0
P Bradshaw – Interim Director of Finance *	5-10	10-15	35-40	95-100	548	179	744	0
H Shaw Director of Communications	0-2.5	N/A	15-20	N/A	222	52	281	0
D Walliker Chief Information Officer	0-2.5	N/A	20-25	45-50	256	58	322	0

Pension table for the year ended 31 March 2018 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 2018	Lump sum at retirement age related to accrued pension at 31 March 2018	Cash Equivalent transfer value at 31 March 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent transfer value at 31 March 2018	Employers contribution to stakeholders pension£000
	Banding £2500	Banding £2500	Banding £5000	Banding £5000	£000s	£000s	£000s	£000s
A Kehoe – Chief Executive (left scheme)								
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 31st July 2017)	0-2.5	0-2.5	35-40	95-100	628	33	684	0
S Clayton – Acting Director of Workforce (to 30th July 2017)	0-2.5	2.5-5	45-50	140-145	993	79	1081	0
H Shaw Director of Communications	0-2.5	N/A	15-20	N/A	189	32	222	0

Fair pay disclosure (Subject to Audit)
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 2018-19 was £200-205k (2017-18: £200-205k). This was 7 times (2017-18, 8 times), the median remuneration of the workforce, which was £28,050 (2017-18: £26,565).

In 2018-19, 2 employees (2017-18: 1) received remuneration in excess of the highest-paid director. Remuneration ranged from £12,222 to £211,558 (2017-18: £15,404 to £213,057).

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 2018-19	**Group 2017-18**
Band of highest paid directors total remuneration	**200-205**	**200-205**
Median total remuneration	**28,050**	**£26,565**
Ratio	**7**	**8**

Staff Numbers (Subject to Audit)
Average Whole Time Equivalent staff numbers for 2018-19 were:

Average Staff Numbers	**2018-19 Total Number**	**2017-18 Total Number**	**2018-19 Total Costs £000s**	**2017-18 Total Costs £000s**
Medical and dental	876	865	89,795	86,377
Ambulance Staff	-	-	43	144
Administration and estates	1,567	1,849	54,436	67,216
Healthcare assistants and other support staff	1,074	802	34,953	27,582
Nursing, midwifery and health visiting staff	1,888	1,938	81,797	81,922
Scientific, therapeutic and technical staff	1,469	1,411	49,946	35,879
TOTAL	**6,874**	**6,865**	**310,970**	**299,120**

Staff Costs

	Permanent £000	**Other £000**	**2018/19 Total £000**	**2017/18 Total £000**
Salaries and wages	258,060	-	**258,060**	255,684
Social security costs	20,850	1,641	**22,491**	20,574
Apprenticeship levy	1,148	-	**1,148**	1,131
Employer's contributions to NHS pensions	27,596	-	**27,596**	26,834
Pension cost - other	27	-	**27**	13

Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	238	-	**238**	501
Temporary staff	-	4,310	**4,310**	6,544
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**307,919**	**5,951**	**313,870**	**311,281**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**307,919**	**5,951**	**313,870**	**311,281**
Of which				
Costs capitalised as part of assets	2,900	-	**2,900**	3,565

Expenditure on consultancy

The Trust spent £1,923k on consultancy during the year (2017/18: £1,028k).

Off payroll engagements

Table 1: Off-payroll engagements longer than 6 months

Off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

No. of existing engagements as of 31 March 2019	6
Of which...the number that have existed	
for less than one year at time of reporting.	0
for between one & two years at time of reporting.	3
for between two and three years at time of reporting.	1
for between three and four years at time of reporting.	0
for four or more years at time of reporting.	2

Table 2 : New off-payroll engagements,

For all new off-payroll engagements between 1 April 2018 and 31 March 2019, or those that reached six months in duration during the year, for more than £245 per day and that last longer than six months:

No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	6
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	6
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	5
No. of engagements that saw a change to IR35 status following the consistency review	0

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 (Subject to Audit)

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 the full costs of departures agreed in the year. Where the Royal Liverpool and Broadgreen University Hospitals NHS Trust has agreed early retirements, the additional costs are met by the Royal Liverpool and Broadgreen University Hospitals NHS Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions 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.

Table 1: Exit packages

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	0	0	0	0	0	0
£10,000 - £25,000	1	22,935	1	18,702	2	41,637	0	0
£25,001 - £50,000	2	67,826	3	128,238	5	196,064	0	0
£50,001 - £100,000	0	0	1	93,725	1	93,725	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	90,761	5	**240,665 Agrees to A below**	8	331,426	0	0

Table 2: Analysis of Other Departures

	Agreements Number	**Total value of agreements £000s**
Voluntary redundancies including early retirement	0	0
Mutually agreed resignations (MARS) contractual costs	4	146,940
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	1	93,725
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval **	0	0
Total	5	240,665

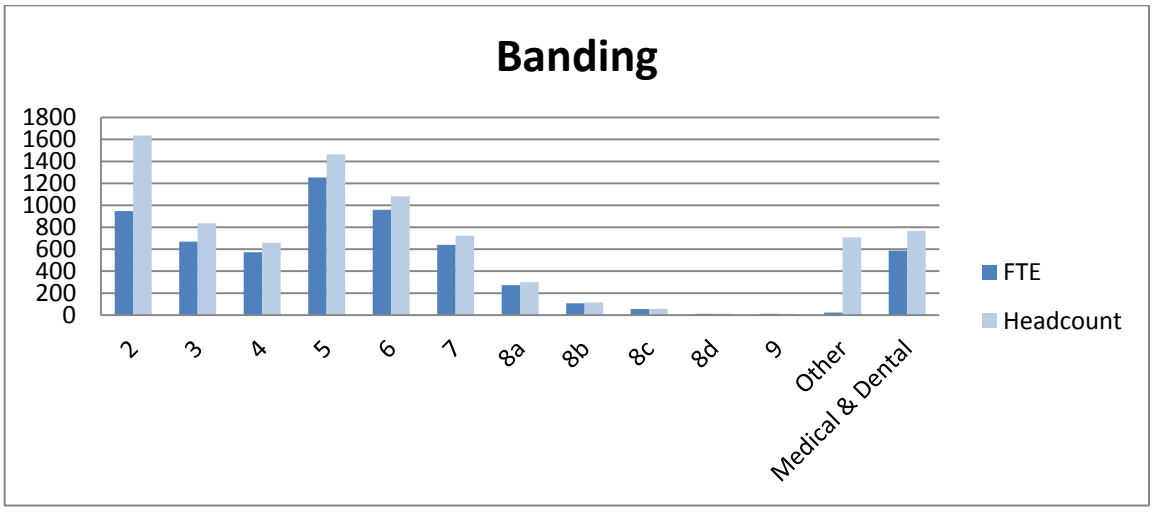
Agrees to total in Table 1

Staff Report

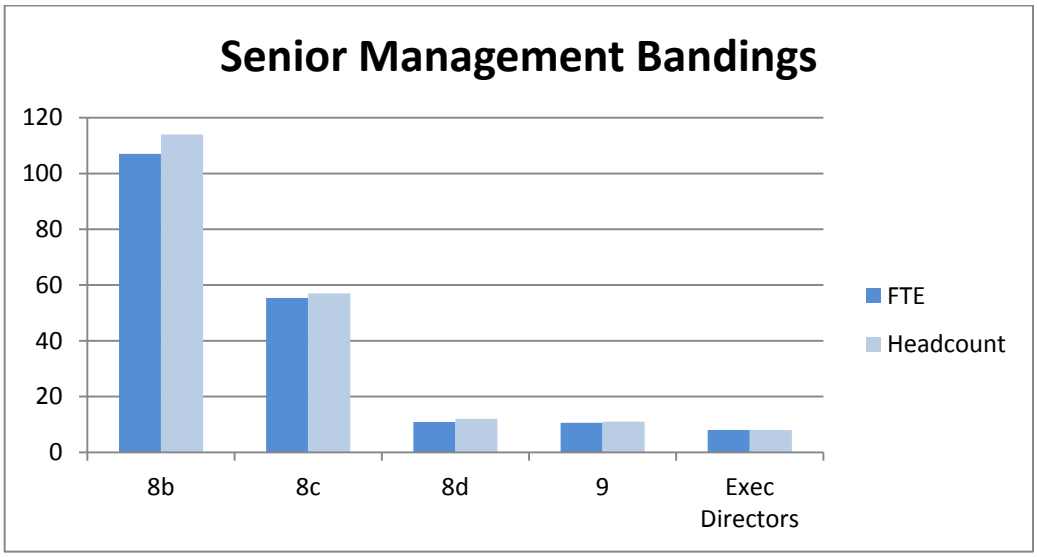
The Trust currently employs around 8,300 people and in addition has temporary bank staff (internal temporary agency) workers, all delivering our services. The following charts provide a breakdown of our workforce based on the number of people employed, referred to as headcount and the contracted hours referred to as full time equivalent (FTE).

Our overall workforce numbers are illustrated below segmented into the pay scale bandings used in the NHS. As the graph shows the largest staff groups are 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:

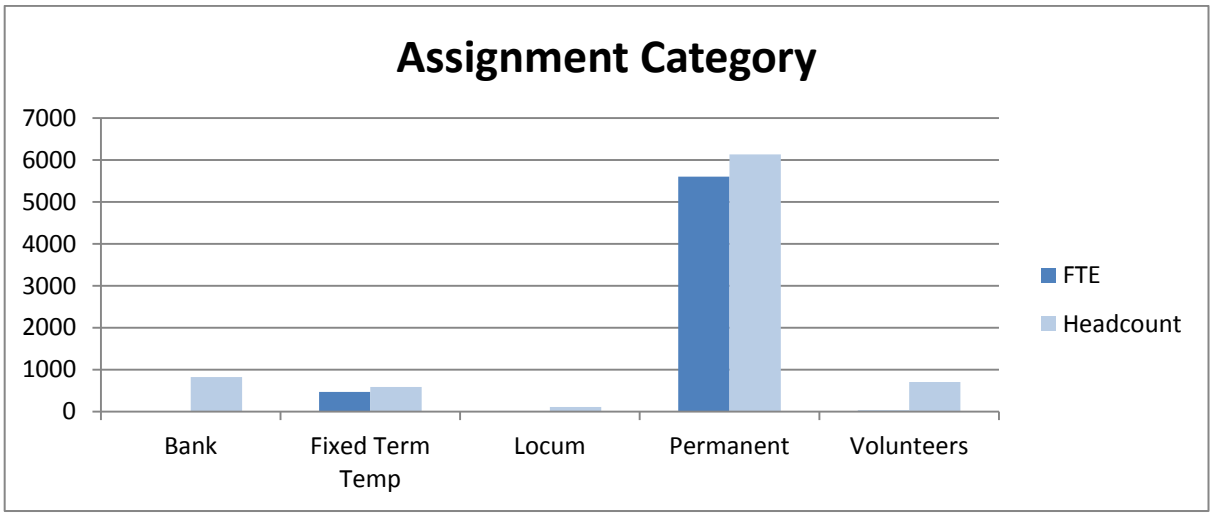
Staffing data was collated prior to March 2019 when a number of new executive appointments were made



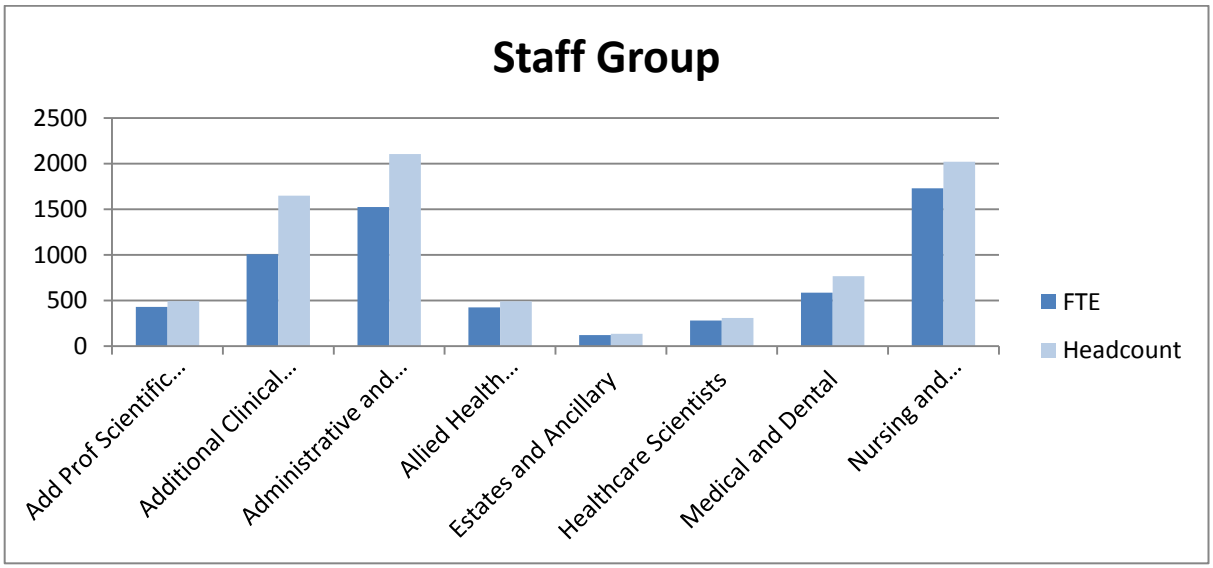
Among our staff, the Trust employs around 200 senior managers and/or technicians (in roles 8b or above). This equates to around 2% of the workforce (based on headcount). The number of senior managers within the organisation by band is illustrated below:



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:

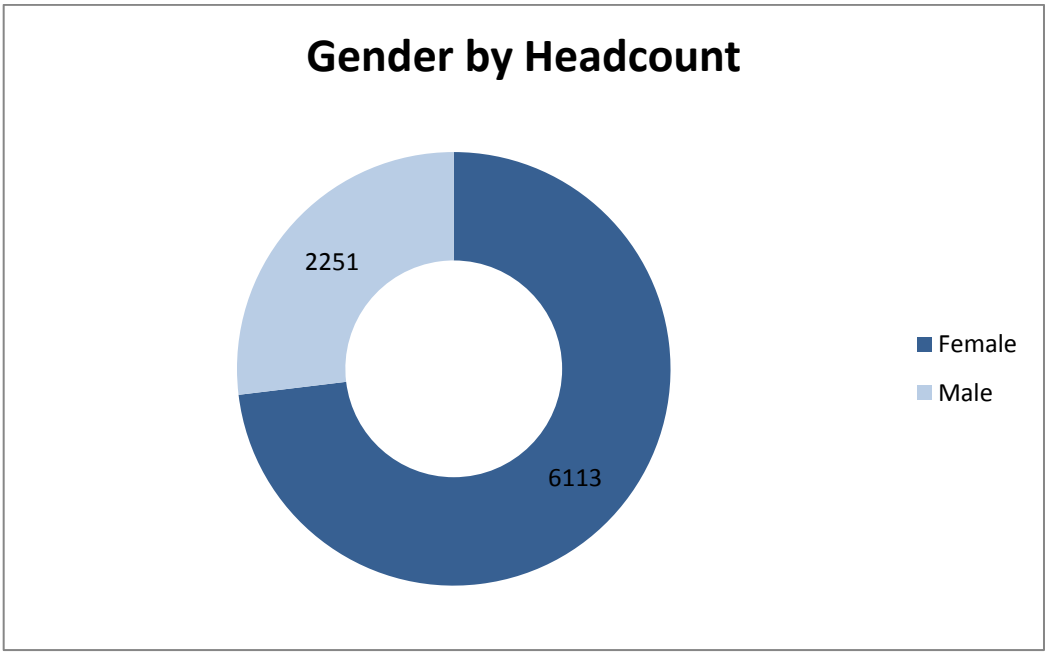


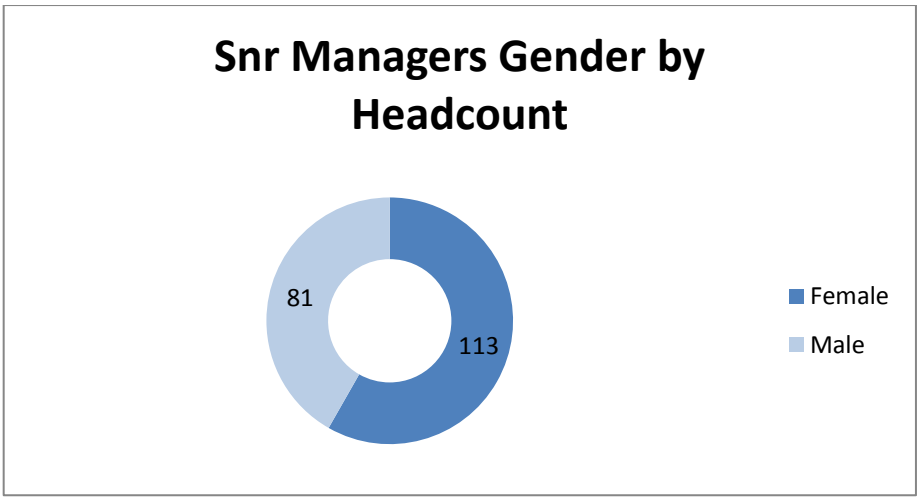
Looking at the type of roles that our staff have, the chart below outlines the workforce by staff group (staff group is derived using the NHS Digitals NHS Occupational Code Manual). This shows that the majority of our staff are in nursing or administrative and clerical roles.

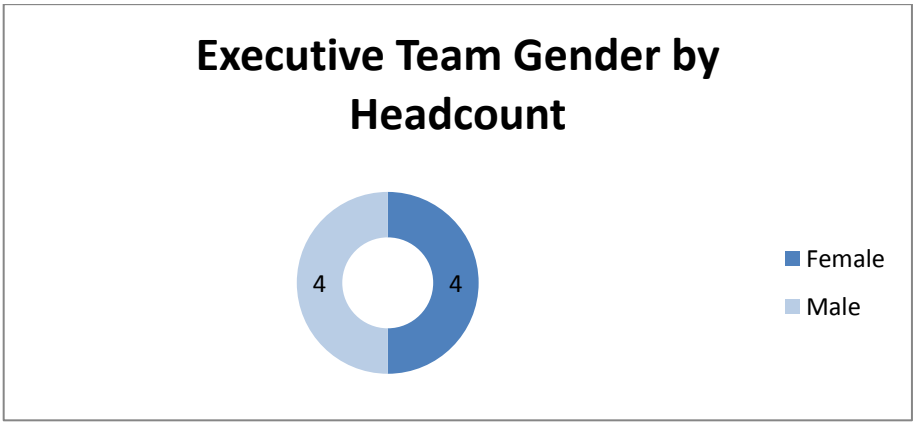


73% of staff at the Trust are female. How gender is split across seniority is illustrated below. N.B This data was collated prior to new appointments to the executive team in March 2019.

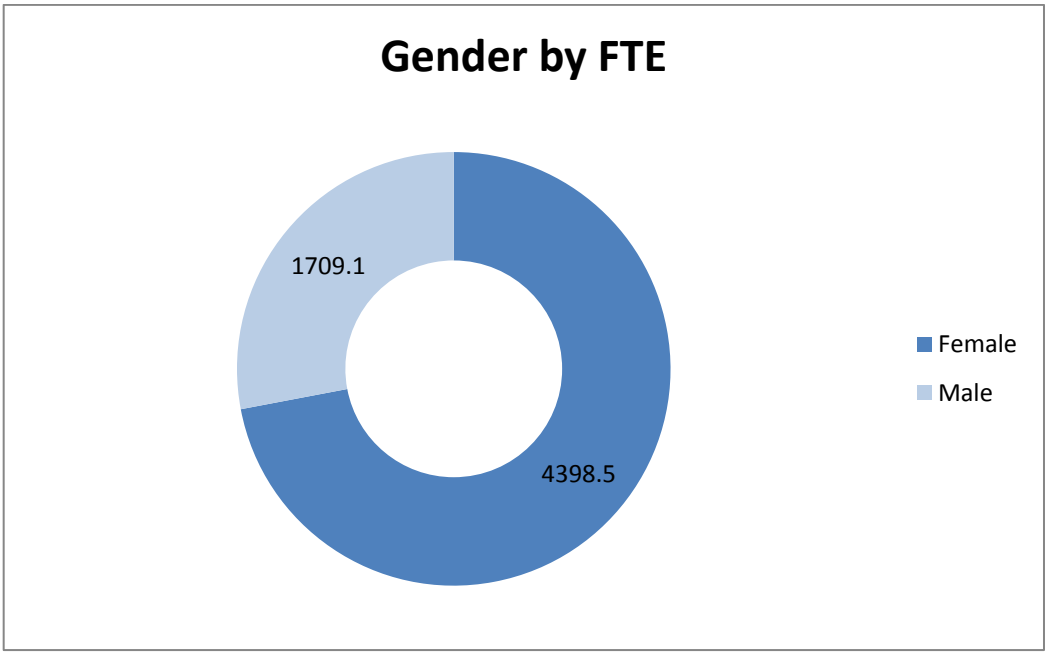
Gender split by headcount:

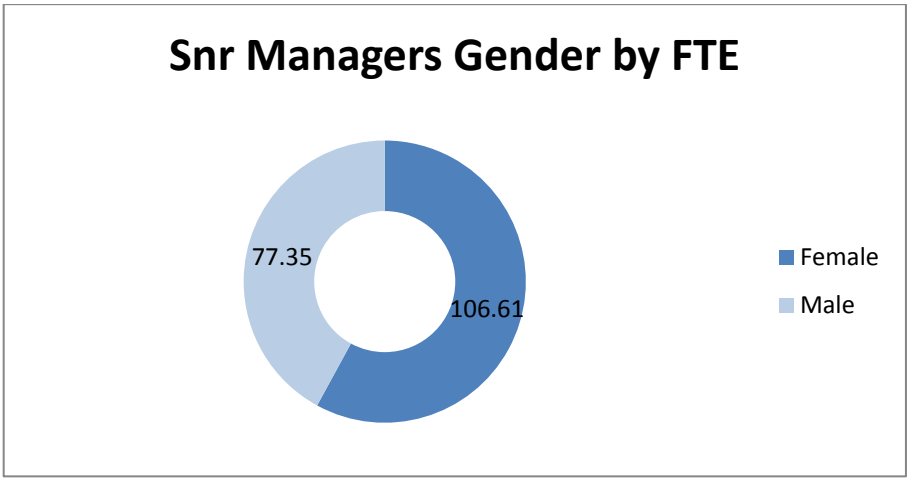


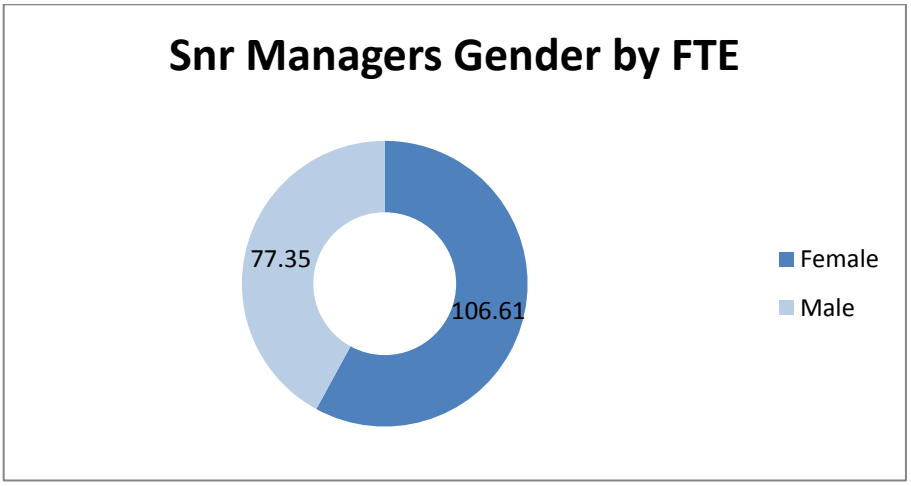




Gender split by full-time equivalent



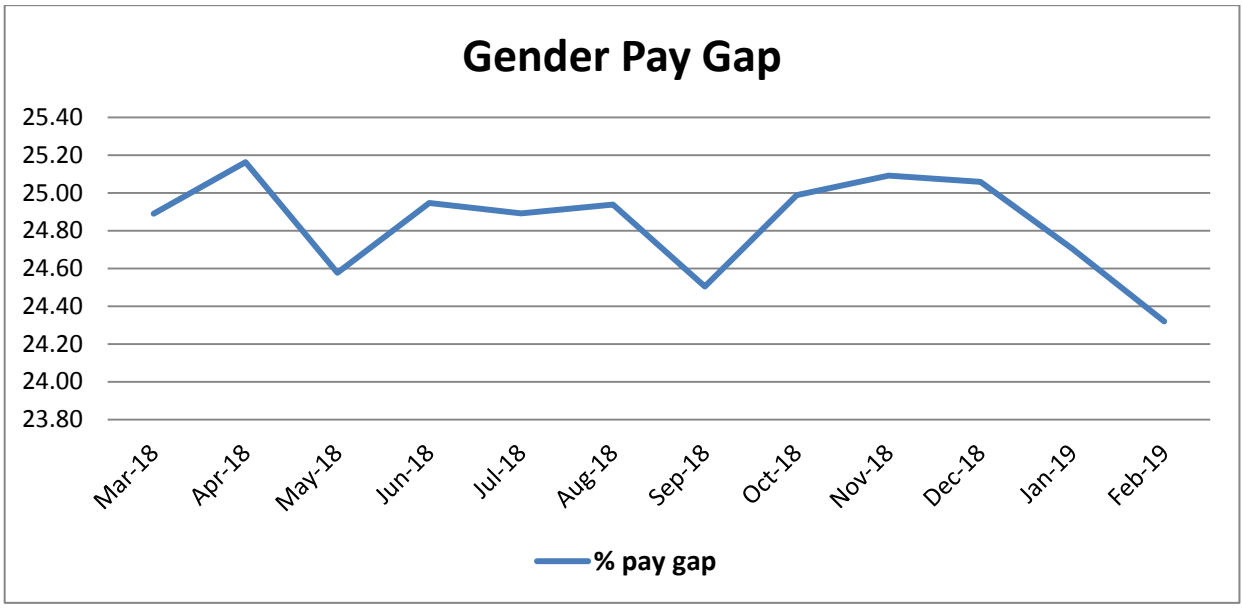




The Trust has reported a gender pay gap of 24.8% which is consistent with other comparable NHS organisations. The gap can largely be accounted for by additional payments, or “bonus payments” which at the Trust relates to clinical excellence awards. The pay gap has fluctuated slightly and reduced over 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.

Pay Gay - Month on Month

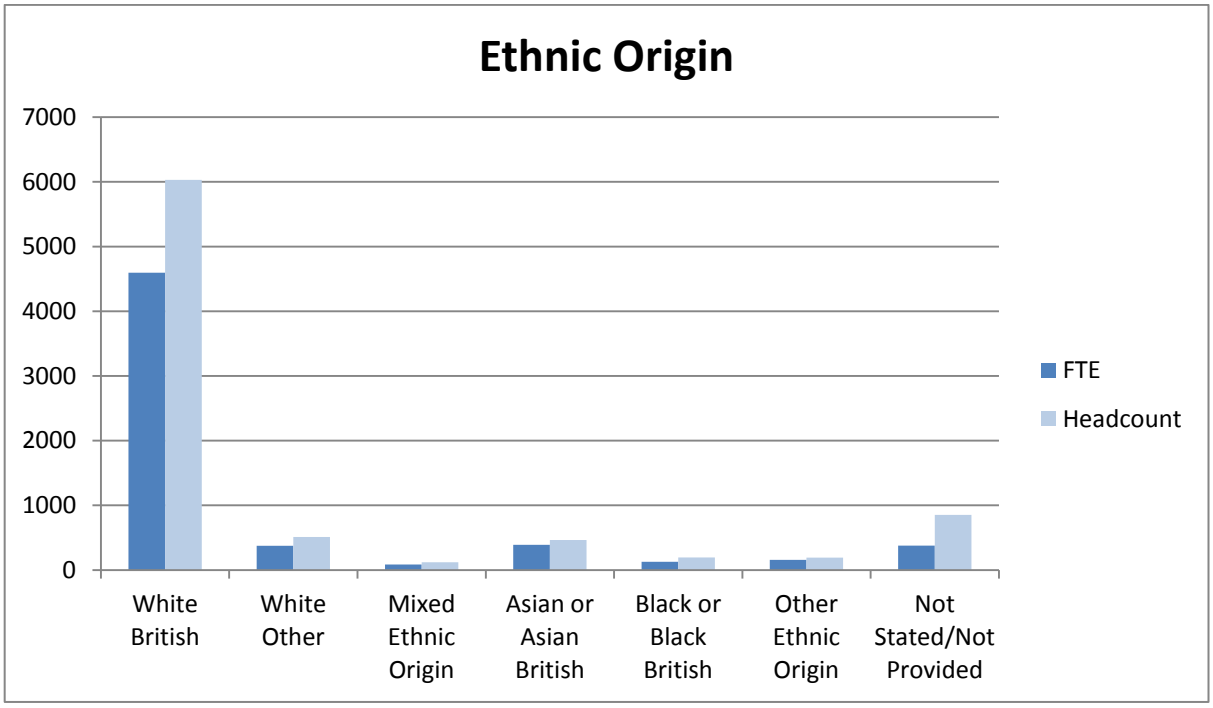


Bonus Payments

	Average Pay (£)	Medium Pay (£)
Female	9641.27	8294.00
Male	11,497.03	8294.00
Difference	1855.76	0
Pay Gap %	16.14	0

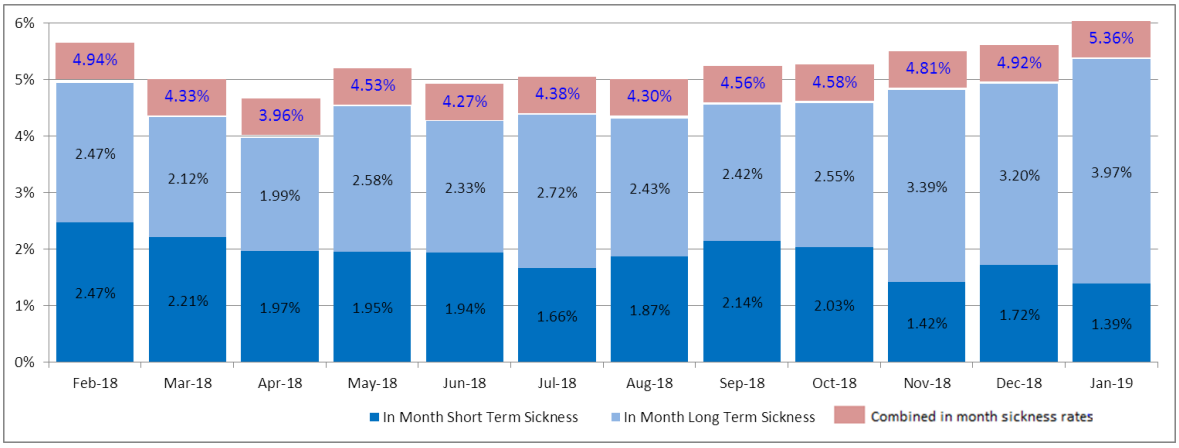
	Employees Paid Bonus (Number)	Total Relevant Employees (Number)	Pay Gap %
Female	34	5855	0.58
Male	117	2030	5.76

The breakdown of the declared ethnic origin of staff at the Trust shows that the majority are ‘white, British’. It also shows that more members of staff do not state their ethnic origin than belong to any other ethnic group. The Trust is working to encourage staff to declare their ethnicity and has an active Black, Asian and minority ethnic (BAME) staff focus group and a BAME mentoring scheme. However, the Trust recognises that it still has some way to go towards achieving its goal of being representative of the local community for BAME across all staff groups and banding structures by 2020.



Sickness absence

Trusts are also required to report on staff sickness. The information below reflects recorded sickness from April to January.



The Trust has a sickness absence support team in place to work with both managers and individuals to support staff through their sickness to a healthy return to work.

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. There is also a confidential staff support service providing a free counselling service, 24/7.

In addition there is a range of health and wellbeing initiatives for staff. These include physical activity, health awareness sessions, weight loss challenges, flu vaccination and mental health support programmes.

Managers receive regular information regarding sickness levels and cases within their departments. These are discussed at monthly meetings with the Trust human resources team. Recently a central log of reasonable adjustments has been

established. The Trust actively provides good practice in relation to these and mental health cases.

The Sickness Absence Improvement Plan is underpinned by the Trust Health and Wellbeing Strategy (2018-2020). This has the aim of creating a culture where staff feel valued and engaged leading to improved clinical outcomes and patient satisfaction.

Engaging with staff

Each year the views of our staff are surveyed as part of the national NHS Staff Survey. In addition, we ask staff for their views on key topics. One key topic we asked staff about this year was the proposed merger with Aintree and to do so we undertook a cultural assessment across both organisations.

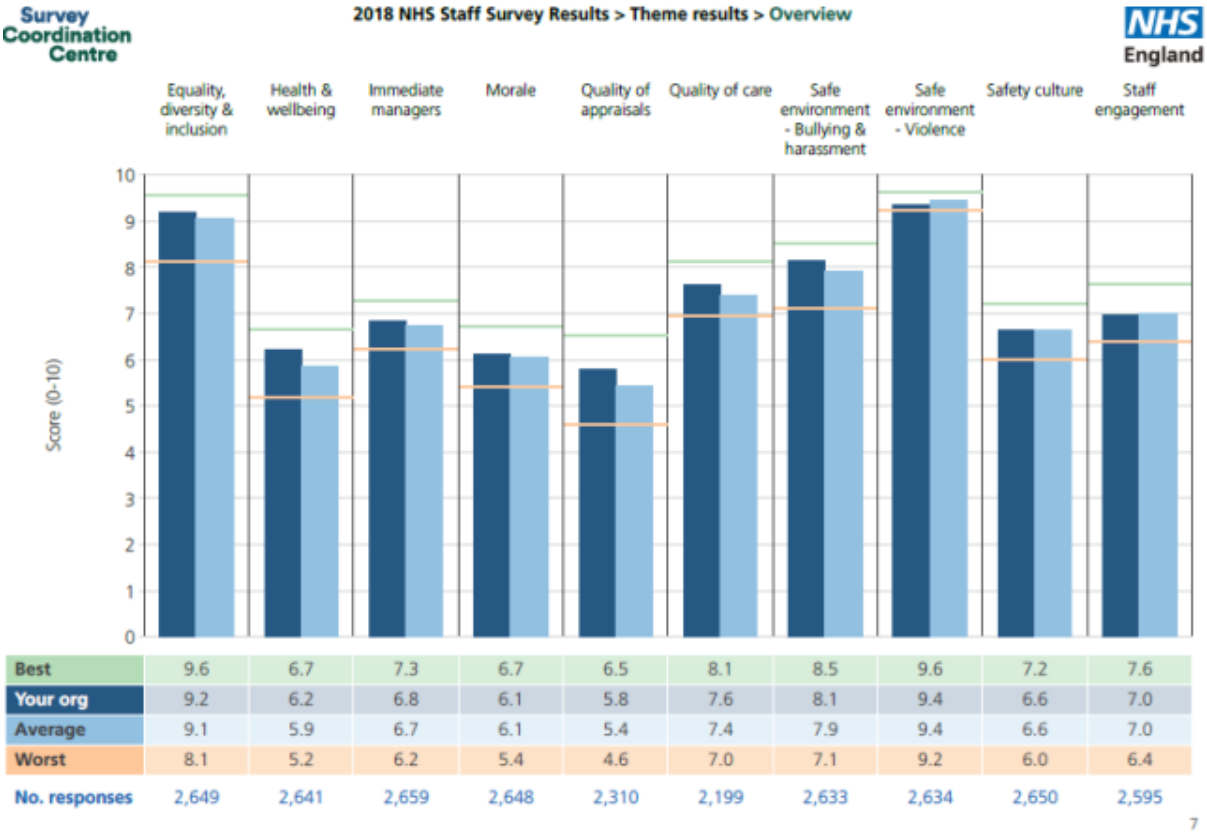
The staff survey was delivered by the external organisational development specialists 'Clever Together' who also delivered the survey for Aintree Hospital NHS Foundation Trust'. This enabled direct comparison of data between the two organisations which will facilitate our merger proposal.

It also facilitated a quicker analysis of results and an overview is included in the Annual Report for the first time.

Whilst the response rate dropped from 48.8% to 41.3%, overall the survey demonstrated an improvement from the previous year in 51 of 79 questions. These questions have been presented in the form of ten main themes:

1. Equality, diversity & inclusion
2. Health and wellbeing
3. Immediate managers (which includes providing support and feedback)
4. Morale (a new area for 2018)
5. Quality of appraisals
6. Quality of care
7. Safe environment - bullying and harassment
8. Safe environment - violence
9. Safety culture
10. Staff engagement.

Performance across these areas is illustrated in the graph below, which also benchmarks the Trust's performance nationally:



Staff scored the Trust on or slightly above the national average on all but one of the ten themes. Areas of improvement since last year include appraisal and managers' behaviour. Areas of deterioration relate to staff having adequate materials to carry out their roles (perhaps indicative of the deterioration of the current Royal Liverpool Hospital) and staff experiencing violence from colleagues, which the Trust is concerned about and is addressing proactively.

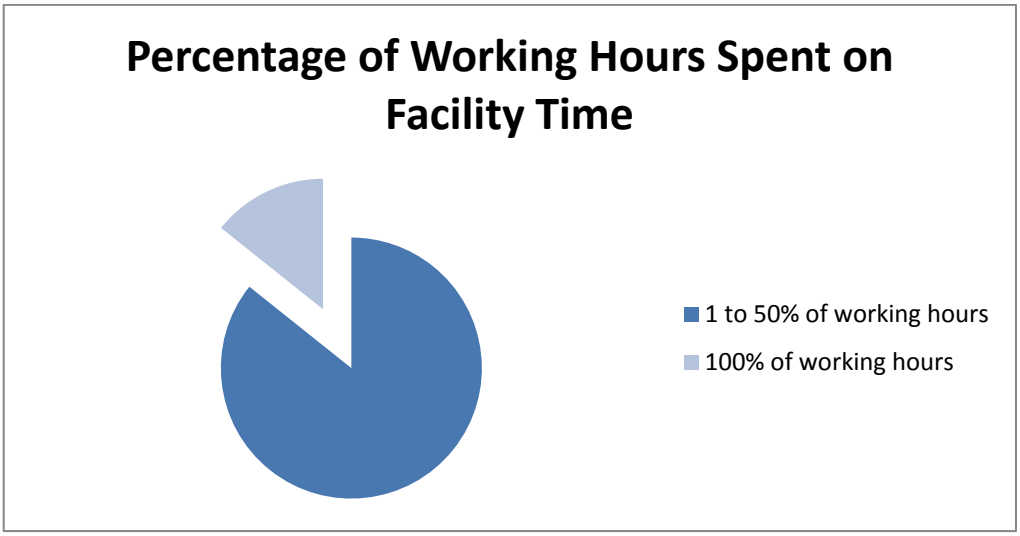
An action plan has been developed with 11 key actions. Care groups and departments have developed their own local action plan templates to address their own areas of concern.

As part of the work on the merger proposals, Clever Together has undertaken an initial cultural assessment with a view to informing the organisation development plan for the new merged organisation. The assessment was conducted using existing staff survey results as well as workshops with a small number of staff and with organisational leaders. This has shown that the two trusts share many of the same challenges. This creates real opportunities to co-create new standards, values and organisational development plans for the future.

Engaging with trade unions

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.

There are 22 employees who were relevant union officials during the reporting period. The breakdown of their time spent on facility is below:



Percentage of paybill spent on facility time:	0.04%
Time spent on paid trade union activities as a percentage of total paid facility time:	7,914.72

Staff policies

The Trust has a range of policies which our staff have access to via the Trust intranet and the Trust induction programme. The Trust also has training for managers in the application of employment policies.

As part of the preparation for the proposed merger, the Trust is working collaboratively with Aintree University Hospital NHS Foundation Trust to develop a suite of employment policies to ensure they are consistent and fair across both organisations

The policies include Equality and Diversity in Employment, including a Reasonable Adjustments Policy.

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.

Independent auditor's report to the Directors of the Royal Liverpool and Broadgreen University Hospital NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Royal Liverpool and Broadgreen University Hospital NHS Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statements of Changes in Taxpayers Equity Group and Trust, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the additional directions issued by the Department of Health and Social Care to the Trust on 5 June 2019 (the "Additional Directions").

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 2019 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 2018-19 and the Additional Directions; 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.

Emphasis of Matter – accounting treatment for the transfer of the New Royal Hospital

We draw your attention to the disclosures in note 1.1b to the financial statements. This note describes the accounting treatment applied for the transfer of the New Royal Liverpool Hospital to the Trust in 2018/19 based on the Additional Directions issued by the Department of Health and Social Care (DHSC). The Directions required the Trust to treat this asset as part purchased and part donated.

As stated in note 1.1b the Trust utilised construction cost certificates to derive the cash price equivalent at the time of transfer and derived the donated element by subtracting the capitalised cost of the Trust's cash contributions. The cumulative certified construction cost of the new hospital was £268 million, the capitalised costs £118 million and £42 million, and the derived donated element £108 million. The new Royal Liverpool Hospital was then revalued at 31 March 2019 at £214 million and a £92.8 million impairment was recognised at that date.

Notes 4, 7 and 15.3 and 15.5 reflect the accounting entries and disclosures that result from the application of these Additional Directions. Our opinion is not modified in respect of this matter.

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 retained deficit of £33.4 million for 2018/19 and a retained NHS adjusted deficit of £55.5 million.

As stated in note 1.6.1, the Trust is falling short of the Better Practice Code Targets but does not anticipate difficulties with creditors if cash support requested from the DHSC is secured. The Trust's 2019-20 plan submission includes £28.9 million of working capital support in the form of loans and £137.1 million of Public Dividend Capital to support the costs to complete the New Royal Liverpool Hospital.

These events or conditions, along with the other matters as set forth in note 1.6.1, indicate that a material uncertainty exists that may cast significant doubt about the group and 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 obtained in the audit 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 the 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 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 2018-19 and the Additional Directions 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 issue a report 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 refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has 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 make 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

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 they have been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the Trust's services to another public sector entity.

The Audit and Assurance Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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

Adverse conclusion

On the basis of our work, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects the Royal Liverpool and Broadgreen University Hospital NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for adverse 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 an adjusted financial performance deficit of £55.5 million for the year ended 31 March 2019 against an initial plan for a £40 million deficit. The principal cause of the deficit being higher than planned was the Trust delivered efficiency savings of £21 million, compared to a planned target of £31 million;
- the Trust is forecasting that it will incur a further deficit of £44.6 million in 2019/20 assuming delivery of a total of £15 million of efficiency savings;
- the Trust is reliant on receiving loans of £28.9 million from the Department of Health and Social Care in 2019/20 to support its planned revenue expenditure.

These matters identify weaknesses in the Trust's arrangements for strategic financial planning, including setting a sustainable budget with sufficient capacity to absorb emerging cost pressures and developing and delivering required levels of efficiency savings plans.

They are evidence of weaknesses in 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

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(1)(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 2019, 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 Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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.

John Farrar

John Farrar, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester

14 June 2019

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Annual accounts for the year ended 31 March 2019

Statement of Comprehensive Income

		Group		Trust	
		2018/19	2017/18	2018/19	2017/18
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	382,941	382,385	382,941	382,385
Other operating income	4	218,367	133,508	217,992	132,987
Operating expenses	6 , 8	(623,339)	(554,573)	(622,195)	(553,668)
Operating surplus/(deficit) from continuing operations		**(22,031)**	**(38,680)**	**(21,262)**	**(38,296)**
Finance income	11	418	308	136	51
Finance expenses	11.1	(4,306)	(2,638)	(4,306)	(2,638)
PDC dividends payable		(7,992)	(8,183)	(7,992)	(8,183)
Net finance costs		**(11,880)**	**(10,513)**	**(12,162)**	**(10,770)**
Other gains / (losses)	12	242	8,800	-	8,705
Gains / (losses) arising from transfers by absorption	34	-	1,129	-	1,129
Corporation tax expense		-	-	-	-
Surplus / (deficit) for the year from continuing operations		**(33,669)**	**(39,264)**	**(33,424)**	**(39,232)**
Surplus / (deficit) for the year		**(33,669)**	**(39,264)**	**(33,424)**	**(39,232)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	-	(1,315)	-	(1,315)
Revaluations		618	1,620	618	1,620
Total comprehensive income / (expense) for the period		**(33,051)**	**(38,959)**	**(32,806)**	**(38,927)**
Surplus/ (deficit) for the period attributable to:					
Non-controlling interest, and		-	-	-	-
Royal Liverpool and Broadgreen University Hospitals NHS Trust		(33,051)	(39,264)	(33,424)	(39,232)
TOTAL		**(33,051)**	**(39,264)**	**(33,424)**	**(39,232)**
Total comprehensive income/ (expense) for the period attributable to:					
Non-controlling interest, and		-	-	-	-
Royal Liverpool and Broadgreen University Hospitals NHS Trust		(33,051)	(38,959)	(32,806)	(38,927)
TOTAL		**(33,051)**	**(38,959)**	**(32,806)**	**(38,927)**
Adjusted financial performance (control total basis):					
Surplus / (deficit) for the period before consolidation of the charity		(33,424)	(39,232)	(33,424)	(39,232)
Remove net impairments not scoring to the Departmental expenditure limit		85,287	15,367	85,287	15,367
Remove (gains) / losses on transfers by absorption		-	(1,129)	-	(1,129)
Remove I&E impact of capital grants and donations		(107,400)	185	(107,400)	185
Retained impact of DEL I&E impairment (*)		(60,343)	-	(60,343)	-
DEL impairment adjustment (*)		60,343	-	60,343	-
Prior period adjustments		-	-	-	-
Remove non-cash element of on-SoFP pension costs		-	-	-	-
CQUIN risk reserve adjustment (2017/18 only)		-	(1,400)	-	(1,400)
Remove 2016/17 post audit STF reallocation (2017/18 only)		-	-	-	-
Adjusted financial performance surplus / (deficit)		**(55,537)**	**(26,209)**	**(55,537)**	**(26,209)**

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

a) the revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial 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 position

c) The impact of donated asset and associated depreciation

* The impairment arising from construction defects in the new Royal Hospital has been removed from adjusted financial performance as agreed with NHS Improvement given it arose before Trust management assumed responsibility for development of the hospital. (see also Note 7)

The notes on pages 7 to 56 form part of this account

Statement of Financial Position

	Note	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Non-current assets					
Intangible assets	14	21,245	17,889	21,245	17,889
Property, plant and equipment	15	380,390	160,164	380,390	160,164
Other investments / financial assets	17	9,187	8,947	-	-
Receivables	20	3,484	124,825	3,484	124,825
Total non-current assets		**414,306**	**311,825**	**405,119**	**302,878**
Current assets					
Inventories	19	8,623	8,626	8,614	8,617
Receivables	20	72,035	64,806	72,321	64,744
Cash and cash equivalents	21	14,901	21,809	13,665	20,406
Total current assets		**95,559**	**95,241**	**94,600**	**93,767**
Current liabilities					
Trade and other payables	22	(50,809)	(47,123)	(50,456)	(46,740)
Borrowings	24, 25	(12,423)	(7,406)	(12,423)	(7,406)
Provisions	26	(410)	(682)	(410)	(682)
Other liabilities	23	(901)	(1,003)	(901)	(1,003)
Total current liabilities		**(64,543)**	**(56,214)**	**(64,190)**	**(55,831)**
Total assets less current liabilities		**445,322**	**350,852**	**435,529**	**340,814**
Non-current liabilities					
Borrowings	24, 25	(143,934)	(94,574)	(143,934)	(94,574)
Provisions	26	(2,166)	(2,473)	(2,166)	(2,473)
Total non-current liabilities		**(146,100)**	**(97,047)**	**(146,100)**	**(97,047)**
Total assets employed		**299,222**	**253,805**	**289,429**	**243,767**
Financed by					
Public dividend capital	2.1	327,720	246,936	327,720	246,936
Revaluation reserve	2.1	45,843	45,225	45,843	45,225
Income and expenditure reserve	2.1	(84,134)	(48,394)	(84,134)	(48,394)
Charitable fund reserves	18	9,793	10,038	-	-
Total taxpayers' equity		**299,222**	**253,805**	**289,429**	**243,767**

The notes on pages 7 to 56 form part of these accounts.

Name P S Williams
Position CHIEF EXECUTIVE
Date [11] June 2019

Statement of Changes in Equity for the year ended 31 March 2019

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**246,936**	**45,225**	**(48,394)**	**10,038**	**253,805**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	(2,316)	-	**(2,316)**
Surplus/(deficit) for the year	-	-	(33,829)	160	**(33,669)**
Other transfers between reserves	-	-	-	-	-
Impairments	-	-	-	-	-
Revaluations	-	618	-	-	**618**
Public dividend capital received	80,784	-	-	-	**80,784**
Other reserve movements	-	-	405	(405)	-
Taxpayers' and others' equity at 31 March 2019	**327,720**	**45,843**	**(84,134)**	**9,793**	**299,222**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**241,786**	**44,392**	**(8,634)**	**10,070**	**287,614**
Prior period adjustment	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2017 - restated	**241,786**	**44,392**	**(8,634)**	**10,070**	**287,614**
Surplus/(deficit) for the year	-	-	(39,368)	104	**(39,264)**
Transfers by absorption: transfers between reserves	-	528	(528)	-	-
Other transfers between reserves	-	-	-	-	-
Impairments	-	(1,315)	-	-	**(1,315)**
Revaluations	-	1,620	-	-	**1,620**
Public dividend capital received	5,150	-	-	-	**5,150**
Other reserve movements	-	-	136	(136)	-
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 2019

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**246,936**	**45,225**	**(48,394)**	**243,767**
Impact of implementing IFRS 9 on 1 April 2018 *	-	-	(2,316)	**(2,316)**
Surplus/(deficit) for the year	-	-	(33,829)	**(33,829)**
Other transfers between reserves	-	-	-	**-**
Impairments	-	-	-	**-**
Revaluations	-	618	-	**618**
Public dividend capital received	80,784	-	-	**80,784**
Other reserve movements	-	-	405	**405**
Taxpayers' and others' equity at 31 March 2019	**327,720**	**45,843**	**(84,134)**	**289,429**

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

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**241,786**	**44,392**	**(8,634)**	**277,544**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2017 - restated	**241,786**	**44,392**	**(8,634)**	**277,544**
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**
Taxpayers' and others' equity at 31 March 2018	**246,936**	**45,225**	**(48,394)**	**243,767**

* The Trust's opening receivables balances were assessed under the requirements of IFRS 9 and an expected credit loss was recognised in respect of the balance held with a specific counterparty due to the Trust's expectations around recovery.

Statement of Cash Flows

		Group		Trust	
		2018/19	2017/18	2018/19	2017/18
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		(22,031)	(38,680)	(21,262)	(38,296)
Non-cash income and expense:					
Depreciation and amortisation	7.1	15,659	13,769	15,659	13,769
Net impairments	8	85,287	15,367	85,287	15,367
Income recognised in respect of capital donations	4	(107,667)	-	(107,667)	-
Amortisation of PFI deferred credit		-	(26)	-	(26)
(Increase) / decrease in receivables and other assets		(10,141)	(23,132)	(10,154)	(23,178)
(Increase) / decrease in inventories		3	(530)	3	(530)
Increase / (decrease) in payables and other liabilities		1,522	(13,067)	1,191	(13,065)
Increase / (decrease) in provisions		(583)	(131)	(583)	(131)
Movements in charitable fund working capital		(13)	337	(13)	-
Other movements in operating cash flows		258	583	-	-
Net cash flows from / (used in) operating activities		**(37,706)**	**(45,510)**	**(37,539)**	**(46,090)**
Cash flows from investing activities					
Interest received		136	51	136	51
Purchase of intangible assets		(6,184)	(2,777)	(6,184)	(2,777)
Purchase of PPE and investment property		(76,133)	(26,939)	(76,133)	(26,939)
Sales of PPE and investment property		-	14,515	-	14,515
Receipt of cash donations to purchase assets		-	(136)	-	(136)
Net cash flows from / (used in) investing activities		**(82,181)**	**(15,286)**	**(82,181)**	**(15,286)**
Cash flows from financing activities					
Public dividend capital received		80,784	5,150	80,784	5,150
Movement on loans from DHSC		47,777	66,269	47,777	66,269
Movement on other loans		(8)	-	(8)	-
Capital element of finance lease rental payments		(1,544)	(4,829)	(1,544)	(4,829)
Capital element of PFI, LIFT and other service concession payments		(722)	(665)	(722)	(665)
Interest on loans		(3,278)	(732)	(3,278)	(732)
Other interest		(1)	-	(1)	-
Interest paid on finance lease liabilities		(101)	(154)	(101)	(154)
Interest paid on PFI, LIFT and other service concession obligations		(897)	(953)	(897)	(953)
PDC dividend (paid) / refunded		(9,032)	(6,761)	(9,032)	(6,761)
Cash flows from (used in) other financing activities		1	-	1	-
Net cash flows from / (used in) financing activities		**112,979**	**57,325**	**112,979**	**57,325**
Increase / (decrease) in cash and cash equivalents		**(6,908)**	**(3,471)**	**(6,741)**	**(4,051)**
Cash and cash equivalents at 1 April - brought forward		**21,809**	**25,280**	20,406	24,457
Cash and cash equivalents at 31 March	32	**14,901**	**21,809**	**13,665**	**20,406**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care, and additional Directions issued by the Department of Health and Social Care. The accounting policies contained in the GAM 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. Additional Directions that are issued are mandatory for the Trust to follow. Where the GAM permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1 b Additional Directions

The Trust has complied with additional mandatory guidance, supplementary to the Department of Health and Social Care's Group Accounting Manual in respect of the accounting treatment for the transfer of the New Royal Liverpool Hospital to the public sector. To reflect the full economic benefit inherent in the New Royal Hospital, The Department of Health and Social Care has directed that the Trust consider these assets as part-purchased and part-donated. In meeting the requirement for this element to have initial recognition equal to current value in existing use, The Department of Health and Social Care requires the Trust utilise construction cost certificates to derive the appropriate cash price equivalent at the time of transfer to the Trust and compute the value of the donated element by subtracting from the construction cost certificate the capitalised cost of the Trust cash contributions. This will then provide a proportionate split as part-purchased and part-donated for use in subsequent accounting. The cumulative certified construction cost was £268m; the payments made by the Trust and capitalised were, £118m of advance contract payment, previously recognised as a long term contract receivable and £42m to terminate the PFI agreement; the value derived for the donated element was £108m. The part donated element is to be recognised as Income as required by IAS 20 and is included in the Other Operating Income line of the Statement of Comprehensive Income. This direction has been followed in the preparation of these accounts. The asset was revalued at 31 March 2019 at £214m. An impairment of £92.8m was recognised at that date and is included in the Operating expenses line of the Statement of Comprehensive Income. This impairment has been apportioned across both the purchased and donated elements; the donated element has a carrying value of £75.1m. The asset will be revalued again when completed and brought into use. Additional information regarding this matter can be found in Note 1.6.1 (New Royal), Note 1.10 (Measurement), Note 1.13 (Donated assets), Note 4 (Other operating income), Note 7 (Impairment of assets), Note 15.3 and 15.5 (Property, Plant and Equipment)

Note 1.2 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.

Note 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.

Note 1.4 Charitable Funds

NHS Charitable Funds
The trust is the corporate trustee to The Royal Liverpool and Broadgreen University Hospitals (NHS) Trust Charitable Funds. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:
- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Note 1.5 Pooled Budgets
The trust has not entered into any pooled budgets.

Note 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 judgments, 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.

Note 1.6.1 Critical judgements in applying accounting policies

The following are the critical judgments, 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 2017-18 Statement of Financial Position
- Key Management
- Legal and statutory proceedings

- The Trust's initial plan for 2018/19 was a £40m deficit and the 2018/19 retained NHS adjusted deficit was £39.7m on a control total basis as at Month 09 2018/19. The Trust's retained deficit for 2018/19 is £33.4m and the retained NHS adjusted deficit is £55.5m. The Trust has a turnaround director in place to assist with financial recovery.

- 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 falling short of the Better Payment Practice Code Targets but does not anticipate difficulties with creditors if cash support requested from DH is secured. The Trust's 2019-20 plan submission includes £28.9m working capital support in the form of loans and £137.106m PDC to support the costs to complete the New Royal Liverpool Hospital.

These factors represent material uncertainties that cast a significant doubt on the ability of the group and Trust to continue as a going concern and therefore the appropriateness of applying the going concern basis for preparation of the financial statements. However 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.

Impact of the New Royal on asset valuations

The Trust plans to demolish buildings on the Royal site once the construction of the New Royal is completed and has determined that the recoverable amount of these buildings is lower than the carrying amount. Buildings that will be demolished have been impaired on a straight line basis by the amount represented by their remaining useful life beyond 31st December 2020 (this date is being used as a working assumption but is subject to confirmation) The valuation of the buildings on 31st March 2019 provided by the District Valuer is used to calculate the impairment of buildings to be demolished.

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.

Recognition of payments relating to the New Royal

The Trust had previously made payments of £118m to the PFI operator in respect of capital contributions during the construction phase of the New Royal and accounted for these as non-current prepayments to be released to write down the long term liability when the asset comes into use. The Trust has terminated the PFI Project Agreement at a cost of £42m and the New Royal is to be completed using public sector funding. The previous payments made to the PFI operator, together with the payments in respect of the termination of the PFI agreement, and subsequent payments of £29m to the new contractor, have been recognised as an asset under the course of construction.

An independent valuation of the asset in the course of construction was undertaken in January 2018 which exceeds both the previous payments to the PFI operator and the payments made in respect of termination of the PFI agreement. This valuation was undertaken in accordance with the professional standards of the Royal Institution of Chartered Surveyors. This valuation was the latest in a series of valuations provided for the lenders and the Trust and was relied upon to make stage payments by the lenders, and contributions towards the cost of construction by the Trust. Measurement of this asset has been undertaken in accordance with the additional Direction issued by the Department of Health and Social Care as set out in Note 1.1b. As a result, the £108m representing the donated element has been included in the initial recognition of the Asset Under Construction as set out in Note 15. Additional information regarding the Donated Asset element is set out in Note 1.13

The Trust has obtained a valuation of the New Royal Hospital as at the 31st March 2019 by the District Valuer to support the Trust's assessment of impairments to the asset under construction. The Trust has reviewed the report provided by the District Valuer and is satisfied that the relevant factors have been considered in arriving at an impairment as at 31st March 2019. The impairment of £92,809k has been accounted for in operating expenses in the Trust's 2018/19 accounts.

New Royal

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 31st December 2020 (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 by 30th September 2020. The handover date of 30th September 2020 is subject to contractual confirmation.

The Trust has disclosed a material contingent liability in respect of a VAT repayment demand from HMRC relating to PFI bullet payments made to The Hospital Company (Liverpool) Limited towards the now terminated PFI Contract for the New Royal Hospital. The Trust obtained advice from specialist advisers and on the basis of this advice, have challenged HMRCs interpretation of the arrangement and existence of any liability to repay previously reclaimed VAT. The Trust has reviewed the advice and believes the challenge to HMRC is sufficiently strong as to represent a signficant uncertainty as to whether this will result in an outflow of resources from the Trust. Note 26.3

Note 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 judgments, estimates and assumptions about recognition and measurements of assets, liabilities, income and expenses. The actual results may differ from the judgments, estimates and assumptions made by management.

Information about significant judgments, 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 2018/19 on the views of the Valuation Office Agency which includes the use of national building indices and location factor indices.

Provisions

For the purposes of calculating provisions balances, estimates are made based upon information supplied by third parties such as NHS Resolution Litigation Authority and the NHS Pensions. 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.

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.

Note 1.7 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the NHS Trust will not disclose information regarding performance obligations as part of a contract that has an original expected duration of one year or less,
- The NHS Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7 (a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the NHS Trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue.

The basis for recognition of the NHS Trust's income is disclosed in detail in the relevant notes to the accounts including details of where income is recognised over time or at a point in time.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation is an assessment of the NHS Trust's efforts or inputs on a straight line basis.

The NHST 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, for instance by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. 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 in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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

Note 1.8 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 Trust 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.

Note 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.

Note 1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalized 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.

Measurement

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.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Except in relation to the specific circumstances regarding the construction of the new Royal Liverpool Hospital, as referred to below, 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 capitalized in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

Except in relation to the specific circumstances regarding the construction of the new Royal Liverpool Hospital, as referred to below, assets donated by third parties, either by gift of the asset or by way of funds to acquire assets (including national lottery-funded assets) are capitalised at current value in existing use or fair value on receipt, depending on whether the assets will be held for their services potential. The funding element is recognised as income as required by IAS 20 as interpreted by the Department of Health and Social Care's Group Accounting Manual.

There were specific circumstances surrounding the demise of Carillion PLC, the lead construction company for the New Royal Liverpool Hospital which involved the transfer of assets to the public sector following a termination sum of £42m. The Trust accounts for these assets as part-donated in accordance with DHSC direction and initial recognition at current value in existing use, derived by using an appropriate valuation being the construction cost value referred to in note 1.1b and subtracting the capitalised cost of the Trust's cash contributions. This provides a measure of the current value in existing use for the purposes of initial recognition of the part-donated element. The initial recognition of the asset equal to current value in existing use is £268m including the part-donated element of £108m representing the excess of the certified cumulative cost of works prior to termination, £268m, over the direct costs of £160m incurred by the Trust. See Note 1.1 b Additional Directions and Notes 1.13 and 15.5

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 capitalized. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalized and any existing carrying value of the item replaced is written-out and charged to operating expenses.

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.

Software that is integral to the operation of hardware, for example an operating system, is capitalized 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 capitalized as an intangible asset. Expenditure on research is not capitalized: 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 as an expense 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

Assets donated by third parties, either by gift of the asset or by way of funds to acquire assets (including national lottery-funded assets) are capitalised at current value in existing use or fair value on receipt, depending on whether the assets will be held for their services potential. The funding element is recognised as income as required by IAS 20 as interpreted by the Department of Health and Social Care's Group Accounting Manual.

Donated assets are subsequently valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluation, 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.

There were specific circumstances surrounding the demise of Carillion PLC, the lead construction company for the New Royal Liverpool Hospital which involved the transfer of assets to the public sector following a termination sum of £42m.. The Trust accounts for these assets as part-donated in accordance with DHSC direction and initial recognition for this element is equal to current value in existing use. Measurement of this asset has been undertaken in accordance with the additional Direction issued by the Department of Health and Social Care as set out in Note 1.1b. This provides a measure of the current value in existing use for the purposes of initial recognition of the part-donated element.

1.14 Government grant funded assets

Government grant funded assets are capitalized 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 NHS 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 the Statement of Comprehensive Income.

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.

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 capitalized where they meet the NHS trust's criteria for capital expenditure. They are capitalized 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 against 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.

The real discount rate applicable on 31st March 2019 is positive 0.29% (2017-18: positive 0.10%). The rate is applicable for all provisions for continuing obligations arising from previous employment service.
General 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 positive 0.76% (2017-18: negative 2.42%) for expected cash flows up to and including 5 years
- A medium term rate of positive 1.14% (2017-18: negative 1.85%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.99% (2017-18: negative 1.56%) for expected cash flows over 10 years.

All 2018-19 percentages are in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

1.21 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to the NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution 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 38.3

1.22 Clinical negligence costs

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 NHS Resolution 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 ton 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 Trust becomes party to the contractual provision of the financial instrument 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 when the asset has been transferred and the NHS Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition

Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

The NHS Trust's financial assets at amortised cost includes trade receivables from both NHS and non-NHS customers.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The NHS Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

Credit losses are determined using historic, current and forward–looking information to determine future expectations.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The NHS Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the NHS Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

The implementation of IFRS 9 has resulted in a reduction to financial assets as a result of the retrospective application of the recognition of impairments on an expected loss basis. The NHS Trust will recognise differences between the previous carrying amount and the carrying amount at the beginning of the 2018-19 annual reporting period in the opening retained earnings as at 1st April 2018.

1.26 Financial liabilities

Financial liabilities are recognised 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 extinguished – that is, the obligation has been discharged or cancelled or has expired

Financial liabilities at fair value through profit and loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss, Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.27 Value Added Tax

Most of the activities of the NHS Trust are outside the scope of Value Added Tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalized purchase cost of non-current 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. Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income 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.

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 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 having 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.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- 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 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

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 majortiy of the Trust's £600,933,000 (2017/18: £515,372,000) income relates to the provision of healthcare. The Trust's income for 2018/19 includes £107,667,000 donated income.

Income from the largest external customer was income from Clinical Commissioning Groups and NHS England of £362,522,000 (2017/18: £368,499,000) 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 2.1 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.

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 18.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.7

Note 3.1 Income from patient care activities (by nature)	Group* 2018/19 £000	2017/18 £000
Elective income	66,445	66,042
Non elective income	83,792	79,385
First outpatient income	33,180	32,549
Follow up outpatient income	41,720	42,053
A & E income	14,251	13,764
High cost drugs income from commissioners (excluding pass-through costs)	37,349	44,546
Other NHS clinical income	101,859	104,046
All services		
Private patient income	294	-
Agenda for Change pay award central funding	4,051	-
Total income from activities	**382,941**	**382,385**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	83,184	97,319
Clinical commissioning groups	279,338	271,180
Department of Health and Social Care	4,070	27
Local authorities	4,432	1,595
Non-NHS: private patients	294	511
Non-NHS: overseas patients (chargeable to patient)	475	179
Injury cost recover scheme	1,040	984
Non NHS: other	10,108	10,590
Total income from activities	**382,941**	**382,385**
Of which:		
Related to continuing operations	382,941	382,385
Related to discontinued operations	-	-

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

Performance obligations in respect of the Trust's income from patient care activities are satisfied over time as healtchare is received and consumed similtaneously by the customer as the Trust performs it. Income related to spells of treatment that are partially completed at the financial year end are allocated across the financial years, applying the principles relating to performance obligations.

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

	Group	
	2018/19	2017/18
	£000	£000
Income recognised this year	475	179
Cash payments received in-year	160	75
Amounts added to provision for impairment of receivables	55	23
Amounts written off in-year	35	21

Note 4 Other operating income (Group)	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Other operating income from contracts with customers:				
Research and development (contract)	18,080	17,481	18,080	17,481
Education and training (excluding notional apprenticeship levy income)	32,723	32,354	32,723	32,354
Non-patient care services to other bodies	54,570	75,386	54,570	75,386
Other contract income	3,645	7,344	3,645	7,344
Other non-contract operating income:				
Receipt of capital grants and donations*	107,667	-	107,667	-
Charitable and other contributions to expenditure	-	-	405	136
Rental revenue from operating leases	530	260	530	260
Amortisation of PFI deferred income / credits	-	26	-	26
Charitable fund incoming resources	780	657	-	-
Other non-contract income	372	-	372	-
Total other operating income	**218,367**	**133,508**	**217,992**	**132,987**
Of which:				
Related to continuing operations	218,367	133,508	217,992	132,987
Related to discontinued operations	-	-		

*The Trust accounted for the transfer of the New Royal Liverpool Hospital to the public sector following a termination sum of £42m. Measurement of this asset has been undertaken in accordance with the additional Direction issued by the Department of Health and Social Care as set out in Note 1.1b. The part-donated funding element is recognised as income of £108m as required by IAS 20 as interpreted by the DHSC Group Accounting Manual. The asset is included within assets under construction 'additions' at Note 15.1.

Performance obligations in respect of the Trust's other operating income are satisfied over time with the provision of services received and consumed similtaneously by the customer as the Trust performs it.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	Group 2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	977

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2019 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
within one year	1,753
Total revenue allocated to remainig performance obligations	**1,753**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6.1 Operating expenses

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	18,014	16,690	18,014	16,690
Purchase of healthcare from non-NHS and non-DHSC bodies	5,031	3,808	5,031	3,808
Staff and executive directors costs	299,913	307,716	299,913	307,716
Remuneration of non-executive directors	87	88	87	88
Supplies and services - clinical (excluding drugs costs)	64,037	69,998	64,037	69,998
Supplies and services - general	15,797	16,337	15,797	16,337
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	51,883	61,177	51,883	61,177
Inventories written down	48	38	48	38
Consultancy costs	1,923	1,028	1,923	1,028
Establishment	6,471	6,732	6,471	6,732
Premises	18,153	17,361	18,153	17,361
Transport (including patient travel)	1,688	1,753	1,688	1,753
Depreciation on property, plant and equipment	12,831	12,790	12,831	12,790
Amortisation on intangible assets	2,828	979	2,828	979
Net impairments	85,287	15,367	85,287	15,367
Movement in credit loss allowance: contract receivables / contract assets	364	-	364	-
Change in provisions discount rate(s)	(26)	21	(26)	21
Audit fees payable to the external auditor	-	-	-	-
audit services- statutory audit	72	69	67	64
other auditor remuneration (external auditor only)	12	12	12	12
Internal audit costs	100	-	100	-
Clinical negligence	6,709	5,161	6,709	5,161
Legal fees	329	234	329	234
Insurance	449	438	449	438
Research and development	8,022	176	8,022	176
Education and training	4,075	1,371	4,075	1,371
Rentals under operating leases	3,870	2,737	3,870	2,737
Redundancy	91	45	91	45
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	12,147	9,812	12,147	9,812
Car parking & security	37	83	37	83
Hospitality	1	7	1	7
Losses, ex gratia & special payments	76	180	76	180
Other NHS charitable fund resources expended	1,139	900	-	-
Other	1,881	1,465	1,881	1,465
Total	**623,339**	**554,573**	**622,195**	**553,668**
Of which:				
Related to continuing operations	623,339	554,573	622,195	553,668

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

The Trust hosts Mersey Internal Audit Agency (MIAA). Internal Audit fees for 2018/19 were £99,569 (2017/18: £63,438)

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	
	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	12	12
Total	**12**	**12**

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m ((2017/18: £2m)

Note 7 Impairment of assets (Group)

	Group	
	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Reversal of impairments	(12,215)	(3,328)
Impairments	97,502	18,695
Total net impairments charged to operating surplus / deficit	**85,287**	**15,367**
Impairments charged to the revaluation reserve	-	1,315
Total net impairments	**85,287**	**16,682**

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 2018/19 which has given rise to impairment and reversal of impairments of assets.

Included within the above impairment total of £97.5m is an impairment of £92.8m in relation to the new Royal Liverpool hospital building. This impairment has been apportioned as £60.3m to owned assets and £32.5m to donated assets.

Measurement of this asset has been undertaken in accordance with the additional Direction issued by the Department of Health and Social Care. In meeting the FReM requirement for this element to have initial recognition equal to current value in existing use, DHSC requires the trust to utilise the construction cost certificates to derive the appropriate cash price equivalent at the time of transfer to the Trust. The initial recognition of the asset equal to current value in existing use is £268m.

As explained in Note 1.1b, this valuation has been derived from the latest in a series of valuations provided for the lenders and the Trust and was relied upon to make stage payments by the lenders, and contributions towards the cost of construction by the Trust. The Trust has obtained a valuation of the New Royal Hospital as at the 31st March 2019 by the District Valuer to support the Trust's assessment of impairments to the asset under construction. The Trust has reviewed the report provided by the District Valuer and is satisfied that the relevant factors have been considered in arriving at an impairment as at 31st March 2019. As a result the Direction the impairment is recognized at the year end , although it occured earlier, and as set out above, the impairment has been applied to both the purchased and donated elements The impairment of £92.8m has been accounted for in operating expenses in the Trust's 2018/19 accounts.

Note 8 Employee benefits (Group)

	Group	
	2018/19 Total £000	**2017/18 Total £000**
Salaries and wages	258,060	255,684
Social security costs	22,491	20,574
Apprenticeship levy	1,148	1,131
Employer's contributions to NHS pensions	27,596	26,834
Pension cost - other	27	13
Termination benefits	238	501
Temporary staff (including agency)	4,310	6,544
Total gross staff costs	**313,870**	**311,281**
Total staff costs	**313,870**	**311,281**
Of which		
Costs capitalised as part of assets	2,900	3,565

Note 8.1 Retirements due to ill-health (Group)

During 2018/19 there was 1 early retirement from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2018). The estimated additional pension liabilities of this ill-health retirements is £21k (£94k in 2017/18).

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 puposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In understaking this actuarial assessment, the methodology prescribed in IAS 19, relevent FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is containted 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases (Group)

Trust as a lessor

This note discloses income generated in operating lease agreements where Royal Liverpool and Broadgreen University Hospitals NHS Trust is the lessor.
The Trust has continued to agree tenancies for the Accelerator building with non-NHS organisation including the Liverpool School of Tropical Medicine.

	Group	
	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	530	260
Total	**530**	**260**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	486	492
- later than one year and not later than five years;	1,770	1,826
- later than five years.	7,508	8,011
Total	**9,764**	**10,329**

Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Royal Liverpool and Broadgreen University Hospitals NHS Trust is the lessee.

	Group	
	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	3,870	2,737
Total	**3,870**	**2,737**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,270	2,566
- later than one year and not later than five years;	5,730	3,605
- later than five years.	3,877	3,317
Total	**11,877**	**9,488**
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	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Interest on bank accounts	136	51	136	51
NHS charitable fund investment income	282	257	-	-
Total finance income	**418**	**308**	**136**	**51**

Note 11.1 Finance expenditure (Group)

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

	Group	
	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	3,179	1,406
Other loans	124	121
Finance leases	101	154
Interest on late payment of commercial debt	1	2
Main finance costs on PFI and LIFT schemes obligations	388	444
Contingent finance costs on PFI and LIFT scheme obligations	509	509
Total interest expense	**4,302**	**2,636**
Unwinding of discount on provisions	4	2
Other finance costs	-	-
Total finance costs	**4,306**	**2,638**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	Group	
	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	2

Note 12 Other gains / (losses) (Group)

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Gains on disposal of assets	-	8,705	-	8,705
Total gains / (losses) on disposal of assets	**-**	**8,705**	**-**	**8,705**
Fair value gains / (losses) on charitable fund investments & investment properties	242	95	-	-
Total other gains / (losses)	**242**	**8,800**	**-**	**8,708**

The Trust disposed of the Multi Storey Car Park on the Royal Liverpool Hospital site and the transaction was completed prior to 31st March 2018.

Note 13 Trust income statement and statement of comprehensive income

The trust's (deficit) for the period was (£33.4) million (2017/18: (£41.1) million). The trust's total comprehensive (expense) for the period was (£33.1) million (2017/18: (£38.9) million).

Note 14 Intangible assets - 2018/19

GROUP	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**19,809**	**-**	**19,809**
Additions	6,184	-	6,184
Valuation / gross cost at 31 March 2019	**25,993**	**-**	**25,993**
Amortisation at 1 April 2018 - brought forward	**1,920**	**-**	**1,920**
Provided during the year	2,828	-	2,828
Amortisation at 31 March 2019	**4,748**	**-**	**4,748**
Net book value at 31 March 2019	**21,245**	**-**	**21,245**
Net book value at 1 April 2018	**17,889**	**-**	**17,889**

Note 14.1 Intangible assets - 2017/18

GROUP	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	**6,822**	**6,456**	**13,278**
Additions	6,531	-	**6,531**
Reclassifications	6,456	(6,456)	-
Valuation / gross cost at 31 March 2018	**19,809**	**-**	**19,809**
Amortisation at 1 April 2017 - as previously stated	**941**	**-**	**941**
Amortisation at 1 April 2017 - restated	**941**	**-**	**941**
Provided during the year	979	-	**979**
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 15.1 Property, plant and equipment - 2018/19

GROUP	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**25,460**	**96,075**	**-**	**8,215**	**99,407**	**176**	**24,363**	**8,067**	**261,763**
Additions	-	11,236	-	303,107	1,816	-	1,395	172	**317,726**
Impairments	-	(6,324)	-	(92,809)	-	-	-	-	**(99,133)**
Reversals of impairments	-	7,313	-	-	-	-	-	-	**7,313**
Revaluations	-	618	-	-	-	-	-	-	**618**
Reclassifications	-	1,827	-	(1,827)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2019	**25,460**	**110,745**	**-**	**216,686**	**101,223**	**176**	**25,758**	**8,239**	**488,287**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**-**	**76,238**	**173**	**18,370**	**6,818**	**101,599**
Provided during the year	-	6,533	-	-	4,497	2	1,587	212	**12,831**
Impairments	-	(1,631)	-	-	-	-	-	-	**(1,631)**
Impairments charged to reval	-	(4,902)	-	-	-	-	-	-	**(4,902)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**80,735**	**175**	**19,957**	**7,030**	**107,897**
Net book value at 31 March 2019	**25,460**	**110,745**	**-**	**216,686**	**20,488**	**1**	**5,801**	**1,209**	**380,390**
Net book value at 1 April 2018	**25,460**	**96,075**	**-**	**8,215**	**23,169**	**3**	**5,993**	**1,249**	**160,164**

Note 15.2 Property, plant and equipment - 2017/18

GROUP	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**26,715**	**90,310**	**1,000**	**24,606**	**98,092**	**176**	**20,550**	**7,538**	**268,987**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**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	(1,315)	(17,695)	(1,000)	-	-	-	-	-	**(20,010)**
Reversals of impairments	-	(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 - as previously stated	**-**	**-**	**-**	**-**	**71,366**	**170**	**16,848**	**6,517**	**94,901**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2017 - restated	**-**	**-**	**-**	**-**	**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**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	(5,249)	(64)	-	-	-	-	-	**(5,313)**
Revaluations	-	(714)	-	-	-	-	-	-	**(714)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
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 15.3 Property, plant and equipment financing - 2018/19

GROUP	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	25,460	99,514	-	141,586	16,671	1	4,326	1,209	**288,767**
Finance leased	-	5,884	-	-	260	-	1,475	-	**7,619**
On-SoFP PFI contracts and other service concession arrangements	-	285	-	-	2,872	-	-	-	**3,157**
Owned - donated (see note 15.5)	-	5,062	-	75,100	685	-	-	-	**80,847**
NBV total at 31 March 2019	**25,460**	**110,745**	**-**	**216,686**	**20,488**	**1**	**5,801**	**1,209**	**380,390**

Note 15.4 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 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**
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 15.5 Donations of Property Plant and Equipment

The Trust received £101k from the Royal Liverpool and Broadgreen University Hospitals NHS Trust Charitable Fund for the purchase of equipment assets.

The Trust has complied with additional mandatory guidance, supplementary to the Department of Health and Social Care's Group Accounting Manual in respect of the accounting treatment for the transfer of the New Royal Liverpool Hospital to the public sector with regards to donations of Property, Plant and Equipment. Measurement of this asset has been undertaken in accordance with the additional Direction issued by the Department of Health and Social Care as set out in Note 1.1b Following the transfer of the New Royal Liverpool Hospital to the public sector, with the inherent economic benefit following a termination sum of £42m, the asset is considered as part-donated. The Trust is required to utilise an appropriate valuation at the time of transfer to the Trust and to compute the value of the donated element by subtracting the capitalised cost of the trust Trust's cash contributions from the valuation. The proportionate split of the asset as part-purchased and part-donated will be used in subsequent accounting. As a result of complying with the Direction issued by the Department of Health and Social Care, and accounting for the Property, Plant and Equipment as part-donated, the Trust's PDC dividend calculation will reduce by approximately £2.6m in future years.

Note 15.6 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 asset were revalued with an effective date of 31st March 2019.

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 2014. 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 2019 where the buildings are to be demolished, and the depreciated value of the buildings based on 31st March 2021, using the working assumption of 31st December 2020 as a completion date for the purpose of calculating the impairment only. A confirmed contractual completion date is awaited.

The amount added to the revaluation reserve in respect of the revaluation of land and buildings was £618k.

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	5	90
Dwellings	20	26
Plant and Machinery	5	20
Transport Equipment	7	7
Information Technology	2	10
Furniture and Fittings	5	15

Note 16 Investments in associates and joint ventures

The Trust did not have any investments in associates and joint ventures during 2018/19.

Note 17 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	
	2018/19	**2017/18**
	£000	**£000**
Carrying value at 1 April - brought forward	**8,947**	**9,155**
Prior period adjustments	-	-
Carrying value at 1 April - restated	**8,947**	**9,155**
Acquisitions in year	7,599	6,096
Movement in fair value through income and expenditure	242	95
Disposals	(7,601)	(6,399)
Carrying value at 31 March	**9,187**	**8,947**

Note 18 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 2019 £000	31 March 2018 £000
Restricted funds:		
Endowment funds	81	82
Other restricted income funds	9,712	9,956
	9,793	**10,038**

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

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

Note 19 Inventories

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Drugs	2,435	2,468	2,435	2,468
Consumables	6,179	6,149	6,179	6,140
Charitable fund inventory	9	9	-	-
Total inventories	**8,623**	**8,626**	**8,614**	**8,608**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £101,085k (2017/18: £116,250k). Write-down of inventories recognised as expenses for the year were £48k (2017/18: £38k)

Note 20.1 Receivables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Contract receivables*	48,431		48,836	-
Trade receivables*		55,279	-	55,279
Allowance for impaired contract receivables / assets*	(765)		(765)	-
Allowance for other impaired receivables	-	(512)	-	(512)
Prepayments (non-PFI)	20,421	8,769	20,421	8,769
PDC dividend receivable	310	-	310	-
VAT receivable	3,519	-	3,519	-
Other receivables	-	1,162	-	1,208
NHS charitable funds: trade and other receivables	119	108		
Total current receivables	**72,035**	**64,806**	**72,321**	**64,744**
Non-current				
Contract receivables*	3,087		3,087	-
Allowance for impaired contract receivables / assets*	(202)		(202)	-
Allowance for other impaired receivables	-	(181)	-	(181)
Prepayments (non-PFI)	599	8,000	599	8,000
PFI prepayments - capital contributions	-	114,258	-	114,258
Other receivables	-	2,748	-	2,748
Total non-current receivables	**3,484**	**124,825**	**3,484**	**124,825**
Of which receivable from NHS and DHSC group bodies:				
Current	36,196	40,024	36,196	40,024
Non-current	-	-		

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

The Trust has complied with the requirements of IFRS 15 and the Department of Health and Social Care's Group Accounting Manual in the calculation of contract assets. There has been an overall reduction in contact assets during 2018/19, however these are not associated with contractual terms or performance obligations. The estimates and judgements required by IFRS 15 are broadly consistent with the Trust's previous accounting treatment.

Note 20.2 Allowances for credit losses - 2018/19

	Group	
	Contract receivables and contract assets	**All other receivables**
	£000	**£000**
Allowances as at 1 Apr 2018 - brought forward		**693**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	693	(693)
New allowances arising	554	-
Reversals of allowances	(190)	-
Utilisation of allowances (write offs)	(90)	-
Allowances as at 31 Mar 2019	**967**	**-**

Note 20.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Group	**Trust**
	All receivables	**All receivables**
	£000	**£000**
Allowances as at 1 Apr 2017 - as previously stated	**1,116**	**1,116**
Prior period adjustments		
Allowances as at 1 Apr 2017 - restated	**1,116**	**1,116**
Transfers by absorption		
Increase in provision	161	161
Amounts utilised	(98)	(98)
Unused amounts reversed	1,637	1,637
Allowances as at 31 Mar 2018	**2,816**	**2,816**

Note 21.1 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	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
At 1 April	**21,809**	**25,280**	**20,406**	**24,457**
Net change in year	(6,908)	(3,471)	(6,741)	(4,051)
At 31 March	**14,901**	**21,809**	**13,665**	**20,406**
Broken down into:				
Cash at commercial banks and in hand	1,245	1,418	9	15
Cash with the Government Banking Service	13,656	20,391	13,656	20,391
Total cash and cash equivalents as in SoFP	**14,901**	**21,809**	**13,665**	**20,406**

Note 21.2 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 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 2019	31 March 2018
	£000	£000
Bank balances	6	6
Total third party assets	**6**	**6**

Note 22 Trade and other payables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Trade payables	18,096	19,369	18,100	19,369
Capital payables	8,212	4,580	8,212	4,580
Accruals	13,357	9,411	13,357	9,411
Receipts in advance and payments on account	-	4	-	4
Social security costs	3,617	3,340	3,617	3,340
VAT payables	-	1,965	-	1,965
Other taxes payable	2,865	2,605	2,865	2,605
PDC dividend payable	-	730	-	730
Accrued interest on loans*	-	817	-	817
Other payables	4,305	3,917	4,305	3,919
NHS charitable funds: trade and other payables	357	385	-	-
Total current trade and other payables	**50,809**	**47,123**	**50,456**	**46,740**
Of which payables from NHS and DHSC group bodies:				
Current	14,872	8,611		

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 35. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 23 Other liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Deferred income: contract liabilities	901	977	901	977
Deferred PFI credits / income	-	26		26
Total other current liabilities	**901**	**1,003**	**901**	**1,003**

Note 24.1 Borrowings

	Group	
	31 March 2019 £000	31 March 2018 £000
Current		
Loans from DHSC	10,579	4,870
Other loans	77	328
Obligations under finance leases	989	1,531
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	778	677
Total current borrowings	**12,423**	**7,406**
Non-current		
Loans from DHSC	119,675	76,770
Other loans	11,495	11,252
Obligations under finance leases	8,578	1,543
Obligations under PFI, LIFT or other service concession contracts	4,186	5,009
Total non-current borrowings	**143,934**	**94,574**

Note 24.2 Reconciliation of liabilities arising from financing activities

GROUP	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**81,640**	**11,580**	**3,074**	**5,686**	**101,980**
Cash movements:					**-**
Financing cash flows - payments and receipts of principal	47,777	(8)	(1,544)	(722)	**45,503**
Financing cash flows - payments of interest	(2,908)	(370)	(101)	(388)	**(3,767)**
Non-cash movements:					**-**
Impact of implementing IFRS 9 on 1 April 2018	566	251	-	-	**817**
Additions	-	-	8,037	-	**8,037**
Application of effective interest rate	3,179	124	101	388	**3,792**
Other changes	-	(5)	-	-	**(5)**
Carrying value at 31 March 2019	**130,254**	**11,572**	**9,567**	**4,964**	**156,357**

Note 25.1 Royal Liverpool and Broadgreen University Hospitals NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group	
	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**14,326**	**3,261**
of which liabilities are due:		
- not later than one year;	1,408	1,644
- later than one year and not later than five years;	2,509	1,617
- later than five years.	10,409	-
Finance charges allocated to future periods	(4,759)	(187)
Net lease liabilities	**9,567**	**3,074**
of which payable:		
- not later than one year;	989	1,531
- later than one year and not later than five years;	1,188	1,499
- later than five years.	7,390	44
Contingent rent recognised as expense in the period	509	509

The Trust entered into a new finance lease arrangement with Liverpool City Council for the provision of a Clinical Sterile Services facility during 2018/19 for a period of 25 years.

Note 26.1 Provisions for liabilities and charges analysis (Group)

GROUP	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**1,211**	**401**	**351**	**1,192**	**3,155**
Change in the discount rate	(20)	(6)	-	-	**(26)**
Arising during the year	77	8	131	-	**216**
Utilised during the year	(271)	(71)	(70)	(234)	**(646)**
Reversed unused	(53)	-	(74)	-	**(127)**
Unwinding of discount	3	1	-	-	**4**
At 31 March 2019	**947**	**333**	**338**	**958**	**2,576**
Expected timing of cash flows:					
- not later than one year;	-	72	338	-	**410**
- later than one year and not later than five years;	-	229	-	958	**1,187**
- later than five years.	947	32	-	-	**979**
Total	**947**	**333**	**338**	**958**	**2,576**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs

The Trust's provisions include the amounts payable by the Trust in respect of historical early retirements in the efficiency of the service, for which the Trust bears the costs of pension paid earlier than normal retirement age. The Trust also provides for injury benefits payable to employees. Legal claims include provisions advised by NHS Resolution. Other provisions include the accumulated surpluses relating to Mersey Internal Audit Agency (MIAA) a service hosted by the Trust. The accumulated surpluses attributable to MIAA would require distribution or transfer should there be a future change to hosting arrangments.

GROUP	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,875**	**280**	**1,129**	3,284
Change in the discount rate	21	-	-	21
Arising during the year	63	203	63	329
Utilised during the year	(333)	(54)	-	(387)
Reversed unused	(16)	(78)	-	(94)
Unwinding of discount	2	-	-	2
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 26.2 Clinical negligence liabilities

At 31st March 2019, £18,953k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal Liverpool University Hospitals NHS Trust (31 March 2018: £17,960k)

Note 26.3 Contingent assets and liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities				
NHS Resolution legal claims	(65)	(37)	(65)	(37)
Other	(22,800)	-	(22,800)	-
Gross value of contingent liabilities	**(22,865)**	**(37)**	**(22,865)**	**(37)**
Amounts recoverable against liabilities	-	-		
Net value of contingent liabilities	**(22,865)**	**(37)**	**(22,865)**	**(37)**
Net value of contingent assets	**-**	**-**		

The 'Other' contingent liability relates to a material contingent liability in respect of a VAT repayment demand from HMRC relating to PFI bullet payments made to The Hospital Company (Liverpool) Limited towards the now terminated PFI Contract for the New Royal Hospital. The Trust obtained advice from specialist advisers and on the basis of this advice, have challenged HMRCs interpretation of the arrangement and existence of any liability to repay previously reclaimed VAT. The Trust has reviewed the advice and believes the challenge to HMRC is sufficiently strong as to represent a signficant uncertainty as to whether this will result in an outflow of resources from the Trust.

Note 27 Contractual capital commitments

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	48,225	6,257	48,225	6,257
Intangible assets	-	-		
Total	**48,225**	**6,257**	**48,225**	**6,257**

Note 28 Other financial commitments

The group / trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
not later than 1 year	1,337	1,337	1,337	1,337
after 1 year and not later than 5 years	5,349	5,349	5,349	5,349
paid thereafter	23,516	24,853	23,516	24,853
Total	**30,202**	**31,539**	**30,202**	**31,539**

Note 29 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 arrangments for the service at Broadgreen the building will become a Trust asset at the end of the contract.

Veolia Energy Contact:

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 enetered into an agreement with a private contractor for the provision of a retail facility on the Royal Liverpool Hospital 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 entered into a control for the provision of car parking for 19 years with Indigo Park Services.

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

Note 29.1 Imputed finance lease obligations

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 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**6,137**	**7,246**	**6,137**	**7,246**
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 five years;	4,489	4,822	4,489	4,822
- later than five years.	539	1,315	539	1,315
Finance charges allocated to future periods	(1,173)	(1,560)	(1,173)	(1,560)
Net PFI, LIFT or other service concession arrangement obligation	**4,964**	**5,686**	**4,964**	**5,686**
- not later than one year;	778	677	778	677
- later than one year and not later than five years;	3,714	3,642	3,714	3,642
- later than five years.	472	1,367	472	1,367

Note 29.2 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 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**69,880**	**75,104**	**69,880**	**75,104**
Of which liabilities are due:				
- not later than one year;	13,060	11,200	13,060	11,200
- later than one year and not later than five years;	46,588	41,754	46,588	41,754
- later than five years.	10,232	22,150	10,232	22,150

Note 29.3 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	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**13,766**	**11,430**	**13,766**	**11,430**
Consisting of:				
- Interest charge	388	444	388	444
- Repayment of finance lease liability	722	665	722	665
- Service element and other charges to operating expenditure	12,147	9,812	12,147	9,812
- Contingent rent	509	509	509	509
Total amount paid to service concession operator	**13,766**	**11,430**	**13,766**	**11,430**

Note 30 Financial instruments

Note 30.1 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. The contract is nearing completion and reducing in value and the Trust considers there is minimal risk.

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 NHS Improvement. 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 2019 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 30.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	50,551	-	-	**50,551**
Cash and cash equivalents	13,665	-	-	**13,665**
Consolidated NHS Charitable fund financial assets	9,187	1,355	-	**10,542**
Total at 31 March 2019	**73,403**	**1,355**	**-**	**74,758**

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000	£000	£000	£000
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**

Trust	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	50,551	-	-	**50,551**
Cash and cash equivalents	13,665	-	-	**13,665**
Total at 31 March 2019	**64,216**	**-**	**-**	**64,216**

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
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**

Note 30.3 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	130,254	-	**130,254**
Obligations under finance leases	9,567	-	**9,567**
Obligations under PFI, LIFT and other service concession contracts	4,964	-	**4,964**
Other borrowings	11,572	-	**11,572**
Trade and other payables excluding non financial liabilities	39,665	-	**39,665**
Consolidated NHS charitable fund financial liabilities	357	-	**357**
Total at 31 March 2019	**196,379**	**-**	**196,379**

Group	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	93,220	-	**93,220**
Obligations under finance leases	3,074	-	**3,074**
Obligations under PFI, LIFT and other service concession contracts	5,686	-	**5,686**
Other borrowings	34,188	-	**34,188**
Total at 31 March 2018	**136,168**	**-**	**136,168**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	130,254	-	**130,254**
Obligations under finance leases	9,567	-	**9,567**
Obligations under PFI, LIFT and other service concession contracts	4,964	-	**4,964**
Other borrowings	11,572	-	**11,572**
Trade and other payables excluding non financial liabilities	39,665	-	**39,665**
Total at 31 March 2019	**196,022**	**-**	**196,022**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	81,640	-	**81,640**
Obligations under finance leases	3,074	-	**3,074**
Obligations under PFI, LIFT and other service concession contracts	5,685	-	**5,685**
Other borrowings	11,580	-	**11,580**
Trade and other payables excluding non financial liabilities	33,803	-	**33,803**
Total at 31 March 2018	**135,782**	**-**	**135,782**

Note 30.4 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 different levels have been defined as follows:

Level 1: quoted prices (unadjusted) in active markets for identical assets and liabilites

Level 2: inputs other than quoted prives included within Level 1 that are observable for the asset or liability, either directly (i.e. as prices) or indirectly (i.e. derived from prices)

Level 3: inputs for the asset or liability that are not based on observable market data (unobservable inputs)

	Group 31st March 2019			
	Level 1 £000s	Level 2 £000s	Level 3 £000s	Total £000s
Equity securities as at fair value through profit or loss	9,187	-	-	9,187

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

Note 30.5 Maturity of financial liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
In one year or less	52,432	41,594	52,075	41,209
In more than one year but not more than two years	67,523	10,488	67,523	10,488
In more than two years but not more than five years	50,797	80,825	50,797	80,825
In more than five years	25,627	3,261	25,627	3,261
Total	**196,379**	**136,168**	**196,022**	**135,783**

Note 31 Losses and special payments

GROUP AND TRUST	2018/19 Total number of cases Number	2018/19 Total value of cases £000	2017/18 Total number of cases Number	2017/18 Total value of cases £000
Losses				
Cash losses	17	9	55	57
Bad debts and claims abandoned	209	81	550	89
Total losses	**226**	**90**	**605**	**146**
Special payments				
Ex-gratia payments	32	76	41	64
Total special payments	**32**	**76**	**41**	**64**
Total losses and special payments	**258**	**166**	**646**	**210**
Compensation payments received		-		-

Note 32.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £566k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0 decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax." & " Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £3,956k

Note 32.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 33 Related parties

Royal Liverpool and Broadgreen University Hospitals NHS Trust is a corporate body 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 Trusts policies around Standards of Personal 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.

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 £990,233 during 18/19 (2017/18 £5,746,699) and made payments totalling £13,177,158 (2017/18 £19,661,960). At 31st March 2019 the Trust owed the University £700,186 (2017/18 £1,135,467) and the University owed the Trust £688,833 (2017/18 £416,499)

A number of the Trust's senior management are Directors of Liverpool Health Partners. During 2017/18 the Trust made payments of £205,200 (2017/18 £80,000) and received £68,166 (2017/18 £175,599) from Liverpool Health Partners. The Trust was owed £37,156 (2017/18 £37,437) at 31st March 2019.

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 Trust Board. Total income received from the Royal Liverpool and Broadgreen University Hospitals NHS Trust Charitable Funds was £1,033,000 (2017/18 £136,000) and as at 31st March 2019 the amount owed to the Trust by the charity was £465,063 (2017/18 £46,000) and the Trust owed the Charity £3,764 (2017/18 £2,000).

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 and member of Cheshire and Mersey digital board and accelerator partnership board

Mr Andrew Loughney is Medical Director at Liverpool Women's Hospital NHS FT

Mr Aidan Kehoe, Chief Executive until 7th March, was a director at Liverpool Health Partners

Dr Peter Williams, interim Chief Executive from 8th March, is a board member of the NHS transformation unit.

Note 34 Transfers by absorption

There were no transfers by absorption during 201/19. 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 in the 2017/18 accounts. The transfer of functions was accounted for as a 'transfer by absorption' as these are classified as 'machinery of government change'.

Note 35 Better Payment Practice code

Non-NHS Payables	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Total non-NHS trade invoices paid in the year	110,812	254,727	122,788	279,211
Total non-NHS trade invoices paid within target	81,245	191,029	46,252	142,048
Percentage of non-NHS trade invoices paid within target	73.3%	75.0%	37.7%	50.9%
NHS Payables				
Total NHS trade invoices paid in the year	4,419	69,165	4,627	67,482
Total NHS trade invoices paid within target	2,883	61,128	1,390	45,133
Percentage of NHS trade invoices paid within target	65.2%	88.4%	30.0%	66.9%

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 36 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	133,028	69,976
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**133,028**	**69,976**
External financing limit (EFL)	139,507	91,443
Under / (over) spend against EFL	**6,479**	**21,467**

Note 37 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	323,910	25,142
Less: Disposals	-	(5,810)
Less: Donated and granted capital additions	(107,667)	(136)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**216,243**	**19,196**
Capital Resource Limit	221,716	21,992
Under / (over) spend against CRL	**5,473**	**2,796**

Note 38 Breakeven duty financial performance

	Trust 2018/19 £000	Trust 2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(55,537)	(26,209)
cquin Risk Reserve - 16/17 adjustment	-	1400
Add back non-cash element of On-SoFP pension scheme charges	-	
IFRIC 12 breakeven adjustment	1,387	464
Breakeven duty financial performance surplus / (deficit)	**(54,150)**	**(24,345)**

Note 39 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000s	2009/10 £000s	2010/11 £000s	2011/12 £000s	2012/13 £000s	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Breakeven duty in-year financial performance		4,021	4,238	5,472	7,420	11,025	11,225	24,543	1,329	(24,345)	(54,150)
Breakeven duty cumulative position	5,215	9,236	13,474	18,946	26,366	37,391	48,616	73,159	74,488	50,143	(4,007)
Operating income		401,461	422,274	424,633	440,705	457,382	483,175	534,415	528,959	515,372	600,933
Cumulative breakeven position as a percentage of operating income		2.3%	3.2%	4.5%	6.0%	8.2%	10.1%	13.7%	3.2%	9.7%	-0.7%