Liverpool University Hospitals
NHS Foundation Trust

Annual Report
and Accounts
for the year ended 31 March 2021

LIVING OUR VALUES

CARING FAIR INNOVATIVE

Annual Report
and Accounts
for the year ended 31 March 2021

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

CONTENTS

PART I

PERFORMANCE REPORT

1. PERFORMANCE REPORT

1.1 Organisation Overview

(i) Purpose of section

The purpose of this section is to provide a summary that provides sufficient information to understand the organisation, its purpose and objectives, how it is has performed during the year and the key risks to the achievement of its objectives for the coming year.

The format and content of the Annual Report and Accounts for 2020/21 have been prepared in line with the revisions published in the NHS foundation trust annual reporting manual 2020/21.

(ii) Chief Executive statement on performance

If there has ever been a year which epitomises our Trust's mission of working together to deliver outstanding healthcare, this last year was it.

The period covered by this annual report is from 1 April 2020 through to 31 March 2021. The year has been dominated by the impact of, and response to, the COVID-19 global pandemic. From the announcement of the first national lockdown in late March 2020 it seemed inconceivable at the time that we would only just be emerging from various local and national lockdowns one year on. Having been established in October 2019, Liverpool University Hospitals NHS Foundation Trust (LUHFT) was just a matter of months into its new organisational life when the COVID-19 pandemic hit.

Liverpool has experienced three waves of COVID-19 – starting on 1 April 2020, 8 October 2020 and 5 January 2021. We were operating in a surge phase from 8 October right through until 14 April 2021. During October 2020, when we had been in existence as an organisation for just a year, we had one of the highest rates of COVID-19 infection of any city in Europe.

I want to express, on behalf of the Trust Board, our deep and sincere gratitude to colleagues working across the organisation for their unwavering commitment and dedication to tackle head-on the unprecedented challenges they faced in safely treating, and caring for, all the patients admitted to our hospitals during this time. So many staff worked tirelessly, under immense pressure and within the tightest of timescales. There is so much to be proud of:

- Colleagues were redeployed into unfamiliar clinical areas driven by their desire to support those clinical teams at the forefront of COVID-19
- Colleagues from respiratory, infectious diseases and critical care worked together to develop Continuous Positive Airway Pressure (CPAP) capacity outside of critical care. That service redesign has now been recognised for its ingenuity to ensure patients could be treated whilst not overwhelming critical care
- Urgent elective and cancer services continued to be delivered, supported by the mutual aid of neighbouring NHS Trusts and some additional capacity and facilities from the independent sector. Patient care and safety drove our efforts

- Our clinical, operations and estates teams worked on delivering the state of the art 'step down' Agnes Jones unit as part of the COVID-19 response, creating a facility that would aid patient's recovery ahead of discharge
- A total of 40% of outpatient appointments were delivered virtually – by telephone or video – enabling the Trust to keep people safe whilst continuing to deliver their essential care
- The resourcefulness and tenacity of our Procurement team ensured we maintained supplies of Personal Protective Equipment critical to keeping the hospital operating safely
- The Family Liaison Service delivered over 37,000 virtual visits enabling patients and their families to communicate and interact during a time when loved ones desperately wanted to be at their relative or friend's bedside but were unable to do so with visiting severely restricted in line with guidance
- Working with city council colleagues we were able to provide a drive through phlebotomy service in the community.

As we moved from the response to COVID-19 into managing the disease, the Trust continued to play a pivotal role:

- LUHFT made a significant contribution to the national COVID-19 research effort. We supported recruitment of the highest number of people into the Oxford-AstraZeneca vaccine study in the country, designed and delivered the national platform study, AGILE, for testing novel treatments for COVID-19 and ensured that the majority of our COVID-19 patients were offered the opportunity to participate in research
- As the various testing programmes have been implemented in our hospitals across Cheshire and Merseyside and in the community, Loop-mediated Isothermal Amplification (LAMP) and lateral flow testing, Liverpool Clinical Laboratories has been the engine room for the testing programmes
- From our Aintree University Hospital and Royal Liverpool University Hospital sites we have operated vaccination centres over recent months integral to the delivery of the national vaccination programme. These delivered over 75,000 vaccines to staff and local communities.

Our local community has supported us in so many ways. There has been an unimaginable outpouring of compassion, kindness and generosity from the local community, businesses (who faced their own challenges) and major corporate organisations that gave their moral and financial support to NHS workers; giving everyone a much needed boost and acknowledgement of the significant challenges colleagues faced on a daily basis.

The support has been overwhelming. From the thank you messages, the rainbows, people out on their doorsteps showing their support, our virtual Royal visit from His Royal Highness the Duke of Cambridge, Prince William, to the generous charitable donations that have enabled us to support the health and wellbeing of patients and staff from wellbeing hubs offering respite and support, to improved rest areas to care packages.

It is also important to acknowledge the invaluable role the local, regional and national media played in providing people with an insight into the challenges our hospitals faced in the peak of each of the COVID-19 waves, recognising the efforts of staff and being an important source of public health information -essential in the fight to reduce the spread of COVID-19.

As we move forward our attention and focus is firmly on our operational reset. It is widely acknowledged that waiting lists have grown as a consequence of COVID-19. Our teams are

working hard to increase our theatre capacity and ensure that patients are accessing outpatient clinics.

Towards the end of this reporting period, as a Trust we marked the commemoration of the anniversary of the first national lockdown. An opportunity to reflect on the events of the past year, to remember those patients and colleagues who had died from COVID-19, and to acknowledge the collective efforts as we came together as a Trust and as a city.

Whilst COVID-19 has absolutely dominated the year, there has been a considerable amount of other work happening as we continue to progress on our journey as a new Trust and to lay strong foundations for the long-term future of LUHFT.

Building on the sense of 'togetherness' fostered during this first year of the organisation and throughout our COVID-19 response, by working together to deliver outstanding healthcare we are committed to playing a vital role in building healthier, happier, fairer lives for the people we serve – our patients, our staff, our city and our region.

How we achieve that is only possible if our values are at the heart of everything we do and we live our values every day in the way we treat each other, our patients, families and communities. This means we behave in ways which are:

Caring, where we are kind to each other and always show compassion to ourselves and others

Fair in that we treat people equitably and value their differences

Innovative through working as a team to continuously improve the way we deliver and transform health care.

Alongside how we will work, the Trust has also developed its first three-year strategy, *'Our Future Together'* that sets out what we want to achieve based on four strategic priorities:

1. **Great Care**, working tirelessly to provide safe, caring, and effective healthcare creating the best safety culture within the NHS over the next three years

2. **Great People** ensuring a great staff experience for all staff and working to attract the best healthcare professionals to become the North West healthcare employer of choice

3. **Great Research and Innovation** focusing on growing our portfolio of high-quality research and innovation, widening access to research opportunities for patients and staff to become an outstanding centre of research and innovation

4. **Great Ambition** building and nurturing successful partnerships where we are a valued and innovative partner, delivering sustainable services, fulfilling our role as an anchor institution and system leader

Our values and behaviours; along with our strategy are critical to our success in

- Working together to improve our services and to deliver the benefits of becoming one organisation for our patients, staff, and communities

- Working with partners to lead improvements in healthcare outcomes and reduce inequalities across the wider health and care system for the people we serve
- Collaborating with patients and partners to expand participation in clinical research and innovation opportunities
- Maximising our social impact as a leading anchor institution across the Liverpool City Region.

Through significant investment in our estates we are creating the healthcare facilities that will improve quality of care and patient experience. We continue to progress major schemes including Aintree University Hospital Tower Block and main entrance developments. Work continues towards completing the new Royal Liverpool University Hospital as planned, opening in summer 2022.

Our commitment to system working and collaboration with our health partners has been illustrated by the transfer of blood cancer wards from the Royal Liverpool University Hospital to the new neighbouring Clatterbridge Cancer Centre. We are also working with our community healthcare partners, Mersey Care NHS Foundation Trust on an integrated care 'out of hospital' service that bridges the gap between acute and community services.

Throughout 2020-2021 the PaperLite project has been progressing to put in place a single unified patient record platform across the Trust. This is essential to enable the integration of our clinical teams.

Following the publication of the National People Plan, we have developed a Trust-specific People Plan that sets out in detail how we will build a reliable and sustainable workforce; we have a clear ambition to become the North West healthcare employer of choice.

Over the last 12 months we have demonstrated the incredible things that can be achieved by working together and supporting each other. Looking ahead, it will be this that will help us to achieve our ambitions for the people of Liverpool.

I want to end by noting my sincere thanks to everyone associated with Liverpool University Hospitals NHS Foundation Trust for all that you have done over the last year, and for what you continue to do. Together, we will continue to deliver outstanding healthcare that contributes to building healthier, happier, fairer lives.

Signed

Steve Warburton
Chief Executive Date: 23 June 2021

(iii) Purpose and activities of the Trust and brief history

Liverpool University Hospitals NHS Foundation Trust was created in October 2019 following the merger acquisition (referred as merger) between Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust, including the Liverpool University Dental Hospital. The merger was driven by our clinicians, who for a long time recognised that bringing together the two organisations would enable us to transform the way we deliver healthcare for the better. Our focus is to ensure our patients receive safe, caring and effective care.

The merger has created one of largest university teaching Trusts in the country, with more than 12,000 staff and a £1.1 billion turnover bringing lots of ambitious and exciting opportunities to transform our services and organisation, to deliver our collective vision of enabling **HEALTHIER, HAPPIER, FAIRER LIVES.**

We are now one of the largest acute Trusts in the country, serving a core population of around 630,000 people across Merseyside, as well as providing a range of highly specialist services to a catchment area of more than two million people in the North West region and beyond.

The Trust is a values-driven organisation. Our ambitions can only be realised if our values are at the heart of everything that we do. They were created by our staff, patients and members of our communities, who felt that by living these values on a daily basis we will be able to achieve our vision for the future. Our values are:

- **Caring**, where we are kind to each other and always show compassion to ourselves and others
- **Fair** in that we treat people equitably and value their differences
- **Innovative** through working as a team to continuously improve the way we deliver and transform health care

Our on-going plans are based on four strategic priorities, which underpin our three year strategy:

- **Great Care** – To achieve outstanding health and care services
- **Great People** – To become the North West healthcare employer of choice
- **Great Research & Innovation** - To become an outstanding centre for research and innovation
- **Great Ambition –** To be a sustainable, valued and innovative partner.

Across Merseyside, deprivation and poor health affects many of our communities. Differences in healthy life expectancy and quality of life vary significantly. This is neither acceptable nor fair. The Trust plays a lead role both within the local health and care system working with partners, taking a population health management approach, to use data and healthcare expertise to provide more effective personalised care that reduces health inequalities and keeps more people healthier for longer. Our ability to work in partnership with others will be strengthened through the national NHS reforms which aim to remove some of the bureaucracy that can get in the way of joining up care. Published in February 2021, the Government's White Paper *Integration and Innovation* builds on work on-going across Merseyside and beyond to join-up health and care services through a new duty to collaborate and by formalising integrated care systems and partnerships. All NHS organisations will also

have a duty to have regard for the 'triple aim' of better health and wellbeing, better care and sustainable use of resources.

Details of the services provided at our hospitals are available on the Trust's website. The operational business model is represented through the following Care Divisions:

- Surgery
- Anaesthetics, Critical Care, Head & Neck and Theatres (ACHT)
- Acute & Emergency Medicine
- Diagnostics and Support Services
- Specialist Medicine

During the year, the Trust has closely monitored the risk of Brexit, specifically the implications for the Trust, both in the near term and further out. In order to mitigate these risks, a number of reviews were undertaken, for example, business continuity plans and review of capacity. Actions required for data protection and a financial impact analysis were also put in place.

A key element of the Trust's exciting future will be the completion of the new Royal Liverpool University Hospital, and work continues apace. During 2020/21 progress on site continued despite the social distancing measures required during the year to operate safely during the COVID-19 pandemic. The first of the new facilities, our new clinical sciences building was handed over to the Trust during 2020/21. The Board continues to monitor progress of the construction and also the move preparation plans, via its New Hospital Committee. Latest programme dates indicate a likely completion of the construction work and opening of the hospital in summer 2022.

(iv) Summary of principal risks

Key risks to the delivery of the Trust's objectives and associated controls are set out in our Board Assurance Framework (BAF). All risks entered onto the BAF are subject to a robust process of review and scrutiny which includes discussions at the relevant Board Committees and scrutiny by the Trust Board every quarter.

The following table (Table 1) summarises the principal risks that were assigned to the Trust's strategic objectives. These were identified and approved by the Board of Directors in September 2020.

Table 1: Principal Risks contained within the Board Assurance Framework

Strategic Objective	Risk Theme
Great Care	A failure to provide safe care
	A failure to provide effective care
	A failure to provide timely access to care
	A failure to provide a great experience for our patients
Great People	A failure to provide a great staff experience
	A failure to become a great place for healthcare professionals to learn and work
	A failure to improve recruitment and retention rate
Great Research & Innovation	A failure to deliver high quality research & innovation
	A failure to widen access to research opportunities
	A failure to embed a culture of research & innovation
Great Ambition	A failure to build upon successful partnerships
	A failure to consolidate sustainable services
	A failure to digitally enable the organisation
	A failure to achieve financial sustainability

Significant operational and clinical risks are identified, managed and monitored in accordance with our Risk Management Policy. This includes risks associated to the completion of the new Royal Liverpool University Hospital. Details of the key risks can be found in the Annual Governance Statement.

(v) Going concern disclosure

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.2 Performance Overview

In this section of the Annual Report we reflect on the most challenging of years, the steps we have taken to continue to offer timely access to care for patients and how we have prioritised those patients with Cancer or who are clinically urgent.

(i) COVID related performance

Throughout the three waves of COVID-19 experienced in our catchment population, the Trust's performance has been driven by the need to provide safe care, maintain access to care, be responsive to both COVID-19 and on-going patient needs, prioritise patients according to their clinical needs and to learn from the challenges and opportunities the COVID -19 pandemic has presented.

COVID-19 has required us to work differently and has put pressure on emergency and urgent care as well as on access to elective care.

The Trust has:

- Treated over 5,000 COVID-19 positive inpatients; with the highest number of COVID-19 positive inpatients at 571 on 25 January 2021
- Supported the discharge of over 5,000 patients via the Single Point of Contact service in collaboration with Merseycare NHS Foundation Trust and system partners
- Maintained access to 11,310 operations for patients with cancer or who are clinically urgent
- Worked with neighbouring trusts to offer 1,232 patients care via Mutual Aid
- Appointed 2,534 patients to urgent care services via NHS 111 First
- Expedited access to diagnostic tests for 6,682 patients who had tests delayed during COVID-19 first wave
- Managed bed occupancy at 98% during the peak of COVID-19 third wave in January 2021, and through system support have reduced occupancy by 10% in March 2021.

Table 2: Performance against Accident & Emergency Waiting (A&E) times 1 April 2020 to 31 March 2021

Accident and Emergency Waiting Times:		
Commitment/measure	**National standard**	**LUHFT 1 April 2020 to 31 March 2021**
* Patients should be admitted, transferred or discharged with four hours of arrival.	95% or above	85.8%
Emergency and urgent attendances (all types)	N/A	238,095
Attendances at emergency department (type 1)	N/A	177,680
Attendances of patients age 75 or over	N/A	28,173
Admissions from A&E	N/A	69,145

(*) Where percentages are used, there have been rounded to the nearest 0.1%
N/A indicates where no national target is available

Accident & Emergency (A&E) Departments at Aintree Hospital and the Royal Hospital have seen fluctuations in attendances over the course of the year reflecting the surges in COVID-19 demand and the periods of national and local lockdown. While this has resulted in less patients attending A&E, patients have been sicker and still required hospital admission.

A&E Departments have had to change the physical environment to minimise the risk of infection between patients and staff and provide clinical pathways that acknowledge the different clinical needs of COVID-19 patients.

As the first point of contact for many patients, A&E Departments have introduced the swabbing of patients for COVID-19 to then allow their care to be managed in accordance with their COVID- 19 status and underlying health needs.

(ii) Access to urgent care

This year has seen further development of initiatives to minimise the time a patient needs to spend in A&E or, where clinically appropriate, signpost patients to other services such as ambulatory care services. The introduction of NHS 111 First in November 2020 allows patients, via telephone or online, to either direct book an appointment in A&E, direct book an appointment in ambulatory care (Same Day Care) or be directed to other services that may be more appropriate. Up to 1,000 patients a month are booking urgent care through NHS 111 First services and urgent care teams continue to work with colleagues in the Trust and our wider healthcare system to develop services that can be directly booked by patients.

(iii) Cancer care

Table 3 –Performance against Cancer Care standards 1 April 2020 to 31 March 2021

Cancer Care:		
Commitment/measure	**National standard**	**LUHFT 1 April 2020 to 31 March**
*Maximum two week wait for first appointment for patients referred urgently for suspected cancer by a GP	93% or above	91.7%
*Maximum two week wait for first appointment for patients referred urgently with breast cancer symptoms	93% or above	87.2%
*Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	96% or above	94.8%
*Maximum 31 day wait for subsequent surgical treatment	94% or above	82.6%
*Maximum 31 day wait for subsequent treatment with anti-cancer drugs	98% or above	97.1%
*Maximum 62 day wait from urgent GP referral to first treatment for cancer	85% or above	68.6%
* Maximum 62 day wait for treatment for cancer following a consultant decision to upgrade their priority	85% or above	83.7%
*Maximum 62 day wait from referral from NHS screening service to first treatment for all cancers	90% or above	71.1%

(*) Where percentages are used, there have been rounded to the nearest 0.1%

Maintaining access to Cancer care for patients either with a suspicion of cancer or confirmed cancer has remained a priority. The Trust has worked collaboratively with all neighbouring providers and the Cheshire and Merseyside Cancer Alliance to share resources and ensure timely access to diagnostics and surgery for all patients.

In the first wave of COVID-19, referrals for patients with a suspicion of cancer reduced significantly. Since then, referrals have increased to levels much higher than those seen pre-COVID-19. Trust services have responded by increasing the number of clinics provided and increasing access to diagnostic tests.

Trust performance against all standards has continued to improve throughout the year and the pathway of every patient is reviewed to minimise delayed access to care.

Improvements in cancer services have not stopped during COVID-19. In fact services, such as community navigators, have been developed to reassure patients that services are safe and that timely access to service remains paramount.

The Trust continues to work with the Cancer Alliance and MacMillan to develop services. This year, this has included:

- Establishing a Rapid Diagnostic Centre for Head and Neck Cancers
- Expanding the Clinical Nurse Specialist role to manage the increase referrals to colorectal cancer services and early transition to personalised care
- Piloting and expanding patient rehabilitation; improving cardiovascular fitness, reducing hospital length of stay and improving patient psychological wellbeing
- Developing pre-cancer services for prostate and primary liver for patients who may initially have a clear cancer screen but are still at risk of developing cancer.

The Trust has appointed an Associate Director of Cancer Improvement to oversee the on-going development of cancer services.

(iv) Elective Care

Table 4 Performance against Elective Care Access targets 1 April 2020 to 31 March 2021

Elective Access:		
Commitment/measure	**National standard**	**LUHFT 1 April 2020 to 31 March 2021**
*Patients should start treatment within 18 weeks of referral	92% or above	58.9%
* Number of operations cancelled for non-clinical reasons	Less than 0.6% of all operations	0.40%
	Number of cancelled ops	221
Inpatients and day cases	N/A	55,833
Planned procedures	N/A	6,917
Unplanned procedures	N/A	90,701
Day case procedures	N/A	48,916
Outpatient appointments	N/A	733,994

(*) Where percentages are used, there have been rounded to the nearest 0.1%
N/A indicates where no national target is available

Throughout the three COVID-19 waves, the Trust's elective programme has, at times, been reduced to allow for the timely management of patients with COVID-19. The introduction of Infection and Prevention Control Guidance has also impacted the volume of patients we can treat in the same facilities. This has required innovation and collaboration to ensure priority patients can continue to access services.

Fewer patients have been referred to the Trust in-year, fewer patients have accessed elective care and fewer patients have had to come to the hospital for appointments.

The ways in which we have been supporting patients this year has changed to include:

- 40% of outpatient appointments are now delivered virtually, by telephone or video. Feedback from patients and clinicians has been positive and services will continue to be delivered in this way where clinically appropriate;
- Establishing community 'drive through' facilities for phlebotomy, reducing the need for patients to travel to hospital for blood tests;
- Staying in touch with patients who may have had their care delayed to make sure their condition is unchanged and reassure them their pathways continue to be managed;
- Working closely with patients to manage pre-operative care and reduce the need to cancel surgery for clinical or non-clinical reasons;
- Working with neighbouring providers and the independent sector to retain access to diagnostics and surgery in a number of services including Endoscopy, Radiology, Ophthalmology, Orthopaedics, Ear Nose and Throat (ENT), Breast Care, Urology, Vascular, Upper Gastrointestinal (GI) and Liver.

The restoration and recovery of the elective programme commenced in early March 2021 as the pressures of COVID-19 third wave diminished. All capacity for outpatients, diagnostics and theatres returned during April and May 2021.

(v) Clinical Performance Indicators

Table 5: Clinical Performance Indicators 1 April 2020 to 31 March 2021

Commitment/measure	National standard	LUHFT 1 Apr 2020 to 31 March 2021
Standardised Hospital Mortality Indicator (SHMI)	100	Dec 19 – Nov 20 105.34
*Patients admitted to hospital receiving a risk assessment for Venous Thrombo-Embolism	95%	93.0%
Cases of C. difficile	N/A	113
Cases of MRSA	N/A	4
Patient falls with Mod> harm per 1,000 bed days	N/A	0.098
Number of Cat 2 Pressure Ulcers	N/A	191
Number of Cat 3 Pressure Ulcers	N/A	22
Number of Cat 4 Pressure Ulcers	N/A	0
*Patients who would recommend our outpatient department to friends and family	N/A	93.9%
*Inpatients who would recommend our service to friends and family	N/A	92.1%
*Patients who would recommend our emergency department to friends and family	N/A	84.0%

(*) Where percentages are used, there have been rounded to the nearest 0.1%
N/A indicates where no national target is available

(vi) Environmental considerations

The Trust is committed to being an environmentally friendly and socially responsible organisation and recognises that some of our activities can have a significant impact on the environment. We continue to take action to ensure these activities are managed effectively to minimise any impact and to ensure that we comply with, or exceed, relevant statutory requirements. We have continued to implement measures during 2020/21 to reduce greenhouse gas emissions and during Q1 of 2021/22 will be developing and agreeing a new Sustainability Strategy.

(vii) Regard to the public sector equality duty

The Trust is committed to promoting and advancing equality of opportunity, celebrating and valuing diversity, eliminating unlawful discrimination, harassment and victimisation, and

promoting good relations between people with different protected characteristics. The Trust works to promote equality for all by reducing discrimination in employment on the grounds of the protected characteristics covered by the Equality Act 2020.

The Trust uses various measures to identify its focus and priorities which include staff survey results, national reporting (Gender Pay Gap reporting), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Delivery System 2 (EDS2) ratings and feedback from key stakeholders. The progress we have made towards meeting the requirements of the general equality duty can be found on our website.

Our policies reflect social, community and human rights issues, for example information governance and safeguarding of vulnerable persons. We have an Equality & Diversity policy and procedure for assessing impacts of significant change to our services on all those affected or vulnerable groups. During 2020/21 we have taken steps to ensure we meet the Trust's responsibilities under the Modern Slavery Act 2015, and further detail can be found under Voluntary disclosures.

We have systems in place to identify whether any incidents or complaints have occurred relating to human rights, equality and diversity issues and for initiating investigations accordingly.

(viii) Friends and Family Test

During what has been an incredibly challenging year, it has been critical that focus remains on both individual patient needs and the needs of the wider family. Given the importance of a relentless focus on infection prevention and control, it has not always been possible for family to remain with patients while they have been receiving care.

Every opportunity has been taken to work with patients and their families to retain contact by other means, including face timing using devices on the ward, introducing cancer navigators to support patients sharing cancer diagnoses with their families and offering virtual outpatient appointments.

Adapting how we have included families in the care of their relatives is reflected in the Friends and Family Test scores which remain high, and in line with previous years.

Table 6: Performance against Friends and Family Test 1 April 2020 to 31 March 2021

Commitment/measure	National standard	LUHFT 1 April 2020 to 31 March 2021
Patients who would recommend our outpatient department to friends and family	N/A	93.9%
Inpatients who would recommend our service to friends and family	N/A	92.1%
Patients who would recommend our emergency department to friends and family	N/A	84.0%

N/A indicates where no national target is available

Additional questions have been added to the Staff Family and Friends Test to gather data on protected characteristics. These relate to:

- Gender
- Ethnic background
- Sexuality
- Disability
- Caring responsibilities

However, the Trust does not currently correlate this data against the responses to the questions.

PART II
ACCOUNTABILITY REPORT

2. Accountability Report

2.1 Directors' Report

(i) Board of Directors

As an NHS Foundation Trust, we are required to comply with the arrangements set out by our independent regulator, NHS England and NHS Improvement (NHSE/I), in Monitor's NHS Foundation Trust Code of Governance (2010, revised 2014). The Code of Governance requires us to have a comprehensive framework in place to ensure we are managed and governed properly. We strive to comply with the provisions of the Code and will continue to observe the spirit of the Code in everything we do.

Our business is managed by the Board of Directors (the Board), which exercises all the powers of the Trust subject to any contrary provisions of the National Health Service Act 2006 and Health and Social Care Act 2012. The Board is responsible for approving the Annual Report and Accounts. In preparing the Annual Plan, the Board takes into account the views of the Council of Governors.

The Board of Directors gives specific attention to:

- Key performance information
- Reports on quality and safety, patient experience and care, operational activity, financial analyses and strategic matters
- Formal consideration of our compliance with NHSE/I's Well Led Framework and Code of Governance.

The balance between Executive and Non-Executive Directors on the Board remains in line with the Code of Governance for NHS Foundation Trusts and with our Standing Orders.

There were a number of changes to Board membership during the year, the details of which can be found in the Remuneration Report. There is also more detail about the background and experience of all individual Board members as at 31 March 2021 later in this section.

All Non-Executive Directors, Chief Executive and no more than six other Executive Directors were able to exercise one full vote in 2020/21. The Chair has second, casting votes on occasions where decisions are tied.

Board Directors have full and timely access to relevant information to enable them to discharge their responsibilities. The Board of Directors meets formally in public a minimum of eight times a year and in private to consider items that are commercial in confidence or that relate to identifiable individuals. There were no extra-ordinary meetings of the Board in public held during the year in addition to scheduled meetings. The Board is responsible for:

- Exercising powers and managing the performance of the Trust
- Providing active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed
- Compliance with NHS Provider Licence issued by NHSE/I, the sector regulator for health services in England
- Compliance with the Trust's Constitution
- Providing high quality and safe healthcare services, education, training and research

- Implementing effective governance measures
- Ensuring the Trust exercises its functions effectively, efficiently and economically
- Setting the Trust's vision, values and standards of conduct and ensuring that these are understood by staff, members, patients and other stakeholders
- Setting Trust policy
- Setting strategy for service development and improvement
- Preparing a statement of accounts for each financial year

The Board has a schedule of matters reserved for it that is detailed within the Standing Orders and Standing Financial Instructions. This clarifies which type of document requires approval by the Board and which can be approved and executed by executive management, under delegated authority. The Board may also delegate executive powers to Committees or through the Chief Executive Officer to individual officers.

The Board of Directors remains accountable for all of its functions even those delegated to Board committees, and these are clearly set out in the respective committees' terms of reference. These terms of reference are reviewed regularly by the Board. The Board has established the following committees which undertake detailed consideration of specific areas of reporting:

- Audit Committee
- Quality Committee
- Finance & Performance Committee
- Nominations & Remuneration Committee
- Charitable Funds Committee
- Research, Development & Innovation Committee
- Workforce & Education Committee
- New Hospital Committee

All Non-Executive Directors are members of at least one Board level Committee. Executive Directors' involvement in Board level Committees relates to their particular operational responsibilities.

As a unitary board, all Executive and Non-Executive Directors have joint responsibility for every decision of the Board and share the same liability. This does not impact upon the particular responsibilities of the Chief Executive Officer as Accountable Officer to Parliament, for ensuring that the Trust operates consistently within national policy and public service values.

All Directors have responsibility for the preparation of the financial statements. The Directors consider whether 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 our performance, business model and strategy.

The Board considers that its composition is appropriate with a balanced spread of expertise to fulfil its function and terms of authorisation, with the Chair and Non-Executive Directors meeting the independence criteria laid down in the NHS Foundation Trust Code of Governance. The Trust continued to ensure that all Board Directors met the criteria of the Fit and Proper Persons Test.

Table 7 below shows the members of the Board, their roles and attendance at the Board and Board Committees during the year.

Table 7: Attendance at Trust Board and Committees 2020/21

Name	Title	Board of Directors	Committees							
			Audit Committee	Nomination & Remuneration	Quality Committee	Finance & Performance	Charitable Funds	Research, Development & Innovation	Workforce & Education	New Hospital
Sue Musson	Chair	9/9		2/2	3/4					
Mike Eastwood	Non-Executive Director	9/9		2/2	12/12	12/12				
Tim Johnston	Non-Executive Director	9/9		2/2					5/5	13/13
Mandy Wearne	Non-Executive Director	9/9	8/8	2/2		12/12	5/5			
Louise Kenny	Non-Executive Director	7/9		1/2	4/9			6/6		
Neil Willcox	Non-Executive Director	9/9	8/8	2/2						11/13
Eustace de Sousa	Non-Executive Director	5/5		1/1	7/7	7/7				
Sheila Samuels	Non-Executive Director	5/5	3/3	1/1				2/2	4/4	
David Fillingham	Non-Executive Director	2/3		1/1	3/3	3/3				
Angela Phillips	Non-Executive Director	3/3	5/5	1/1						
Steve Warburton	Chief Executive	9/9			7/8					11/13
Rob Forster	Director of Finance	9/9				12/12	5/5	1/6	5/5	10/11
Beth Weston	Chief Operating Officer	9/9			12/12	12/12				12/13
Tristan Cope	Medical Director	9/9			12/12		0/5	5/6	3/5	
Dianne Brown	Chief Nurse	9/9			11/12		3/5	2/4	4/5	
Debbie Herring	Chief People Officer	9/9			11/12				5/5	

Notes

The Board of Directors met on nine occasions during 2020/21. Due to COVID-19, all meetings during the reporting period were undertaken virtually with members of the public able to attend on request from November 2020. The table shows attendance by members of the Committees not attendees.

Eustace de Sousa and Sheila Samuels were appointed from 01.9.20

David Fillingham's term of office ended Term of office elapsed 30.6.20

Angela Phillip's term of office ended on Term of office elapsed 30.9.20

Tristan Cope attendance details for the Charitable Funds Committee reflects the focus of the Medical Directors on COVID-19

The Chief Executive Officer is responsible for the annual performance appraisals of Executive Directors. The performance of the Chief Executive is reviewed by the Chair through an annual performance appraisal.

The Chair is responsible for ensuring that Non-Executive Directors have the necessary skill set and experience and for conducting an annual appraisal. The performance of the Chair is reviewed by Governors, Board of Directors and External Stakeholders. The Senior Independent Director leads the Chair's appraisal process with the arrangements agreed by the Council of Governors.

All Non-Executive vacancies are managed by the Council of Governor's Nominations Committee to ensure the Board has the necessary skills and experience required and that the Board is well balanced. The terms of office for both Chair and Non-Executive Directors is reviewed regularly to ensure succession planning is adequate and effective.

All Executive Director positions covering issues of recruitment, accountability and performance are managed by the Chief Executive in line with the Trust's organisational policies. The current appointment terms of Non-Executive directors and the contract start dates for Executive Directors and their remuneration, can be found in the Remuneration Report. Non-Executive Director appointments may be terminated on performance grounds or for contravention of the qualification criteria set out in the Constitution, with the approval of three-quarters of the members of the Council of Governors, or by mutual consent for other reasons.

For the year ending 31 March 2021, the Board comprised the following members:

Chair: Sue Musson

Sue Musson became Chair of Liverpool University Hospitals NHS Foundation Trust in October 2019. Prior to that, she was appointed as Chair designate of the interim Board for the merged Trust in July and was chair of the Royal Liverpool and Broadgreen University Hospitals NHS Trust from 1 September 2019 until the merger of the two trusts was completed.

Sue has nearly 25 years' board-level experience as an executive and non-executive director in commercial and public sector organisations, helping them improve their strategy, performance and organisational cultures. She has extensive experience of building local partnerships and of working collaboratively to integrate, develop and improve services.
Sue's term of office runs from 1 February 2020 to 31 March 2023.

Chief Executive Officer: Steve Warburton

Steve Warburton has been Chief Executive at Aintree University Hospital since 2015, where he was also previously Director of Finance and Deputy Chief Executive. Steve was appointed Chief Executive of the interim Board for the merged Trust in July 2019 and became Chief Executive of the Royal Liverpool & Broadgreen University Hospital NHS Trust in September 2019 prior to being appointed Chief Executive of Liverpool University Hospitals NHS Foundation Trust following merger in October 2019.

Non-Executive Directors:

Mike Eastwood (Deputy Chair)
Mike was appointed a Non-Executive Director at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 – he was previously interim Chair and Non-Executive Director at Royal Liverpool and Broadgreen University Hospitals NHS Trust. Mike is currently Diocesan Secretary (Chief Executive) of the Diocese of Liverpool as well as the Director of Operations at Liverpool Cathedral.

He has significant experience of working at director level in the third sector. He currently holds a number of voluntary positions supporting the church and local community development. Mike chairs the Finance and Performance Committee and is a member of the New Hospital and Nominations and Remuneration Committees.

Mike's term of office runs from 1 April 2020 to 31 March 2023.

Tim Johnston (Senior Independent Director)
Tim was appointed a Non-Executive Director at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 – he was previously Non-Executive Director at Aintree University Hospital NHS Foundation Trust having been appointed to the board in January 2013. He is a graduate economist and a chartered accountant. He is a major shareholder and Chair of AMION Consulting – an economics and business planning consultancy. Tim was previously the national partner in KPMG with responsibility for its Infrastructure and Government line of business. He was also a leading partner in KPMG's national regeneration team. He is Chair of Langtree Property Partners Ltd, a national commercial property developer and chairs The Big Trust Ltd.

Tim is chair of the New Hospital Committee and a member of the Workforce & Education and Nominations & Remuneration Committees.

Tim's term of office runs from 1st April 2020 to 31st March 2023.

Professor Louise Kenny
Louise is the Executive Pro-Vice Chancellor of the Faculty of Health and Life Sciences at the University of Liverpool and Deputy Chair of the Board of Liverpool Health Partners. Louise was previously a Professor of Obstetrics at University College Cork, Consultant Obstetrician and Gynaecologist at Cork University Maternity Hospital (2006 – 2018) and the founding Director of the Science Foundation Ireland funded Irish Centre for Foetal and Neonatal Translational Research.

Louise is chair of the Research, Development and Innovation Committee and a member of the committees for Quality and Nominations & Remuneration.

Louise's term of office runs from 1 April 2020 to 31 March 2023.

Mandy Wearne
Mandy was appointed a Non-Executive Director at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 – she was previously Non-Executive Director at Aintree University Hospital NHS Foundation Trust. Mandy set up her own independent company to inspire excellence in the quality of care experience. She has an extensive background in NHS leadership, management, clinical practice and public health, working in a variety of

health care settings. She has held a number of executive director roles, including health care strategy, performance, and provider and market development, as well as being policy advisor to the Department of Health (DH) on the development of social value led provider models.

As the first regional director of Service Experience in England in 2008, she led the DH Patient Experience Policy Programme working on the development of national indicators and a review of the national survey architecture. Acclaimed as a passionate and practical force for change, she was nominated for the NHS Inspiration Leadership Award in 2010. Mandy is committed to supporting NHS leadership and service experience improvement through her role as an executive coach and mentor to many aspiring and future leaders. Mandy chairs the Charitable Funds Committee and is a member of the committees for Finance & Performance, Audit and Nominations & Remuneration.

Mandy's term of office runs from 1 April 2020 to 31 March 2022

Neil Willcox
Neil was appointed a Non-Executive Director at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 – he was previously Non-Executive Director at Royal Liverpool and Broadgreen University Hospitals NHS Trust. Neil is a chartered accountant. He began work in the 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 chairs the Audit committee and is a member of the committees for the New Hospital and Nominations & Remuneration.

Neil's term of office runs from 1 April 2020 to 31 March 2022.

Eustace de Sousa
Eustace was appointed a Non-Executive Director at Liverpool University Hospitals NHS Foundation Trust on 1 September 2020.

Eustace has worked in social care, health and wellbeing for 20 years in the North West. He has managed adult and children's social services, and led a range of regeneration, community and housing programmes. He worked for the NHS in regional health authorities, overseeing health service performance and commissioning.

During 2013-2020 he worked at a national level for Public Health England, leading on health inequalities, child health and healthy ageing. He is now an independent Public Health Specialist Consultant and an Honorary Fellow at the Royal College for Paediatric and Child Health.

Eustace is chair of the Quality Committee and is a member of the committees for Finance and Performance and Nomination and Remuneration.

Eustace's term of office runs from 1 Sept 2020 to 31 August 2023.

Sheila Samuels
Sheila joined the Trust in September 2020 and has a wealth of experience in public sector management and leadership. She has previously held Executive and Non -Executive Director Board level roles in local government and the NHS.

As a Fellow of the Chartered Institute of Personnel and Development, Sheila has been instrumental in furthering effective Human Resource Management within organisations. Since retiring in 2013 after 35 years public service, Sheila has undertaken a number of consultancy assignments to support public sector and charitable organisations in addressing major organisational challenges.

Sheila also possesses an MSc in Humanitarian Studies gained from the Liverpool School of Tropical Medicine. As part of this she studied health systems in developing and post conflict countries. Such insight has given her a gratitude and passion to ensure the continued effectiveness and success of patient care.

Sheila is chair of the Workforce and Education Committee and is a member of the Audit, Research and Innovation and Nomination and Remuneration Committees.

Sheila's term of office runs from 1 Sept 2020 to 31 August 2023.

David Fillingham CBE
David was appointed a Non-Executive Director at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 with his term of office ending on 30 July 2020. He was previously Non-Executive Director at Aintree University Hospital NHS Foundation Trust. David was also the first Chief Executive of AQuA (Advancing Quality Alliance) from April 2010 to July 2019.

David joined the NHS in 1989 from a career in manufacturing. He went on to take a number of chief executive posts including Wirral FHSA, St Helens and Knowsley Health Authority, North Staffordshire Hospitals NHS Trust, and Royal Bolton Hospital NHS FT. From 2001 to 2004 David was Director of the NHS Modernisation Agency developing new ways of working and promoting leadership development across the NHS as a whole.

David's term of office ended on 30 July 2020.

Angela Phillips
Angela was appointed a Non-Executive Director at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 with her term of office ending on 30 September 2020. She was previously Non-Executive Director at Royal Liverpool and Broadgreen University Hospitals NHS Trust. Angela is a qualified chartered accountant and a senior board member and finance professional with experience in both the public and private sector leading major change projects. Angela was previously employed as the Director of Finance at the University of Bradford. She worked in different roles in NHS commissioning as well as senior roles in a private hospital group.

Angela's term of office ended on 30 September 2020.

Executive Directors

Chief People Officer: Debbie Herring
Debbie was appointed Chief People Officer at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 – she was previously Executive Director of workforce and Deputy Chief Executive at the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT).

Debbie has held various senior roles in the NHS including Director of Strategy and Development at Alder Hey Children's Hospital, Director of Strategy, Human Resources (HR) and Organisational Development (OD) at Liverpool Heart and Chest Hospital, Director of HR and Organisational Development at Aintree University Hospital and Director of HR and Organisational Development at the Countess of Chester Hospital. Debbie is a Chartered Fellow of the Chartered Institute of Personnel Development (CIPD) and is also the Vice Chair of NHS Employers' policy board.

Chief Operating Officer – Beth Weston
Beth was appointed Chief Operating Officer at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019. She was previously Chief Operating Officer at Aintree University Hospital. Beth joined Aintree University Hospital in April 2015 and was appointed acting Chief Operating Officer in October 2017 before becoming substantive on 1 February 2019. Beth previously worked at Central Manchester University Hospitals NHS Foundation Trust for 12 years and has a Masters in Managing Healthcare Organisations.

Chief Nurse: Dianne Brown
Dianne was appointed Chief Nurse at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 – she was previously Chief Nurse at Aintree University Hospital. Dianne trained in the 1980s with Wrightington, Wigan and Leigh NHS Trust and then chose to specialise in women's health, working at Billinge Hospital for 17 years in all areas of women's health.

An experienced board director, Dianne joined Aintree University Hospital in April 2017, following her previous role of Director of Nursing and Midwifery at Liverpool Women's NHS Foundation Trust which she held for three years. She has had a variety of leadership and managerial roles prior to her successful appointment as Chief Nurse.

Medical Director: Dr Tristan Cope
Tristan was appointed Medical Director at Liverpool University Hospitals NHS Foundation Trust on 1 October 2019 – he was previously Medical Director at Aintree University Hospital from April 2017. He graduated from the Aberdeen University in 1992 and subsequently trained in anaesthesia and intensive care medicine in North Wales and Merseyside.

He was appointed as a consultant in Anaesthesia and Critical Care at Aintree in 2001 and has held positions as Clinical Director of Critical Care, Clinical Head of Division of Surgery, Director of the Cheshire and Mersey Simulation Centre, and Deputy Medical Director. Tristan received a Master's degree in Medical Leadership from Birkbeck, University of London and holds an NHS Leadership Academy Award in Executive Healthcare Leadership.

He is a Fellow of the Royal College of Anaesthetists (FRCA), Fellow of the Faculty of Intensive Care Medicine (FFICM) and Fellow of the Faculty of Medical Leadership and

Management (FFMLM). In addition to his duties as Medical Director, Tristan continues to work part time as a consultant in Critical Care.

Chief Finance Officer: Rob Forster
Rob was appointed Deputy Chief Executive and Chief Finance Officer at Liverpool University Hospitals NHS Foundation Trust on 1 April 2020. He was previously Director of Finance and Deputy Chief Executive at Wrightington, Wigan and Leigh NHS Foundation Trust. After qualifying academically and professionally in Law, Rob then went on to become a Chartered Accountant with PricewaterhouseCoopers LLP and subsequently achieve a Master's in Business Administration.

Rob worked in a variety of senior finance and director roles within General Motors in both the UK and working and living in Europe for a number of years. Rob joined the NHS in 2009. In addition to his Trust role, Rob chairs the national Healthcare Financial Management Association Technical Issues Group, Cheshire & Merseyside provider Chief Finance Officer Group, Finance Skills Development Steering Group and is on the Board of The NHS Finance Leadership Council. Rob is passionate about advancing the inclusive reach and effectiveness of the Finance profession in the NHS and beyond with a special interest in innovation and Social Value.

(ii) Directors' Interests

Under the Trust's Constitution, members of the Trust Board are individually required to declare any interest which may conflict with their appointment as a Director of the Foundation Trust. The Board of Directors annually reviews its Register of Declared Interests.

Company directorships and other declarations including receipt of gifts and hospitality are declared by all Board members. The Trust has updated its Standards of Business of Conduct Policy to reflect guidance from NHS England and the full register of interests is available at: Board of Directors - Register of Interests | Liverpool University Hospitals (liverpoolft.nhs.uk).

(iii) Compliance with HM Treasury Policy

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

(iv) Political donations

The Trust did not receive any political donations during the reporting period nor in the previous financial year.

(v) Better payment practice code

The Trust endeavours to pay its suppliers within 30 days of receipt of goods or a valid invoice (whichever is later) in line with the Better Payment Practice Code and monitors performance against this target.

Table 8: Better Payment Practice Code performance 1 April 2020 to 31 March 2021

	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non NHS				
Total invoices paid in the year	139,190	684,271	171,423	475,099
Total invoices paid within target	80,263	486,693	91,219	309,080
Percentage of invoices paid within target	**57.7%**	**71.1%**	**53.2%**	**65.1%**
NHS				
Total invoices paid in the year	5,773	223,175	7,314	176,834
Total invoices paid within target	2,946	193,259	3,358	143,023
Percentage of invoices paid within target	**51.0%**	**86.6%**	**45.9%**	**80.9%**
TOTAL				
Total invoices paid in the year	**144,963**	**907,446**	**178,737**	**651,933**
Total invoices paid within target	**83,209**	**679,952**	**94,577**	**452,103**
Percentage of invoices paid within target	**57.4%**	**74.9%**	**52.9%**	**69.3%**

No interest was due or paid to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998.

(vi) NHS Improvement's Well Led Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

NHS Improvement has placed the Trust in Segment 2.

This segmentation information is the Trust's position as at 11 May 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHSI website.

During the year we have built upon the work described in the previous year's annual report to improve and integrated our governance arrangements. Due to the pressures of the COVID-19 response, the Trust has not undertaken a review against the Well-Led Framework during 2020-21.

During Q1 (2021/22), the Trust will undertake an independent review against elements of the Well-Led Framework with a full review scheduled for 2022/23.

The 2020/21 Internal Audit programme considered aspects of quality governance such as risk management, Board Assurance Framework, Review of Safety Standards for Invasive Procedures, CQC action planning, COVID-19 safety, Fit Testing and Safeguarding. All of these audits are intrinsic to the Well Led Framework. Progress against the improvement actions identified from these audits was monitored by the Audit Committee.

The Board received Integrated Performance Reports at each meeting providing analysed information in relation to operational performance, quality, people and finance. Further details on our performance can be found in the Integrated Performance Report.

Throughout the year, we have reported compliance against the NHS Oversight Framework in accordance with NHSE/I reporting requirements. There have been no exceptions to report during the year. The Trust met with NHSE/I during the year to review performance and quality but the frequency of these meetings was determined by the COVID-19 pandemic. You can find more about our quality governance in the Annual Governance Statement.

Details of our performance in relation to key health targets, our financial position, use of resources and other locally agreed targets can be found in the Performance Report. Details of how we are improving information for patients and carers, how we handle complaints and how we responded to patient and staff surveys can be found in the Quality Report which is published separately.

The Board agreed the 2019/20 annual report and accounts at its meeting in July 2020. The annual report was submitted to NHSE/I and was presented to Members and the general public at the Annual Members' Meeting in September 2020.

There are no material inconsistencies between the Annual Governance Statement, the Corporate Governance Statement and Annual Report arising from Care Quality Commission (CQC) planned and response reviews and action plans we have developed in response to the CQC Reports.

All NHS Trusts are required to register with the CQC. The Trust's current registration status, at the end of 2020/21, is registration without conditions. The Trust is currently registered as providing services across 22 locations.

The CQC undertakes checks to ensure that trusts are meeting the Fundamental Standards and Key Lines of Enquiry (KLOE) under safe, effective, caring, responsive and well-led. If the CQC has concerns that providers are non-compliant there are a wide range of enforcement powers that it can utilise which include issuing a warning notice and suspending or cancelling registration.

The CQC plan their inspections based on what they know about services. This includes whether they appear to be getting better or worse. The CQC conducted a focused inspection of the safe and well-led domains between 8 and 17 September 2020 due to information they had received.

A further focused, responsive inspection of the medical care core service took place on the 28th and 29th October 2020. During this inspection parts of safe, effective, caring and well-led key questions were reviewed.

On the 29 January 2021, the CQC published the final inspection reports following their inspections undertaken in September and October 2020. There were 28 actions noted that the Trust must take to comply with legal obligations and 25 should do actions recommended in these reports. Work at Board level and with divisional teams has resulted in 182 actions.

As these were focussed inspections, previous ratings given to Aintree University Hospital NHS Foundation Trust, prior to the acquisition of the Royal Liverpool and Broadgreen University Hospitals NHS Trust in October 2019 are still applicable to the Trust.

The Trust liaises closely with the CQC in order to provide regular updates on the work being undertaken to address any issues including those identified during inspections. During the reporting year, this included issues in relation to Gastroenterology.

Action Plan Update
The Trust had begun work on addressing the areas for improvement identified at the time of these inspections and is now working on all of the areas for improvement identified in the reports. There are a total of 182 actions of which 77 (42%) are currently complete. There are currently 105 outstanding actions to be completed on the CQC Improvement Plan. Monitoring of the improvement plan is undertaken by the Trust's Quality Committee.

(vii) Relations with Stakeholders

The Board recognises the importance of effective communication with a wide range of stakeholders, including Liverpool City Council's Health and Wellbeing Board which brings together partners from across Health and Social Care and the Scrutiny Committee

The Trust plays a lead role both within the local health and care system and as one of the major anchor institutions in the wider NHS. The Trust works with partners, taking a population health management approach, to use data and healthcare expertise to provide more effective personalised care that reduces health inequalities and keeps more people healthier for longer.

Our ability to work in partnership with others will be strengthened through the national NHS reforms which aim to remove some of the bureaucracy that can get in the way of joining up care. Published in February 2021, the Government's White Paper *Integration and Innovation* builds on work on-going across Merseyside and beyond to join-up health and care services through a new duty to collaborate and by formalising integrated care systems and partnerships. All NHS organisations will also have a duty to have regard for the 'triple aim' of better health and wellbeing, better care and sustainable use of resources.

(viii) Disclosure to Auditors

As far as the Directors are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

(ix) Joint Ventures and Subsidiary Companies

In July 2007, the Trust established a wholly owned subsidiary company called Liverpool Healthcare Limited. The purpose of this company is to provide community healthcare projects. As of 31 March 2021, the company had not commenced trading.

(x) Accounting Policies

The Trust's significant accounting policies are set out in Note 1 in the Notes to the Accounts of the full accounts included in this report. There were no material changes made to the accounting policies and all of the changes implemented were in line with the Department of Health & Social Care Group Accounting Manual (DHSC GAM).

Accounting policies for pensions and other retirement benefits are set out in a note to the accounts (Note 1.6) and details of senior employees' remuneration can be found in the Remuneration Report.

(xi) Compliance with Income Sources Restriction

The Trust has complied with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Other income received by the Trust in 2020/21 has had no adverse impact on the delivery of our services. The Trust is, therefore, compliant with Section 43(3A) of the NHS Act 2006.

Signed

Steve Warburton
Chief Executive Date: 23 June 2021

2.2 Remuneration Report

i. Annual Statement on Remuneration

The Trust has a Nominations & Remuneration Committee whose purpose is to develop, apply and monitor the remuneration and Terms of Service for Executive Directors.

The aim of the Nominations & Remuneration Committee is to ensure that there is a transparent process for determining pay for the Chief Executive and other Executive Directors. The Committee also recommends and monitors the level and structure of remuneration for the first layer of management below Board level, albeit that these roles may be remunerated within the terms and conditions for Agenda for Change or the Medical and Dental contract terms and conditions. The remit covers salary (including any performance related elements/bonuses or additional payments), benefits (e.g. lease cars, pensions) and contracted terms of employment (e.g. service contracts, terminations).

The Nominations & Remuneration Committee which is chaired by the Trust's Chair met twice times during the year.

Table 9: Attendance at the Nominations & Remuneration Committee 1 April 2020 to 31 March 2021

Core Members	12/06/2020	15/12/2020
Sue Musson	✓	✓
Mike Eastwood	✓	✓
Tim Johnston	✓	✓
David Fillingham	✓	
Louise Kenny	X	✓
Angela Phillips	✓	
Mandy Wearne	✓	✓
Neil Willcox	✓	✓
Eustace De Sousa		✓
Sheila Samuels		✓

Eustace de Sousa and Sheila Samuels were appointed from 01.9.20
David Fillingham's term of office ended Term of office elapsed 30.6.20
Angela Phillip's term of office ended on Term of office elapsed 30.9.20

On the recommendation of the Nominations & Remuneration Committee, the Trust retained independent advice on executive pay from an external company, Korn Ferry. The Committee was satisfied that Korn Ferry was independent since it operates at arms-length to the Trust, on a commercial basis and is a recognised advisor to the sector. No fees were paid during the reporting year.

The Trust's Nominations & Remuneration Committee considers each of the proposed salaries for Executive Directors at the time of their appointment. The Trust can demonstrate that it reviews remuneration on a regular basis and where new appointments are to be made, takes into account national benchmarking when setting remuneration levels.

The Trust does not have a Performance Related Pay policy, so performance-related bonuses are not applicable, nor are recruitment and retention premia applied to senior management roles.

During 2020/21, there have been no changes within the Executive Director team. The Nominations & Remuneration Committee has overseen the appointment to a number of Senior Managers.

The Nominations & Remuneration Committee also took into account the Trust's People Plan which sets out our commitment to promoting equality and inclusion.

ii. Remuneration Policy for Executive Directors and Very Senior Managers (VSM)

Executive Directors and other Board Directors' contracts of employment include a fixed annual salary payment, which is disclosed in the Annual Report and Accounts.

In September 2019 the Nomination and Remuneration Committee approved a pay framework for those employed on Very Senior Managers (VSM) contracts and terms and conditions. This framework complies with NHS Improvement's national guidance and sets out a formal and transparent process for benchmarking and agreeing Executive Director and VSM level pay. The principles in this framework have been followed in agreeing the remuneration of all Executive Directors and Very Senior Managers in the Trust. The framework was reviewed by the Nominations & Remuneration Committee in December 2020.

iii. Remuneration for the Chair and Non-Executive Directors

The remuneration and terms of service for the Chair and the Non-Executive Directors are set, in line with statute and the Trust's Constitution, by the Council of Governors and implemented locally by the Trust. The Council of Governors reviewed the remuneration of the Chair and Non-Executive Directors in September 2019, (assisted by benchmark data and advice provided by an external consultancy) and again in January 2020 (assisted by updated guidance published by NHS England / Improvement in September 2019).

iv. Future Policy Table

Executive Directors

Table 10: Future Policy Table Executive Directors

Element	Purpose and Strategy	Operation	Maximum
Salary	To attract and retain high calibre individuals and reflect level of responsibility	All the Executive Directors are remunerated based on a local VSM scale system which is reviewed annually	Change to basic salary is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements, to ensure parity across the Trust.
Taxable Benefits	To attract and retain high calibre individuals	This covers the provision of a lease car	There is no specific maximum set but costs including fuel and insurance excess in the event of an accident are met by the director
Pension Related Benefits	To attract and retain high calibre individuals	Directors are eligible for membership of the NHS pension scheme	In line with the NHS pension scheme

There is no link between individual performance and salary. However, should individual performance fall below the expected standard, it would be addressed through the Trust's performance management arrangements. All Executive Directors have clear objectives based upon the Trust business priorities

Non-Executive Directors

Table 11: Future Policy Table Non-Executive Directors

Fees Payable Additional	Fees Payable	Purpose and Strategy	Operation	Maximum
See Table 12	Annual allowance of £1,656 for the following posts:- • Deputy Chair • Senior Independent Director • Chair of Audit Committee	To attract and retain high calibre candidates	Reviewed by the Council of Governors Nominations Committee and any changes are approved by the Council of Governors	No maximum is specified but market rates are considered

v. Service contract obligations

Appointments to Executive Director positions are made in open competition and can only be terminated by resolution of the Board other than in cases of normal resignation. Directors hold permanent contracts with a standard six-month period of notice. Non-Executive Directors are appointed for a period of three years and can only be removed in accordance with Monitor's Code of Governance.

vi. Loss of office

All contracts for Executive Directors are substantive NHS contracts and are subject to the giving of six months' notice by either party. The Trust's normal disciplinary policies apply to Executive Directors, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff. In the eventuality of a senior manager's loss of office, the Chief Executive (for executive directors) or the Chair (for the Chief Executive) may alter, postpone or disallow any individual payment they deem appropriate. These actions must be supported by the Nominations & Remuneration Committee. There were no loss of office payments in the current year.

vii. Council of Governors' Nominations Committee

The Nominations Committee is chaired by the Trust's Chair and comprises of two Elected Governors and one Appointed Governor. The Senior Independent Director will deputise and chair the meeting when the Chair is being considered for appointment or the annual appraisal process for the Chair is under review. The membership is also supported by two additional elected governors on reserve and who are trained.

In addition, the Committee also has responsibility for the Removal of the Chair or another Non-Executive Director which requires the approval of three quarters of the members of the Council of Governors, on the recommendation of its Nomination Committee. This action

would only be taken in extreme circumstances once all other opportunities have been used to resolve issues.

Meetings of the Nominations Committee are held as deemed necessary by the Chair but not less than once a year. During the reporting year, the Nominations Committee met twice.

viii. Consideration of employment conditions elsewhere in the Foundation Trust

Details of remuneration are set out in the tables overleaf and have been subject to audit. The tables include the following:

- salaries and fees - annual basic pay
- taxable benefits – additional tax benefits
- pension-related benefits – the annual increase in pension entitlement, determined in accordance with the HM Revenue and Customs method.

The Trust's Nominations & Remuneration Committee considered each of the proposed salaries for the Executive Directors at the time of their appointment. The Trust can demonstrate that it reviews remuneration on a regular basis and, where new appointments are to be made, takes into account national benchmarking when setting remuneration levels.

Salary and Pension Entitlements of Senior Managers

Table 12: Remuneration 2020/21(Audited by PricewaterhouseCoopers LLP)

	Salary and Fees (bands of £5000)	All Taxable Benefits (Rounded to the nearest £100)	Annual Performance Related Bonuses (in bands of £5000)	Long Term Performance Related Bonuses (in bands of £5000)	All Pension Related Benefits (bands of £2500)	Total including Pension Benefits (bands of £5000)
	£000		£000	£000	£000	£000
Musson S, Chair	55-60	0	0	0	0	55-60
Johnston T, Non-Executive Director	10-15	0	0	0	0	10-15
Wearne M, Non-Executive Director	10-15	0	0	0	0	10-15
Fillingham D, Non-Executive Director (to 30/07/20)	0-5	0	0	0	0	0-5
Willcox N, Non-Executive Director	10-15	0	0	0	0	10-15
Eastwood M, Non-Executive Director	10-15	0	0	0	0	10-15
Phillips A, Non-Executive Director (to 30/09/20)	5-10	0	0	0	0	5-10
Kenny L, Non-Executive Director	10-15	0	0	0	0	10-15
Samuels S, Non-Executive Director (from 01/09/20)	5-10	0	0	0	0	5-10
de Sousa E,	5-10	0	0	0	0	5-10

	Salary and Fees (bands of £5000)	All Taxable Benefits (Rounded to the nearest £100)	Annual Performance Related Bonuses (in bands of £5000)	Long Term Performance Related Bonuses (in bands of £5000)	All Pension Related Benefits (bands of £2500)	Total including Pension Benefits (bands of £5000)
Non-Executive Director (from 01/09/20)						
Warburton S, Chief Executive	240-245	129	0	0	97.5-100	340-345
Forster R, Chief Finance Officer	190-195	0	0	0	67.5-70	260-265
Cope T,[1] Medical Director	200-205	0	0	0	150-152.5	350-355
Brown D, Chief Nurse	155-160	0	0	0	0	155-160
Weston B, Chief Operating Officer	155-160	0	0	0	120-122.5	275-280
Herring D, Chief People Officer	145-150	6,000	0	0	37.5-40	190-195

[1] The clinical element to T Cope's role equates to £25k

Table 13: Remuneration 2019/20 (Audited by PricewaterhouseCoopers LLP)

	Salary and Fees (bands of £5000)	All Taxable Benefits (Rounded to the nearest £100)	Annual Performance Related Bonuses (in bands of £5000)	Long Term Performance Related Bonuses (in bands of £5000)	All Pension Related Benefits (bands of £2500)	Total including Pension Benefits (bands of £5000)
	£000		£000	£000	£000	£000
Goodwin N, Chair (to 30/09/19)	20-25	0	0	0	0	20-25
Musson S, Chair (from 01/10/19)	30-35	0	0	0	0	30-35
Johnston T, Non-Executive Director	10-15	0	0	0	0	10-15
Wearne M, Non-Executive Director	10-15	0	0	0	0	10-15
Fillingham D, Non-Executive Director	10-15	0	0	0	0	10-15
Ryan K, Non-Executive Director (to 30/09/19)	5-10	0	0	0	0	5-10
Willcox N, Non-Executive Director (from 01/10/19)	5-10	0	0	0	0	5-10
Eastwood M, Non-Executive Director (from 01/10/19)	5-10	0	0	0	0	5-10
Phillips A, Non-Executive Director (from 01/10/19)	5-10	0	0	0	0	5-10
Kenny L, Non-Executive Director (from 01/10/19)	5-10	0	0	0	0	5-10
Warburton S, Chief Executive	205-210	500	0	0	115-117.5	320-325

	Salary and Fees (bands of £5000)	All Taxable Benefits (Rounded to the nearest £100)	Annual Performance Related Bonuses (in bands of £5000)	Long Term Performance Related Bonuses (in bands of £5000)	All Pension Related Benefits (bands of £2500)	Total including Pension Benefits (bands of £5000)
Jones I, Interim Chief Finance Officer (to 31/03/20)	130-135	0	0	0	27.5-30	160-165
Cope T,[2] Medical Director	185-190	0	0	0	150-152.5	335-340
Smithson A, Deputy Chief Executive/Integration Director (to 31/08/19)	60-65	0	0	0	45-47.5	110-115
Brown D, Chief Nurse	135-140	0	0	0	0	135-140
Hoyte R, Director of HR & OD (to 12/07/19)	35-40	1,800	0	0	0	35-40
Weston B, Chief Operating Officer	140-145	0	0	0	120-122.5	265-270
Herring D, Chief People Officer (from 01/10/19)	65-70	5,600	0	0	37.5-40	110-115

[1] The clinical element to T Cope's role equates to £24k

1 S Musson remuneration includes £4k relating to her role as chair designate during the period 1 July 2019 to 30 August 2019, prior to being appointed chair.

Pension Benefits (Audited by PricewaterhouseCoopers LLP)

"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."

Table 14: Pension Benefits

	Real Increase in Pension at age 60 (bands of £2500)	Total Accrued Pension at age 60 at 31 March 2021 (bands of £5000)	Real Increase in related lump sum at age 60 (bands of £2500)	Related lump sum at age 60 at 31 March 2021 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2021 (To nearest £1000)	Cash Equivalent Transfer Value at 1 April 2020 (To nearest £1000)	Real Increase / (Decrease) in Cash Equivalent Transfer Value (To nearest £1000)	Employers Contribution to Stakeholder Pension (To nearest £100)
	£000	£000	£000	£000	£000	£000	£000	£
Warburton S, Chief Executive	5-7.5	80-85	5-7.5	175-180	1,638	1,533	78	0
Forster R, Chief Finance Officer	2.5-5	35-40	0	0	510	434	69	0
Cope T, Medical Director	7.5-10	60-65	15-17.5	135-140	1,143	956	171	0
Brown D, Chief Nurse								
Weston B, Chief Operating Officer	5-7.5	45-50	10-12.5	105-110	846	713	120	0
Herring D, Chief People Officer	2.5-5	55-60	5-7.5	130-135	1,179	1,054	107	0

As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accumulated 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 the 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 pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. The CETV values at 1 April 2020 and 31 March 2021 may have been calculated using different methodologies, any change could have impacted the real increase in CETV figures. 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.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

ix. Governors/Directors receiving expenses

During 2020/21 there have been 31 Governors with no Governors submitting an expense claim. The total amount of expenses paid to governors in 2020/21 was £0. In 2019/20, the amount of expenses paid was £0. Due to COVID-19, meetings and activities involving Governors were undertaken virtually.

During 2020/21 there have been 16 directors (10 Non-Executive Directors and 6 Executive Directors in office. Two directors (1 Non-Executive Director and 1 Executive Director) submitted expense claims. The total amount of expenses paid to directors in 2020/21 was £440. In 2019/20, 16 directors submitted expense claims with the amount of expenses paid was £5,027.

x. Senior managers paid more than £150,000

All of the Trust's Executive Directors are paid more than £150,000, the threshold considered a suitable benchmark for NHS Foundation Trusts. The Trust can demonstrate that it reviews remuneration on a regular basis and, where new appointments are to be made, takes into account national benchmarking when setting remuneration levels.

xi. Median remuneration

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 2020/21 was £242,500 (2019/20, £207,500). This was 7.9 times (2019/20, 6.9) the median remuneration of the workforce, which was £30,615 (2019/20, £30,112) as audited by PricewaterhouseCoopers LLP. The Trust's Remuneration Committee undertook a review of VSM remuneration in December 2020. The review which took into account benchmarking data from across the NHS including trusts of similar size and complexity resulted in increases to remuneration levels. Details of remuneration are set out in Table 12.

In 2020/21, one employee received remuneration in excess of the highest-paid director (in 2019/20 this was 10 individuals). Remuneration of this employee was £259k (2019/20: £211k – £290k).

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

xii. Payments for loss of office

- Exit Packages

NHS Foundation Trusts are required to disclose summary information of their use of exit packages in the year. The exit payments were calculated in accordance with contractual terms based on length of service.

The tables below set out the analysis, as audited by PricewaterhouseCoopers LLP:

Table 15: Exit Packages 2020/21 (Audited by PricewaterhouseCoopers LLP)

Reporting of other compensation schemes - exit packages 2020/21 (LUHFT)			
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages**
	Number	**Number**	**Number**
<£10,000	1	28	29
£10,001 - £25,000		6	6
£25,001 - 50,000	1	1	2
£50,001 - £100,000	2	3	5
£100,001 - £150,000			0
£150,001 - £200,000			0
>£200,000			0
Total number of exit packages by type	**4**	**38**	**42**
Total resource cost	**£175,000**	**£417,000**	**£592,000**

Table 16: Exit Package 2019/20 (Audited by PricewaterhouseCoopers LLP)

Reporting of other compensation schemes - exit packages 2019/20 (AUHFT& LUHFT)			
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages**
	Number	**Number**	**Number**
<£10,000		32	32
£10,001 - £25,000		2	2
£25,001 - 50,000	3	2	5
£50,001 - £100,000	1	2	3
£100,001 - £150,000			0
£150,001 - £200,000	1		1
>£200,000			0
Total number of exit packages by type	**5**	**38**	**43**
Total resource cost	**£347,000**	**£320,000**	**£667,000**

- Non compulsory

The table below provides details of the number of non-compulsory departures which attracted an exit package agreed in the year and the values of the associated payments by individual type:

Table 17: Exit Packages (non-compulsory) 2020/21 (Audited by PricewaterhouseCoopers LLP)

Exit packages: other (non-compulsory) departure payments – 2020/21 (AUHFT & LUHFT)	**2020/21 Agreements**	**2020/21 Total value of agreements**	**2019/20 Payments agreed**	**2019/20 Total value of agreements**
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs	2	153	2	107
Early retirements in the efficiency of the service contractual costs			3	90
Contractual payments in lieu of notice	36	264	33	123
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT approval*				
Total**	**38**	**417**	**38**	**320**
of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary				

xiii. Payments to past senior managers

During the reporting period the Trust did not make any payments of money or other assets to any individual who was not a senior manager during the financial year but has previously been a senior manager at any time.

Signed

Steve Warburton
Chief Executive Date: 23 June 2021

2.3 Staff Report

i. Staff overview

Our staff, volunteers, students and contractors of the Trust are the reason for our continued success. Our workforce is the key to ensuring we continue to deliver high quality care. Without them we would not be able to deliver the standard of care, or offer the range of clinical services, that we do. We have great people.

Through our ongoing commitment to deliver our People Plan we are dedicated to ensuring that we give our staff the best experience in order to support them to provide the best possible care.

We continue to develop how we embed our values and behaviours into the Trust's ethos. Our values and associated behaviours are:

- **Caring**, where we are kind to each other and always show compassion to ourselves and others
- **Fair** in that we treat people equitably and value their differences
- **Innovative** through working as a team to continuously improve the way we deliver and transform health care.

Our values and behaviours underpin the way we all work in order to consistently deliver the best quality of service. We strive to achieve exceptional engagement and leadership. We continue to recognise the great work that individuals and teams carry out via in a number of ways, and have recognised the outstanding work of our staff during COVID-19 by providing treats and meal/drink vouchers.

ii. Analysis of Staff Costs

This is set out in the tables below:

Table18: Staff Costs 2020/21

Staff Costs 2020/21: (Audited by PricewaterhouseCoopers LLP)

	2020/21 Permanently Employed £000	2020/21 Other £000	2020/21 TOTAL £000
Salaries and wages (including bank and locum staff)	499,490	40,744	**540,234**
Social security costs	45,636	4,132	**49,768**
Apprenticeship Levy	2,572	0	**2,572**
Employer's contribution to NHS Pensions	76,510	3,236	**79,746**
Employer's contribution to National Employer Savings Trust	95	0	**95**
Termination benefits	417	0	**417**
Agency / contract staff	0	17,036	**17,036**
Total	**624,720**	**65,148**	**689,868**

Table19: Staff Costs 2019/20

Staff Costs (2019/20 – AUHFT & LUHFT): (Audited by PricewaterhouseCoopers LLP)

	2019/20 Permanently Employed £000	2019/20 Other £000	2019/20 TOTAL £000
Salaries and wages (including bank and locum staff)	320,432	17,692	**338,124**
Social security costs	28,690	2,426	**31,116**
Apprenticeship Levy	1,587	0	**1,587**
Employer's contribution to NHS Pensions	49,934	1,880	**51,814**
Employer's contribution to National Employer Savings Trust	87	0	**87**
Termination benefits	667	0	**667**
Agency / contract staff	0	14,376	**14,376**
Total	**401,397**	**36,374**	**437,771**

iii. Analysis of Staff Numbers

This is set out in the tables below:

Table20: Staff Numbers 2020/21

Staff Numbers 2020/21: (Audited by PricewaterhouseCoopers LLP)

	2020/21 Permanently Employed	2020/21 Other	2020/21 TOTAL
Medical and dental	1,597	136	**1,733**
Administration and estates	3,334	101	**3,436**
Healthcare assistants and other support staff	2,215	453	**2,668**
Nursing, midwifery and health visiting staff	3,120	217	**3,337**
Scientific, therapeutic and technical staff	993	43	**1,036**
Healthcare Science Staff	695	17	**712**
Total average numbers	**11,954**	**968**	**12,922**

Table21: Staff Numbers 2019/20

Staff Numbers (2019/20 – AUHFT & LUHFT): (Audited by PricewaterhouseCoopers LLP)

	2019/20 Permanently Employed	2019/20 Other	2019/20 TOTAL
Medical and dental	1,452	153	**1,605**
Administration and estates	2,623	149	**2,772**
Healthcare assistants and other support staff	1,268	432	**1,700**
Nursing, midwifery and health visiting staff	3,888	206	**4,094**
Scientific, therapeutic and technical staff	2,258	55	**2,313**
Total average numbers	**11,489**	**995**	**12,484**

iv. Year-end data on gender split

The following tables provide a high level summary of the diversity of our workforce in context:

Table 22: Gender Split 31/03/2021

Role Category	Female	Male	Grand Total
Chair	1	0	1
Executives	3	3	6
Non Executives	3	4	7
Senior Managers (Band 8b and above, including Consultants) *	568	825	1,393
All other staff	10,775	2,804	13,579
Grand Total	11,350	3,636	14,986

*Senior Manager is defined as Agenda for Change Band 8b and above including Consultants

Table23: Age Profile 31/03/2021

Age Band	Headcount
<=20 Years	274
21-25	1,615
26-30	1,987
31-35	1,754
36-40	1,686
41-45	1,588
46-50	1,583
51-55	1,714
56-60	1,535
61-65	915
66-70	264
>=71 Years	71
Grand Total	14,986

Table 24: Ethnicity 31/03/2021

Ethnicity	Headcount
Asian	1,004
Black	339
Mixed	195
Not Specified	1,221
White British/ Irish	11,857
White Other	370
Grand Total	14,986

Table 25: Staff Gender 31/03/2021

Gender	Headcount
Female	11,350
Male	3,636
Grand Total	14,986

Table 26: Disability 31/03/2021

Disability	Headcount
No	10,223
Not Declared	805
Prefer Not To Answer	3
Unspecified	3,562
Yes	393
Grand Total	14,986

At 31 March 2021 the Trust Board of Directors had fourteen voting members, seven male and seven female. Women represent 40.77 per cent of senior staff at band 8b and above.

The current Trust headcount at 31 March 2021 was 14,986. Female employees comprised 75.8 per cent of the workforce and 24.2 per cent were male.

It became mandatory for public sector organisations with over 250 employees to report annually on their Gender Pay Gap. The gender pay gap describes the difference between the average earning of all the women in the Trust compared to the average earnings of all the men in the Trust. This is not the same as equal pay, which is about ensuring men and women doing the same or comparable jobs are paid the same. Analysis for 2021 indicates that for our Trust there is a mean hourly pay gap in favour of men of 32.5 per cent. This pay gap is largely accounted for by the fact that we have a male dominated workforce in senior medical (consultant) posts.

This submission will be the first report published as a merged organisation and therefore comparisons are not available.

Table 27: Gender Pay Gap 2020/21

	Mean Hourly Rate 2020	Median Hourly Rate 2020
Female	£16.01	£14.49
Male	£21.21	£15.60
Difference	£5.20	£1.11
Pay Gap %	**32.5%**	**7.7%**

High level actions in place to address this gap include:

- Continue to deliver on our People Plan which prioritises equality, diversity and inclusion
- Consider how we can attract more men into the organisation to work in unregistered roles and attract more women into the medical workforce to create a more gender balanced workforce
- Raise awareness of shared parental leave entitlements and flexible working opportunities for all
- Continue to provide career developments opportunities for all staff.

Information about the Trust in relation to the gender pay gap can be found on the Cabinet Office website at https://gender-pay-gap.service.gov.uk/.

v. Sickness absence data

Data for average sick days per full time equivalent (FTE) and staff turnover is provided by the Department of Health and Social Care and is published by NHS Digital at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

vi. Staff policies and actions applied during the financial year

Policies relating to our staff continued to be reviewed and updated throughout 2020/21. The Trust's policies, including the Recruitment Policy ensure that training, career development and promotion opportunities are equally available to the Trust's disabled employees. The Trust takes all reasonable steps to make adjustments and remove barriers that put disabled workers at a disadvantage. These policies are formally consulted upon and agreed in conjunction with our staff side colleagues.

The Trust is proactive in its focus and efforts to be an inclusive employer and promote equality and diversity for our patients and staff. Throughout the year our Equality Diversity & Inclusion (EDI) Group and the Ethnic Minority Strategic Group has directed, supported and celebrated our progress.

The EDI Group also oversees the development and delivery of the Workforce Race Equality Standard (WRES) and The Workforce Disability Equality Standard (WDES). The Trust publishes the data from both assessments and this can be accessed at: https://www.liverpoolft.nhs.uk/about-us/reports-and-publications/workforce-race-equality-standard-wres/

https://www.liverpoolft.nhs.uk/about-us/reports-and-publications/workforce-disability-equality-standard-wdes/

vii. Communication with staff and opportunities for involvement

Staff engagement is a priority for the Trust. It is an important element in our ability to deliver consistently high quality clinical services. Part of our underpinning workforce strategy is to employ caring and cared for staff.

The Trust is committed to involving staff in decision-making, engaging them on key developments and keeping them informed about changes across the organisation.

We use a range of well-established communications channels to ensure that all staff are aware of both internal and external developments that may affect the Trust. These include a regular briefing from the Chief Executive and a weekly email bulletin to all staff. Our Intranet pages provide access for staff to Trust policies, guidance and online resources and our Corporate Induction programme acts as a valuable source of information to all new starters within the Trust. The Trust Management Group also holds monthly briefing meetings with members of the Clinical Divisions and Corporate Departments.

The Trust has a well-established Partnership Forum where management and union representatives meet to discuss Trust-wide workforce issues. Through this forum, policies and procedures are formally agreed and wider views sought on a broad range of subjects that may affect staff, including formal consultation on areas of organisational change. During 2020 additional (weekly) Staff Partnership meetings were set up to review and address all COVID-related staff issues and ensure swift, responsive action to resolve issues for staff during a difficult period.

The Trust's Council of Governors is another forum for consultation, membership of which includes staff representatives.

We recently received the results of our 2021 Staff Survey and are actively reviewing this feedback to identify themes so that we can work with our staff to improve their experience at work. More detail on our results is included at section xii.

The Trust's Freedom to Speak Up Guardian (FTSU), supported by a number of Freedom to Speak Up Champions, have focused on expanding our support infrastructure for employees wishing to raise concerns. Their contact details can be found on the website and are publicised on posters across the organisation. Regular communication bulletins including profiles of the Trust Guardian have been issued to increase awareness of these roles.

The Trust participates in the staff Friends and Family Test on a quarterly basis as well as undertaking a full census staff survey once a year. Despite the challenges due to COVID-19, the Trust Executive Team continues to spend time in clinical and non-clinical departments to take the opportunity to meet with staff and listen to their feedback.

Additional Staff Partnership meetings took place during the COVID-19 period and were chaired by the Chief People Officer. Virtual Trust wide team briefings have been held on a monthly basis Membership included senior operational and clinical management and both local and regional union representatives. Issues raised were fed back to the Trust Executive Team and the Board of Directors was informed about issues and appropriate action taken.

In recognition that some staff with a protected characteristic had specific concerns about their own health and that of their families during the pandemic, virtual session were held with the Trust psychologist and Occupational Health experts to address concerns and provide a safe space for them to be heard.

Staff engagement is measured in the NHS by nine questions in the Staff Survey broken down into three themes of motivation, involvement and advocacy. The scores are combined to create an overall engagement score out of 10.

This year's overall score was **6.9**, compared **to 7.0** last year and an average score of 7.0.

Performance overall has not declined significantly but is worse than average in a number of areas including:

- Looking forward to going to work
- Opportunities to make a difference in own department and use initiative

However, staff still feel more confident than average that they would be happy for friends or family to be treated at LUHFT.

There are local departmental variations which will be addressed in local action plans.

viii. Health & Safety and Occupational Health

The Trust's People Plan includes a commitment to promoting wellbeing to ensure that we identify and proactively manage risks to the health, safety and wellbeing of our staff to prevent harm and promote long term health.

To achieve this we have in place robust health and safety management systems to ensure that risks to health and safety are identified, evaluated and controlled to minimise harm.

An annual health, Safety and Security report is presented to the Quality Committee along with a regular report relating to staff incidents and employer and public liability claims.

The table below shows the number of incidents reported over the last two years involving staff (including bank / agency) and contractors. In addition to monitoring incident data centrally, it is monitored at divisional level via formal governance management processes. Increased levels of reporting was due to the impact of COVID-19.

Table 28: Incident Reporting 2020/21

Total number of incidents by work group	2020/21	2019/20
Accident/Incident involving contractor	100	133
Accident/Incident involving member of staff	2401	1807
Total number of incidents	2501	1940

The Trust offers comprehensive wellbeing support with a range of interventions for our staff. The impact of COVID19 has identified the clear need for enhanced psychological support for the workforce and during 2020/21 the Occupational Health and Wellbeing Team (OHWB) have proactively facilitated targeted interventions aligned to protected characteristics and our vulnerable workforce.

At the start of the pandemic there was recognition that traditional routes would not be enough to support staff at this time. A Staff Psychological Service was developed using trained Trust psychologists. In addition to this 40 staff volunteers were trained in Psychological First Aid. The Trust has also promoted a number of holistic initiatives including financial health and wellbeing support, safeguarding support for staff at risk of domestic abuse and the promotion of physical and nutritional activities available online.

The Trust has ensured that COVID-19 Risk Assessments were undertaken for all staff and those staff identified as clinically vulnerable have been supported to work from home or re-deployed into alternative roles. Support has been provided to these staff members for their safe return to the workplace after a period of shielding.

ix. Policies and Procedures for countering fraud and corruption

The Trust does not tolerate any form of fraud, bribery or corruption by, or of, its employees, associates or any person or body acting on its behalf. Maintaining fraud levels at an absolute minimum ensures that more funds are available for patient care and services.

The Trust engages Merseyside Internal Audit Agency to provide its Local Counter Fraud Specialist (LCFS) to support the Board of Directors' commitment to maintaining an honest and open culture, ensuring that all concerns involving potential fraud have been identified and rigorously investigated. In all cases appropriate civil, disciplinary and / or criminal sanctions have been applied, where guilt has been proven. This supports the embedding of deterrence and prevention measures across the organisation.

The Trust's Audit Committee agrees the annual work plan for the LCFS and receives routine reports on progress against its delivery. The Committee has agreed the Trust's policy for dealing with suspected fraud, bribery and corruption and the Trust's Standards of Business Conduct Policy.

x. Diversity and inclusion policies, initiatives and longer term ambitions

The Trust continues to be proactive in our focus and efforts to be an inclusive employer and promote equality and diversity for our patients and staff.

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

The Trust is committed to promoting and advancing equality of opportunity, celebrating and valuing diversity, eliminating unlawful discrimination, harassment and victimisation, and promoting good relations between people with different protected characteristics. The Trust works to promote equality for all by reducing discrimination in employment on the grounds of the protected characteristics covered by the Equality Act 2010. Throughout the year our Equality Diversity & Inclusion (EDI) Group and the Ethnic Minority Strategic Group has directed, supported and celebrated our progress in relation to the Trust's strategic approach to meeting the relevant duties set out in the Equality Act 2010, and the duties embedded in the NHS Equality Delivery System

The Trust uses various measures to identify its focus and priorities, these include staff survey results, national reporting (Gender Pay Gap reporting), WRES (Workforce Race Equality Standard), WDES (Workforce Disability Equality) Standard, EDS2 (Equality Delivery System 2) ratings and feedback from key stakeholders.

As a Trust we are continually building our capabilities to ensure we provide the best possible care and give our staff the best possible experience. The COVID-19 pandemic has shone a spotlight on existing social and health inequalities and we recognise that this has a disproportionate impact on our Ethnic Minority colleagues.

Some of the actions and achievements of the past year are:

- Commissioned an external cultural assessment to understand and improve the experience of our ethnic minority colleagues
- Identified our EDI gaps and developed a solutions analysis
- Developed an anti-racism and discrimination strategy
- Invested in EDI posts to support the implementation of the strategy
- Delivered Unconscious Bias & Bystander Training to senior leaders within the organisation to support meaningful conversations about equality and diversity
- Established a career coaching, mentoring programme for staff from diverse backgrounds
- Established a cohort of Disability Ambassadors
- Developed an apprenticeship strategy that will promote the recruitment of staff that are reflective of our local community
- Worked with local schools to provide cadetships and widen participation for the Trust.

xi. Staff Turnover

Data for staff turnover is provided by the Department of Health and Social Care and is published by NHS Digital at
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

xii. Staff Survey

The NHS Staff Survey is the largest survey of staff opinion in the UK. It is carried out annually to gather the views of staff experience at work in a number of key indicators. The survey is administered electronically and completely anonymous. Indicators are measured on a scale of 10 and we are benchmarked against the average score of other similar trusts.

This annual survey provides invaluable information to ensure that the views of staff are heard and appropriate responses are provided. The Trust is benchmarked in the combined acute and community Trust group.

The response rate was as follows with comparator data for acute and community trusts:

Table 29: NHS Staff Survey 2020/21

Site	2019	2020	Similar Org Average
LUHFT		44%	45%
Aintree	51%		
Royal	44%		

The benchmarked findings of the 2020 survey are presented across a number of theme scores (scored out of 10) as outlined in the following table. For the 2020 survey there were only ten themes as the Appraisal theme was deliberately excluded in line with guidance from professional bodies including the Nursing & Midwifery Council (NMC) and General Medical Council (GMC):

Table 30: NHS Staff Survey 2020/21 - Themes

	2020/21		2019/20			2018/19		
	LUHFT	Average	Aintree	Royal	Average	Aintree	Royal	Average
Equality, Diversity & Inclusion	9.1	9.1	9.2	9.1	9.0	9.2	9.2	9.1
Health & Wellbeing	6.0	6.1	5.7	5.9	5.9	5.9	6.2	5.9
Immediate Managers	6.6	6.8	6.8	6.9	6.8	6.7	6.8	6.7
Morale	6.0	6.2	6.1	6.1	6.1	6.0	6.1	6.0
Quality of Appraisals	Excluded this year due to COVID-19		5.4	5.3	5.6	5.6	5.8	5.4
Quality of Care	7.6	7.5	7.5	7.7	7.5	7.4	7.6	7.4
Safe Environment – B&H	8.2	8.1	8.1	8.1	7.9	8.0	8.1	7.9
Safe Environment – Violence	9.4	9.5	9.4	9.5	9.4	9.3	9.3	9.4
Safety Culture	6.6	6.8	6.7	6.7	6.7	6.6	6.7	6.7
Staff Engagement	6.9	7.0	7.0	7.0	7.0	6.9	7.0	7.0
Team working	6.4	6.5	6.6	6.6	6.6	6.5	6.6	6.5

Of the ten themes in the 2020 benchmarked report, two scored above average:

- Quality of Care – Place to receive treatment
- Safety of Environment – Bullying and Harassment

There were three themes where the Trust deviated (negatively) more than 1 point from the average:

- Immediate Managers
- Morale
- Safety Culture

Key issues relating to Immediate Managers show that staff want the following to improve:

- Managers to provide regular feedback to staff on their work
- Managers to seek feedback from staff before taking decisions that affect staff members' work
- Managers to find out from the staff how they want their work to be valued and recognised.

Key issues relating to Morale show that staff want the following to improve:

- Regularly encourage staff in a way that they find motivating – need to ask them what this looks like for them at local and individual level where possible
- Wherever possible, allow staff the freedom to choose how they do their work – set clear outcomes or objectives but allow the staff to decide how those objectives are achieve
- Involve staff in decision making – use suggestion boards, survey tools, feedback posters, team meetings and staff survey data to inform decisions.

Key issues relating to Safety Culture show that staff want the following to improve:

- Review processes relating to the reporting of incidents to understand how they are applied and where any unfairness may occur and embed the framework of values and behaviours into processes; hold focus groups with staff involved in recent incidents to explore their experience and identify possible improvements
- Ensure that feedback is given to staff who have reported incidents – review all tools used for incident reporting to identify how the process is working and where feedback can be improved – important to note that feedback must be understood not just provided
- Review patient and service user processes to ensure that this is acted upon and equally importantly that this is fed back to staff.

To address the issues raised by the survey, a number of actions are being taken:

- The development of a Trust wide action plan to ensure matters are dealt with systematically
- Implementation of the three targeted actions described above
- The development of staff engagement action plan templates for use at local level
- Agreement with Operations to monitor completion of local action plans via operational management structures with plans to check progress in June and September 2021
- Agreement with Communications to provide regular information to staff about what actions are being taken as a result of their feedback
- Staff Survey briefings for managers followed by workshops to support development of local action plans (voluntary for managers)
- Development of reports, templates and detailed guidance on acting on staff feedback
- Areas of greatest challenge invited individually to develop their action plans with direct input from HR and OD
- Appointment of Board level Wellbeing Guardian (Chair of the Workforce & Education Committee) in line with the NHS People Plan
- Ethnic minority and disabled staff experience to be explored with FTSU Guardian and at Staff Experience Operational Group for targeted actions.

Local action plans cover the following points:

- Employee relations data such as sickness absence, turnover, mandatory training, appraisal etc.
- Questions regarding how departments will communicate and engage with staff about their results

- Questions relating to staff engagement
- Questions relating to how departments will address Trust level key theme challenges (immediate managers, morale and safety culture)
- Space to record and share any improvements
- Sections on supporting the Workplace Race Equality Scheme and the Workplace Disability Equality.

Due to the response to COVID-19 we have worked to improve both health and wellbeing support through the provision of psychological support, home working, up skilling training programmes and the vaccination programme. The establishment of a Staff Psychology Service with directly employed psychologists will enable to Trust to better respond to the local mental health needs of staff.

Work to implement the actions specified above are being undertaken by the Trust during quarters 1 & 2 (2021/22). Progress against the delivery of expected outcomes is monitored through the Trust' Workforce & Education Committee with issues escalated to the Board of Directors where required. Details of the Trust's full survey results are available at www.nhsstaffsurveys.com.

xiii. Trade Union Facility Time Disclosures

The Trust has a Partnership Working Agreement (including Trade Union Recognition, Facilities and Time Off Provisions in place). The Trust recognises its responsibility under this agreement to afford time off work and other agreed facilities to trade union representatives, to allow them to discharge their responsibilities under this agreement.

The Trust has two full time union officials, however due to COVID-19 the individuals provided support to clinical services. Within the reporting period, approximately 50% of time was focused on clinical duties.

The breakdown of hours spent by the relevant union officials during the reporting period is included in the graphs below:

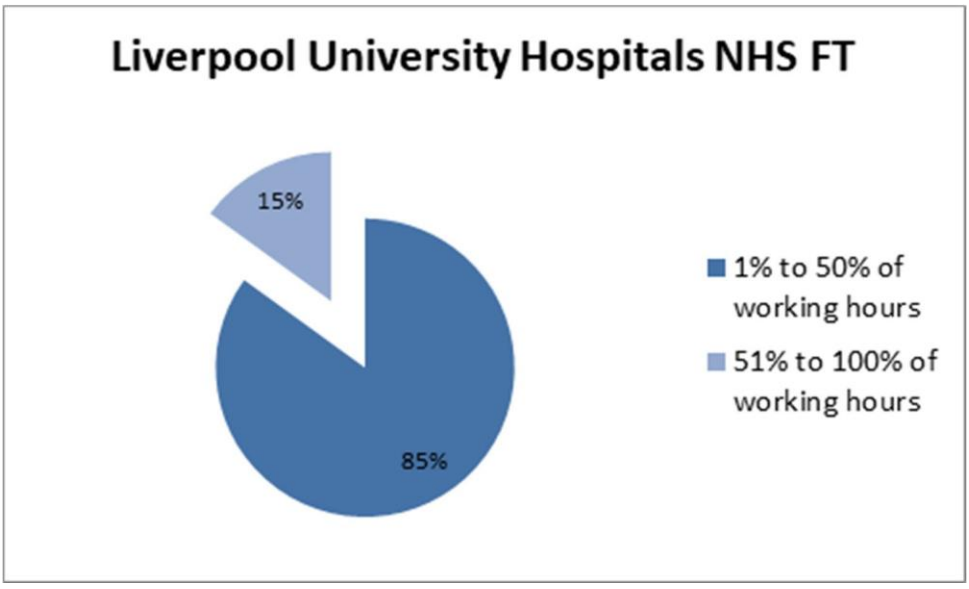


Table 31: Trade Union Facility Time

Percentage of Pay bill spent on facility time:	0.25%
Time spent on paid trade union activities as a percentage of total facility time:	13,191.20

xiv. Consultancy

During 2020/21, the Trust spent £2,545,000 on consultancy, this largely related to costs associated with the Trust hosting the North West Health and Care Partnership. During 2019/20, the Trust spent £1,035,000 on consultancy.

xv. High paid off payroll arrangements disclosures

The Trust is required to publish information about any off-payroll engagements that cost more than £245 per day and that last longer than six months.

All Trust Board-level appointments are included on the payroll. The Trust only uses off-payroll engagements where there is a genuine commercial requirement to allow the Trust to buy in specialist skills on a short term basis, for which no internal expert exists and for which the Trust would have no long term requirement.

Table 32: Highly-paid off-payroll worker engagements as at 31 March 2021 earning £245 per day or greater:

Number of existing engagements as of 31 March 2021	11
Of which…	
No. that have existed for less than one year at the time of reporting	7
No. that have existed for between one and two years at the time of reporting	4
No. that have existed for between two and three years at the time of reporting	0
No. that have existed for between three and four years at the time of reporting	0
No. that have existed for four or more years at the time of reporting	0

All of the existing off-payroll engagements, as outlined in the table above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 33: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2021	13
Of which:	
Not subject to off-payroll legislation	0
Number assessed as within the scope of IR35	1
Number assessed as not within the scope of IR35	12
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 34: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and / or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	16

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

i. Code of Governance Overview

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

The statement confirms that the Trust complies with all provisions of the Code of Governance.

NHS foundation trusts are required to provide a specific set of disclosures in their annual report to meet the requirements of the Code of Governance. Schedule A to the Code of Governance specifies everything that is required within these disclosures.

Schedule A is divided into six categories:

1. statutory requirements of the Code of Governance but do not require disclosures
2. provisions which require a supporting explanation, even where the NHS foundation trust is compliant with the provision*
3. provisions which require supporting information to be made publicly available, even where the NHS foundation trust is compliant with the provision
4. provisions which require supporting information to be made to governors, even where the NHS foundation trust is compliant with the provision
5. provisions which require supporting information to be made to members, even where the NHS foundation trust is compliant with the provision and
6. other provisions where there are no special requirements as per 1-5 above and there is a "comply or explain" requirement. The disclosure should therefore contain an explanation in each case where the trust has departed from the Code of Governance, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code of Governance (see pages 13-16 of that document).

* Where the information is already contained within the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

The information in the paragraph and table below only covers items falling into category 2 and category 6 above.

The requirements of parts 2 and 6 of schedule A to the Code of Governance are listed below. This table also includes requirements that are not part of the Code of Governance but are required by the FT ARM.

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
2: Disclosure	Board and Council of Governors	A.1.1	There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the CoG (as described in Section B). This statement should also describe how any disagreements between the CoG and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the CoG operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.	The Board meets in public at least eight times a year, in addition to this regular Board Workshops/development sessions are held. Matters reserved for the Board are included in the Trust's Standing Orders and Scheme of Reservation and Delegation which were reviewed approved by the Audit Committee in January 2021 and is subject to an annual review. Annex 7 of the Trust's Standing Orders outlines the process for resolving disputes between the COG and the Board of Directors. The roles and responsibilities of governors are contained in the Trust's Constitution which was last revised in October 2019.	Council of Governors Report Directors Report
2: Disclosure	Board, Nomination Committee (s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	The annual report will identify the Chair, Deputy Chair, Chief Executive, the Senior Independent Director and the Chair and members of the Nominations, Audit and Remuneration Committees. Records are maintained by the Corporate Governance Team of the number of meetings of the Board and Committees with a summary of meeting attendance included in the annual report	Directors Report Nominations Committee Report Audit Committee report Remuneration Report

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
A2: Disclosure	Council of Governors	A.5.3.	The annual report should identify the membership of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed and the duration of their appointments. The annual report should also identify the lead governor.	The annual report contains the relevant information as per the disclosure requirements of the Accountability Report.	Council of Governors Report Directors Report
Additional requirement of FT ARM	Council of Governors	N/A	The annual report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors	The annual report contains the relevant information as per the disclosure requirements.	Council of Governors Report
2: Disclosure	Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent.	The Trust's Constitution sets out the authorised numbers for voting Board members. In addition, the Trust's Standing Orders sets out the statutory roles of the Board of Directors. A declaration relating to the independence of the Non-Executives was provided to the Board in May 2020 and members confirmed that they were satisfied that all Non-Executives met the requirements.	Directors Report
2: Disclosure	Board	B.1.4	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	The Directors Report of the annual report identifies the skills and knowledge of board members and the balance and completeness as to the requirements as a Board of a Foundation Trust. Directors' biographies are contained on the Trust's internet site.	Directors Report
Additional Requirement of FT ARM	Board	N/A	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	The Directors Reports of the annual report identifies the length of appointment and how they may be terminated	Directors Report

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
2: Disclosure	Nominations Committee	B.2.10	A separate section of the annual report should describe the work of the nominations committees including the process it has used in relation to board appointments.	The annual report describes the work of the Remuneration and Nominations & Remuneration committees. Both committees have clear terms of reference which are reviewed appropriately.	Nominations Report
Additional requirement of FT ARM	Nominations Committee	N/A	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director	The annual report describes this requirement	Nominations Committee Report
2: Disclosure	Council of Governors	B.3.1	Chairpersons other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	The recruitment process for the Chair takes into consideration any significant commitments of candidates and the Nomination and Remuneration Committee would consider if these were material. The Chair completes an annual declaration of interest and any significant changes would be reported to the Council of Governors	Directors Report
2: Disclosure	Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	The Trust's Membership Strategy sets out how the governors engage with the members and public. Activity during 2020/21 was limited due to the COVID-19 pandemic. The Cycle of Business for the Council of Governors defines the items that will be presented to the Governors in relation to the forward plans of the trust. Governors have the opportunity through their attendance at Board meetings to raise questions in relation to key strategies and plans that the Board are considering.	Council of Governors Report

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				A statement will be included in the annual report to describe this process	
Additional requirement of FT ARM	Council of Governors	N/A	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	N/A	N/A
2: Disclosure	Board	B.6.1	The Board of directors states in the annual report how performance evaluation of the board, its committees and it its directors including the Chair person is conducted	The Board considers its performance at the end of all Board formal meetings. Through the review of the terms of reference of the Committees consideration is given as to whether they remain effective in discharge their role. This is also considered when the Standing Orders and Financial Instructions are reviewed.	Directors Report
2: Disclosure	Board	B.6.2	Where there has been external evaluation of the Board and/or governance of the trust, the external	A Well Led assessment of the Trust was most recently undertaken in June 2019 with details included within the	Directors Report

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	annual report. The Trust is planning to undertake a further external evaluation during 2021/22.	
2: Disclosure	Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report)	The disclosures in the annual report detail the Directors response in line with NHS FT ARM. The Annual Governance Statement specifically refers to quality governance.	Directors Report Annual Governance Statement
2: Disclosure	Board	C.2.1	The Board of directors should maintain continuous oversight of the effectiveness of the NHS FTs risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.	The Board of Directors conducts an annual review of effectiveness of its internal control systems supported by its Internal Auditors. The Trust's Risk Management Strategy and contains a section on risk appetite and the level of risk that the Board is prepared to take in pursuing its strategy. The Board of Directors receive the Board Assurance Framework quarterly.	Annual Governance Statement

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				As Accountable Officer, the Chief Executive has responsibility for maintaining a sound system of internal control which is detailed within the Annual Governance Statement and included in the annual report.	
2: Disclosure	Audit Committee/control environment	C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Reference to Internal Audit is detailed within the Annual Governance Statement. The annual report is prepared in compliance with the requirements detailed within the FT Annual Reporting Manual.	• Annual Governance Statement • Annual Report Audit & Risk Committee
2: Disclosure	Audit Committee/ Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Issue has not arisen but the requirements contained in the Code are noted.	Audit & Risk Committee
2: Disclosure	Audit Committee	C.3.9	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; an explanation of how it has assessed	The required section will be included in the annual report with the Annual Governance Statement relating to the work in year of the Audit Committee.	Audit & Risk Committee

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.		
2: Disclosure	Board/ Remuneration Committee	D.1.3.	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	None of the Executive Directors holds non-executive roles or received remuneration for other roles. Table 12 of the Annual Report would cover any relevant related party payments.	Remuneration Report
2: Disclosure	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the CoG, direct face-to-face contact, surveys of members' opinions and consultations.	The Non-Executive Directors are in attendance at Council of Governors Meetings to hear the views of governors and members. Governors also regularly attend meetings of the Board in order for them to observe the discussion and to have direct access to Board members.	Directors Report Council of Governors Report
2: Disclosure	Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. This information should be used to	The Council of Governors approved a revised Membership Strategy in June 2020 which sets out how the Trust will measure effective engagement with its members. The Membership and Engagement Committee is a sub-	Membership Report

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			review the trust's membership strategy, taking into account any emerging best practice from the sector.	committee of the Council of Governors	
2: Disclosure	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and or directors/ should be made clear on the Trust's website and in the annual report.	The Trust's website provides details of how members can contact their governor.	Council of Governors Report
Additional requirement of FT ARM	Membership	N/A	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	The requirements are set out within the Membership Report	Membership Report
Additional requirement of FT ARM (based on FReM requirements	Board/Council of Governors	N/A	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and	This information is provided within the annual report with a link to the Trust website.	Directors Report Council of Governors Report which signpost to the Trust's Register of Interest

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.25 as directors' report requirement.		
6. Comply or explain	Board	A.1.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	The Trust's strategic framework was developed to ensure compliance with national and local healthcare standards are integral to objectives from Board to team level. Delivery of these objectives is monitored via assurance reporting to the Quality Committee and Finance & Performance Committee. The Board of Directors measures and monitors the Trust's performance through the Integrated Performance Report (IPR). The IPR provides evidence of performance against defined metrics required by the NHS Oversight Framework. The IPR provides assurances on current and historical performance relating to quality, effectiveness, finance, operational performance, and organisational health. It also includes information relating to performance against peers, national comparators and its strategic goals. The Board also receive reports from the	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				executive outlining any changes to targets/standards and guidance as they arise.	
6. Comply or explain	Board	A.1.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and, in particular, in high risk or complex areas, independent advice, for example, from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	The Integrated Performance Report is aligned to the NHS Oversight Framework and provides the Board with evidence of performance against key metrics and milestones. This is reviewed at each Board meeting and is underpinned by more detailed dashboards and assurance reports at Committee level. An agreed internal audit plan, to review areas of risk or required assurance is developed between senior management and executive directors, and approved by the Audit Committee. When required, independent 'deep dives' or reviews are commissioned to provide additional assurance.	Compliant
6. Comply or explain	Board	A.1.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where within the structure of the organisation, consideration of clinical governance matters occurs.	The Trust publishes its Quality Account on an annual basis, and this sets out its priorities for improving quality for the year ahead in line with national directives. The Board has established a Quality Committee that meets regularly and receives appropriate reports on clinical effectiveness, patient safety, infection prevention and control, clinical risk. This Quality Committee also receives a	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				quality dashboard which provides key trends across KPI's at a divisional level. Whilst the Quality Committee oversees the overall system of clinical governance, the Audit Committee approves the Clinical Audit Programme which is designed to test clinical standards throughout the Trust. A new Quality & Safety Strategy is being developed with support from the Dalton Consultancy and is due to be approved by the Board of Directors in June 2021.	
6. Comply or explain	Board	A.1.7	The Chief Executive as the accounting officer should follow the procedure set out by Monitor for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	The Chief Executive is fully aware of their responsibilities as Accounting Officer and follows the procedure as set out by NHS Improvement.	Compliant
6. Comply or explain	Board	A.1.8	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).	The Trust has an approved Constitution and has a Standards of Business and Personal Conduct policy which references the Nolan Principles. The Trust last reviewed and updated its Constitution during 2019 and the amendments were approved by the Board and the Council of Governors.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				The Trust values underpin the Trust's strategic objectives and the leadership approach taken by the organisation.	
6. Comply or explain	Board	A.1.9	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.	The terms and conditions of employment/service for board members are subject to the Trust's Standards of Business and Personal Conduct Policy. Members of the Trust Board make an annual declaration regarding their individual interests. In addition, as a standing agenda item at each board meeting members are required to declare any conflicts of interests relevant to the agenda. The Board meetings are open to the public and Governors All minutes of meetings and key papers are published on the Trust website and only those papers which are specifically exempt under the FOIA are unpublished.	Compliant
6. Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	The Trust has in place professional indemnity insurance via NHS Resolution Liability that covers decisions taken by directors.	Compliant
6. Comply or explain	Chair	A.3.1	The chairperson should, on appointment, by the council of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be chairperson of the same NHS foundation trust.	The Chair's appointment is approved by the Council of Governors and as part of the process the independence of the Chair is confirmed. The Chair was not previously a Chief Executive of the Trust	Compliant
6. Comply or	Board	A.4.1	In consultation with the council of	The role of Senior Independent Director	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
explain			governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channel of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	is undertaken by a current Non-Executive Director who is also the NED contact for Freedom to Speak Up. The Senior Independent Director is available to all Directors if they have concerns and they attend meetings of the Council of Governors. They are available to Governors should they have concerns that cannot be raised through the normal channels. The appointment of Tim Johnson as Senior Independence Director was agreed by the Nomination and Remuneration Committee of the Council of Governors and approved by the Council of Governors at its meeting on 12 March 2020 for a term of 3 years.	
6. Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson at least annually to appraise the chairperson's performance and on such other occasions as are deemed appropriate.	During 2020/21 the Chair met virtually with Non-Executive Directors without the Executive Directors present on several occasions to update on the strategic direction of the Trust. The Trust's Lead Governor and Senior Independent Director (SID) meet on an annual basis to appraise the Chair's performance. An appraisal meeting took place between the Senior Independent Director, the Lead and Deputy Lead Governors in November 2020. The Lead and Deputy Lead Governors who represented the council collectively.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				The outcomes were presented to the Council of Governors at its meetings 10th December 2020.	
6. Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	The role of the Senior Independent Director is available to support the escalation of concerns. All Board members are encouraged to articulate their views in Board meetings and the minutes clearly and accurately reflect this. All Executive Directors have regular 1:1's with the Chief Executive and therefore the opportunity to raise concerns and also recognise that they have access to the Chair. No such concerns arose during the reporting period.	Compliant
6. Comply or explain	Council of Governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year, Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	The Council of Governors meets on a quarterly basis. Meetings are scheduled at a time and location convenient for the majority of governors. Due to the COVID-19 pandemics, meetings during the reporting period were undertaken in virtual form. In cases of non-attendance, steps are taken to address this informally prior to seeking a formal resolution through the Trust's Constitution	Compliant
6. Comply or explain	Council of Governors	A.5.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and	The structure and size of the Council of Governors was reviewed and agreed by task and finish Groups of the former trusts AUH and RLBUHT Shadow Governors in 2019. The decision on the	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			procedures of the council of governors should be reviewed regularly.	Council of Governors were made based on majority vote of the task and finish group and the results reflected in the Constitution which was agreed by the Board of Directors	
6. Comply or explain	Council of Governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	The roles and responsibilities of the Council of Governors are set out in the Trust's Constitution. Governors also receive a 'Governors' Handbook' providing information about their role and the Trust. This was updated in February 2021 and circulated to governors	Compliant
6. Comply or explain	Council of Governors	A.5.5	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant directors present at the meeting about the affairs of the NHS foundation trust.	The Chief Executive attends all meetings of the Council of Governors and the executive directors attend as the agenda requires. The Non-Executive Director Committee Chairs are in attendance and available to answer queries in relation to the activity of each Committee.	Compliant
6. Comply or explain	Council of Governors	A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the new provider licence or other matters related to the overall wellbeing of the NHS	The Trust's Constitution includes a statement relating to the handling of disputes. The Council of Governors approved the appointment of the Senior Independent Director in 2019.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			foundation trust. The council of governors should input into the board's appointment of a senior independent director.		
6. Comply or explain	Council of Governors	A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting of advance meeting agendas and, where possible, using clear, unambiguous language.	The cycle of business for the Council of Governors is structured to support the governors in discharging its role and defines the reports that it will receive throughout the year. Governors comment on this and request further agenda items that they require.	Compliant
6. Comply or explain	Council of Governors	A.5.8	The council of governors should exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	This has not been tested however there is a clear process in place contained within the Trust's Constitution in the event that this action was required.	Compliant
6. Comply or explain	Council of Governors	A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example, clinical statistical data and operational data.	The cycle of business for the Council of Governors is structured to support the governors in discharging its role and defines the reports that it will receive throughout the year. Governors comment on this and request further agenda items that they require. Governors have provided feedback on the quarterly performance report that they receive. Papers from the Board of Directors are published on the Trust's website and available to governors	Compliant
6. Comply or explain	Board	B.1.2	At least half the board of directors, excluding the chairperson, should	The composition of the Board is set out in the Trust's Constitution. This requires	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			comprise non-executive directors determined by the board to be independent.	the number of Executive Directors not to outnumber the number of Non-Executive Directors including the Chair. The Board is made up of 8 Non-Executive Directors including the Chair and 6 Executive Directors.	
6. Comply or explain	Board/ Council of Governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	The Standing Orders (Annex 5 paragraph 4.2)/Employment Contracts prevents an individual holding office as both director and governor at the same time.	Compliant
6. Comply or explain	Nominations Committee	B.2.1	The Nomination Committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The Nomination Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board.	The Remuneration Committee has responsibility for Chief Executive and Executive Directors appointments and terms & conditions. Upon identification of a vacancy, the skills requirement is considered prior to drafting a job description and recruitment process taking place. In the case of the appointment of the Chief Executive this is then referred to the Nomination, Remuneration Committee of the Council of Governors before receiving final approval by the full Council. All Non-Executive Director roles are considered by the Nomination, Remuneration Committee of the Council of Governors	Compliant
6. Comply or explain	Board/ Council of Governors	B.2.2	Directors on the board of directors and governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and	All Non-Executive and Executive Directors and, Deputy Directors are subject to the 'fit and proper' test which is undertaken as part of the appointment process.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			application criteria, 'fit and proper' persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). In exceptional circumstances and at Monitor's discretion an exemption to this may be granted. Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations.	There is an annual revalidation process in place which is reported to the Board. Governors complete a declaration as part of the election process and a declaration of interest is made upon appointment	
6. Comply or explain	Nominations Committee	B.2.3	There be may one or two Nominations Committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The Nominations Committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the Nominations Committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors, and, in light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	The Trust has a Remuneration Committee for considering executive director appointments and terms & conditions. The Nominations and Remuneration Committee of the Council of Governors is responsible for the appointment and terms and conditions of Non-Executive Directors/Chair appointments. The Committee reviewed the Board skills matrix in July 2020 as part of the appointment process for the new Non-Executive Directors.	Compliant
6. Comply or explain	Nominations Committee	B.2.4	The chairperson or an independent non-executive director should chair the Nominations Committee.	Both Remuneration Committee and the Nominations & Remuneration Committee are chaired by the Trust	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				Chair	
6. Comply or explain	Nominations Committee/ Council of Governors	B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the Nominations Committee should make recommendations to the council of governors.	The Nominations Committee and Council of Governors have an agreed process for the nomination of a new Chair and other Non-Executive Directors. Recommendations made by the Nominations Committee are considered for approval by the Council of Governors.	Compliant
6. Comply or explain	Nominations Committee	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist only of a majority of governors. If only one nominations committee exists, when nominations for non-executive, including the appointment of the chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	The Nominations & Remuneration Committee of the Council of Governors is made up of 3 governors and the Chair of the Trust. Terms of Reference are in place outlining its membership and remit.	Compliant
6. Comply or explain	Council of Governors	B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The Council of Governors received a report outlining the process for the appointment of Non-Executive Directors 21st July 2020. The process took into consideration the views of the Board and external stakeholders.	Compliant
6. Comply or explain	Council of Governors	B.2.8	The annual report should describe the process followed by the council of governors in relation to appointments of the chairperson and non-executive	The Remuneration Report of the Annual Report sets out the process for the Chair and Non-Executive Directors.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			directors.		
6. Comply or explain	Nominations Committee	B.2.9	An independent external adviser should not be a member of or have a vote on the Nominations Committee(s).	The Terms of Reference for the Remuneration Committee clearly define membership as restricted to the Non-Executive Directors with provision for others to attend as the agenda requires.	Compliant
6. Comply or explain	Board	B.3.3	The board of directors should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation.	The Declaration of Interest process requires all Directors to declare their outside interests. The Standards of Business Conduct policy deals with outside employment and no outside employment can be sought without prior agreement from the Board.	Compliant
6. Comply or explain	Board/ Council of Governors	B.5.1	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decision they have to make. The board of directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	The covering sheet of Board papers provides clarity over a paper's salient points and the action required during the meeting. The Board and Council of Governors have an annual cycle of business to ensure that all key governance information is presented in the appropriate manner at the relevant time. Further in depth information is provided to the Board assurance committees. All committee terms of reference allow for members to call upon other staff members to attend to answer queries and/or provide information.	Compliant
6. Comply or explain	Board	B.5.2	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They	The SFIs/SORD contains the provision for all board members to obtain professional advice where appropriate.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.	During 2020/21 a mix of internal and external assurance has been used to provide analysis of complex and high risk issues.	
6. Comply or explain	Board	B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decision to appoint an external adviser should be the collective decision of the majority of directors. The availability of independent external sources of advice should be made clear at the time of appointment.	The SFIs/SORD allow for the provision of professional advice where appropriate. External advice will only be sought if deemed appropriate by all members.	Compliant
6. Comply or explain	Board/ Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of governors is provided with sufficient resource to undertake its duties with such arrangements agreed in advance.	The Trust Secretary is responsible for ensuring that there is adequate resource to support the Board and its committees and the Council of Governors through the Corporate Governance Team. The Corporate Governance Team	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				structure has been reviewed in 2020 to ensure that the Board, its Committees and the Council of Governors have sufficient and effective support to enable them to undertake their duties.	
6. Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson within a framework agreed by the council of governors and taking into account the views of the directors and governors.	The appraisal process for the evaluation of the Chair is undertaken by the Senior Independent Director and the Lead Governor in line with the Trust's approved appraisal process. The outcome is reported to the Nomination and Remuneration Committee of the Council of Governors.	Compliant
6. Comply or explain	Chair	B.6.4	The chairperson, with the assistance of the Company Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties.	The board development agenda is set jointly by Executive and Non-Executive Directors to include whole day sessions, Board days with key partner organisations and personal development including executive coaching. Sessions during 2020/21 have included: Developing the Trust's enabling strategies including Digital, Communication and Engagement , People, and Financial Planning	Compliant
6. Comply or explain	Chair/ Council of Governors	B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on: • Holding the non-executive	The Trust periodically undertakes an effectiveness review of the Council of Governors via a self-Assessment to enable them to identify their skills and knowledge needs. The resulting actions are captured and reported to the Council of Governors and following this an improvement plan e developed and monitored by the Council of Governors.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			directors individually and collectively to account for the performance of the board of directors • Communicating with their member constituencies and the public and transmitting their views to the board of directors; and • Contributing to the development of forward plans of the NHS foundation trust. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.		
6. Comply or explain	Council of Governors	B.6.6	There should be clear policy and fair process, agreed and adopted by the council of governors for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both	The Trust's Constitution provides for the removal of any governor who fails to attend more than 3 meetings of the Council of Governors and outlines how governors may seek an independent view of such decisions. However for the 20020/21 year it is recognised that the COVID-19 pandemic inhibited the ability of some Governors to attend meetings and therefore treated each case on its own merits. At its meeting of 10th Dec 2020 the Council of Governors approved its Code of Conduct which provides clear guidance on the standards of conduct and behaviour expected of all Governors. Also found within the code is the agreed process for the removal of	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	a Governor.	
6. Comply or explain	Board/ Remuneration Committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Not required during the reporting period. However, a full risk assessment would be undertaken and presented to the Remuneration Committee in the event that an Executive Director requested to terminate their employment outside of their contract terms.	Compliant
6. Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	The Audit Committee received the Trust's going concern statement in May 2021. This was reported to the Board of Directors and included within the Annual Report.	Compliant
6. Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board of directors should set out clearly it's financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	The Performance Report Section of the Annual Report sets out this information in line with the NHS FT ARM requirements. This information is presented at the Annual Members Meeting.	Compliant
6. Comply or explain	Board	C.1.4	a) The board of directors must notify NHS Improvement and the CoG without delay and should consider whether it is in the public's interest to bring to the	All new developments that might affect the Trust's financial or service performance or reputation are brought to the attention of regulators and the	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify NHS Improvement and the CoG without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: the NHS foundation trust's financial condition; the performance of its business; and/or the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.	Council of Governors. Consideration is also given by the Board of Directors as to whether such developments should be brought to the attention of the public. All significant changes that might affect the Trust's financial or service performance or reputation are brought to the attention of regulators and the Council of Governors.	
6. Comply or explain	Board/ Audit Committee	C.3.1	The board of directors should establish an audit committee composed of at least 3 members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities	The membership of the Audit Committee consists of 3 Non-Executive Directors but does not include the Trust Chair as outlined in the Terms of Reference. The Trust enlisted the support of a	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			effectively; including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. They can, however, attend meetings by invitation as appropriate.	recruitment consultant to support the Trust to identify a Non-Executive Director with relevant financial qualifications.	
6. Comply or explain	Council of Governors/ Audit Committee	C.3.3	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing the external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.	A panel drawn from the Council of Governors considers the recommendations of the Audit Committee when the contract for the external auditors is due to expire. The last contract award was made in 2017. The current contract ends following the 2020/21 audit. Governors will be involved in the appointment process for identifying the Trusts new external Auditors for 2021/22.	Compliant
6. Comply or explain	Council of Governors/ Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three-to-five year period of appointment.	See C.3.3. above	Compliant
6. Comply or explain	Council of Governors	C.3.7	When the council of governors ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the	This has not been tested during 2020/21.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			reasons behind the decision.		
6. Comply or explain	Audit Committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	The Terms of Reference of the Audit Committee refer to the committee's role in overseeing whistleblowing in relation to Anti-Fraud and Bribery. In line with national guidance the Freedom to Speak Up Raising Concerns Policy was approved by the Board of Directors in 2019 and is supported by the Freedom to Speak Up Guardian. The Guardian reports on a bi-annual basis to Trust Board and any themes or concerns are monitored. Concerns that relate to the misappropriation of Trust resources are referred to the Trust's Local Anti-Fraud Specialist and the outcome reports are reported to the Audit Committee.	Compliant
6. Comply or explain	Remuneration Committee	D.1.1	Any performance related elements of the remuneration of executive directors should be designed to align their interest with those of patients, service users and taxpayers to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: • The remuneration committee should consider whether the	The Trust does not offer its director's performance related pay. It does however benchmark salaries with other similar trusts	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public and patients. • Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group for comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. • The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.		
6. Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other non-executive	Levels of remuneration for the Chair and Non-Executive Directors are based	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			directors should reflect the time commitment and responsibilities of their roles.	on guidance issued by NHS Improvement. This contains provision for local discretion to award supplementary payments in recognition of designated extra responsibilities. Proposals for amendments to the remuneration of Non-Executives Directors are considered by the Nomination and Remuneration Committee of the Council of Governors who recommend any subsequent changes to the full Council of Governors.	
6. Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced reflecting a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	The Remuneration Committee approves each executive appointment and approves the terms of conditions for each role. In the event of a redundancy/severance any claw back arrangements would be reflected in a settlement agreement, stating the requirement for the individual to pay back a proportion of the payment if they were to take up another NHS post. However, the employment contracts do not reflect a departing director's requirement for compensation to be reduced.	Compliant
6. Comply or explain	Remuneration Committee	D.2.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g. local Healthwatch, the OSC, and the League	The Trust's Quality Strategy sets out the Trust's aims in relation to ensuring that the interests of patients, carers and the public are served.The Trust's Membership Strategy outlines the role of governors in relation to representing the views of members.	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			of Friends and staff groups).		
6. Comply or explain	Council of Governors/Remuneration Committee	D.2.3	The chairperson should ensure that the view of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	Following the formal Council of Governors meetings and informal discussions with governors, the Chair updates the board on the matters considered by the Council via the Chair's report. Non-Executive Directors attend the formal meetings of the Council of Governors and present their Chairs Reports from their relevant assurance committees. Governors are also invited to observe Board meetings and are provided with the opportunity to ask questions relevant to the agenda at the end of the formal business.	Compliant
6. Comply or explain	Board	E.1.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g. local Healthwatch, the OSC, and the League of Friends and staff groups).	The Trust's Quality Strategy sets out the Trust's aims in relation to ensuring that the interests of patients, carers and the public are served.The Trust's Membership Strategy outlines the role of governors in relation to representing the views of members.	Compliant
6. Comply or explain	Board	E.1.3	The chairperson should ensure that the view of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors to listen to their views in order to help develop a	Following the formal Council of Governors meetings and informal discussions with governors, the Chair updates the board on the matters considered by the Council via the Chair's report. Non-Executive Directors attend the formal meetings of the Council of Governors and present their Chairs	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
			balanced understanding of the issues and concerns of governors.	Reports from their relevant assurance committees. Governors are also invited to observe Board meetings and are provided with the opportunity to ask questions relevant to the agenda at the end of the formal business.	
6. Comply or explain	Board	E.2.1	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	The board has a duty to co-operate e.g. NHS Improvement; NHS England, Commissioners, CQC and Local Authorities. Members of the Board and senior managers are the nominated contacts for these organisations. The Communication and Engagement Strategy outlines the mechanisms of engagement that the Trust adopts across key stakeholders.	Compliant
6. Comply or explain	Board	E.2.2	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	The Trust's Communications and Engagement Strategy describes the mechanisms by which the Trust will communicate and engage with stakeholders commissioners, NHS Provider Trusts, Regulators, A&E Delivery Boards, local MPs and patient and public groups. Executive Leads are identified as the relevant contact for specific stakeholder's e.g. CQC, Commissioners, Healthwatch etc. and they report relevant matters through the executive team meetings and to Trust Board. Through the bi-annual review of the Trust's Strategy the Board considers the effectiveness of these	Compliant

PART OF SCHEDULE A (SEE ABOVE)	RELATING TO	CODE	CODE PROVISION	TRUST RESPONSE	LOCATION IN ANNUAL REPORT
				arrangements and where necessary additional focus is given to improve them.	

ii. Audit Committee Report

The Board of Directors undertakes a balanced and understandable assessment of the Trust's position and position and prospects, maintains a sound system of internal control and ensures effective scrutiny through regular reporting which comes directly to the Board itself or through the Audit Committee.

The Audit Committee is responsible for the relationship with the Trust's auditors, and its duties include providing an independent and objective review of the Trust's system of internal control, including financial systems, financial information, governance arrangements, approach to risk management compliance with legislation and other regulatory requirements, monitoring the integrity of the financial statements of the Trust and reviewing the probity of all Trust communications relating to these systems. The Audit Committee receives instructions from the Board of Directors as to any areas where additional assurance is required and formally reports to the Board of Directors on how it has discharged its duty.

PricewaterhouseCoopers LLP were appointed by the Council of Governors as the Trust's external auditor with effect from 1 April 2007.

The Trust's internal audit function is provided through a contract with Merseyside Internal Audit Agency. The role of the internal auditors is to provide independent, objective assurance on the risk management, control, and governance processes within the Trust, through a systematic, disciplined approach to evaluation and improvement of the effectiveness of such processes.

<u>The Role of the Audit Committee</u>

The Audit Committee is a formal sub-committee of the Board with defined Terms of Reference. The Terms of Reference were reviewed on 15 January 2020 and last approved by the Board on 28 January 2020.

The Terms of Reference for the Committee state that meetings should take place not less than five times per year. During 2020/21 the Committee met on eight occasions, all of which were quorate.

Membership of the Audit Committee is made up of three Non-Executive Directors and chaired by Neil Willcox. The Chair of the Trust may not be a substantive member of the Committee, but has an open invitation to attend any meeting during the financial year.

The table below shows attendance of members of the Committee for the period 1 April 2020 to 31 March 2021:

Table 35: Attendance at Audit Committee meetings 2020/21

Member	18 May	18 Jun	25 Jun	9 Jul	17 Jul	8 Oct	14 Jan	17 Mar
Neil Willcox	✓	✓	✓	✓	✓	✓	✓	✓
Angela Phillips	✓	✓	✓	✓	✓			
Mandy Wearne	✓	✓	✓	✓	✓	✓	✓	✓
Sheila Samuels						✓	✓	✓

Sheila Samuels were appointed from 01.9.20
Angela Phillip's term of office ended on Term of office elapsed 30.9.20

During 2020/21 meetings of the Audit Committee were attended on a regular basis by the Chief Financial Officer; and the Director of Corporate Governance. Internal audit and counter fraud representation was provided by Mersey Internal Audit Agency (MIAA). External audit representation was provided by the audit team from PricewaterhouseCoopers LLP.

In addition to the officers that regularly attend the committee, invitations were extended to members of the executive team and senior managers who attended meetings to present papers and provide assurances as required.

To ensure that committee members have the skills required to carry out their role they have the opportunity to attend training courses. Some of these are provided by MIAA and cover topics which are relevant specifically to members of the audit committee and also those which are relevant to the issues facing NHS organisations.

The chair of the Audit Committee makes a report regarding the most recent meeting of the committee at the next scheduled Board of Directors' meeting. This report assures the Board of the main items discussed by the committee. Should it be necessary to make the Board aware of any matters of concern this will be done by the chair of the committee in that report, and an outline given of how the committee will take this forward. Where the matter is of significant concern the committee will ask for direction from the Board, or it may be that the Board takes a decision to receive reports directly.

During 2020/21 the chair of the committee made reports after each meeting to the Board of Directors. The Committee escalated a matter regarding the use of the Malnutrition Universal Screening Tool (MUST) and this was to be followed up by the Quality Committee to review progress and monitor the situation in April 2020.

Conversely where the Board requires greater assurance on a matter this can be referred to the Audit Committee. The Board requested that the Committee gain further assurance of aged debtors related to Royal Liverpool & Broadgreen Hospital for the period prior to the merger. An update was provided to the committee and further assurances were sought regarding the new process.

During 2020/21 the evidence shows that the Committee has fulfilled its role as the primary governance and assurance committee in accordance with its Terms of Reference. Areas of work on which the committee received assurance during 2020/21 are set out below.

<u>Internal Audit, Counter-fraud:</u>

Approved the Internal Audit Annual Plan for 2020/21 and received internal audit progress reports on a regular basis to update the committee on the major findings, with assurance being provided on the actions taken to address any weaknesses in the systems of control.

Approved the Counter Fraud Annual Plan for 2020/21 and received assurances about the processes in place to tackle fraud and bribery.

Local Counter-fraud progress reports were received on a regular basis including numbers of referrals and updates in respect of existing cases in order to update the committee on the major findings and any lessons learned from individual cases.

The Counter-fraud Annual Report was also received which brought together work from across the year.

A series of briefings regarding best practice throughout the response to COVID-19 were provided by the auditor.

The Committee scrutinised the Legacy Audit actions from the Workforce & Education Committee and gained assurance that there were plans in place to address the outstanding actions.

External Audit

The Committee reviewed and approved the work plan for 2020/21 and the associated fees. They received regular update reports about the work of the auditors and also information about changes within the health sector with potential impact on the Trust.

Reviewed the content for the year-end Letter of Representation and Auditors Report on the Annual Report and Accounts for 2019/20.

Risk and governance framework

The Committee reviewed the actions being taken to implement the Trust's Risk Management Strategy in 2020.

- The Board Assurance Framework was presented to enable the committee to gain assurance that strategic risks had been identified and were being managed.
- Agreed to recommend the approval of the Managing Conflicts of Interest Policy to the Board
- The Losses and Compensations Reports for Quarters 1 and 2 were reviewed by the committee and a risk was identified regarding potential claims as a result of harm during COVID-19.
- In respect of information security the committee received the Cyber Security Annual Report 2019/20 and a biannual report on information security. In addition it received regular reports regarding Information Governance incidents.
- The Clinical Audit Annual Report was reviewed by the Committee and provided assurance regarding the work being progressed to combine the different approaches to clinical audit at both sites.

Annual Report and Accounts for 2019/20

The Annual Report and Accounts for both RLBUHT (April to September 2019) and LUHFT (2019/20) were reviewed prior to being presented to the Board of Directors for approval.

The ISA 260 was also received and the findings from the audit of the annual accounts discussed.

The Head of Internal Audit Opinion and the Annual Governance Statement were reviewed and found to be consistent.

Assurance was received on the process for the declarations required by General Condition G6 and Condition FT4 (for foundation trust governance) of the NHS Provider Licence.

Financial governance

The Committee received assurances on the reasons for the Tender Waivers on a quarterly basis. It was recognised that due to the new hospital build and COVID-19 it was likely that there would be an increased number during the reporting year.

The Accounting Policies for were reviewed and approved by the Committee

iii. Council of Governors' Report

As a NHS Foundation Trust, we are required to comply with the arrangements set out by our independent regulators, NHS England and NHS Improvement, in the NHS Foundation Trust Code of Governance (2014). The Code of Governance requires us to have a comprehensive framework in place to ensure the Trust is managed and governed properly. We comply with the provisions of the code and will continue to observe the spirit of the code in everything we do.

Our business is managed by the Board of Directors which exercises all the powers of the Trust subject to any contrary provisions of the NHS Act 2006 and the Health and Social Care Act 2012. The Board of Directors is responsible for approving the Annual Report and accounts. In preparing the Annual Report they take into account the views of the Council of Governors which contain information about our forward planning.

This section describes the composition of the Council of Governors during the year, their roles and responsibilities, how they work together and the types of decisions taken during the year to develop the organisation and describes how disagreements between the Board of Directors and the Council of Governors will be resolved.

The information contained in the report sets out the steps taken during the year by the Council of Governors to engage with members and the public on our forward planning, our objectives, priorities and strategy. Due to the impact of COVID-19 and in line with national guidance, all visits, face to face meetings and engagement work ceased in March 2020. The Board continued to engage with the Council of Governors electronically throughout the reporting period.

Roles and responsibilities

The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with the Trust's Constitution and NHS Provider Licence, are as follows:

- ✓ To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- ✓ To represent the interests of the Members of the Foundation Trust as a whole and the interests of the public
- ✓ To appoint or remove the Chair and the other Non-Executive Directors
- ✓ To approve an appointment (by the Non-Executive Directors) of the Chief Executive
- ✓ To decide the remuneration, allowances and other terms and conditions of office of the Non-Executive Directors
- ✓ To appoint or remove the Foundation Trust's external auditor
- ✓ To be presented with the annual accounts, any report of the auditor on them and the annual report

- ✓ To provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning
- ✓ To undertake such functions as the Board of Directors may from time to time request
- ✓ To review at least annually the Foundation Trust's membership strategy
- ✓ To make recommendations to the Board of Directors for any amendments in the Constitution to the composition of the Council of Governors
- ✓ To respond as appropriate when consulted by the Board of Directors on any proposed revision of the Constitution or any other matter.

On 31 March 2021, the Council of Governors chaired by the Trust Chair consisted of 31 governors representing the Public and Staff constituencies and representatives from the Local Authority and Partner Organisations as identified by the Trust's Constitution.

In accordance with the Trust's Constitution and NHS Provider Licence, all governors are required to meet the 'Fit and Proper Persons Test' on appointment and on reappointment.

Elections for appointment as an elected governor of the Trust were undertaken during October and November 2020 with the successful candidates taking up office from 2 December 2020. The elections were administered by Electoral Reform Services in accordance with the model election rules in the Trust's Constitution.

Lead Governor and Deputy Lead Governor

The Lead and Deputy Lead Governors are elected by their peers for a term of one year or until their term ends, which is sooner.

Lead Governor – Andrew Moran
Deputy Lead Governor – Doreen Schlechte

Details of the composition of the Council of Governors together with details of attendance at meetings are set out in the table below.

Table 36: Council of Governors composition 31/03/2021

	Term of Office (Years)	Term Ends	Attendance at Council of Governors Meetings
Public: City Region North			
Mr Robert Cannon	3	2 Dec 2022	0/5
Mr Paul Denny	2	2 Dec 2021	0/5
Mr Ray Humphreys	2	2 Dec 2021	2/5
Mrs Juliette Kumar	3	2 Dec 2022	3/5
Mr Andrew Moran	3	2 Dec 2022	5/5
Mr Karl Roberts	3	2 Dec 2022	4/4
Mrs Anne Trevor	2	2 Dec 2021	4/5
Public: City Region South			
Mrs Dorcas Olanike Akeju OBE	3	2 Dec 2022	5/5
Mr Gerrard Ashley	2	2 Dec 2021	5/5
Mrs Alison Cohen	3	2 Dec 2022	4/5
Mrs Sheila Coleman	3	2 Dec 2022	5/5
Mr Kieran Harrison-Foulkes	3	2 Dec 2022	4/5
Mr John Lloyd-Jones	2	2 Dec 2021	5/5
Mrs Doreen Schlechte	2	2 Dec 2021	5/5
Public: North West England and North Wales			
Mr David Blanchflower	3	2 Dec 2022	5/5
Mr Stanley Mayne	3	2 Dec 2023	3/5
Staff: Allied Health Professionals Scientists and Technicians			
Mrs Fiona Daglish	3	2 Dec 2022	5/5
Mrs Sarah Dyson	2	2 Dec 2021	5/5
Staff: Medical Practitioners and Dentists			
Dr Bhavna Kalpesh Pandya	3	2 Dec 2022	5/5
Dr Emma Walker	2	2 Dec 2021	3/5
Staff: Nursing			
Ms Tracy Greenwood	2	2 Dec 2021	4/4
Ms Kelly Hughes	3	2 Dec 2021	1/1
Mr Peter Halliday	3	2 Dec 2022	3/5
Staff: Other Non-clinical Staff			
Mrs Angela McShane	2	2 Dec 2021	5/5
Mrs Joanne Pepper	3	2 Dec 2022	5/5
Appointed Governors			
Professor Raphaela Kane, Liverpool John Moores University	3	2 Dec 2022	3/5
Professor Graham Kemp, University of Liverpool	3	2 Dec 2022	5/5
Kathryn Drury, Edge Hill University	3	2 Dec 2022	4/5
Councillor Anthony Carr, Sefton Council	3	2 Dec 2022	3/4
Cllr Linda Mooney, Knowsley Council	3	2 Dec 2022	5/5
Val O'Donnell, YPAS	3	2 Dec 2022	0/5
Roz Gladden, Liverpool City Council	3	2 Dec 2022	1/5

Due to COVID-19 all meetings in the 2020-21 financial year have taken place virtually, as such some Governors were unable to take part

Details of company directorships of Governors

The register of interests for members of the Council of Governors is available on the Trust's website or from the Corporate Governance Team.

Supporting the role of governor

The Health and Social Care Act s151(5) places a duty on Foundation Trusts to take steps to secure that governors are equipped with the skills and knowledge they require in their capacity as such. This duty is also included within the Trust Constitution.

In order to ensure governors are equipped with the skills and knowledge they require to fulfil their role, governors are provided with training and development opportunities throughout their tenure. The training and development programme continues to be adapted to meet the needs of the governors.

Communications between the Board of Directors, Governors' Council and members

The Board of Directors (the Board) and Council of Governors work closely together. All members of the Board have an open invitation to attend the Council of Governors meetings.

Executive and Non-Executive Directors are invited to make formal presentations at these meetings for the purpose of obtaining information on the Trust's performance of its functions and the Directors' performance of their duties and to hear the views of the governors, members and the public. There are also ad-hoc meetings and discussions between individual Board members and governors on specific subjects of interest.

The Senior Independent Director (SID) attends the Council of Governors meeting to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors. The SID also attends/chairs the Nominations Committee when considering the Chair appraisal or Chair appointment.

The Council of Governors meeting is held in public and advertised on our website. The public has an opportunity at the meeting to give their views or ask questions on the agenda. Non-Executive Directors attend Council of Governor meetings to feedback on progress of issues from the Board Committees to help governors fulfil their role in 'holding Non-Executive Directors to account'.

Dispute between the Council of Governors and the Board of Directors

There were no disputes during 2020/21. In the event of any unresolved dispute between the Council of Governors and the Board of Directors, the Chair will:

- Take such steps as the Chair considers appropriate to try to reach a common and clear understanding of the issues in dispute
- Consider whether independent advice will help to resolve the dispute and if appropriate arrange for independent advice to be made available to the Foundation Trust
- If the dispute continues to be unresolved, ensure that an appropriate record of it is made in the minutes of a meeting of the Council of Governors and in the minutes of a meeting of the Board of Directors.
- Ensure that an appropriate record of any unresolved dispute is made in our annual report for the relevant period including a summary of the issues in dispute and the action taken by the Board and the Council of Governors to attempt to resolve the dispute

iv. Nominations Committee Report

The Nominations Committee is a sub-committee of the Council of Governors and its primary function is to ensure that the Board includes an appropriate number of independent, skilled, experienced and effective Non-Executive Directors including a Chair. The Committee must also ensure that the levels of remuneration for the Chair and other Non-Executive Directors reflect the time commitment and responsibilities of their roles.

The Committee must work to ensure that appointments to the Board:

- Are made on merit, against objective criteria
- Meet the fit and proper persons test described in the NHS Provider Licence issued by NHSE/I
- Have due regard for the benefits of diversity on the Board and the requirements of the Trust, and that appointees have enough time available to discharge their responsibilities effectively.

The Committee should satisfy itself that plans are in place for orderly succession for Non-Executive Director appointments, including the Chair, to the Board and that the Board maintains an appropriate balance of skills and experience.

The Nominations Committee is chaired by the Trust's Chair and comprises of two Elected Governors and one Appointed Governor. The Senior Independent Director will deputise and chair the meeting when the Chair is being considered for appointment or the annual appraisal process for the Chair is under review. The membership is also supported by two additional elected governors on reserve and trained.

In addition, the Committee also has responsibility for the Removal of the Chair or another Non-Executive Director which requires the approval of three quarters of the members of the Council of Governors, on the recommendation of its Nomination Committee. This action would only be taken in extreme circumstances once all other opportunities have been utilised to resolve issues.

Meetings of the Nominations Committee are held as deemed necessary by the Chair but not less than once a year. During the reporting year, the Nominations Committee met on two occasions to consider Non-Executive Directors appointments.

The Committee undertook an external recruitment process in line with the agreed procedure and identified preferred candidates for the two Non-Executive Director vacancies. The Committee recommended Eustace de Sousa and Sheila Samuels to the Council of Governors meeting on 21 July 2020. The Council of Governors approved both recommendations.

v. Membership Report

<u>What is membership?</u>
All Foundation Trusts have a duty to engage with their local communities and encourage local people to become Members and to take steps to ensure that their membership is representative of the communities they serve. We are committed to an engaged and vibrant membership community.

Anyone who lives in the area or who works for us, and is 14 years or older, can apply to become a member (exclusions apply as detailed in our Constitution).

They will be eligible to join one of two membership groups:

- Public membership – divided into three constituencies
- Staff membership – divided into four constituencies

An individual cannot be a member of more than one group.

You can find out more about the eligibility criteria and the process for membership application in our Constitution which can be accessed via our website https://www.liverpoolft.nhs.uk/about-us/reports-and-publications/trust-constitution/ or request a copy from the Corporate Governance Team on 0151 529 4766 or email governors@liverpoolft.nhs.uk

Public membership

We have three public constituencies which are open to all residents of the following areas who are over the age of 14 years.

1. City Region North - electoral areas specified in the Trust's Constitution covering Liverpool, Knowsley and Sefton
2. City Region South - electoral areas specified in the Trust's Constitution covering Liverpool and Knowsley
3. North West England and North Wales - All local government electoral wards within the counties of: Merseyside (other than those covered by City North and City South Public Constituencies), Cheshire, Cumbria, Greater Manchester, Lancashire, Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham.

Staff membership

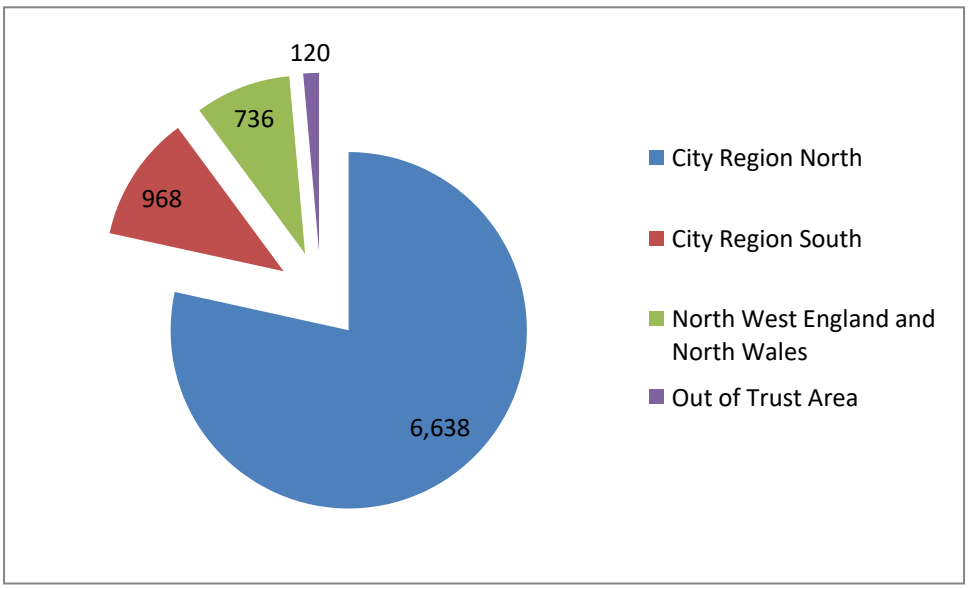
The staff constituency is divided into four classes that are based according to the role the member of staff operates within the Trust:

1. Allied Health Professionals, Scientists and Technicians
2. Medical Practitioners and Dentists
3. Nursing
4. Other Non-clinical Staff

We have adopted an opt-out scheme and all staff who are employed (including indirectly employed) by us for 12 months or more are included as Members. New employees who meet the criteria above are automatically included as Members.

Membership profile

Information on the total number of Public Members and the number of Members in each constituency at 31 March 2021 is shown in the chart below.



The total public membership figure at 31 March 2021 is 8,462, an increase of 65 from the previous year.

Membership Engagement Strategy 2020- 2023

Our ambition is to have a membership base which is engaged and actively involved in co-producing future service design and delivery, reflective of the needs of patients and the local community. The Engagement Strategy which was refreshed in 2020 sets out the ways in which the Council of Governors and the Trust should engage with our membership.

The strategy aims to:

- Ensure that membership is representative of the community it serves; and
- Ensure a continuous approach to developing membership based on active engagement targeting staff groups or services.

The Council of Governors will agree how we will deliver these aims and monitor progress against their delivery. We aim to have as many actively participating members as possible and with this in mind there is a drive to improve engagement.

2.5 Statement of Chief Executive's responsibilities as the Accounting Officer of Liverpool University Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Liverpool University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Liverpool University Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts *and overseeing the use of public funds*, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- 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 foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed

Steve Warburton
Chief Executive Date: 23 June 2021

2.6 Annual Governance Statement

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

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Liverpool University Hospitals NHS Foundation Trust (LUHFT), 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 LUHFT for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
Overall responsibility for the management of risk within LUHFT rests with the Board of Directors. Reporting mechanisms are in place to ensure that the Board of Directors receives timely, accurate and relevant information regarding the management of risks.

Through the annual planning cycle, LUHFT sets out its principal aims for the year ahead. Each Executive Director has responsibility for identifying any risks that could prevent the Trust from achieving these aims. These strategic risks are documented in the Board Assurance Framework (BAF). The BAF maps the key controls employed to manage the strategic risks and provides the Board of Directors with assurance about the effectiveness of the controls and any gaps. The BAF is normally reviewed every quarter and considered by the Board's committees including the Audit Committee, the Executive Director team and the Board.

The Risk Management Strategy defines the risk framework and processes together with key responsibilities of the Board, its committees, individual executives and other staff. A Risk Management Strategy was approved by the Board on the merger to create LUHFT in October 2019 and was updated in May 2021.

Operational delivery of the risk management arrangements are further defined within the Trust's Risk Management Policy, which was updated and approved by the Board in February 2021. The Risk Management Policy includes guidance for staff on the methodology that should be followed to ensure a consistent approach to risk management across all areas of the Trust.

Central to our approach to risk is risk appetite. Our risk appetite statement was last reviewed in October 2019. In setting out our appetite for risk, we use a risk appetite framework based upon that promoted by the Good Governance Institute. The Board's appetite for risk is included in the Risk Management Strategy and the associated Risk Management Policy.

Risk Management Training
Risk management training is provided to staff appropriate to their role and where necessary staff are trained in the use of investigation techniques (including root cause analysis) to support them in identifying lessons from serious incidents and complaints.

The Trust's mandatory training programme reflects essential training needs and includes health and safety, clinical risk management, fire safety, safeguarding patients, infection prevention, information governance and equality and diversity training.

The risk and control framework
The Board of Directors is responsible for the strategic direction of the Trust in relation to Risk Management. It is supported by the Audit Committee which provides assurance to the Board via its oversight of the Internal Audit Programme. In addition, the other committees of the Board provide detailed scrutiny of plans and risks in relation to clinical quality, finance and operational performance, workforce, education and research and innovation. The role of these committees is described more fully in the Directors Section of this report.

No changes have occurred within the Executive Director team during 2020/21 but two changes have taken place within the Non-Executive Director Team: -

- Term of office for David Fillingham ended on the 30/06/2020
- Term of office for Angela Phillips ended on the 30/09/2020
- Eustace de Sousa and Sheila Samuels both joined on 01/09/2020

As at 20/05/2021, the Trust has:
- Eight Non-Executive Directors (the Chair plus seven other Non-Executive Directors)
- Six Executive Directors all of whom have voting rights
- There are no Non-Executive Director or Executive Director vacancies

The Council of Governors have continued to fulfil their responsibilities during 2020/21 with all meeting taking place virtually. Whilst engagement activities have been curtailed due to COVID-19, the Trust's governors were able to under a range of training and development opportunities during the year.

Risk identification and evaluation
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 and trend analysis
- Health and Safety and Infection Control audits
- Complaints and CQC reports and recommendations
- Inquest findings and recommendations from HM Coroners
- legal claims and litigation
- feedback from patients, members of the public
- stakeholder/partnership feedback
- Reviews by external regulators
- Internal and external audit reports

Identified risks are added to departmental Risk Registers and reviewed on a monthly basis to ensure that action plans are being implemented and that risks are being managed or

accepted as appropriate. Any non-compliance is addressed with the appropriate Divisional Management Team and where required, risks are escalated to the Board by the relevant Executive Director.

Strategic Risks

The Board Assurance Framework (BAF) is the mechanism by which the Trust evaluates the risks that could impact on the achievement of the Trust's strategic objectives. These risks are linked to the Trust's three year strategy and the plans for the financial year. This process ensures that the Board is informed about the most serious risks faced by the Trust.

During the year, the Internal Audit opinion on the Trust's BAF supporting process noted: -

I. The BAF is structured to meet NHS requirements
II. The BAF is visibly used by the organisation
III. The BAF clearly reflects the risks discussed by the Board.

All of the risks on the BAF have mitigation plans in place which are reviewed at least quarterly by the relevant Director and subsequently by the Board. At year end the key risk themes on the BAF were:

Strategic Objective	Risk Theme
Great Care	A failure to provide safe care
	A failure to provide effective care
	A failure to provide timely access to care
	A failure to provide a great experience for our patients
Great People	A failure to provide a great staff experience
	A failure to become a great place for healthcare professionals to learn and work
	A failure to improve recruitment and retention rate
Great Research & Innovation	A failure to deliver high quality research & innovation
	A failure to widen access to research opportunities
	A failure to embed a culture of research & innovation
Great Ambition	A failure to build upon successful partnerships
	A failure to consolidate sustainable services
	A failure to digitally enable the organisation
	A failure to achieve financial sustainability

Quality Governance

Quality governance is a key activity of the Board to ensure essential levels of quality and safety are met. External sources of assurance include:

- Internal auditors
- CQC
- NHS Resolution
- Other visits and inspections from regulatory agencies

The role of internal audit is to provide independent, objective assurance on the robustness and effectiveness of the Trust's systems and processes and to add value by identifying opportunities for improvement. The role of external audit is to perform an audit, in accordance with specific laws or rules, of the Trust's financial statements and is independent of the Trust.

Internal sources of assurance include:

- Activities undertaken by Care Divisions, Clinical Governance Department and the Corporate Governance Department
- Performance metrics
- Non-Executive Director visiting programme

- Incident reporting
- Patient and carer feedback and staff surveys

During the year we have built upon the work described in the previous year's annual report to improve and integrated our governance arrangements. Due to the pressures of the COVID-19 response, the Trust has not undertaken a review against the Well-Led Framework during 2020-21.

During Q1 (2021/22), the Trust will undertake an independent review against elements of the Well-Led Framework with a full review scheduled for 2022/23.

Care Quality Commission
Through the effective operation of the clinical compliance framework, the Trust gains assurance of compliance with the CQC Fundamental Standards of Quality and Safety and other national requirements. The Regulatory Advisory Group receives regular reports on compliance with these standards and regularly reports the outcome to the Quality Committee. This is complemented by reports from the Quality of Care Group which also provides regular reports to the Quality Committee. In turn the Chair of the Quality Committee reports directly to the Board of Directors and escalates any matters requiring attention.

The CQC conducted a focused inspection of the safe and well-led domains between 8 and 17 September 2020 due to information they had received. A further focused, responsive inspection of the medical care core service took place on the 28th and 29th October 2020. During this inspection parts of safe, effective, caring and well-led key questions were reviewed.

On the 29 January 2021, the CQC published the final inspection reports following their inspections undertaken in September and October 2020. Improvements to address the issues identified by the CQC are monitored by the Trust's Quality Committee.

The Executive Chief Nurse reports on quality metrics via the Integrated Performance Report presented to each meeting of the Board of Directors. This is supported by a number of annual reports relating to Safeguarding, Infection Prevention Control, Health and Safety and analysis of the National Inpatient Survey.

Never Events
Every Never Event is treated and a serious untoward incident and a comprehensive root cause investigation completed. Lessons learnt from the investigations are shared both through the care divisions and within the Trust's monthly Safety first newsletter which is issued to all clinical staff across all of the Trust's sites. The Trust also introduced a new Managing Serious Incidents and Never Events Standing Operating Procedures (SOP) in October 2020 which brought the legacy trusts practices for incident management into a single process; this included Serious Incident Panel Meetings at varying stages of the progress.

A total of six never events were declared by the Trust in 2020/21, in comparison to eight Never events declared in 2019/20, thus achieving a reduction of 25% at year end. The events that occurred were as follows:

Never event type	Never event date	Harm level
Wrong site surgery (mole)	01/07/20	Low harm
Misplaced NG tube	08/07/20	Moderate harm
Wrong side surgery (stent)	14/07/20	Moderate harm
ABO blood incompatibility	15/07/20	Moderate harm
Retained foreign object (Ophthal)	27/10/20	Moderate harm
Retained foreign object	25/02/21	Moderate harm

The Provider Licence

On an annual basis the Board considers an assessment of compliance with the Trust's licence and identifies any areas of risk for the forthcoming financial year. These risks are monitored via the corporate risk register. This includes compliance with Condition 4 – Foundation Trust Governance. During 2020/21 and the COVID-19 response, the Board has taken into consideration guidance issued by NHS Improvement in relation to reducing certain requirements relating to governance whilst maintaining compliance with its Licence.

Whilst meetings could not take place on the Trust's premises they have been conducted virtually. In addition the executive directors and the Chair have maintained service visits to ensure that the views of patients and staff could be triangulated with the data presented to the Board and its committees. These arrangements have been kept under review during the year.

The Board assessed compliance at its meeting on 25 May 2021 and believes that effective systems and processes are in place to maintain compliance with the conditions of its Licence. These conditions are detailed within the Corporate Governance Statement, the validity of which is assured via review of the supporting evidence by the Audit Committee.

The Trust is fully compliant with the registration requirements of the CQC.

Conflicts of Interest

Conflicts of interest are managed in line with '*Managing Conflicts of Interest in the NHS*' guidance and the Trust has published on its website an up-to-date register of interests, including gifts and hospitality. As part of this, mandatory declarations for decision making staff are being monitored and cross referenced against external sources of assurance, for example records held by Companies House relating to individual directorships and the Association of British Pharmaceutical Institute for transfers of value from Pharmaceutical companies to individuals employed by the Trust. The results are published on an annual basis as required under the guidance.

Developing Workforce Safeguards

The Trust is committed to ensuring that our patients receive the highest quality of care through ensuring that our staffing processes are safe, sustainable and effective. Internally a corporate workforce plan is developed and supported by recruitment and training plans. These are reviewed on a regular basis by board committees and the Trust Board.

Any changes to workforce establishments, introduction of new roles/working practices or changes to current roles are considered by Chief Nurse and the Medical Director who consider the Quality Impact Assessment undertaken by the service, prior to approving or rejecting the changes.

Systems are in place to monitor staffing levels across the Trust including short term strategies enabling appropriate response to day to day challenges for the workforce. Demand

and capacity modelling across services enables the Trust to establish where hot spot areas may be. A clear escalation process is in place, with daily calls to review safe staffing and other operational issues.

Where staffing pressures cannot be addressed the Trust has the ability to draw on third party providers to support patient and staff safety. Regular updates are provided to the Workforce and Education Committee and the Trust Board for appropriate assurance.

Robust workforce governance systems continue to be utilised and embedded to ensure the Trust's compliance with legislative requirements and to enable oversight of the Trust's short, medium and long-term workforce strategies. The Staff Experience and Resourcing Group and the Education Group support improved governance arrangements and oversight of performance, policies and practice across the Trust. As part of this, a range of workforce metrics, quality and outcome indicators are considered and reported to the Workforce and Education Committee of the Board.

NHS Pension Scheme
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.

Equality and Diversity
Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. These are described in detail within the Performance and Staff Reports.

Sustainability
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.

Review of economy, efficiency and effectiveness of the use of resources
The Financial Plan is approved by the Board of Directors and submitted to NHS Improvement (NHSI). The plan, including forward projections, is monitored by the Finance & Performance Committee on a monthly basis. The Trust's resources are managed within the structures defined within the Governance Framework and scheme of delegation and standing financial instructions.

The Board receives and reviews a monthly Integrated Performance Report which draws together operational performance, quality metrics, workforce metrics and financial metrics in an integrated dashboard format. More detailed finance and quality reports are also presented as separate agenda items to enable the Board to triangulate performance across a number of domains and understand the actions being taken to address any exceptions.

The Trust's Use of Resources was assessed by NHSI as part of the overall CQC inspection in May/June 2019. The Trust was assessed as 'requires improvement'. The CQC report published in January 2020 gave rating of "Good", in the Well Led domain.

During 2020-21 the activities of the Trust were materially affected by the NHS response to the COVID-19 outbreak. The formal contracting and planning framework was suspended and replaced by a system which incorporated block payments, supplemented by additional top up payments to bridge the gap where additional expenditure was incurred or income lost. The Trust has, and continues to work closely with commissioners. Over the last 12 months it has not been possible due to service pressures to provide the same level of focus to Cost Improvement Programme as has been the case in the past.

Looking forward to 2021-22, the first 6 months of the year will continue with a fixed financial envelope as the Trust restores operations to a business as usual footing. The financial arrangements for the second 6 months of 2021/22 are still under review by the Department of Health & Social Care.

During 2020/21 the Trust engaged with Deloitte to undertake a review of COVID-19 expenditure. The objective of the COVID-19 expenditure review was to assess whether COVID-19 revenue expenditure and capital expenditure claims were made by the Trust in accordance with the instructions, guidance and templates issued by NHSE/I and supported by evidence.

In summary the report was positive, with no concerns raised in relation to the spend incurred by the Trust on its COVID-19 response. The report identified some minor issues identified relating to the categorisation of spend items and timing of the goods receipted.

The capital programme required to complete the new Royal Hospital project and related schemes is significant and is under constant review by the Board's New Hospital Committee, chaired by a Non-Executive Director. Frequent updates including updates on move preparation plans are provided to the Board.

Whilst the new Royal has been delayed, due to the liquidation of Carillion in January 2018, work restarted in November 2018 following the appointment of Laing O'Rourke as management contractor. During 2020/21 progress on site continued despite the social distancing measures required on site during the year to operate safely during the pandemic. The first of the new facilities, our new clinical sciences building was handed over to the Trust during 2020/21. Latest programme dates indicate a likely completion of the construction work and opening of the hospital in summer 2022.

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. We continue to invest the Trust's existing estate against our planned proactive and reactive maintenance programmes. 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.

Assurance on economy, efficiency and effective use of resources is also provided by Internal and External Audit, as their work-plan includes audits of the major areas of resource utilisation. The effectiveness of the Board and its committees, notably the Audit Committee and the Remuneration Committee are discussed in more details in the Directors Section of this report.

Information governance and cyber security

Risks to personal information are managed and controlled in accordance with the Trust's Information Governance (IG) Strategy and Policy and the Information Security Policy.

Oversight of compliance with the policies is gained via the Information Governance, Cyber Security and Data Quality Group, chaired by the Chief Financial Officer, who is the Trust's Senior Information Risk Officer. The Medical Director, as Caldicott Guardian is responsible for the protection of patient information. The Information Governance, Cyber Security & Data Quality Group utilises the ISO27001 standard as a benchmark for compliance monitoring of the Trust's assets and supplier management.

The Audit Committee receives regular reports regarding the systems of control for information including an annual self-assessment against the Data Security and Protection Toolkit, which details Data Security Awareness (DSA) training compliance, controlling third party access to data, as well as technical controls such as penetration testing and acting on CareCERT critical alerts, which are subject to internal audit.

Between 1 April 2020 and 31 March 2021 there were 366 information governance incidents reported across all sites. These figures include 'near misses' which provides the opportunity for lessons to be learned.

There were three reportable incidents to the Information Commissioner's Office (ICO) and NHS Digital (via the DSP toolkit) in the reporting period. The ICO have indicated in all incidents that no further action is necessary.

The Trust receives regular communications from NHS Digital which supports notification of potential information security incidents and enhances the Trust's resilience and resistance to cyber-attack, accreditation for which has been obtained in Cyber Essentials accreditation. The Trust identified vulnerabilities following a penetration test where weaknesses and opportunities for improvement were identified via IT Health Check and remediation work undertaken. A further test is planned again during 2021/22.

Data quality and governance

The Trust has in place a Data Quality Strategy and Policy developed to provide guidance through which all staff involved in the collection, use and management of data can assist the Trust to achieve and maintain high levels of data quality to support high quality patient care.
The quality of data recorded on the Trusts systems is subject to local audit and the outputs of these audits are reported to the Information Governance, Cyber Security and Data Quality Group. Data also receives external validation via secure submission to the Secondary Uses Service (SUS).

On an annual basis the Trust produces a Data Quality Report, which is reviewed by the Information Governance Group and in the event of any exceptions reports these to the Audit Committee.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. I have also taken into consideration the recommendations made by the CQC following two inspections conducted in late 2020 during the second wave of COVID-19 and issues identified during the year such as those relating to the Gastroenterology service.

The Trust's governance arrangements have continued to respond to COVID-19 reflecting the guidance issued during the year by NHSE/I. The Trust recognised the importance of retaining effective and robust governance arrangements whilst also focusing on our response to the pandemic.

To comply with the governance conditions of the Provider Licence, the Trust is required to provide a Corporate Governance Statement to NHSE/I. The Corporate Governance Statement relating to 2020/21 was presented to the Board of Directors for formal acceptance in May 2021.

My review is also informed by comments made by the external auditors in their management letter. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Committee, as appropriate, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In maintaining and reviewing the effectiveness of the system of internal control the Board has received regular performance and assurance reports highlighting any exceptions to delivery. The Board also receives assurance reports via the reports of each of its committees. These include reports from the Audit Committee which highlight the work of the Trust's Internal and External Auditors in their oversight of the Trust's internal control processes.

The Board's review of the Trust's risk and internal control framework is supported by the opinion provided by the Head of Internal Audit based upon and limited to their work performed on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes.

The Head of Internal Audit Opinion noted that Substantial Assurance can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The opinion covered a number of critical business systems where substantial assurance was noted including core financial systems, payroll and risk management. Where recommendations were made by Internal Audit, action plans have been agreed and completion tracked by the Audit Committee on behalf of the Board.

Conclusion

My overall opinion is that, taking account of the items referred to above and the mitigations put in place, that there is an adequate system of internal control designed to meet the Trust's objectives and that controls are generally being applied consistently. I can confirm that the system of internal control has been in place for the period to 31 March 2021 and up to the date of approval of the annual report and accounts.

I can therefore conclude that no significant control issues have been identified.

Signed

Steve Warburton
Chief Executive Officer Date: 23 June 2021

2.7 Voluntary Disclosures

i. Modern Slavery Act

As of October 2015 all commercial organisations carrying on business in the UK with a turnover of £36m or more have to complete a slavery and human trafficking statement for each financial year. The Modern Slavery act consolidates offences relating to trafficking and slavery (both in the UK and overseas). As a large business we need to publicly state each year the actions we are taking to ensure our suppliers are slavery free. We continue to work within the Act.

Details of the actions taken by the Trust can be found on our website.
https://www.liverpoolft.nhs.uk/about-us/reports-and-publications/modern-slavery-statement/

Independent auditors' report to the Council of Governors of Liverpool University Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Qualified Opinion

In our opinion, except for the possible effects of the matter described in the Basis for qualified opinion paragraph below Liverpool University Hospitals NHS Foundation Trust's financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2021; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for qualified opinion

When performing the audit of the Trust for the year ended 31 March 2020, the Trust did not perform an inventory count on or near 31 March 2020 due to restrictions resulting from the COVID-19 pandemic. We were unable to obtain sufficient appropriate audit evidence through alternative procedures to verify the existence or condition of inventories with a value £12.7m as at 31 March 2020. Any adjustments necessary to this inventory amount could impact on the accuracy of the use of inventory (drug costs (drugs inventory consumed and purchase of non-inventory drugs), supplies and services – general and supplies and services – clinical (excluding drug costs)) expenditure for the year then ended, and whether the expenditure has been recorded in the correct year. Accordingly, we issued a qualified opinion in respect of the financial statements for the year ended 31 March 2020.

As these opening inventory balances enter into the determination of the drug costs (drugs inventory consumed and purchase of non-inventory drugs), supplies and services – general and supplies and services – clinical (excluding drug costs) expenditure for the year ended 31 March 2021, we are unable to satisfy ourselves regarding the existence of opening inventories. Given this, our opinion for the current year is also qualified because of the possible effects of this matter on the income and expenditure for the year ended 31 March 2021 and the comparability of the current year's inventory balance with its comparative.

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Conclusions relating to going concern

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

However, because not all future events or conditions can be predicted, this conclusion is not a guarantee as to the Trust's ability to continue as a going concern.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance 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 an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2020/21 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2021 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports required to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21 and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they 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 Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

Auditors' 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 auditors' 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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

Based on our understanding of the Trust and industry, we identified that the principal risks of non-compliance with laws and regulations related to the Data Protection Act 2018, and we considered the extent to which non-compliance might have a material effect on the financial statements. We also considered those laws and regulations that have a direct impact on the financial statements such as the National Health Service Act 2006 and related legislation governing NHS Foundation Trusts. We evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to the use of journals to manipulate financial performance and management bias in accounting estimates and judgements. Audit procedures performed by the engagement team included:

- Enquiring with management, internal audit, local counter fraud specialists and those charged with governance, to understand the relevant laws and regulations applicable to the Trust, their assessment of fraud related risks and consideration of known or suspected instances of non-compliance with laws and regulations and fraud;
- Identifying and testing unusual journal entries, including entries posted with unusual account combinations; and
- Challenging assumptions and judgements made by management in determining significant accounting estimates (because of the risk of management bias), including accruals, provisions and the valuation of property, plant and equipment.

There are inherent limitations in the audit procedures described above. We are less likely to become aware of instances of non-compliance with laws and regulations that are not closely related to events and transactions reflected in the financial statements. Also, the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion.

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

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Liverpool University Hospitals NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Under the Code of Audit Practice we are required to report, by exception, whether any significant weaknesses were identified during our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources, and to refer to any associated recommendations. As explained further in our Auditor's Annual Report, our work was performed in the context of the COVID-19 pandemic and resulting changes in both the operating and financing regimes for the NHS for the year.

We determined that there were no significant weaknesses to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if, in our opinion:

- the statement given by the directors in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model, and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2020/21 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all of the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility except in relation to the limitation on obtaining the information and explanations we require for the purpose of our audit work relating to inventory as described in the Basis for qualified opinion paragraph above.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Rebecca Gissing (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Manchester
23 June 2021

Liverpool University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Liverpool University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Liverpool University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed: ……

Name: Steve Warburton

Job title: Chief Executive Officer

Date: 23 June 2021

Statement of Comprehensive Income for the year ended 31st March 2021

	Note(s)	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	867,685	563,323
Other operating income	4	241,699	130,159
Operating expenses	6, 8	(1,098,103)	(691,125)
Operating surplus from continuing operations		**11,281**	**2,357**
Finance income	11	5	200
Finance expenses	12	(2,886)	(5,400)
PDC dividends payable		(6,990)	(6,222)
Net finance costs		**(9,871)**	**(11,422)**
Gains arising from transfers by absorption	30	-	292,224
Surplus for the year from continuing operations		**1,410**	**283,159**
Surplus / (deficit) for the year		**1,410**	**283,159**
Other comprehensive income / (expenditure)			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(9)
Revaluations	16	4,087	1,243
Other reserve movements *		-	(11,647)
Total comprehensive income for the year		**5,497**	**272,746**

All revenue and expenditure is derived from continuing operations.

* Absorption transfers are recorded based on the book values of assets and liabilities transferring. Accounting adjustments relating to Partially Completed Spells, Inventories and Intangible Assets were actioned as a result of harmonising accounting policies and were made immediately after the initial transfer. As per the 2019-20 NHS Group Accounting Manual (para 4.237) the adjustment was made directly in taxpayers' equity.

The notes on pages 125 to 161 form part of these accounts.

Statement of Financial Position as at 31st March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	13	13,762	16,899
Property, plant and equipment	14	831,810	646,068
Receivables	18	3,879	3,617
Total non-current assets		**849,451**	**666,584**
Current assets			
Inventories	17	6,380	12,696
Receivables	18	67,910	107,386
Cash and cash equivalents	19	167,533	43,643
Total current assets		**241,823**	**163,725**
Current liabilities			
Trade and other payables	20	(177,139)	(101,840)
Borrowings	22	(16,394)	(236,066)
Provisions	24	(1,101)	(1,125)
Other liabilities	21	(14,481)	(9,711)
Total current liabilities		**(209,115)**	**(348,742)**
Total assets less current liabilities		**882,159**	**481,567**
Non-current liabilities			
Borrowings	22	(50,479)	(55,116)
Provisions	24	(4,965)	(3,829)
Other liabilities	21	(168)	(204)
Total non-current liabilities		**(55,612)**	**(59,149)**
Total assets employed		**826,547**	**422,418**
Financed by			
Public dividend capital		858,691	460,059
Revaluation reserve		93,029	88,942
Income and expenditure reserve		(125,173)	(126,583)
Total taxpayers' equity		**826,547**	**422,418**

The financial statements, including the notes on pages 125 to 161, were approved by the Liverpool University Hospitals NHS Foundation Trust board on 10th June 2021 and are signed on its behalf by:

Signed: .....

Name: Steve Warburton

Position: Chief Executive Officer

Date: 23 June 2021

Statement of Changes in Equity for the year ended 31st March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**460,059**	**88,942**	**(126,583)**	**422,418**
Surplus for the year	-	-	1,410	**1,410**
Revaluations	-	4,087	-	**4,087**
Public dividend capital received *	398,632	-	-	**398,632**
Taxpayers' and others' equity at 31 March 2021	**858,691**	**93,029**	**(125,173)**	**826,547**

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**115,963**	**41,865**	**(60,028)**	**97,800**
Surplus for the year	-	-	283,159	**283,159**
Transfers by absorption: transfers between reserves	292,224	45,843	(338,067)	**-**
Impairments	-	(9)	-	**(9)**
Revaluations	-	1,243	-	**1,243**
Public dividend capital received	51,872	-	-	**51,872**
Other reserve movements	-	-	(11,647)	**(11,647)**
Taxpayers' and others' equity at 31 March 2020	**460,059**	**88,942**	**(126,583)**	**422,418**

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.

* On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS Cash Regime for the 2020/21 financial year. During 2020/21, existing DHSC interim revenue and capital loans to the value of £218,489k have been extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow repayment.

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

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

The notes on pages 125 to 161 form part of these accounts.

Statement of Cash Flows for the year ended 31st March 2021

	Note(s)	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus		11,281	2,357
Non-cash income and expense:			
Depreciation and amortisation	6	28,147	15,030
Net impairments	7	-	9,003
Income recognised in respect of capital donations	4	(1,387)	(270)
Decrease / (increase) in receivables and other assets		42,263	(919)
Decrease / (increase) in inventories		6,316	(1,142)
Increase in payables and other liabilities		47,352	7,498
Increase in provisions		1,118	1,679
Net cash flows generated from operating activities		**135,090**	**33,236**
Cash flows from investing activities			
Interest received	11	5	212
Purchase of intangible assets		(2,137)	(2,465)
Purchase of PPE and investment property		(170,460)	(72,223)
Net cash flows used in investing activities		**(172,592)**	**(74,476)**
Cash flows from financing activities			
Public dividend capital received		398,632	51,872
DHSC loans received	22.2	-	39,542
DHSC loans repaid	22.2	(220,912)	(4,612)
Other loans repaid	22.2	(8)	(4)
Capital element of finance lease rental payments	22.2	(1,395)	(730)
Capital element of PFI, LIFT and other service concession payments	22.2	(830)	(392)
Interest on loans	22.2	(2,618)	(4,583)
Interest paid on finance lease liabilities	22.2	(649)	(344)
Interest paid on PFI, LIFT and other service concession obligations	12 & 22.2	(789)	(420)
PDC dividend paid		(10,039)	(7,110)
Net cash flows generated from financing activities		**161,392**	**73,219**
Increase in cash and cash equivalents		**123,890**	**31,979**
Cash and cash equivalents at 1 April - brought forward		**43,643**	**7,638**
Cash and cash equivalents transferred under absorption accounting	30	-	4,026
Cash and cash equivalents at 31 March	19	**167,533**	**43,643**

Notes to the financial statements

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, 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 2020/21 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. 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.

The Trust has determined that the transactions of the two associated Charitable Funds, for which the Trust is the Corporate Trustee, are immaterial in the context of the Trust and the transactions have not been consolidated. The Turnover of the two combined Charity's during the reporting period equates to <1% of the Trusts turnover.

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 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that it will continue to be appropriate to adopt the going concern basis of accounting because, in such an event, services it performs can be expected to continue to be delivered by related public authorities and preparing the financial statements on a going concern basis will still provide a faithful representation of the items in the financial statements

Note 1.3 Interests in other entities

Joint operations
The Trust does not hold a joint business arrangement with another organisation.

Subsidiaries
In July 2007, the Trust established a wholly owned subsidiary company called Liverpool Healthcare Limited. The purpose of this company is to provide community healthcare projects. As of 31 March 2021, the company had not commenced trading.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

As per paragraph 121 of IFRS 15, the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. The GAM does not require the Trust to 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.

Note 1.4 Revenue from contracts with customers (continued)

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for healthcare services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System/Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the year, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration. The reimbursement and top up income relates to funding received during the COVID-19 pandemic – which in turn reflects additional costs incurred and income lost during the period. Please see note 4.1 for income relating to top-up and reimbursement.

Comparative year (2019/20)

In the comparative year (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The 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 Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, 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 an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Note 1.5 Other forms of income (continued)

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Sale of Non-Current Assets
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 1.6 Expenditure on employee benefits

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

Pension costs – NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting year. The contributions are charged to operating expenses as and when they become due.

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

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

The Trust's Global Digital Excellence NHS accreditation and the move to the New Royal Liverpool Hospital will be considerations when capitalising expenditure. A Global Digital Exemplar is an internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information. Exemplars will share their learning and experiences through the creation of blueprints to enable other trusts to follow in their footsteps as quickly and effectively as possible.

Note 1.8 Property, plant and equipment (continued)

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Following an impairment review in 2019 following transfer of the project from Carillion plc, the Trust has managed the construction itself. In line with the accounting policy for assets under construction in the DHSC Group Accounting Manual and specific additional guidance issued by NHS England and NHS Improvement on the 18th June 2021, the asset is held at cost less impairment. In light of this guidance, the Trust has not identified any indicators of impairment. When the asset construction is complete, the asset will be valued on a different methodology, consistent with other NHS specialised buildings assets.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting year. Current values in existing use are determined as follows:

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

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

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

Subsequent Expenditure

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

Depreciation

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

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

Note 1.8 Property, plant and equipment (continued)

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

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

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

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

De-recognition
Assets intended for disposal is reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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

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

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.8 Property, plant and equipment (continued)

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

	Min life Years	Max life Years
Buildings, excluding dwellings	5	88
Dwellings	5	26
Plant & machinery	4	20
Transport equipment	4	7
Information technology	5	10
Furniture & fittings	5	15

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

Note 1.9 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. In line with requirements of IAS 38, Intangible Assets are only recognised where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38. The Trust have assessed the level of intangible assets held and considered whether the assets have future service potential or whether an impairment review is required. The Trust concluded that the balances that remain within intangible non-current assets represent future service potential, predominantly relating to future software solutions such as a paper free initiative and patient tracking solutions (along with numerous other internally generated software solutions that provide future benefit to the Trust).

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

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

	Min life Years	Max life Years
Information technology	1	7
Software licences	1	7

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method less any provisions deemed necessary.

On 1 October 2019, as part of the acquisition of Royal Liverpool and Broadgreen University Hospital NHS Trust, inventory balances totalling £9,379k (£3,194k of drugs and £6,179k of consumables, £9k related to Charitable Funds) were transferred into Liverpool University Hospitals. As part of a process of harmonisation of accounting policies, £838k of the consumables inventory balance was adjusted for in taxpayer's equity at the point of acquisition.

In the prior year the Trust's inventory balance of £12,696k was material to the Trust's accounts and the Trust is satisfied that its inventory balance was presented fairly in all material respects. However, due to restrictions on movements which resulted from the COVID pandemic, the Trust's auditor was unable to perform its planned year-end inventory counts. This point is further covered in note 1.24.2 Sources of Estimation Uncertainty.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 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 Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Note 1.12 Financial assets and financial liabilities (continued)

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss

allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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 estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

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

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

Note 1.13 Leases

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

The trust as a lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position 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 year in which they are incurred.

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

The trust as a lessor

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

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

	Nominal rate
Short-term - Up to 5 years	0.51%
Medium-term - After 5 years up to 10 years	0.55%
Long-term - Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 24.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to 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 when the liability arises.

Note 1.15 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. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

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

Note 1.17 Corporation tax

Liverpool University Hospitals NHS Foundation Trust is a Health Service body within the meaning of s519A ICTA 1988 and accordingly is temporarily exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA), accordingly, the Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare and where the profits exceed £50,000 per annum. However, there is no tax liability in respect of the current financial year.

Note 1.18 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

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

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.19 Third party assets

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

Note 1.20 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 trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.21 Transfers of functions to/from other NHS bodies

For functions that have been transferred to the trust from another NHS government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / (loss) corresponding to the net assets/ (liabilities) transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.21 Transfers of functions to/from other NHS bodies (continued)

There were no transfers of functions either to or from the Trust during 2020-21. During 2019-20, the Trust acquired Royal Liverpool and Broadgreen University Hospitals NHS Trust. This transaction was treated as an acquisition through absorption as at 1 October 2019.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020-21.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases
IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

Other standards, amendments and interpretations
The IASB has deferred the effective date of IFRS 17, Insurance Contracts, to annual reporting periods beginning on or after 1 January 2023. IFRS 17 as interpreted and adapted by the FReM is to be effective from 1 April 2023.

Note 1.24 Critical judgements and 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 1.24.1 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.

A) 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

Note 1.24.1 Critical judgements in applying accounting policies (continued)

have been impaired on a straight line basis by the amount represented by their remaining useful life beyond 31 March 2023 (this date is being used as a working assumption but is subject to confirmation). The valuation of the buildings on 31st March 2020 provided by the District Valuer was used to calculate the impairment of buildings to be demolished.

B) Recognition of payments relating to the New Royal
On 1st October 2019, the Trust acquired the Royal Liverpool and Broadgreen University Hospitals NHS Trust. As part of this acquisition, the Trust absorbed the book value of all assets and liabilities which included the new Royal Hospital.
The value of the new Royal Hospital has been arrived at as follows:

The previous Trust had made payments 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. However, following termination of the PFI Project Agreement 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 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 a result, the £108m representing the donated element had been included in the initial recognition of the Asset Under Construction.

Following an assessment on the work remaining to be completed, the Trust obtained a valuation of the new Royal Hospital as at 31st March 2019 by the District Valuer. This resulted in an impairment of £92.8m which was accounted for in operating expenses in the 2018/19 accounts of the previous Trust. At each subsequent year end, the Trust considered whether there were any indications for impairment and concluded that no further impairment reviews were required until the asset is brought into operational use.

Note 1.24.2 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 Buildings
The valuation of buildings is based upon the views of an independent professional valuer. The Trust based the valuation of buildings as at 31 March 2020, on the views of the Valuation Office Agency which includes the use of national building indices and location factor indices. In order to reflect any changes in value that may have occurred since the full valuation on 31 March 2020, the Trust has applied indexation to all building assets (apart from Assets under Construction). The rate of indexation used was derived from the Office of National Statistics Construction Index. Please see note 16 for further information.

There has been no diminution identified in the Trusts ongoing requirement of its operational assets, nor reduction in its ongoing remaining economic service potential as a result of the incidence of Covid-19.

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

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 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

Note 1.24.2 Sources of estimation uncertainty (continued)

on historical experience with similar assets as well as anticipation of future events which may impact their life such as changes in technology.

Inventories
In the prior year the Trust's inventory balance of £12,696k was material to the Trust's accounts and the Trust is satisfied that its inventory balance was presented fairly in all material respects. However, the restrictions on movement in the United Kingdom in March 2020 meant that the Trust's auditor was unable to perform its planned year-end inventory counts, and the auditor has been unable to gain sufficient audit evidence from alternative procedures. The auditor was therefore unable to complete the procedures required by auditing standards and as a consequence required to issue a qualified opinion.

Note 1.25 Segmental Analysis

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker. The Chief operating decision maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board that makes strategic decisions

Note 2 Segmental reporting

All of the activities of the Trust arise from a single business segment, the provision of healthcare, which is an aggregate of all the individual speciality components therein. Similarly the large majority of the Trust's revenue arises from within the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust, together with the related supplies and overheads needed to establish this production. The business activities which earn and incur these expenses are of one broad nature and therefore on this basis one segment "Healthcare" is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes professional Non-Executive Directors.
The Trust Board review the financial position of the trust as a whole, rather than individual components included in the totals, in terms of allocating resources. This process implies a single operating segment of healthcare in its decision making process.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Acute services		
Block contract / system envelope income*	733,338	477,585
High cost drugs income from commissioners (excluding pass-through costs)	67,441	44,642
Other NHS clinical income	27,687	23,895
All services		
Private patient income	237	1,455
Additional pension contribution central funding**	24,224	15,746
Other clinical income ***	14,758	-
Total income from activities	**867,685**	**563,323**

On the 1st October 2019 Liverpool University Hospitals NHS Foundation Trust acquired The Royal Liverpool and Broadgreen University Hospitals NHS Trust. The timing of the acquisition at the half way point of 2019/20 is the principle driver when comparing the income figures of 2020/21 against 2019/20.

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year. Whilst the presentation of the prior year income has been restated, the nature of it remains consistent.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** Non recurrent income received in relation to employee benefits.

Note 3.2 Income from patient care activities (by source)	2020/21 £000	2019/20 £000
Income from patient care activities received from:		
NHS England	197,247	129,081
Clinical commissioning groups	642,991	408,346
Department of Health and Social Care	30	76
Other NHS providers	267	3,582
NHS other	18	15
Local authorities	7,484	5,665
Non-NHS: private patients	237	1,455
Non-NHS: overseas patients (chargeable to patient)	453	251
Injury cost recovery scheme	2,989	2,464
Non NHS: other	15,969	12,388
Total income from activities	**867,685**	**563,323**
Of which:		
Related to continuing operations	867,685	563,323

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

	2020/21 £000	2019/20 £000
Income recognised this year	453	251
Cash payments received in-year	123	121
Amounts added to provision for impairment of receivables	448	21
Amounts written off in-year	455	15

Note 4 Other operating income

Note 4.1 Other operating income

	2020/21			19/20		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	19,522	-	**19,522**	9,977	-	**9,977**
Education and training	43,765	540	**44,305**	28,500	202	**28,702**
Non-patient care services to other bodies	54,507	-	**54,507**	33,196	-	**33,196**
Provider sustainability fund (2019/20 only) ***	-	-	**-**	11,095	-	**11,095**
Financial recovery fund (2019/20 only) ***	-	-	**-**	33,527	-	**33,527**
Marginal rate emergency tariff funding (2019/20 only) ***	-	-	**-**	142	-	**142**
Reimbursement and top up funding *	96,352	-	**96,352**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	153	-	**153**	62		**62**
Receipt of capital grants and donations	-	1,387	**1,387**	-	270	**270**
Charitable and other contributions to expenditure **	-	13,861	**13,861**	-	-	**-**
Rental revenue from operating leases	-	776	**776**	-	342	**342**
Other income	10,836	-	**10,836**	12,846	-	**12,846**
Total other operating income	**225,136**	**16,564**	**241,699**	**129,345**	**814**	**130,159**
Of which:						
Related to continuing operations			241,699			130,159

On the 1st October 2019 Liverpool University Hospitals NHS Foundation Trust acquired The Royal Liverpool and Broadgreen University Hospitals NHS Trust. The timing of the acquisition at the half way point of 2019/20 is the principle driver when comparing the income figures of 2020/21 against 2019/20.

* This income relates to funding received during the COVID-19 pandemic – which in turn reflects additional costs incurred and income lost during the period.

** This income relates to contributions received towards expenses relating to COVID-19 pandemic – most notably for equipment and consumable items.

Note 4.1 Other operating income (continued)

*** PSF, FRF and MRET are all income incentives due on the delivery of control total targets that are established. The control total is an annual financial target that must be achieved to unlock access to national funding and other financial benefits. All NHS providers are offered a control total that they can accept or reject. Access to national sustainability and transformation funding is conditional on providers agreeing and delivering their control total. During the reporting period 2019/20, the Trust over-achieved its control total (the Trust did not sign up to a control total during 2020/21).

Note 4.2 Analysis of other contract income

	2020/21 £000	2019/20 £000
Car park income	878	3,196
Catering	1,776	3,269
Staff and accommodation rental	434	483
Clinical excellence award	2,215	1,370
Income generation schemes	896	1,129
Other income	4,637	3,399
	10,836	**12,846**

Note 5 Additional information on contract revenue (IFRS 15) recognised in the year

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

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting year that was included in within contract liabilities at the previous year end	6,007	3,568

Note 5.2 Income from activities arising from commissioner requested services

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

	2020/21 £000	2019/20 £000
Income from services designated as commissioner requested services	856,207	549,815
Income from services not designated as commissioner requested services	11,478	13,508
Total	**867,685**	**563,323**

Note 6 Operating expenses

Note 6.1 Operating expenses

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	2,748	1,614
Purchase of healthcare from non-NHS and non-DHSC bodies	9,030	5,194
Staff and executive directors costs	674,588	430,430
Remuneration of non-executive directors	178	141
Supplies and services - clinical (excluding drugs costs)	109,224	72,943
Supplies and services - general	45,209	24,900
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	87,995	60,113
Consultancy costs	2,545	1,035
Establishment	10,314	7,328
Premises	50,686	28,279
Transport (including patient travel)	3,522	2,833
Depreciation on property, plant and equipment	22,873	12,886
Amortisation on intangible assets	5,274	2,144
Net impairments	-	9,003
Movement in credit loss allowance: contract receivables / contract assets *	13,887	1,380
Increase in other provisions	565	229
Audit fees payable to the external auditor's		
audit services- statutory audit	382	254
Internal audit costs	22	118
Clinical negligence	15,020	9,962
Legal fees	1,147	328
Insurance	354	511
Research and development	10,940	4,355
Education and training	6,979	2,850
Rentals under operating leases	4,790	3,932
Redundancy	175	347
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	10,516	5,241
Hospitality	17	75
Other services, eg external payroll	978	580
Other	8,145	2,120
Total	**1,098,103**	**691,125**
Of which:		
Related to continuing operations	1,098,103	691,125

On the 1st October 2019 Liverpool University Hospitals NHS Foundation Trust acquired The Royal Liverpool and Broadgreen University Hospitals NHS Trust. The timing of the acquisition at the half way point of 2019/20 is the principle driver when comparing the expenditure figures of 2020/21 against 2019/20.

* The increased movement in credit loss allowance relates to an increased allowance for impaired contract receivables. This increase reduces future risk to the Trust from impaired receivables.

Note 7 Impairments

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus resulting from:		
Changes in market price	-	9,003
Total net impairments charged to operating surplus	**-**	**9,003**
Impairments charged to the revaluation reserve	-	9
Total net impairments	**-**	**9,012**

No impairments have been recorded during 2020/21

The 2019/20 asset impairment is based on the asset value at 31st March 2020 and the remaining useful life provided by the District Valuer. The impairment represents the difference between the value of the buildings at 31st March 2020 (for those buildings due to be demolished upon completion of the new hospital) and the estimated depreciated value of these buildings over the period 1st April 2020 to 31st March 2023, resulting in a net book value of zero at 31st March 2023.

Note 8 Employee Benefits

Note 8.1 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	540,234	338,124
Social security costs	49,768	31,116
Apprenticeship levy	2,572	1,587
Employer's contributions to NHS pensions	79,746	51,814
Pension cost - other	95	87
Termination benefits	417	667
Temporary staff (including agency)	17,036	14,376
Total gross staff costs	**689,868**	**437,771**
Of which		
Costs capitalised as part of assets	1,294	1,326

On the 1st October 2019 Liverpool University Hospitals NHS Foundation Trust acquired The Royal Liverpool and Broadgreen University Hospitals NHS Trust. The timing of the acquisition at the half way point of 2019/20 is the principle driver when comparing the expenditure figures of 2020/21 against 2019/20.

Head count disclosures have been included within the Staff Report.

Senior staff salary and pension disclosures have been included within the Remuneration Report.

Note 8.2 Retirements due to ill-health

During 2020/21 there were 4 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2020). The estimated additional pension liability of these ill-health retirements is £199k (£112k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

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 for Health and Social Care 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 year.

Note 9 Pension costs (continued)

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

Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021 is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

National Employment Savings Scheme (NEST)

The Pensions Act 2008 introduced automatic enrolment of eligible workers into a qualifying workplace pension scheme. The National Employment Savings Scheme (NEST) is a defined contribution pension scheme and the Trust has a duty to automatically enrol employees into the scheme, subject to certain criteria. However, the number of enrolments and the level of contributions are not material to the Trust's Accounts.

Note 10 Operating Lease

Note 10.1 Liverpool University Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Liverpool University Hospitals NHS Foundation Trust is the lessor.

The Trust has continued to agree tenancies for the Accelerator building with non-NHS organisations including the Liverpool School of Tropical Medicine.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	776	342
Total	**776**	**342**

Note 10.1 Liverpool University Hospitals NHS Foundation Trust as a lessor (continued)

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	813	59
- later than one year and not later than five years;	2,564	236
- later than five years.	899	-
Total	**4,276**	**295**

On the 1st October 2019 Liverpool University Hospitals NHS Foundation Trust acquired The Royal Liverpool and Broadgreen University Hospitals NHS Trust. The timing of the acquisition at the half way point of 2019/20 is the principle driver when comparing the expenditure figures of 2020/21 against 2019/20.

Note 10.2 Liverpool University Hospitals NHS Foundation Trust as a lessee

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

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	4,790	3,932
Total	**4,790**	**3,932**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	3,755	4,476
- later than one year and not later than five years;	8,083	10,884
- later than five years.	2,442	4,880
Total	**14,280**	**20,240**

Note 11 Finance Income

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

	2020/21 £000	2019/20 £000
Interest on bank accounts	5	200
Total finance income	**5**	**200**

Note 12 Finance Expenses

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

	2020/21 £000	2019/20 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,332	4,582
Other loans	122	61
Finance leases	649	344
Main finance costs on PFI and LIFT schemes obligations	279	165
Contingent finance costs on PFI and LIFT scheme obligations	510	255
Total interest expense	**2,892**	**5,407**
Unwinding of discount on provisions	(6)	(7)
Total finance costs	**2,886**	**5,400**

Note 13 Intangible Assets

Note 13.1 Intangible assets - 2020/21

	Software licences £000	Internally generated information technology £000	Assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**1,109**	**22,007**	**-**	**23,116**
Additions	1,597	540	-	**2,137**
Disposals / derecognition	-	(76)	-	**(76)**
Valuation / gross cost at 31 March 2021	**2,706**	**22,471**	**-**	**25,177**
Accumulated amortisation at 1 April 2020 - brought forward	**606**	**5,611**	**-**	**6,217**
Provided during the year	289	4,985	-	**5,274**
Disposals / derecognition	-	(76)	-	**(76)**
Accumulated amortisation at 31 March 2021	**895**	**10,520**	**-**	**11,415**
Net book value at 31 March 2021	**1,811**	**11,951**	**-**	**13,762**
Net book value at 1 April 2020	**503**	**16,396**	**-**	**16,899**

Note 13.2 Intangible assets - 2019/20

	Software licences £000	Internally generated information technology £000	Assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 – brought forward	**1,109**	**-**	**-**	**1,109**
Transfers by absorption	-	26,006	2,551	**28,557**
Additions	-	2,465	-	**2,465**
Reclassifications	-	2,551	(2,551)	**-**
Disposals / derecognition	-	(9,015)	-	**(9,015)**
Valuation / gross cost at 31 March 2020	**1,109**	**22,007**	**-**	**23,116**
Accumulated amortisation at 1 April 2019 – brought forward	**317**	**-**	**-**	**317**
Transfers by absorption	-	6,613	-	**6,613**
Provided during the year	289	1,855	-	**2,144**
Disposals / derecognition	-	(2,857)	-	**(2,857)**
Accumulated amortisation at 31 March 2020	**606**	**5,611**	**-**	**6,217**
Net book value at 31 March 2020	**503**	**16,396**	**-**	**16,899**
Net book value at 1 April 2019	**792**	**-**	**-**	**792**

Note 14 Property, Plant and Equipment

Note 14.1 Property, plant and equipment – 2020/21

	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 2020 – brought forward	**32,105**	**286,934**	**1,690**	**280,077**	**132,969**	**194**	**42,688**	**8,980**	**785,637**
Additions *	-	11,176	-	164,728	19,389	158	9,035	42	**204,528**
Revaluations	-	4,242	24	-	-	-	-	-	**4,266**
Disposals	-	-	-	-	(27,477)	(176)	(4,691)	(2,469)	**(34,813)**
Valuation/gross cost at 31 March 2021	**32,105**	**302,352**	**1,714**	**444,805**	**124,881**	**176**	**47,032**	**6,553**	**959,618**
Accumulated depreciation at 1 April 2020 – brought forward	**-**	**-**	**-**	**-**	**102,271**	**184**	**29,329**	**7,785**	**139,569**
Provided during the year	-	12,551	66	-	6,583	5	3,429	239	**22,873**
Revaluations	-	178	1	-	-	-	-	-	**179**
Disposals	-	-	-	-	(27,477)	(176)	(4,691)	(2,469)	**(34,813)**
Accumulated depreciation at 31 March 2021	**-**	**12,729**	**67**	**-**	**81,377**	**13**	**28,067**	**5,555**	**127,808**
Net book value at 31 March 2021	**32,105**	**289,623**	**1,647**	**444,805**	**43,504**	**163**	**18,965**	**998**	**831,810**
Net book value at 1 April 2020	**32,105**	**286,934**	**1,690**	**280,077**	**30,698**	**10**	**13,359**	**1,195**	**646,068**

* The capital addition expenditure within assets under construction during relates primarily to the development of the New Royal Hospital.

Note 14.2 Property, plant and equipment – 2019/20

	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 2019 – as previously stated	**5,056**	**178,298**	**1,766**	**2,652**	**25,912**	**18**	**8,132**	**692**	**222,526**
Transfers by absorption	25,460	111,055	-	238,465	103,022	176	31,062	8,267	**517,507**
Additions	-	23,212	-	43,525	5,925	-	2,130	-	**74,792**
Impairments	-	(23,745)	-	-	-	-	-	-	**(23,745)**
Reversals of impairments	-	7,578	-	-	-	-	-	-	**7,578**
Revaluations	1,589	(11,177)	(76)	-	-	-	-	-	**(9,664)**
Reclassifications	-	1,713	-	(4,565)	1,467	-	1,364	21	**-**
Disposals	-	-	-	-	(3,357)	-	-	-	**(3,357)**
Valuation/gross cost at 31 March 2020	**32,105**	**286,934**	**1,690**	**280,077**	**132,969**	**194**	**42,688**	**8,980**	**785,637**
Accumulated depreciation at 1 April 2019 – as previously stated	**-**	**5,849**	**86**	**-**	**18,955**	**4**	**6,225**	**487**	**31,606**
Transfers by absorption	-	5,322	-	-	82,732	175	21,127	7,140	**116,496**
Provided during the year	-	6,761	44	-	3,941	5	1,977	158	**12,886**
Impairments	-	(1,391)	-	-	-	-	-	-	**(1,391)**
Reversals of impairments	-	(5,764)	-	-	-	-	-	-	**(5,764)**
Revaluations	-	(10,777)	(130)	-	-	-	-	-	**(10,907)**
Disposals	-	-	-	-	(3,357)	-	-	-	**(3,357)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**102,271**	**184**	**29,329**	**7,785**	**139,569**
Net book value at 31 March 2020	**32,105**	**286,934**	**1,690**	**280,077**	**30,698**	**10**	**13,359**	**1,195**	**646,068**
Net book value at 1 April 2019	**5,056**	**172,449**	**1,680**	**2,652**	**6,957**	**14**	**1,907**	**205**	**190,920**

Note 14.3 Property, plant and equipment financing – 2020/21

	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 2021									
Owned - purchased	32,105	276,506	1,647	369,705	38,110	163	15,599	998	**734,833**
Finance leased	-	6,553	-	-	49	-	3,364	-	**9,966**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	1,974	-	-	-	**1,974**
Owned - donated/granted *	-	6,564	-	75,100	3,371	-	2	-	**85,037**
NBV total at 31 March 2021	**32,105**	**289,623**	**1,647**	**444,805**	**43,504**	**163**	**18,965**	**998**	**831,810**

Note 14.4 Property, plant and equipment financing – 2019/20

	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 2020									
Owned - purchased	32,105	274,120	1,690	204,977	25,725	10	8,581	1,195	**548,403**
Finance leased	-	5,930	-	-	240	-	4,778	-	**10,948**
On-SoFP PFI contracts and other service concession arrangements	-	378	-	-	2,268	-	-	-	**2,646**
Owned - donated/granted *	-	6,506	-	75,100	2,465	-	-	-	**84,071**
NBV total at 31 March 2020	**32,105**	**286,934**	**1,690**	**280,077**	**30,698**	**10**	**13,359**	**1,195**	**646,068**

* The Owned – donated value of £75.1 million is a proportion of the total value of the New Royal Liverpool Hospital (under construction) which transferred at book value from the demised Royal Liverpool and Broadgreen University Hospital NHS Trust. In arriving at this donated valuation, the Royal Liverpool and Broadgreen University Hospital NHS Trust had 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 (under construction) to the public sector with regards to donations of Property, Plant and Equipment. The Trust was 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. This proportionate split of the asset as part-purchased and part-donated will be used for subsequent accounting purposes and maintained during asset revaluations.

Note 15 Donations of property, plant and equipment

During 2020-21 the Trust received donations by way of tangible assets (non-cash) to the value of £257k from the Trusts associated Charitable Funds (Donations of £270k were received in 2019/20).

Also during the year the Trust received donations by way of tangible assets (non-cash) to the value of £1,130k from the Department of Health and Social Care to support the COVID-19 response. These assets included items such as ventilators, imaging equipment and testing Equipment.

The total £1,387k donation accounts for a small proportion of the overall Property, Plant and Equipment addition total of £204,528k, which can be seen in note 14.1.

Note 16 Revaluations of property, plant and equipment

In accordance with the Department of Health and Social Care Group accounting manual, the land and buildings 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 valuations were undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the NHS, and the requirements of the RICS Valuation Professional Standards. The valuer declared a 'material valuation uncertainty' in the valuation report as a result of COVID-19, however subsequently confirmed that there has been no diminution identified in the public sectors ongoing requirement for these assets, nor a reduction in their ongoing remaining economic service potential, therefore no impact was noted.

During 2019/20, the Trust contracted the services of the District Valuer to comprehensively value all of its sites (with the exception of the ongoing New Royal Hospital) following the transfer of assets by absorption which significantly increased the non-current fixed assets under its control. This revaluation increased the estate value by £1,243k.

The Land, Buildings and Dwellings asset base was professionally and independently revalued as at 31 March 2020 (by the District Valuation Office). This included a thorough review of every asset within these categories including signs of impairment and a review of lives. This comprehensive review was undertaken a year ago (concluded in March 2020), and is within the recommended 3 to 5 year revaluation window and is still considered to be a fair and accurate reflection of the PPE asset base.

It is the view of management that there has been no indication of “volatility of asset values” during the financial year. Therefore, a full valuation is not required. However, due to the increase in costs relating to the time since the previous valuation, it is necessary to add an appropriate level of indexation to the Property element of the asset base.

As the DHSC Group Accounting Manual (GAM) does not specify which index to use, the Trust has considered it appropriate to use the Office for National Statistics produced Construction Output Price Indices, which is a nationally recognised, independent and is relevant to the task at hand. This indicates that Construction Output Prices increased by 1.4% over the 12 month period.

Shown through Property, Plant and Equipment (note 14.1)

	Buildings excluding dwellings	Dwellings	Total
	£000	£000	£000
Valuation/gross cost	4,242	24	4,266
Accumulated depreciation	(178)	(1)	(179)
	4,064	**23**	**4,087**

Note 17 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	4,710	5,004
Consumables	1,670	7,692
Total inventories	**6,380**	**12,696**

Note 17 Inventories (continued)

Inventories recognised in expenses for the year were £107,473k (2019/20: £88,733k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £13,456k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Due to the operational pressures the hospital was facing in March 2020 (resulting from preparing for the COVID pandemic), it was not possible to undertake a physical stock count in all areas. Consequently, the Trust undertook alternative procedures which involved estimation of stock levels based on previous year's levels. This estimation applied to less than 9% of the overall stock value and therefore was not significant.

Note 18 Receivables

Note 18.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables *	62,957	99,104
Allowance for impaired contract receivables / assets	(12,468)	(3,834)
Prepayments (non-PFI)	7,522	6,313
PDC dividend receivable	3,837	788
VAT receivable	3,617	1,779
Other receivables	2,445	3,236
Total current receivables	**67,910**	**107,386**
Non-current		
Contract receivables	-	338
Prepayments (non-PFI)	1,130	1,115
Other receivables	2,749	2,164
Total non-current receivables	**3,879**	**3,617**
Of which receivable from NHS and DHSC group bodies:		
Current	34,074	73,849
Non-current	2,749	2,164

* The significant reduction to contract receivables is driven by the settlement of bonus incentive income received in year relating to 2019/20.

Note 18.2 Allowances for credit losses

	2020/21 Contract receivables and contract assets	2019/20 Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**3,834**	**1,924**
Transfers by absorption	-	1,059
New allowances arising *	14,839	1,592
Reversals of allowances	(952)	(212)
Utilisation of allowances (write offs)	(5,253)	(529)
Allowances as at 31 Mar 2021	**12,468**	**3,834**

* During the year the Trust reviewed the overall receivables and concluded that in order to be prudent further allowances for credit losses needed to be established. This is in line with the requirements of the IFRS 9.

Note 19 Cash and Cash Equivalents

Note 19.1 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.

	2020/21 £000	2019/20 £000
At 1 April	**43,643**	**7,638**
Transfers by absorption	-	4,026
Increase in year	123,890	31,979
At 31 March	**167,533**	**43,643**
Broken down into:		
Cash at commercial banks and in hand	128	30
Cash with the Government Banking Service	167,405	43,613
Total cash and cash equivalents as in SoFP	**167,533**	**43,643**
Total cash and cash equivalents as in SoCF	**167,533**	**43,643**

Note 19.2 Third party assets held by the trust

Liverpool University Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2021 £000	31 March 2020 £000
Bank balances	-	5
Total third party assets	**-**	**5**

Note 20 Trader and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	21,313	23,067
Capital payables *	38,242	5,561
Accruals **	90,900	48,914
Social security costs	7,166	6,508
Other taxes payable ***	6,816	5,596
Other payables	12,702	12,194
Total current trade and other payables	**177,139**	**101,840**

* The increase in Capital payables is driven by a combination of the Trusts capital programme being heavily weighted to the final quarter of the fiscal year and the timing of contractual payments relating to the construction of the New Royal Hospital.

** The increase in Accruals is driven by a number of factors relating to outstanding payments due to be paid. The majority of the increase relates to staff related costs such as accrued annual leave, bank and agency cover.

*** Taxes payable relates to monies owed to HMRC and relates to both employee salary deductions and employer contributions.

Note 21 Other Liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	14,481	9,711
Total other current liabilities	**14,481**	**9,711**
Non-current		
Deferred income: contract liabilities	168	204
Total other non-current liabilities	**168**	**204**

Note 22 Borrowings

Note 22.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	2,642	222,280
Other loans	11,538	11,560
Obligations under finance leases	1,331	1,396
Obligations under PFI, LIFT or other service concession contracts	883	830
Total current borrowings	**16,394**	**236,066**
Non-current		
Loans from DHSC	36,273	38,697
Obligations under finance leases	11,736	13,066
Obligations under PFI, LIFT or other service concession contracts	2,470	3,353
Total non-current borrowings	**50,479**	**55,116**

Note 22.1 Borrowings (continued)

Analysis of DHSC Normal Course of Business (NCB) loans	Interest rate	Term (years)
Loan 1 - (Original value £24,000,000, remaining value £13,744,000) Agreement date March 2010 – End date March 2035	4.27%	25
Loan 2 - (Original value £20,000,000, remaining balance £13,451,000) Agreement date December 2011 – End date December 2036	2.92%	25
Loan 3 - (Original value £15,000,000, remaining balance £11,720,000) Agreement date December 2014 – End date December 2039	2.62%	25
Analysis of other loans		
Chrysalis loan – (Original value £11,500,000, remaining value £11,500,000) Agreement date November 2015 – End date August 2022	1.05%	7
Salix loan – (Original value £38,268, remaining value £38,268) Agreement date January 2017 – End date October 2021	0.00%	4

In total the Liverpool University Hospitals NHS Foundation Trust holds 3 DHSC interim loans and 2 external to DHSC loans, all of which have various start dates, original borrowing amounts, interest rates and terms.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS Cash Regime for the 2020/21 financial year. During 2020/21, existing DHSC interim revenue and capital loans to the value of £218,489k have been extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow repayment.

Note 22.2 Reconciliation of liabilities arising from financing activities – 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**260,977**	**11,560**	**14,462**	**4,183**	**291,182**
Cash movements:					
Financing cash flows - payments of principal	(220,912)	(8)	(1,395)	(830)	**(223,137)**
Financing cash flows - payments of interest	(2,482)	(136)	(649)	(279)	**(3,554)**
Non-cash movements:					
Application of effective interest rate	1,332	122	649	279	**2,382**
Carrying value at 31 March 2021	**38,915**	**11,538**	**13,067**	**3,353**	**66,873**

Note 22.3 Reconciliation of liabilities arising from financing activities – 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**73,700**	**-**	**-**	**-**	**73,700**
Cash movements:					
Financing cash flows - payments and receipts of principal	34,930	(4)	(730)	(392)	**33,804**
Financing cash flows - payments of interest	(4,583)	-	(344)	(165)	**(5,092)**
Non-cash movements:					
Transfers by absorption	152,348	11,503	15,192	4,575	**183,618**
Application of effective interest rate	4,582	61	344	165	**5,152**
Carrying value at 31 March 2020	**260,977**	**11,560**	**14,462**	**4,183**	**291,182**

Note 23 Finance leases where Liverpool University Hospitals NHS Foundation Trust is the lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**18,116**	**20,160**
of which liabilities are due:		
- not later than one year;	1,898	2,045
- later than one year and not later than five years;	4,900	6,246
- later than five years.	11,318	11,869
Finance charges allocated to future years	(5,049)	(5,698)
Net lease liabilities	**13,067**	**14,462**
of which payable:		
- not later than one year;	1,331	1,396
- later than one year and not later than five years;	3,370	4,449
- later than five years.	8,366	8,617
Contingent rent recognised as expense in the year	(510)	(255)

Note 24 Provisions

Note 24.1 Provisions for liabilities and charges analysis 2020/21

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Clinician's Pension £000	Other £000	Total £000
At 1 April 2020	**793**	**668**	**714**	**2,164**	**615**	**4,954**
Arising during the year	193	18	237	585	735	**1,768**
Utilised during the year	(295)	(105)	(148)	-	-	**(548)**
Reversed unused	-	-	(102)	-	-	**(102)**
Unwinding of discount	(4)	(2)	-	-	-	**(6)**
At 31 March 2021	**687**	**579**	**701**	**2,749**	**1,350**	**6,066**
Expected timing of cash flows:						
- not later than one year;	296	104	701	-	**-**	**1,101**
- later than one year and not later than five years;	318	465	-	2,749	1,350	**4,882**
- later than five years.	73	10	-	-	**-**	**83**
Total	**687**	**579**	**701**	**2,749**	**1,350**	**6,066**

Pensions - include the likely cost of permanent injury and early departure pension compensation settlements and the subsequent application of the appropriate value supplied by the Government's Actuary Department to assess the total provision required for the anticipated duration of the liability. The provision is calculated using life expectancy tables provided by the Office of National Statistics. Payments are made quarterly to the NHS Pension Scheme and NHS Injury Benefit Scheme It does not include any provision relating to former Directors.

Legal claims - comprises provisions in respect of the Trust's employer and public legal liabilities.

Clinician's Pension - tax owed by Consultants in respect of the growth of their NHS pension benefits above their pension savings annual allowance.

Other - includes the accumulated surpluses relating to Mersey Internal Audit Agency (MIAA). The accumulated surpluses attributable to MIAA would require distribution or transfer should there be a future change in arrangements.

Note 24.2 Provisions for liabilities and charges analysis 2019/20

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Clinician's Pension	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**127**	**446**	**340**	-	-	**913**
Transfers by absorption	817	296	298	-	958	**2,369**
Arising during the year	32	3	280	2,164	-	**2,479**
Utilised during the year	(178)	(75)	(118)	-	(343)	(714)
Reversed unused	-	-	(86)	-	-	(86)
Unwinding of discount	(5)	(2)	-	-	-	(7)
At 31 March 2020	**793**	**668**	**714**	**2,164**	**615**	**4,954**
Expected timing of cash flows:						
- not later than one year;	299	112	714	-	**-**	**1,125**
- later than one year and not later than five years;	343	535	-	2,164	**615**	**3,657**
- later than five years.	151	21	-	-	**-**	**172**
Total	**793**	**668**	**714**	**2,164**	**615**	**4,954**

Note 24.3 Clinical negligence liabilities

At 31 March 2021, £49,127k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Liverpool University Hospitals NHS Foundation Trust (31 March 2020: £34,242k).

Note 25 Contractual Capital Commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	100,434	90,630
Total	**100,434**	**90,630**

£92.3m (31 March 2020: £89.9m) of the contractual capital commitment is in relation to the ongoing construction of the new Royal Hospital site. The commitment will be cash settled during 2021-22 as construction milestones are achieved.

Note 26 On-SoFP PFI, LIFT or other service concession arrangements

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

Warrington Dialysis Unit:
Contract Start Date: 29/01/1996
Contract End Date: 08/04/2021

Broadgreen Dialysis Unit:
Contract Start Date: 19/05/1999
Contract End Date: 08/04/2023

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

Veolia 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

Note 26 On-SoFP PFI, LIFT or other service concession arrangements (continued)

Retail Development:
The Trust has entered 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 26.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**3,916**	**5,025**
Of which liabilities are due		
- not later than one year;	1,109	1,109
- later than one year and not later than five years;	2,807	3,885
- later than five years.	-	31
Finance charges allocated to future years	(563)	(842)
Net PFI, LIFT or other service concession arrangement obligation	**3,353**	**4,183**
- not later than one year;	883	830
- later than one year and not later than five years;	2,470	3,273
- later than five years.	-	80

Note 26.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**40,458**	**52,330**
Of which payments are due:		
- not later than one year;	11,434	11,596
- later than one year and not later than five years;	29,024	39,333
- later than five years.	-	1,401

Note 26.3 Analysis of amounts payable to service concession operator
This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21 £000	2019/20 £000
Unitary payment payable to service concession operator	**12,135**	**6,053**
Consisting of:		
- Interest charge	279	165
- Repayment of balance sheet obligation	830	392
- Service element and other charges to operating expenditure	10,516	5,241
- Contingent rent	510	255
Total amount paid to service concession operator	**12,135**	**6,053**

On the 1st October 2019 Liverpool University Hospitals NHS Foundation Trust acquired The Royal Liverpool and Broadgreen University Hospitals NHS Trust. The timing of the acquisition at the half way point of 2019/20 is the principle driver when comparing the expenditure figures of 2020/21 against 2019/20.

Note 27 Financial instruments

Note 27.1 Financial Risk Management

Although the Trust does not hold or deal in complex financial instruments, it is required to comment upon such risk and how it is managed.

Credit Risk
The majority of the NHS Foundation Trust's income is due from NHS commissioners and NHS England and is subject to legally binding contracts which limits credit risk. Non-NHS customers form only a small proportion of total income and the majority of those customers are organisations that are unlikely to cease trading in the short term or default on payments (e.g. councils, universities, Woodlands Hospice, etc.).

To manage credit risk, the NHS Foundation Trust has documented debt collection procedures which are regularly reviewed and ensures that its credit control staff are adequately trained and resourced. Potential payment defaulters are identified at an early stage and appropriate action is taken on a timely basis. The carrying amount of financial assets (see note 27.2) represents maximum credit exposure.

Liquidity Risk
The NHS Foundation Trust is exposed to liquidity risk in that it needs to maintain sufficient cash balances to meet payable obligations in order to ensure continuity of service. However, that risk is mitigated by the regular monthly receipt of contractual cash from NHS commissioners in addition to non-recurrent revenue support loans from the Department of Health and Social Care (in line with the Trusts annual plan).

The NHS Foundation Trust ensures that daily cash flows are examined and the investment of surplus cash is restricted to a term of three months. Cash investments are also restricted to highly rated, UK domiciled, financial institutions and the levels of cash deposited in any individual institutions at any one time is restricted. Cash management is governed by a regularly reviewed Board Policy and departmental procedure notes.

Market Risk
As the NHS Foundation Trust does not deal in currencies, invest cash over the long term, borrow at variable rates or hold any equity investments in companies (other than its own subsidiary, Liverpool Healthcare Limited) its exposure to market risk (either interest rate, currency or price) is limited.

Market risk is managed by limiting investments to fixed rate and fixed term with credit worthy institutions, based upon market knowledge as to the likely movements in interest rates.

Note 27.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	55,683	**55,683**
Cash and cash equivalents	167,533	**167,533**
Total at 31 March 2021	**223,216**	**223,216**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	101,008	**101,008**
Cash and cash equivalents	43,643	**43,643**
Total at 31 March 2020	**144,651**	**144,651**

Note 27.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	38,915	**38,915**
Obligations under finance leases	13,067	**13,067**
Obligations under PFI, LIFT and other service concession contracts	3,353	**3,353**
Other borrowings	11,538	**11,538**
Trade and other payables excluding non-financial liabilities	163,157	**163,157**
Total at 31 March 2021	**230,030**	**230,030**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	260,977	**260,977**
Obligations under finance leases	14,462	**14,462**
Obligations under PFI, LIFT and other service concession contracts	4,183	**4,183**
Other borrowings	11,560	**11,560**
Trade and other payables excluding non-financial liabilities	89,736	**89,736**
Total at 31 March 2020	**380,918**	**380,918**

Note 27.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	181,386	326,731
In more than one year but not more than five years	21,622	19,824
In more than five years	42,868	40,905
Total	**245,876**	**387,460**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis as required by IFRS 7 paragraph B11D. The prior year total was £380,918k; in one year or less £325,802k, in more than one year but not more than two years £4,637k, in more than two years but not more than five years £12,777k and in more than five years £37,702k

Note 27.5 Fair values of financial assets and liabilities

The carrying value of the financial liabilities is considered to approximate to fair value as the arrangement is of a fixed interest and equal instalment repayment nature and the interest rate is not materially different to the discount rate.

The carrying values of short-term financial assets and financial liabilities are considered to approximate to fair value.

Note 28 Losses and special payments

There were 1,982 losses and special payments in 2020/21 totalling £4,339k (365 in 2019/20 totalling £696k). These are accounted for on an accruals basis and exclude provisions for future losses. No individual losses exceeded £300,000 (no individual losses exceeded £300,000 in 2019/20).

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	2	1
Bad debts and claims abandoned *	1,898	4,101	307	529
Total losses	**1,898**	**4,101**	**309**	**530**
Special payments				
Compensation under court order or legally binding arbitration award	3	12	-	-
Ex-gratia payments	81	226	56	166
Total special payments	**84**	**238**	**56**	**166**
Total losses and special payments	**1,982**	**4,339**	**365**	**696**

* The increase in both numbers of cases and value of cases predominantly relates to the in year write-down of irrecoverable receivables.

Note 29 Related parties

Liverpool University Hospitals NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006, and the Department of Health and Social Care are the Trust's parent. The Trust is therefore a related party to all bodies within the government accounts boundary.

All government bodies which fall within the whole of government accounts boundary are regarded as related parties because they are all under the common control of HM Government and Parliament. This includes, for example, all NHS bodies, all local authorities and central government bodies. The main bodies with whom the Trust has financial transactions with are included below:

- Liverpool CCG
- South Sefton CCG
- Knowsley CCG
- Health Education England
- HMRC

During the year reported in these accounts, none of the Board Members, Governors or key management staff has undertaken any material transactions with Liverpool University Hospitals NHS Foundation Trust. Details of Directors' remuneration and other benefits are included in the Annual Report's Remuneration Report.

Some staff and Governors of the Trust have an interest in the management of Woodlands Hospice Charitable Trust (a Hospice sited on the Trust grounds). The Trust does not enter into income and expenditure transactions with the Charity, it does however undertake some transaction processes on its behalf, such as procurement.

One member of the Board of Directors and Governors of the Trust holds a similar position at Liverpool University.

	Income		**Receivables**	
	2020/21 £000	**2019/20 £000**	**31 March 2021 £000**	**31 March 2020 £000**
Liverpool University	**1,897**	923	**1,009**	999

	Expenditure		**Payables**	
	2020/21 £000	**2019/20 £000**	**31 March 2021 £000**	**31 March 2020 £000**
Liverpool University	**4,641**	3,853	**322**	1,395

Note 30 Transfer by absorption (relating to 2019/20)

Analysis of balances transferred to successor organisations (£000)			
Amounts transferred from:		**Amounts transferred to:**	
Royal Liverpool and Broardgreen University Hospitals NHS Trust		**Liverpool University Hospitals NHS Foundation Trust**	
Non-Current Assets	426,725	Non-Current Assets	426,725
Current Assets	105,714	Current Assets	105,714
Current Liabilities	(91,910)	Current Liabilities	(91,910)
Non-Current Liabilities	(148,305)	Non-Current Liabilities	(148,305)
Net Assets	**292,224**	**Net Assets**	**292,224**

On 1 October, The Royal Liverpool and Broadgreen University Hospital NHS Trust were acquired by Aintree University Hospital NHS Foundation Trust, as approved by NHS Improvement in September 2019.

The net assets of the Trust were transferred to Aintree University Hospital NHS Foundation Trust (which subsequently renamed on 1 October 2019 to Liverpool University Hospitals NHS Foundation Trust) on 1 October 2019 by means of a Deed of Transfer, as approved by Secretary of State for Health.

All of the services previously provided by the Royal Liverpool and Broadgreen University NHS Trust continue to be provided as part of the acquisition.