Annual report
2017/18

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[Inside front cover]

Trust values

Respect our patients and colleagues

- Actively engage patients, carers and staff in decision-making at every level

Commitment to quality of care

- Provide high quality, safe and effective care
- Use resources effectively and efficiently to deliver excellent patient experience
- Be open and transparent about our performance

Compassion

- Put patients, their families and carers at the heart of everything we do
- Listen and respond to feedback from patients, GPs and other stakeholders

Improving lives

- Deliver the right care in the right place at the right time
- Encourage innovation in all that we do
- Work together for patients
- Support our staff and make sure they have access to the education, training and development opportunities they need to do their job well

Working together for patients

- Work creatively with local partners to secure benefits for local people
- Support our staff and ensure they have access to the education, training and development opportunities they need to do their job well

Everyone counts

- Be respectful of everyone's views
- Ensure we are open minded and willing to change and do things differently

INTRODUCTION AND BACKGROUND

1. Chair's foreword

We hope that you find the annual report a useful guide to progress over 2017/18.

I am extremely proud of how hard staff at Lewisham and Greenwich NHS Trust have worked over the year to serve patients and our local communities. This has resulted in improvements to safety and quality, as you can see in the following pages.

The Care Quality Commission (CQC) carried out a full inspection of the Trust in March last year (2017). They complimented the Trust for making improvements since the previous inspection, and noted a number of areas of best practice, such as our community services, which were rated "outstanding". However, it was clear that, at the time of the inspection, we were not getting it right consistently across the Trust for every patient, leading to an overall rating of "requires improvement".

Recognising the improvements we need to make, we launched a quality and safety improvement plan to address the issues raised by the CQC. We have made many improvements since the inspection, such as introducing regular safety checks for all patients, developing new services and improving medicines management (see section 5). We have also made significant improvements for patients requiring emergency services (section xx). There is more still to do, and we will continue to focus on our improvement plan over 2018/19.

The last year has been a time of significant change to the Trust Board, and I would like to thank my predecessor Elizabeth Butler, and our former chief executive Tim Higginson, for their superb work and leadership over many years. Elizabeth and Tim oversaw the merger of Lewisham Healthcare and Queen Elizabeth Hospital to form Lewisham and Greenwich NHS Trust in 2013, and many of the achievements in the following pages are testament to their leadership and commitment.

We are delighted that we were able to appoint Ben Travis as our chief executive from a strong field of candidates. Ben joined us from one of our partners in south east London, Oxleas NHS Foundation Trust, and so knows our local community and health economy. I am sure you will join me in welcoming him to the organisation.

We are also delighted to welcome Angela Helleur as our new chief nurse. Angela spent time at the Trust last year, supporting us in delivering our quality and safety plan, in her role as NHSI improvement director. As chief nurse she will have a key role as we continue to improve the services we provide for our local communities.

Change is inevitably unsettling for any organisation but it also brings opportunities through fresh ideas about the we way we think and do things. Although the operational pressures are significant, I do believe we are in a strong position to create a high performing Trust that staff want to work in and that our communities look to as their preferred place of treatment.

Thank you for your ongoing support.

Val Davison, Chair

2. Chief executive's introduction

Welcome to our annual report for 2017/18.

I joined Lewisham and Greenwich NHS Trust in April 2018 and have been struck by how committed our staff are to doing their absolute best for patients. It is clear from the following pages that there is a huge amount of good work being carried out across the organisation, with staff going the extra mile every day.

It is also clear that staff have faced significant pressures over the last year. In particular, the CQC report highlighted some safety and quality issues, and there have been high levels of scrutiny from regulators and stakeholders. It has been a difficult winter, and we have faced challenges meeting national performance standards, as well as challenges managing our financial resources.

We are committed to making the necessary improvements to quality and safety while returning to financial stability. This means doing more to share all the good work that takes place within the Trust, celebrating and learning from what we do well, so we can get it right for every patient, every time. It is vital that we provide timely treatment for our patients, and we have been developing our plans to meet key performance targets by the end of 2018/19.

We need to ensure that all our staff get the support they need, so that the Trust is a rewarding place to work. This will reduce the need for expensive agency staff and ensure that we are continuing to attract and retain the best people. There are a range of initiatives that are already in place to help us do this (see section xxx), and this will continue to be a major priority over 2018/19.

I'm new to the organisation, and we have a new chair and chief nurse, so it's a good opportunity to review the Trust's core values. Our values form the framework for how we deliver services and relate to one another. We will speaking to staff and partners to ensure that we have the right values in place, and then working to embed them across the organisation, from the wards to the board.

Linked to this, we are developing a "roadmap" for the Trust. This will outline our priorities and key areas of work for the next couple of years. By setting out what we need to do, we can work with partners and staff to ensure that we are all pulling in the same direction, and working towards achieving the same goals.

As well as developing our clinical strategy, we know that one of our aims is to manage our resources more efficiently. We recorded a deficit of £57.6m in 2017/18, and we need to deliver an improved financial position in 2018/19 as we move to financial stability. This is about getting better value for tax payers' money, ensuring that public resources are focused on quality and safety.

There is much to do, but I am excited to be part of this organisation, and proud to work alongside so many amazing people. Like our chair, I believe that we have got a real opportunity to deliver significant improvements for patients, staff and local people.

I look forward to working with you.

Ben Travis, chief executive

3. About us

Background

Lewisham and Greenwich NHS Trust was established on 1 October 2013. The Trust is responsible for:

- Queen Elizabeth Hospital in Woolwich
- University Hospital Lewisham
- A range of community health services in Lewisham
- Some services at Queen Mary's Hospital in Sidcup.

One Trust – serving our local communities

We serve our local communities with a range of high quality health services. Our aim is to become a consistently high performing organisation, so that we get it right for every patient, every time.

The populations we serve

We provide a comprehensive range of high quality hospital services to more than 526,000 people living across the London boroughs of Lewisham, Greenwich and Bexley. Our community services are used primarily, but not exclusively, by people living in Lewisham.

Affluence and life expectancy

There are areas of affluence in each of the three boroughs we serve, but considerable variation and areas of significant deprivation. Overall, in terms of deprivation rates, out of the 326 boroughs in England:

- Lewisham is rated the 48th most deprived borough (with 1 being the most deprived)
- Greenwich is rated 78th
- Bexley is rated 191st

Overall life expectancy in the three boroughs is slightly below the London average (83.8 years for women, 79.6 years for men) in Lewisham and Greenwich, and slightly above this in Bexley

There is significant variation for life expectancy across Lewisham, Greenwich and Bexley:

- In Lewisham, the life expectancy for men is five years longer in Crofton Park than in New Cross
- In Bexley, there is a gap of seven years in mortality rates between the most and least deprived areas – the lowest areas are North End, Thamesmead East and Belvedere
- In Greenwich, the gap is 5.7 years between the most and least deprived areas.

Age profile

In Lewisham, Greenwich and Bexley, the 2011 census found around a quarter of the population was aged 19 or under. Bexley also has a higher percentage of people aged over 65. According to the Office for National Statistics, 20% of Bexley's population is expected to be over 65 by 2036, compared to 13% in Lewisham and 14% in Greenwich.

Lewisham has the highest proportion of children (29.6%) and older people (25.7%) in economic deprivation in England

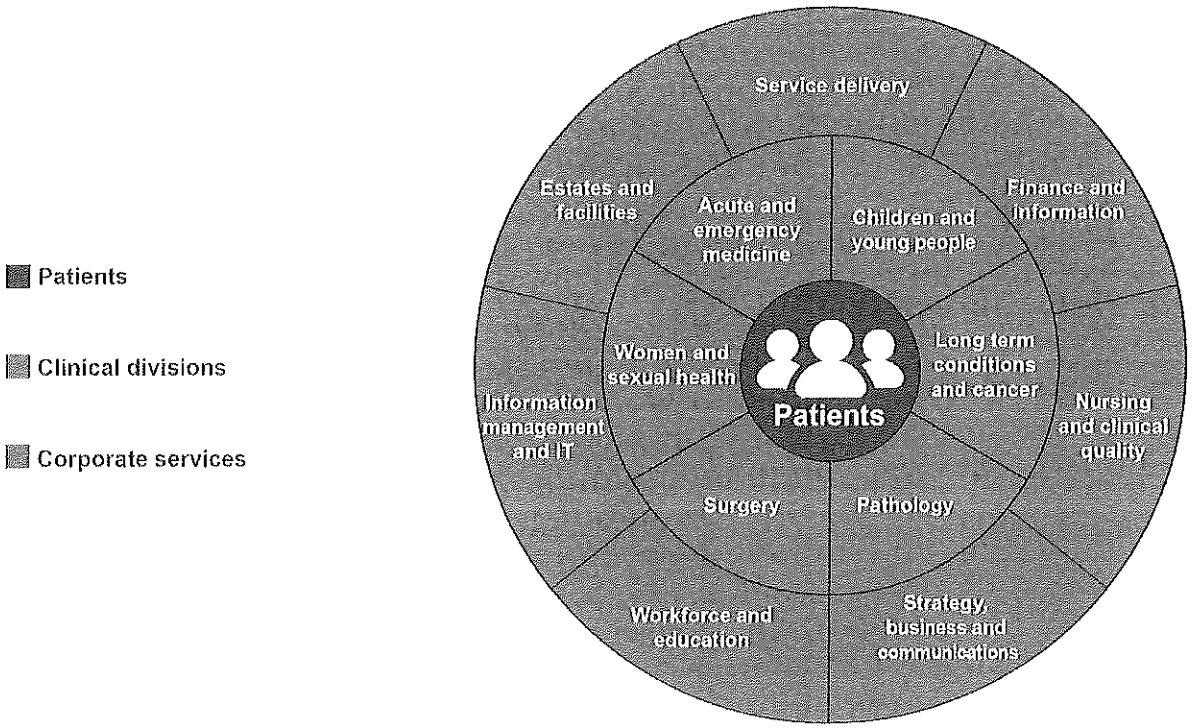
Ethnicity

In Lewisham, 46% of the overall population are from black, asian and ethnic minority groups, compared to 38% in Greenwich and 18% in Bexley (2011 census data)

Bexley is becoming more diverse – BAME groups are expected to account for 27% of the population by 2030).

How we are set up

We have around 6,100 staff, and our services are set up to ensure that patients are at the heart of what we do. Our clinical divisions are led by healthcare professionals, and supported by corporate divisions. All this work is then overseen by the Trust Board (see section xx).



Our services
Queen Elizabeth Hospital provides a wide range of inpatient and outpatient services, as well as emergency and planned care for people living in Greenwich, Bexley and other neighbouring boroughs. University Hospital Lewisham provides both planned and emergency healthcare to residents of Lewisham and other local boroughs, including Greenwich, Bexley and Bromley.

The Trust is a centre for the education and training of medical students enrolled with King's College London's GKT School of Medical Education.

In Lewisham, our health professionals also provide care to adults and children in a range of health centres, community clinics, and in patients' own homes. Our services for adults include community matrons and midwives, district nurses, the diabetes team, the home enteral nutrition team and our sexual and reproductive health team. Services for children and young people include health visiting, occupational therapy, physiotherapy and speech and language services.

In Greenwich, community services are provided by Oxleas NHS Foundation Trust (www.oxleas.nhs.uk).

Academic activities and research
Lewisham and Greenwich NHS Trust has an established partnership with King's Health Partners (KHP), the Academic Health Science Centre for south east London. We work closely with KHP to deliver local clinical services, research, education and training activities.

Lewisham and Greenwich NHS Trust is part of the London (South) Comprehensive Local Research Network and the South London Academic Health Science Network. The Trust plays a part in many clinical networks across south east London, predominantly for specialist services including cancer, cardiac, stroke, maternity and neonatal services. Our participation in these networks gives local people access to specialist and local care.

Key improvements since the Trust was formed
We have made many improvements since the Trust was formed in October 2013, including important clinical developments at our hospitals. At Queen Elizabeth Hospital we've developed a birth centre, state-of-the-art centralised pathology services, opened a clinical decision unit alongside the emergency department, developed a new ambulatory care centre (see page xxx) and opened a new discharge lounge. Developments at University Hospital Lewisham include our new ambulatory care centre (see page XX), a kidney treatment centre due to open later this year, additional operating theatre capacity, expanded stroke services and a new audiology centre. We have also:

- **Made significant health and safety improvements** "Sign up to safety" has reduced serious falls and pressure ulcers
- **Recruited more staff** 500 additional permanent staff members since October 2013, and attracted 43 consultant doctors to join our Trust
- **Developed stronger links between hospital and community services** This includes introducing an IT system to enable GPs, hospital staff, district nurses and key staff in health and social care organisations to share important information about the people they care for. For example they can now check which medications a patient is taking or a child's immunisation history.

Healthcare professionals can now securely share information across Lewisham, Greenwich, Bexley, Bromley, southwark and Lambeth.For more information, visit www.lewishamandgreenwich.nhs.uk/connectcare.

- **Better use of IT and technology** We have introduced electronic patient records across the Trust so that healthcare professionals can get key information at the press of a button. We have also introduced Wi-Fi for staff, patients and visitors and are introducing technology to save staff time when working with patients in the community.

PERFORMANCE REPORT

Overview

4. Our performance against key targets

The Trust's performance is measured against a number of national and local targets. This section provides an overview of our performance in these areas. You can see a table of where we met key targets in section 5, page x.

An overview of our performance against financial targets is included in section 12.

You can find up-to-date performance data on our website: www.lewishamandgreenwich.nhs.uk/performance.

Emergency department four-hour wait

The national standard is to ensure that 95 per cent of patients are treated within four hours of entering our emergency departments.

Our performance has improved from the previous year, when we treated an average of 84.4% of patients within four hours. In 2017/18, we treated an average of 88.9% patients within four hours. We met the local trajectory agreed by local commissioners and NHS Improvement for most of the first six months of the year, until our performance was affected by the winter pressures faced by hospitals throughout the country.

For 2018/19, we have agreed a trajectory of 92 per cent for performance against the four hour target, as the pressures we face mean that 95 per cent is not yet realistic. We aim to reach the national standard by the end of March 2019. Our improvement plan includes continuing to improve services for older patients with a range of healthcare conditions, extending our ambulatory care services to provide care in an outpatient setting, and improving the discharge of patients from hospital. You can read more in section 9.

Infection control

We were set a target of no patient acquiring an MRSA bacterial infection at the Trust in 2017/18. The Trust reported four cases of MRSA bacteraemia, all of which were investigated thoroughly. Where learning was identified, the clinical teams have led on making sure that actions were implemented to help prevent future cases.

Clostridium difficile, also known as C. difficile, is a bacterium that can infect the bowel and cause diarrhoea especially in elderly patients who have been prescribed antibiotics. Over 2017/18 we reported 17 cases of C. difficile against a target of no more than 39. Although we are pleased to have met our target, we continue to investigate each case of C. difficile so that we can take appropriate action.

Cancer targets

We have provided more timely treatment for cancer patients in 2017/18 than in the previous year. Progress includes seeing more patients within two weeks of referral.

However, meeting the national standard to ensure all patients start treatment within 62 days of referral remains a challenge across the whole of south east London. We are investing in diagnostic services and working with our partners to improve

performance (see section 9 for more information). We have agreed a local trajectory to meet the 62 day target consistently by September 2018.

An overview of performance against the key cancer targets is below:

Two week waiting standard
Ninety three per cent of patients should wait no more than two weeks to be seen following an urgent referral for any type of cancer. This national standard is also measured separately for patients with symptoms of breast cancer.

We met the two week wait target in all months other than December 2017.

31 day standard
Following diagnosis, all patients who need treatment for cancer should begin their treatment within 31 days of the decision to treat. The Trust met this target consistently over 2017/18.

62 day standard
The standard is that all patients needing treatment for cancer should start their treatment within 62 days of referral.

Meeting the 62 day cancer treatment target remains a challenge across the whole of south east London and is a key priority for the Trust. We are working with the other providers in the area to improve performance with a joint improvement plan. Over 2017/18, we increased our diagnostic capacity significantly at Queen Elizabeth Hospital and University Hospital to enable us to provide more timely treatment for cancer patients.

Referral to treatment targets
The NHS standard is that 92 per cent of patients should be treated either as an inpatient or as a day case within 18 weeks of referral. We narrowly missed this target in most months during 2017/18, and NHS England relaxed the target nationally for January 2018 due to winter pressures, resulting in a backlog of patients.

Work to improve our performance includes developing our theatre capacity. We have agreed a trajectory to get to 90 per cent against the standard by the end of 2018/19. We will then aim to meet the national standard in 2019/20.

See section 10 for more information.

Safer staffing
The safer staffing target specifies the number of nursing and midwifery staff needed to deliver safe, high-quality patient care. We met the target consistently over 2017/18 and actively continue to recruit and retain high quality staff.

VTE
The national standard is that 95% of patients are screened on admission for venous thromboembolism, more commonly known as VTE. This is the collective term for blood clots known as deep vein thrombosis (DVT) and pulmonary embolism (PE) – a significant cause of death, long-term disability and chronic health problems. We met this target consistently over 2017/18.

Childhood obesity
Measuring a child's height and weight is part of the Government's strategy to tackle obesity; this initiative is led by the National Child Measurement Programme (NCMP). Children are weighed and measured at age 4 to 5 in reception class and again in year 6 (aged 10 to 11 years) to assess the percentage of children who are overweight or obese within primary schools.

The Trust's community services in Lewisham met all the targets for measuring children so that early action can be taken to detect and treat obesity. The target in Greenwich is not one for our Trust as we only directly provide community services in Lewisham.

Breastfeeding
The health benefits of breastfeeding are well documented and the Department of Health recommends children are breastfed for at least a year, as it continues to provide both significant nutritional benefits and protection from illnesses.

We are delighted that our Trust gained level 3 UNICEF Baby Friendly accreditation at University Hospital Lewisham in 2017, having gained it at Queen Elizabeth Hospital the previous year. The UNICEF Baby Friendly standards aim to improve the information, support and encouragement provided to parents in order to promote, protect and support breastfeeding and appropriate introduction to solid foods. Level 3 means that the relevant staff have reached the highest level in supporting breastfeeding effectively.

Our community team in Lewisham have met all targets for ensuring that the majority of infants are fully or partially breastfed at six to eight weeks. Again, this is not a target in Greenwich as the Trust only directly provides community services in Lewisham.

Mortality data
Our mortality data (facts and figures about numbers and causes of patient death) indicates that we provide a good level of care.

We review mortality data about our patients so we can check that our services are safe and take action to improve where necessary. The Summary Hospital-level Mortality Indicator (SHMI) is a mortality measure that takes account of a number of factors. It includes patients who have died while having treatment in hospital or within 30 days of being discharged. The SHMI score is measured against the NHS average – which is 100. A score below 100 denotes a lower than average mortality rate and therefore indicates good, safe care.

To help understand the SHMI data, Trusts are categorised into one of three bands:

- Trust's SHMI is 'higher than expected' – Band 1
- Trust's SHMI is 'as expected' – Band 2
- Trust's SHMI is 'lower than expected' – Band 3.

Over 2017/18, Lewisham and Greenwich NHS Trust score was "as expected" (Band 2) in the SHMI indicating that our care is safe.

5. Performance table

National target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Emergency cases: 95% of all patients attending A&E should be treated, admitted or discharged within a maximum of four hours. (The table shows performance against our local trajectory)	90.2%	89.4%	94.1%	91.8%	92.5%	89.9%	92.3%	89.3%	86.0%	83.3%	85.6%	83.7%
Infection control: the Trust should have no cases of MRSA bacteraemia	2	1	0	0	0	0	1	0	0	0	0	0
Infection control: the Trust should have no more than 39 cases of Clostridium difficile. The table lists the total number of cases in each month of the year to date (so there was a total of 17 cases over the year).	3	1	2	0	1	1	3	0	1	2	2	1
Cancer: patients should wait no more than two weeks for an urgent referral. The standard is 93%	95.0%	94.5%	94.9%	95.6%	94.7%	93.4%	95.4%	95.5%	93.7%	96.1%	96.3%	96.6%
Cancer: patients with symptoms of breast cancer should wait no more than two weeks for treatment following an urgent referral. The standard is 93%.	99.5%	98.9%	99.5%	99.4%	97.4%	97.9%	96.4%	95.7%	89.0%	87.0%	93.1%	93.8%

Cancer: patients should not wait more than 31 days from confirmed diagnosis to treatment. The standard is 96%	98%	99%	98%	97%	100.0%	98.2%	97.9%	96.8%	96.3%	95.7%	100.0%	100.0%
Cancer: patients should not wait more than two months for treatment from GP referral. The standard is 85%	81.5%	71.2%	81.6%	68.1%	73.0%	80.1%	80.1%	80.1%	73.4%	83.0%	78.0%	80.0%
Cancer 62 day performance excluding shared pathway patients	87.1%	80.0%	91.2%	82.6%	78.3%	89.2%	85.9%	89.1%	84.5%	92.3%	92.7%	90.5%
18 weeks target: patients who have not been treated yet should not have waited longer than 18 weeks. The standard is 92%.	90.3%	90.9%	90.7%	91.1%	90.8%	89.8%	90.2%	90.2%	88.6%	88.9%	88.7%	88.1%
Safer staffing: we should be meeting 90% of staffing requirements	99.4%	98.5%	98.2%	98.5%	96.4%	97.2%	97.1%	98.5%	96.3%	97.2%	97.2%	97.2%
95% of inpatients should receive a VTE assessment	96.6%	96.7%	97.1%	96.0%	96.1%	97.1%	97.1%	97.0%	96.9%	96.6%	96.7%	96.8%
Breastfeeding: ensure the feeding status of 95% of infants is checked within 6-8 weeks after birth		98.3%			98.2%			99.0%			99.3%	
Breastfeeding: ensure that 72.5% of infants are fully or partially breast fed at 6-8 week check		74.6%			75.6%			79.1%			79.2%	

Childhood obesity: ensure that 87% of children in reception are measured as part of the Government's National Childhood Measurement Programme – academic year 2016/17	95.1%			
Childhood obesity: Ensure that 87% of children in Year 6 are measured – Academic Year 2016/17	92.0%			
Standardised Hospital Mortality Indicator (SHMI)	1.0003	1.0044	1.008	1.0076

6. CQC report and Trust improvement plan

Following its Trust-wide inspection in March 2017, the Care Quality Commission (CQC) gave the Trust an overall inspection rating of "requires improvement". This was also the Trust's overall rating in each of the CQC's five domains.

Dr Elizabeth Aitken, medical director for Lewisham and Greenwich NHS Trust, said:

"We launched a major safety and quality improvement plan immediately after the CQC inspection in March and to make improvements for patients. This is a joint plan with our health and social care partners.

"It's clear that we need to do more to get it right for patients consistently. The CQC report does acknowledge several areas of good and outstanding practice and highlights many areas where Lewisham and Greenwich NHS Trust has improved since the last Trust-wide inspection in 2014. Our community services were rated as "outstanding", with particular praise for our community services for children."

The improvements we've made since March through the systems-wide safety and quality improvement plan include:

- Ensuring that patients coming through our emergency departments are treated in a more timely manner – so they do not have to wait in corridors and are treated in the right place at the right time. We are meeting our local targets for reducing waiting times and are focusing on making sure we can sustain these improvements
- Making sure patient safety checks are carried out consistently – so that all patients in our hospitals are checked at least every two hours by nurses (and hourly in the emergency departments) to ensure they are safe and comfortable, including checking that patients have something to eat and drink
- Working with staff to make sure that we get the basics right for all our patients – including improving our management of medicines and infection control
- Developing specialist services at both hospitals to ensure that older people who come through our emergency departments receive an early comprehensive assessment of all their needs and support from a specialist team for older people
- Developing ambulatory care services at both hospitals to treat more people in an outpatient setting, enable patients to leave hospital sooner and improve the patient experience. We recently opened a new ambulatory care centre at Queen Elizabeth Hospital, following the opening last year of a new centre at University Hospital Lewisham
- Ensuring patients in hospital do not have to wait for diagnostic tests
- Running major recruitment campaigns locally, nationally and internationally to help us address staff shortages. We have recently recruited over 90 additional nursing staff who will join us this year. It is important to note that we do make sure that we are providing safe staffing levels by bringing in temporary staff

where there are shortages. We have also been working hard to increase the numbers of staff attending all the training they require

- Working with staff to improve end-of-life care, ensuring that we have early discussions with patients, their families and carers so we can offer support that fits with patients' wishes toward the end of their lives
- Developing community services to reduce pressures on our hospitals and improve the patient experience. This includes a new community acute assessment unit in Eltham for older people, which our commissioners opened in 2017. The assessment unit will reduce pressures on our emergency departments by providing comprehensive assessments and support from a specialist team in the community.

We have also made significant improvements to our Intensive Care Unit (ICU) at Queen Elizabeth Hospital (QEH), including:

- Recruitment of additional consultants to meet the national guidance around consultant to patient ratios
- Strengthening clinical leadership, including the appointment of a new clinical director, lead clinician and clinical lead
- Improving the working of the whole team, including the introduction of regular meetings involving all the different clinical staff in the unit, ensuring relevant clinical staff review all deaths (previously, only selected deaths were reviewed).

The CQC noted that we needed to improve how we provide end of life care. We have subsequently been promoting guidelines for staff to help ensure that patients live as well as possible until they die, and are supported to die with dignity. Dr Elizabeth Aitken, medical director, commented: "It is vital that we support people to live as fully as possible until death, as well as actively recognising the importance of supporting their family and loved ones. This will continue to be a major area of focus over 2018/19, as we work with partners to make improvements across the whole health and care system."

Signature
Ben Travis, Chief Executive

21/5/18.

Date:

QUALITY AND SAFETY DEVELOPMENTS OVER 2017/18

7. Sign up to Safety

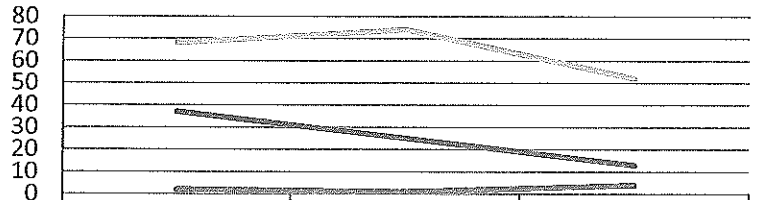
In July 2014 we joined the national Sign Up to Safety initiative. At the end of this three-year commitment, we are pleased to report significant improvements to patient safety. We continue to make patient safety our top priority and encourage staff to report any concerns to build a culture of openness in which we can constantly improve our practice.

Sign up to safety – our progress

Goal	Progress
Improve hand hygiene to combat the spread of infection	The hand hygiene of all our healthcare professionals has improved over the last year, with 96% reaching compliance. Our midwives scored 100% hand hygiene compliance, and we will work hard to achieve this for all staff groups. We are delighted to report a significant reduction in the number of hospital acquired infections of Clostridium-Difficile and Escherichia Coli. (See table) Disappointingly, four cases of MRSA bacteraemias were attributed to the Trust in 2017. Two were contaminants and two were related to care of intravenous lines, so we will continue to work hard to focus on hand hygiene and improving intravenous line care.
Identify when the health of a patient starts to get worse suddenly because of blood poisoning or infection (sepsis). Taking early action helps save lives and reduces avoidable heart attacks	Our nurses are better than ever at calculating "early warning scores" so early action is taken when patients' health is deteriorating. In 2017, 98% of scores were calculated compared to 88% in 2015. We ran a successful campaign in October 2017 that increased the detection and escalation of care of patients whose scores were a cause for concern. As a result of the campaign, fewer patients (not already receiving critical care) experienced cardiac arrests. Staff in our emergency departments have significantly increased screening for sepsis, sustaining 100% compliance in our monthly audits. Our emergency departments also exceeded the national target for delivering intravenous antibiotics within one hour of arrival to patients identified as at risk of sepsis. We will continue to work on improving our compliance with sepsis best practice following inpatient admission, and plan to audit the effectiveness of accurate handover of patients with sepsis.

Improve the safety of maternity services	Throughout the three years of the Sign Up to Safety initiative our stillbirth rate has remained slightly above the national average of 3.87 births per 1000. We continue to raise staff awareness of the significance of reduced fetal movements and improved measurement of fundal height to identify babies who might not be growing as expected. We review all stillbirths across the Trust to identify any trends in causes. The introduction of centralised monitoring, expert fetal wellbeing midwives and masterclasses in the interpretation of fetal monitoring has resulted in far fewer babies born with hypoxic brain injuries (10 in 2016/17 compared to 17 in 2015/16).
Protect patients from pressure sores	Our enhanced staff training programme has delivered a significant reduction in pressure sores acquired by inpatients. The incidence of the most serious sores – known as grade 3 and 4 sores – has decreased by over 75%.
Improve medication safety	Over the three year programme no patient suffered severe harm from a medication incident. Meanwhile our staff have got better at reporting near miss incidents so that we can learn from them and improve our practice. In addition we have increased the percentage of prescribed doses being given to patients within 24 hours of the dose being due.
Reduce the number and harm from patient falls	We have improved our completion of falls risk assessments and saw fewer falls in the first half of 2017. However, over the three years of our Sign Up to Safety initiative, the number of reported falls and the number of falls resulting in harm has increased. We are working hard to establish reasons for this and the most effective measures for preventing falls.

Number of hospital acquired infections 2015–2018



	2015-16	2016-17	2017-18
MRSA Bacteraemia	2	1	4
Clostridium Difficile	37	25	13
Escherichia Coli Bacteraemia	68	74	52

8. Patient Safety Awards

Helping people with difficulty swallowing

Last year our speech and language therapy team at Queen Elizabeth Hospital won the Care of Older People Award at the Health Service Journal (HSJ) Patient Safety Awards. The team won the award for their excellent work to improve safety for older people who have difficulty swallowing and who are at risk when eating and drinking. They produced guidelines that have now been adopted by a number of other health organisations.

Three Trust initiatives have also been shortlisted for this year's HSJ Patient Safety awards on 9 July (see below).

Improving medication safety for older people

The Lewisham integrated medicines optimisation service (LIMOS) pharmacy team work across the hospital, local care homes and community settings. Their coordinated work now means that, if a care home resident is admitted to hospital, or vice versa, there is a seamless approach to managing medication, which ensures smooth transfers from one setting to another.

LIMOS works with care home staff, GPs and other clinical colleagues to review medication for residents and develop individualised medicine care plans.

Lead pharmacist Kath Howes says: "We have proved that working across organisations in an integrated way keeps patients safe, avoids unnecessary hospital admissions and saves money. We hope this model of working will be adopted more widely across the health and social care sector."

Innovative maternity training to support the safe delivery of twins

Our maternity team has been shortlisted for introducing a new training scheme to support the safe delivery of twins. Sophie Windsor, consultant midwife at Queen Elizabeth Hospital (QEH), explains: "There are higher risk levels when giving birth to twins or multiple babies, and maternity staff can do a number of things to support safe deliveries. However, training for maternity staff across the NHS tends to focus almost exclusively on single births.

"Recognising this gap, we have introduced our own training programme to help all our midwives, obstetricians and anaesthetists support twin and multiple deliveries. We use mannequins to simulate multiple births, giving maternity staff a chance to put theory into practice in a realistic but safe environment.

"Following great feedback from staff, we are in discussions with the Twin and Multiple Birth Association about promoting this initiative across the NHS."

Reducing harm in chest drains

The respiratory team at Queen Elizabeth Hospital has been shortlisted for an HSJ Patient Safety Award for their work in reducing harm in chest drains.

The team has developed competency standards and chest drain study days. These have been attended by staff from many specialities including critical care, A&E, medicine and our practice development team.

We are especially proud of respiratory specialist nurse Sally Hickman, who has developed a unique teaching tool that simulates clinical scenarios and emergencies. This is now being developed as a commercial teaching innovation for training in other settings.

Respiratory consultant Dr Moerida Belton said: "We believe passionately in raising standards of care through enhancing the education of our staff. Our work has helped promote a culture of openness and a willingness to challenge any poor practice, something we are immensely proud of. We are delighted to be given the opportunity to promote and share our work and achievements."

Our teams will find out whether they've won at the awards ceremony on 9 July 2018. Check our website, www.lewishamandgreenwich.nhs.uk, for the latest information.

9. Emergency care improvements

"We have made improvements over 2017/18 for patients who need unplanned treatment, while our partners have also worked hard to improve services outside hospital. We will continue to build on this good work in 2018/19." Dr Elizabeth Aitken, medical director

Getting it right for older patients

We have made changes over 2017/18 to ensure that older people with complex needs receive specialist support in a timely manner. Dr John Miell, director of acute and emergency medicine, explains:

"Like most hospitals, the majority of our patients are older people who have complex care needs. The research shows that early treatment from the right healthcare professional can make a huge difference in promoting recovery. To do this, we have set up 'frailty units' at Queen Elizabeth Hospital (QEH) and University Hospital Lewisham (UHL). When older people are admitted to hospital for treatment, they can receive early treatment from specialist staff, including doctors who specialise in older people's health, other specialist consultants, doctors-in-training and nurses. Through this approach, we are able to support people to leave hospital sooner – improving the patient experience and freeing up hospital beds for patients who need to be admitted."

In 2018/19 we will build on this work, introducing assessment chairs on our dedicated frailty unit at UHL.

Developing new services

We started using a new, dedicated £750,000 health facility that helps manage the demand for emergency services and winter pressures at QEH in 2017. The new ambulatory care unit follows the development of a similar new unit at University Hospital Lewisham (UHL) last year.

Ambulatory care helps patients to get the treatment they need sooner, often avoiding unnecessary hospital admissions, so it will reduce some of the pressure on the hospital's emergency department. Ambulatory care also means that some patients can safely be discharged early sooner, as we can schedule follow-up appointments for patients to return and have tests as an outpatient.

Both ambulatory care centres are currently open five days a week. In 2018/19, we plan to provide ambulatory care services at both hospitals seven days a week. We also plan to develop the range of services at the UHL ambulatory care service to provide more care for patients that reduces the need for hospital admission.

Improving the patient environment
In November 2017, we completed building works at UHL and QEH to enable our Trust to treat more patients.

At UHL, we relocated the extended hours GP service to free up space for patients in the ambulatory care unit. We have also put in four more cubicles for patients in the emergency department and an additional treatment room in the urgent care centre. This will enable us to carry out consultant-led rapid assessment and treatment for patients in the emergency department, reducing waiting times.

At QEH, we have built an extra treatment room in the ED to see patients early in their pathway and reduce the time they have to wait. We have also carried out significant improvements to the urgent care centre, including an additional treatment room and larger waiting areas, with a new dedicated waiting area for children. In a new "patient champion room" by the entrance to the urgent care centre, staff will help patients to arrange a GP appointment as well as registering patients with local GPs.

Improvements across the health and social care system
Our partners have been supporting the Trust to make improvements for patients who require emergency treatment. This includes the development of a new Community Assessment Unit for frail and elderly patients, based in Eltham Community Hospital.

Developed by Greenwich Clinical Commissioning Group, this new specialist community hub provides vital support for elderly or frail residents, enabling them to avoid unnecessary visits to A&E or admissions to hospitals. Staff at the unit carry out assessments and create care plans tailored to the needs of the individual patient, whether that involves the patient needing hospital care, care in their own home or at a residential home.

Improving hospital discharge
Freeing up hospital beds by enabling patients who do not need to be in hospital to be discharged sooner. Building on last year's work, we will enable nursing staff and therapists to lead on discharges for patients who do not have complex needs. We will aim for 30% of these "simple" discharges to happen before 12 midday, as well as increasing our use of discharge lounges to free beds up earlier for new patients.

We are also working to improve discharges for patients with more complex needs. A range of initiatives is being introduced to make sure that patients who do not require

specialist hospital care are transferred to the right setting, outside of hospital, to get the right care.

Preparing for winter 2018/19
We are currently building a new clinical decant facility at QEH, next to the emergency and day surgery departments. It will be ready in late 2018 and will initially:

- **Provide beds for the additional patients requiring treatment over winter** (from late 2018) – helping our staff cope with the winter pressures
- **Improve the environment of the existing wards** – the six bed bays in some of our wards are cramped and do not meet modern standards. We are addressing this issue by moving some of these beds to the new facility. Giving patients more space will improve infection control, patient privacy and the overall patient experience
- **Give us decant space to use while essential infrastructure works are carried out across the hospital** - the new building will house clinical services from wards and departments while we address longstanding infrastructure issues including electrics, ventilation and water systems at QEH.

10. More timely treatment for cancer patients

"Early treatment for cancer saves lives, and over the last year our teams have been making improvements to ensure that patients get the right treatment sooner. However, meeting the key 62 day target has been a challenge, so this is a key area of focus over 2018/19." Julie Baker, Macmillan lead cancer nurse

Over 2017/18, we have improved the referral system for patients who need to be assessed and treated within two weeks, moving to an online, paperless referral system. Our two-week wait cancer team is one of the first in the country to start using the NHS Electronic Referral Service (e-RS), and has worked closely with Lewisham, Greenwich and Bexley Clinical Commissioning Groups to introduce the new system.

The new e-RS system allows patients to choose the hospital, date, and time of their first appointment, and they can manage their appointment online if they need to change it. The two-week wait team introduced the new system in January 2018. Alison Poole, general manager for cancer and outpatients, said: "This is a huge achievement and I'm so proud of the cancer team. They worked really hard to change our processes in an incredibly short space of time, and it's already paying dividends. We are meeting the two-week wait standard for cancer referrals, which is fantastic – especially considering that the Trust receives 150 urgent cancer referrals a day."

As well as meeting the two week cancer target, we have performed well in other areas for cancer patients. However, meeting the target for ensuring that patients are treated within 62 days of referral remains a challenge across the whole of south east London, and improving performance in this area is a key priority for us.

One of the challenges of meeting the 62 day target is coping with rising demand for cancer tests. The NHS as a whole is expecting a 7% increase in cancer tests each

year between now and 2020/21. Over 2017/18, we have invested in increasing our diagnostic capacity significantly at Queen Elizabeth Hospital (QEH) and University Hospital Lewisham (UHL), so that we can provide more timely treatment for cancer patients. We installed a new MRI scanner at UHL in April 2018, and are replacing the CT scanner at QEH in June 2018.

Many cancer tests involve using a thin, flexible camera called an endoscope to look inside patients and take biopsies. We plan to significantly expand our endoscopy services and in 2018/19 we are upgrading our endoscopy suite at Queen Elizabeth Hospital. This will provide better changing and recovery facilities for patients, a new disinfection unit and an additional procedure room so that we can treat more patients. When complete in early 2019, we will be able to do more tests, with shorter waiting times and a better patient environment. We are also developing a business case to apply for funds from NHS Improvement to expand endoscopy services at University Hospital Lewisham.

One of our priorities is enabling people to have improved lives after cancer. We have worked with Macmillan Cancer Support to fund a survivorship programme in 2018/19. Macmillan has also helped with a psychological support service across both hospital sites.

In response to patient feedback, we are making it easier for patients to contact our cancer nursing specialist teams. Funded by Macmillan, we are introducing a single point of contact and patient support phone service, so patients can receive emotional and practical support and book into daily nurse-led cancer clinics.

11. Treating patients within 18 weeks

"We have clear plans to address the longer waiting times experienced by some patients. In the longer term, we are expanding our theatre capacity to cope with increasing demand for services and to help us meet the target." Dr Ashraf Molokhia, divisional director for surgery

We have found it challenging to meet the 18 week referral to treatment (RTT) standard throughout the year, in the face of an increased demand for our planned services and the high number of patients who require treatment after being seen in our emergency departments.

To address these issues, we recommissioned a theatre that was no longer in use at Queen Elizabeth Hospital (QEH) in April 2017 to provide extra capacity for all surgical specialties. We are also planning to expand theatre capacity at University Hospital Lewisham (UHL) and to refurbish two operating theatres at UHL with a specialist air filtering system called "laminar flow", which reduces the risk of wound infection. These theatres will provide a dedicated orthopaedic suite and will enable us to meet the demand for referrals with increased productivity.

The Trust is running a major programme to improve how we maximise the use of our operating theatres. Our focus is on ensuring that theatre lists are not cancelled for non-clinical reasons. We are reviewing our internal processes, for example making sure that beds will be available so that we can start theatre sessions on time, ensuring that theatre lists are fully booked, and reducing the length of waiting lists.

We are also looking to improve how we manage emergency surgery, ensuring that a senior clinician's opinion is given early so that a decision can be made without disrupting planned specialist surgery.

12. Developing our maternity services

"We are proud of our amazing midwifery team, who work closely with local families to meet their needs and provide the best care. We are continuing to improve our award-winning services." Helen Knower, Director of Midwifery

British Journal of Midwifery Awards

Justine White, maternity support worker, won a British Journal of Midwifery Award in February 2018 for her work to support women with breastfeeding. The trust's infant feeding lead, Lillian Oorthuysen-Dunne, commented:

"Justine has done amazing work with all women but especially women who are unable to give birth and who have used a surrogate. Through medication and stimulation, it can be possible for these women to breastfeed their babies. This can play a key role in helping mother and baby to build a close bond, as well as giving them both the health benefits associated with breastfeeding."

The support we give to student midwives was also recognised by the British Journal of Midwifery. Vikki Coleman, clinical practice facilitator, was shortlisted for an award for her contribution to midwifery education. Meanwhile our University of Greenwich midwifery "link" lecturers won an award for supporting student midwives as well as the qualified midwives who mentor them.

Helen Knower, director of midwifery, said: "We have about 75 to 80 student midwives at each of our hospitals at any one time. Vicki and the link lecturers do a wonderful job of making sure that that their needs are met, liaising with the student midwives, their mentors, the university and Health Education England. It means that the midwives who join us are excellent at their jobs and fully motivated."

Maternity and midwifery festival in London

In February 2018, the Trust's midwifery team won two prizes at the first ever London Maternity and Midwifery awards, at the London Maternity and Midwifery Festival.

Our Lewisham "Indigo" midwifery team won the team award for providing support for vulnerable women – those who have moderate to severe mental health problems and/or learning disabilities, and/or suffer from domestic violence as well as younger mums. Women who are vulnerable are identified early in their care and the Indigo team ensures they receive additional support they need from specialist midwives, and help from other relevant agencies and services.

Amy Robson, QEH student midwife, won the student midwife award, which recognises a student midwife who has grown in confidence during her studies and who always puts patients at the heart of care.

Personalised care
We have been working to meet the national Better Births guidelines for providing continuity of care and ensuring that each woman's care is personalised. The Trust has introduced a specialist team of midwives – the POPPIE team – to support women who are at risk of having a premature birth. Giuseppe Labriola, head of midwifery at University Hospital Lewisham, said:

"If a woman is cared for by the POPPIE team, she will receive care from her named midwife antenatally and after her baby is born. The team will also care for her during the labour in whichever area she chooses to give birth (at home, midwifery-led birth centre or in our delivery suite). There is lots of evidence that this helps to build trust and to improve the health and wellbeing of the mother and baby. Our POPPIE team is leading the way in researching whether continuity of care can also reduce the likelihood of having a premature baby. We are working with Professor Jane Sandall CBE on this high profile research project, which we hope to publish in January 2019."

Working with local families
We work closely with local families to make sure that our maternity services meet their needs. Sue Chatterley, head of midwifery at Queen Elizabeth Hospital, said: "We have made a number of improvements to services after running workshops with women who use our services, and also with our student midwives.

"Over 2017, we also held workshops with fathers. Following this, we've liaised with the Working with Men charity and now run an education session each month for expectant dads. We've had feedback that this really helps men understand the emotional changes they may experience after they become fathers, and how they can best support their partners. We've also improved the information we have available for local dads to cover the concerns and issues that they have raised with us."

The Trust has also worked closely with the local Maternity Voices Partnerships (MVPs) to improve patient information over the year. You can find out about the local MVPs which represent local women – and how to get involved in these groups – on the maternity pages of our website: www.lewishamandgreewnich.nhs.uk.

Helping families to give up smoking
Over 2018/19, the maternity service will be focusing on reducing smoking among pregnant women. This is part of a national initiative to half the number of stillbirths by 2030. The team will be offering women a carbon monoxide screening test at their antenatal booking appointment to detect when people are at risk through smoking, and will then give specialist advice about becoming a smokefree household.

Financial overview

13. Getting best value for taxpayers' money

"We are working hard to improve quality and safety while getting better value for taxpayers' money." Usman Niazi, interim finance director

One of our key priorities is to manage our resources more efficiently while continuing to improve the safety and quality of our services.

In 2017/18, we ended the year with a deficit of £57.6m. A key reason is that the savings which had been identified across the NHS in south east London through the shared Sustainability and Transformation Plan (STP) were not achieved. This meant that we were unable to receive all the additional national funding that is allocated to NHS Trusts that meet their financial targets.

NHS Improvement (NHSI) carried out an investigation into the Trust due to the financial deficit in 2017/18. The investigation has now been closed and we need to deliver an improved financial position in 2018/19 as we work towards financial recovery in the longer term. We have agreed to deliver a deficit of no more than £35.5m in 2018/19. This takes into account receipt of national funding which will be allocated if we meet our key financial and performance targets.

To deliver an improved financial position, we have launched a financial recovery programme, and developed cost improvement plan (CIP) saving schemes of £25m. These plans have all been assessed to ensure that there is not adverse impact on the quality of safety of our services.

The Trust has also introduced an initiative to control expenditure, ensuring that all requests for spending money are reviewed by a daily panel of staff across the organisation, including healthcare professionals. There are key surgical, medical, pharmacy and other exemptions which do not need approval from the daily panel.

PATIENT EXPERIENCE

14. Improving patient experience

"We work closely with local people and patient representatives to make improvements for visitors and service users." Sophie Gayle, associate director of governance and patient experience

Meeting the needs and expectations of patients and stakeholders

The Trust works closely with local people and patient groups, including Healthwatch, the Patient Welfare Forum (PWF) at University Hospital Lewisham and the Patient User Group (PUG) at Queen Elizabeth Hospital.

Patient Welfare Forum

Jan Ferrari, chair, says: "Over the course of the year PWF members visited all of the wards and outpatient clinics in University Hospital Lewisham, reporting our findings to the Trust – including feedback from patients, carers and staff.

"We work with the Trust's patient experience team, and through them we have again contributed to a range of improvements. These include providing new breast pumps for women breastfeeding babies in neonatal intensive care, a more efficient procedure for babies needing antibiotics and the providing healthier snacks in the A&E area.

"Our members continue to represent the patient voice on Trust-wide committees, such as patient experience, complaints and catering, and this year PWF members also joined the stakeholder panels for the selection of the new chair and chief executive of the Trust."

Patient User Group

Judy Lyons, chair, says: "The Patient User Group (PUG) for Queen Elizabeth Hospital continues to work for the benefit of patients and visitors. Our aim is to contribute to continuous improvement. This last year has seen us change direction slightly in that we have not undertaken as many observations of wards as in the past, but have worked with the patient experience team on improving five key areas:

- Internal communication
- Food
- Emergency department
- Focused observations
- Complaints

"We have talked to patients, visitors, staff and other service providers and have made recommendations to the Patient Experience Committee particularly in relation to food. We will continue to be involved in many aspects of hospital life, offering comments and observations via the Trust's Food Focus Group and the Complaints Committee and to review hospital literature to ensure it is patient friendly and fit for purpose as we strive to improve the patient experience."

PALS and complaints

The Trust runs a Patient Advice and Liaison Service (PALS) which seeks to assist patients, their carers and their relatives. Help from PALS staff can include providing information, liaising with healthcare staff to resolve issues or providing help in making a complaint.

During 2017/18 we received over 5,500 contacts through PALS and 610 formal complaints; this is a downward trend from 2016/17 with 743 complaints and from 2015/16, when we received 1,250 complaints.

Complaint themes over 2017/18

The main themes for complaints we received were around medical and surgical treatment, communication and information given to patients, nursing care and the attitude of staff.

We expect the highest standards of care from all our staff and work hard to listen to patients and put things right at the earliest opportunity. Learning from complaints is

discussed monthly and the actions we need to take are shared between different teams to ensure that we are sharing good practice.

We also use the learning from complaints along with all the other feedback we receive from patients, to implement changes in practice or process throughout our services. Some of these improvements are highlighted below.

Expanding the way we collect feedback from patients
As part of our patient experience strategy we continue to listen to patients about how we can make it easier to give us informal feedback. This year we have introduced new ways for patients to give us feedback..

As well as receiving feedback through formal routes such as PALS and complaints, the NHS Friends and Family test and via informal email and social media, we have introduced suggestion and comments boxes in areas where we treat patients. In addition we spend dedicated time each week talking to patients in clinical areas about their experience. These have proved a great success and the wealth of feedback we have received has been used to inform a range of improvements which are shown in our 'You said...We did' posters displayed across the Trust and on the 'Listening to you' section of our website: www.lewishamandgreenwich.nhs.uk/givefeedback.

Improving services for people with dementia
The Trust continues to introduce ways to improve how our services are experienced by people with dementia and their carers. We held a dementia event in May 2017 to review our dementia strategy and how services for patients with dementia and their carers can be improved. Local charities, CCGs, patients, carers and staff discussed a range of scenarios and topics, which explored key local issues and identified opportunities for change.

Improvements implemented during the year include extending the range of activities for dementia patients, introducing dementia volunteers, new food options for elderly care patients and making improvements to the environment in our elderly care wards.

We have continued our drive to recruit our staff as 'dementia friends' to raise awareness and gain a better understanding of dementia. In 2017/18 we built on the success of this initiative and trained a further 615 staff as dementia friends.

We have also reintroduced our pets as therapy programme and further enhanced our music therapy programme. Through developing partnerships with local organisations, we have been able to deliver regular music therapy visits which extend beyond our elderly care wards, visiting a whole range of departments. The music performances really do give everyone a lift and provide moments of joy that allow patients to focus on their life and wellbeing rather than on their treatment or illness.

Patient information
In response to feedback, the Trust has made improvements to patient information. All patient information now undergoes a formal review to ensure it meets accessible

information standards and is patient friendly. A range of patient representatives also contribute to this process to ensure it meets user needs. A vast number of new leaflets are now in circulation, including key information requested by patients about Trust services as well as specific conditions and procedures.

DEVELOPING OUR WORKFORCE

15. Improving staff experience

"We are committed to supporting all our staff to reach their potential. Particular focus is on valuing the diversity within our workforce and enabling flexible working." Janet Lynch, Director of Workforce and Education

Recruitment and retention plan

One of the Trust's key priorities is reducing the number of vacancies and supporting our staff to maximise their potential. Janet Lynch, Director of Workforce and Education, commented: "We have launched a major recruitment and retention plan in 2018/19 with a number of initiatives. We have got more to do and we will be engaging with staff further on how we can support them more".
Recent progress includes:

- Successful recruitment open days promoting working for the Trust
- Our career clinics for nursing staff, enabling them to gain experience across the organisation by moving into new roles internally
- Introducing apprentice roles in the Trust, including the new nursing associate role, which bridges the gap between healthcare assistants and registered nurses.. Our leadership development programme – enabling senior staff to develop the skills they need to lead successful teams
- Developing flexible working opportunities for staff.

Valuing diversity and equality and respecting human rights

We are committed to ensuring that all our staff are valued and supported, and that there are good career opportunities for everyone. Control measures are in place to ensure that the organisation complies with its obligations under equality, diversity and human rights legislation.

Over 2017/18, we have been engaging with staff about our improvement plan and have set up an equality and diversity staff network to involve staff in this work. We have also been running staff training on diversity and equality.

In response to feedback in the staff survey, the Trust has also set up a new initiative to help nursing and midwifery staff with black and minority ethnic backgrounds to progress in their careers. The six-month programme enables staff to get involved in projects outside of their existing job roles in order to gain the experience and networking opportunities to progress. The programme includes enabling staff to see first-hand how decisions are made in the Trust, as well as involvement in priority projects and interview practice.

Staff wellbeing and benefits programme
Our staff wellbeing programme includes the opportunity to take part in free healthy activities such as pilates and mindfulness, as well as a free staff physiotherapy service. We have also expanded our benefits scheme, offering staff discounts on goods including cars, electrical goods, cycles and childcare vouchers. Over 2018/19, we will be engaging with staff to ensure the wellbeing and benefits programmes meet their needs.

Countering fraud and corruption
The Trust is committed to ensuring the best use of NHS resources. All staff have access to our counter fraud policy and these are promoted during fraud awareness week. A counter fraud specialist works within the Trust's internal audit team to provide guidance and support to staff who raise concerns, and conduct investigations.

Celebrating our staff
We celebrate staff who go the extra mile through our annual staff awards. In 2017 the awards were funded by generous donations from some of the Trust's partners: Abbey Travel, Cerner, Interserve, ISS World, Meridian Hospital Community, Muffin Break and Vinci Facilities.

Staff in our ear, nose and throat (ENT) team were awarded the Trust's prestigious Healthcare Hero Award for 2017, following a nomination by Sidcup mum, Simone Reynolds, for the care of her daughter Rosie-May.

Simone said: "The ENT team are FAB! They absolutely need to be recognised for their outstanding care because I feel they are seen as being a 'routine' service but what I saw was really exceptional. My daughter had a procedure to have her ears pinned back and when the day came to have the bandages removed she was very anxious and collapsed. The whole team rushed to help, with consultants, clinic managers, nurses and healthcare assistants all working as a team and doing what they could to make her, and my partner Paul and I, feel relaxed.

"The ENT team showed that they are not only specialists in their field but that they also had all round skills, which enabled them to assist in an emergency. They have done such a wonderful job and it has given Rosie-May a new confidence and she is like a different girl. She definitely has a new life with her new ears, so we are all so grateful."

So many of our staff have also won prestigious awards from external professional bodies over the last year and we are delighted to see their excellent work recognised.

16. Seven day working

"We want to make sure that our patients get the best treatment 24/7. If you need an urgent investigation or to be seen by a specialist consultant we aim to make that happen for you as quickly as possible, including in the evenings and at weekends." Dr Elizabeth Aitken, Medical Director

If you come into hospital you want to find out what's wrong and be treated as quickly as possible. One of the ways that we make this happen is to increase the availability of diagnostic tests and reviews by our specialist consultants at evenings and weekends. We've made great progress in 2017/18, and came fourth in London for one of the most important national standards, known as Standard 2 (see below), meeting it for 86% of patients.

NHS England ask us to focus on four national clinical standards, explained below. We expect to meet all four of these standards for 90 per cent of our patients by April 2018.

- **Standard 2 – Time to consultant review**
  All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.

- **Standard 5 – Access to diagnostics**
  Hospital inpatients must have scheduled seven-day access to diagnostic services such as X-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and their reporting to be available seven days a week:
  - Within one hour for critical patients
  - Within 12 hours for urgent patients
  - Within 24 hours for non-urgent patients.

- **Standard 6 – Access to consultant-directed interventions**
  Hospital inpatients must have 24 hour access, seven days a week, to consultant-directed interventions either on-site or through formally agreed networked arrangements with clear protocols, such as:
  - Critical care
  - Interventional radiology
  - Interventional endoscopy
  - Emergency general surgery.

- **Standard 8 – Ongoing review**
  All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once transferred to a general ward, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

17. Making the best use of technology

"We're using more technology that gives us instant access to the information we need and the tools to do our job. It's a smarter way to work, and it benefits both patients and staff." Dr John O'Donohue, clinical director for IT

Sharing information for better healthcare
Thanks to work over 2017/18, our staff now have fast, safe access to electronic care records across south east London. We have enabled the different systems used across the area by different health and care professionals to be connected so that staff can get quick and accurate information about the people they are caring for – allowing them to offer the right care at the right time.

For south east London, this means information can now be shared between GP practices, hospitals and social care services in Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. This includes local providers of NHS 111 and GP out-of-hours services.

The benefits include fewer delays to treatment and smoother transfers between services. For more information, visit:
www.lewishamandgreenwich.nhs.uk/connectcare

We will be building on this work in 2018/19, using IT systems to enable improvements in the care given to patients.

Mobile working for hospital staff
Last year we introduced a secure app that makes it easier for doctors to carry out their clinical duties on the ward more conveniently, giving them easy access to key clinical tools on the go. We've gone one step further this year, enabling doctors to access the app securely from outside of the Trust, for example when they are travelling between our hospitals, or at a community clinic.

New technology for community staff
We've learned a lot from our cancer of the head and neck team, home enteral nutrition team and school nurses – 120 of them have been trialling mobile devices such as laptops and tablets to work more efficiently. They have really appreciated being able to input notes in a timely manner, and not having to return to their office base to type them up. In the longer term we plan to extend this way of working to 600 community-based staff.

Improved connectivity for staff
We've linked up our staff Wi-Fi to a government supported system called "govroam". It means that staff can use their Trust username and password to log on to secure Wi-Fi when they are visiting other NHS and council buildings. Having easy access to Wi-Fi to check emails or use the internet while out working with our partner organisations is making the working life of our staff easier.

We've also made Skype for Business available so that staff can make low-cost video conference calls to link up for team meetings. The secure Skype for Business video calls are much easier to follow than dialling into on a regular voice conference call, and it includes the option to discuss documents on screen together.

Our neonatal intensive care team were one of the first in the Trust to use this technology to avoid the need to travel between our two hospitals for every team meeting. This saves valuable time that they can spend caring for our tiniest patients. And it's not just clinicians who benefit. Our medical equipment team, who play a vital role in keeping all our complex medical devices in good working order, freed up eight hours of staff time simply by introducing a Skype team meeting.

Keeping track of paper medical records
In October 2017 we introduced clever new technology to automatically track and file our patients' medical records.

This radio frequency technology helps us track the movement of medical records around both our hospitals. Our new system, called iFiT, keeps track of a smart label attached to the patient's file and makes it easier for us to retrieve and send them on to the next clinic, ward or doctor who requests them.

Electronic patient records
Our electronic patient record systems were developed separately before we became one Trust in 2013. Currently a patient may have one record at University Hospital Lewisham and one at Queen Elizabeth Hospital, making it harder and time consuming for staff to see all the information we hold about a patient.

We will be merging these two systems in the summer of 2018 so that we can see all the information on each patient in one place – iCareLGT. Maintaining one system will be more cost effective and provide a better more consistent experience for staff across the Trust.

Once we have a united system we will be able to introduce more effective ways of working, and gradually reduce our reliance on paper patient records.

Over the coming year we will begin to use iCare LGT to prescribe, keep track of medicines, and to complete some of our clinical forms – such as admissions assessments, care plans and handover notes. This will save doctors and nurses lots of time and duplication – it means that multiple clinicians, across different specialities, will be able to see the same version of a patient's notes at the same time. This makes a huge difference for patients being looked after by staff from different specialties. iCare is already being used very successfully in these ways in other NHS hospitals across London.

When we introduce e-prescribing it will improve patient safety. Electronic prescribing reduces medication errors caused by copying drug names or dosages incorrectly or misinterpreting handwriting. The system will also alert the pharmacist to review any requests for drugs which may interact with other drugs that the patient has been prescribed before it is dispensed. The patient's prescribing history will be visible to other clinicians caring for the patient and remain available for any future hospital attendances.

18. Sustainability report

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term, even in the context of the rising cost of natural resources.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our environmental footprint.

As a part of the NHS, it is our duty to contribute towards the ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline). This is equivalent to a 28% reduction from a 2013 baseline by 2020.

Sustainable Development Management Plan

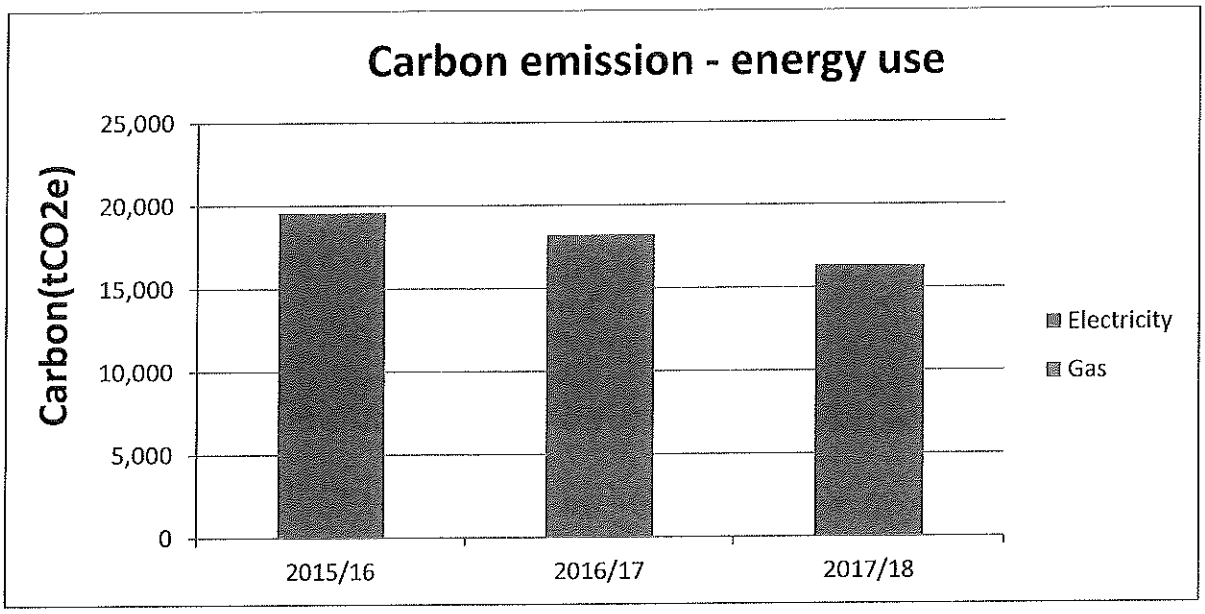
One way that an organisation can embed sustainability is to use a Sustainable Development Management Plan (SDMP). We will be putting together an SDMP in the near future for consideration by the board.

As an organisation we acknowledge our responsibility towards creating a sustainable future. To help us achieve that goal we run awareness campaigns that promote the benefits of sustainability to our staff.

Climate change brings new challenges to our business both in direct effects to our buildings, facilities and land, but also to patient health. Examples in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. As an organisation we have identified the need to develop a board approved plan for future climate change risks affecting our area.

Energy use over 2017/18

Lewisham and Greenwich NHS Trust spent £3,981,917 on energy in 2017/18, which is a 2% less than we spent on energy last year.



The above shows a 10% reduction in CO2 emission from the year 2016/17

Carbon(tCO2e)	Gas	Electricity
2015/16	6,443	13,143
2016/17	6,457	11,766
2017/18	6,250	10,078

Travel

We can improve local air quality and improve the health of our community by promoting environmentally friendly ways of travelling – for example through the "Cycle to Work" scheme.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness.

BUILDING FOR THE FUTURE

19. Trust objectives

Trust objectives 2018/19

We have five key priorities for 2018/19.

1. Improve the safety and quality of our care, focussing on getting the best results for patients every time. We will:
   - Deliver the national performance standards with a continued focus on the safety and quality of care we deliver – the A&E four hour wait standard, the 18 week referral to treatment standard and the national cancer targets
   - Get the basics right, keeping patients safe within the emergency department and placing patients in the right place at the right time
   - Improve the quality of the end-of-life-care pathways across acute and community settings and the health care system
   - Continue to embed the improvements delivered in critical care services over 2017/18 and support ongoing improvements across the organisation for this clinical pathway
   - Demonstrate the continued delivery of outstanding community services through robust clinical outcome measures across community services
   - Deliver the national Getting It Right First Time (GiRFT) programme, aiming to reduce variation in clinical outcomes
   - Ensure we have sufficient diagnostic capacity to deliver safe and effective care to all the patients we treat
   - Adopt a consistent quality improvement methodology across the organisation to deliver our priorities
   - Deliver our ambitious information technology programme to support improvements to patient care – getting the right information to the right people at the right time and place.

2. Develop and deliver all aspects of our emergency care improvement plans working closely with our health and care partners. We will:
   - Reduce bed occupancy rates at both our hospitals and improve the flow of patients through our hospitals
   - Expand ambulatory care services, developing integrated services that avoid admission and provide rapid access, including emergency surgical ambulatory care and frailty clinics
   - Work in partnership with mental health providers to reduce pressures on the Trust's emergency departments and improve the patient experience for patients with mental health issues
   - Work with our health and care partners to continue to play our part in delivering the system-wide improvement plan.

3. Recruit skilled staff in the numbers needed to deliver quality care and ensure the experience of our staff is positive, making LGT a place where people want to work. We will:
   - Improve staff experience and address concerns raised in the staff survey
   - Implement our recruitment plan, reducing vacancies by 2% and reducing agency spend so it is in line with the national limit

- Increase the number of apprenticeships, building the workforce from local communities and laying the foundations for the development of a skills academy
- Create a more agile workforce through implementing the community mobile working strategy
- Ensure we deliver our equality, diversity and inclusion commitments, supporting staff from all backgrounds and stopping discrimination where it occurs
- Actively listen to our staff and improve our communication with them to ensure they know they are valued.

4. Ensure the financial stability of the organisation. We will:
   - Deliver the 2018/19 financial plan and demonstrate a clear trajectory to financial sustainability
   - Develop greater financial discipline, awareness and responsibility across the organisation leading to increased financial grip and control
   - Ensure effective and timely decision making, improving the timeliness of information provided and increasing use of benchmarking data such as NHS Improvement's Model Hospital information service.

5. Develop the Trust's clinical service strategy, consistent with the south east London Sustainability and Transformation Plan, with estates development as a key enabler. We will:
   - Develop service models that demonstrate delivery of safe, effective, high quality patient care
   - Ensure that the clinical service model is aligned with estates redevelopment plans and demonstrate optimal use of NHS estate
   - Develop a strategic outline case for each hospital's redevelopment plans and start the work on the next stage outline business case
   - Work with our partners to develop integrated care and deliver new approaches to out of hospital care in Lewisham; this will be underpinned by the implementation of a population health management system, transformation of adult community services programme and improvements to community facilities.

20. Risks to the Trust achieving our objectives

All staff are encouraged to report risks and issues, and the Board oversees a corporate risk register – ensuring that we have action plans to deal with the risks that the Trust faces. Key risks for 2018/19 include:

Risks to ensuring the financial stability of the organisation

We need to report an improved financial position in 2018/19 as we work towards achieving long-term financial stability. To manage the risks around this, we have introduced a financial cost recovery programme (see section 12 for the overview). All cost improvement schemes are assessed to ensure that there is no adverse affect on the safety and quality of our services.

Recruitment and retention of staff
The national shortage in some roles, such as qualified nurses, means there is a risk that we will not be able to meet our staffing requirements. This could then affect our ability to improve performance and meet national standards for providing timely treatment. Staff shortages would also affect the Trust's financial position due to the cap on agency spend that has been imposed on NHS trusts.

To manage these risks, we will continue our recruitment drive, and we have been holding a series of recruitment days over 2018. We are also working to improve staff morale so that the Trust can attract and retain the best people. We are developing our staff engagement programme to do this.

21. Our Healthier South East London

"Our Healthier South East London" (OHSEL) is the name for the south east London's Sustainability and Transformation Partnership (STP). This is a coming together of our health and social care partners in south east London to make sure we are doing all we can to work in partnership to get the best health outcomes for our population.

It has evolved from a commissioner-led strategy – established in 2013 – into a partnership between local commissioners and providers, working with local authorities, patients and the public.

The STP is not a blueprint for the next five years: it is a series of plans for different clinical areas and enablers, such as workforce and estates, which are at different stages of development.

The STP was published in November 2016 on the OHSEL website:
http://www.ourhealthiersel.nhs.uk

Our STP has set the following five priorities:

1. **Developing consistent and high quality community based care (CBC), primary care development**
   This includes promoting self-care, prevention and co-operative structures across parts of the health and care system

2. **Improving quality and reducing variation across both physical and mental health**
   This includes better integration of mental health, and reducing the pressure on urgent and emergency care

3. **Reducing costs through provider collaboration**
   This includes consolidation of some non-clinical support services, including pathology and finance back office

4. **Developing sustainable specialised services**
   This includes mental health collaboration, renal and cardiac work

5. **Changing how we work together to deliver transformation**
   This includes the development of integrated care. It also focuses on how we can make sure that we are able to provide care for the population of south east London as it grows and ages in a way that is affordable.

Engagement
In the summer of 2017, the STP held a series of six public events, one in each of the boroughs across south east London. The aim was to further engage with our communities about how they would like health services to develop in south east London, and to get feedback on our existing plans. The overall message was that we need to focus more on prevention, partnership working and better co-ordination of services. There was also a strongly held view that we need to do more to explain and engage on the STP. We published an independent feedback report from these events and will be working to resond to this feedback.

In addition:

- We have patient and public voices and Healthwatch representatives on each of our clinical and decision-making workstreams influencing all our key programmes of work and feeding into our Patient and Public Advisory Group
- We are working with Maternity Voice Partnerships from each borough to co-produce our Better Births Implementation Plan, setting our maternity transformation priorities for the whole of south east London.

We also continue to hold south east London-wide Equalities Steering and Stakeholder Reference Group meetings to ensure our plans are assured around patient and public engagement and equalities issues.

Our approach has been informed and endorsed by The Consultation Institute, who advise on best practice engagement at national level. The engagement programme was also shortlisted for a national award by the Association of Healthcare Communications and Marketing (AHCM).

Some highlights from 2017
Better access to GPs: An extra £7.5 million has gone into primary care in south east London so that patients can book a GP at a time that suits them – including more evening and weekend slots. From 2018, all practices will offer online as well as telephone booking, allowing every single patient who chooses to, to manage their prescription and medical records online. We are developing community-based teams of family doctors, nurses and others to respond rapidly to people in crisis in their own homes and other settings to address. These teams deliver immediate care and put coordinated care plans in place to help manage on-going care, so that people can stay at home when they would otherwise have been taken to hospital.

GP workforce: SE London STP secured national funding to recruit 45 international GPs to the boroughs of Bexley, Bromley, Greenwich and Lewisham. The first 25 recruits are anticipated to arrive in south east London in autumn 2018. Lambeth and

Southwark have since indicated that they too wish to participate in this programme and a further bid has been made to the national programme.

Faster cancer diagnosis: A Rapid Access Diagnostic Clinic based at Guy's and St Thomas' Hospital was launched to provide swift access to a range of diagnostic tests for patients presenting with unexplained symptoms. They have received over 400 referrals, with 31 of those resulting in a cancer diagnosis. Following a successful pilot in Lambeth and Southwark, the service is being extended to Bromley, Bexley, Lewisham and Greenwich from April 2018.

Mental health services: We are improving the link between physical and mental health and mental health support and liaison team in A&Es 24/7 and working towards no out-of-area placements for non-specialist care by 2021. We introduced an initiative to improve the mental health of people with diabetes through the 'three dimensions of care for diabetes' pilot. The overall aim is to integrate medical, psychological and social care for people with persistent and poorly controlled diabetes.

Digitalisation of GP patient records: OHSEL secured funding to help 22 GP practices across south east London to digitise their paper records. This will mean space can be made available for further clinical care and end reliance on paper records. This is due to be completed by March 2018.

NHS 111: The online service was launched at www.111.nhs.uk, enabling patients to self-assess, receive self-care advice, be signposted to an appropriate service or receive a call back from an NHS 111 clinician, the pan-London Dental Nurse Triage Service or one of the out-of-hours GP services.

ACCOUNTABILITY REPORT

22. Directors' report

Role of the Trust Board

Our Board plays a key role in shaping the strategy, vision and purpose of the organisation. They hold the Trust to account for the delivery of strategy and ensure value for money. They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. The Board is led by an independent chair and composed of a mixture of independent non-executive members appointed by NHS Improvement and executive members, who work for the Trust. The Board has a collective responsibility for the performance of the organisation.

Trust Board members

Members of the Trust Board during 2017/18 are listed below. Co-opted members are non-voting members.

- Ms Elizabeth Butler – Chair – left 31 May 2017
- Ms Val Davison
  Non-Executive Director up to 31 May 2017
  Acting chair 1 June to 26 July 2017
  Substantive chair from 27 July 2017
- Mr John Ballard – non-executive director
- Mr Harry Bright – non-executive director – from 1 January 2018
- Ms Sukhvinder Kaur-Stubbs – non-executive director
- Ms Binka Layton – non-executive director – from 30 April 2017
- Prof Peter Littlejohns – non-executive director – from 1 January 2018
- Dr Julia Mundy - non-executive director
- Ms Veronika Simons - non-executive director
- Mr Tim Higginson – chief executive
- Dr Elizabeth Aitken – medical director
- Ms Claire Champion – director of nursing and clinical quality – left on 30 April 2017
- Mr John Hennessey - director of finance and information - left on 1 December 2017
- Ms Janet Lynch – director of workforce and education / deputy Chief executive
- Mr Usman Niazi – interim director of finance and information – from 2 December 2017
- Ms Selina Trueman – interim director of nursing and patient experience – from 24 March 2017
- Mr Keith Howard – redevelopment director – co-opted
- Mr Lee McPhail – chief operating officer – co-opted
- Ms Belinda Regan – interim director of governance and patient experience from 24 March 2017 – co-opted

- Ms Lynn Saunders – director of strategy, business and communications – co-opted

How the Board is appraised
The chief executiveexecutive is appraised by the chair who also appraises the non-executive directors. A independent director reviews the chair's personal appraisal and the chair is appraised by NHS Improvement. The chief executiveexecutive appraises the executive members of the Board.

Audit committees
A range of committees report directly to the Board and are chaired by non-executive directors. These include the audit committee, which meets five times a year and approves the annual accounts and annual report. Over 2017/18, membership of the audit committee included:

- John Ballard, audit committee chair
- Binka Layton
- Russell Manley
- Julia Mundy

The other Board committees are the finance and investment committee, remuneration committee, workforce and education committee, redevelopment committee and integrated governance committee.

Details of company directorships and other significant interests
The register of interests for Board members is in the table below, as of 1 April 2018:

NAME	DECLARATION
Ms Elizabeth Butler	Self Employed Chartered Accountant, some clients are NHS employees or businesses seeking to do business with the NHS. Co-opted member of the Audit and Risk Committee of the General Medical Council; Chair of the Audit and Risk Committee of the Royal College of Veterinary Surgeons and Trustee of the Nankseido Education and Welfare Trust.
Mr John Ballard	Treasurer – Life and Deaf Association, not for profit body promoting mental health of deaf young people
Ms Val Davison	Director of Dulwich Consulting Ltd – provide management consultancy and interim management to NHS and other organisations seeking/undertaking work with the NHS.
Dr Elizabeth Aitken	Nil
Mr John Hennessey	Director, Lewisham and Greenwich Choir Limited. Fully owned by Lewisham and Greenwich NHS Charitable Fund.
Mr Tim Higginson	Nil
Mr Keith Howard	Nil

Ms Sukhvinder Kaur-Stubbs	MD and major shareholder of Engage –Us Ltd. Providing consultancy support to charities in social care and advice to Department of Health. May seek opportunities on personalisation and user involvement among independent care providers, local authorities and if relevant NHS. Chair/Director of Taylor Bennett Foundation. CEO of Advice Lewisham/CAL. Providing debt, welfare and advice services to residents across the borough. Director of Swan Housing. Undertakes supported housing in East London and new house building in Lewisham.
Ms Janet Lynch	London Vice President - Healthcare People Management Association Provides a professional HR voice in healthcare and aims to support and develop HR staff to improve the people management contribution in healthcare
Mr Lee McPhail	Nil
Dr Julia Mundy	Director, Lewisham and Greenwich Choir Limited. Fully owned by Lewisham and Greenwich NHS Charitable Fund. Employee of University of Greenwich.
Ms Belinda Regan	Nil
Ms Lynn Saunders	Nil
Ms Veronika Simons	Nil
Ms Selina Trueman	Nil

23. Statement of Accounting/Accountable Officer's responsibilities

The statement explaining the Accountable Officer's responsibility, letter of representation and the independent auditors report can be found in the annual accounts section

24. Governance statement

The annual govenance statement can be found in the annual accounts section.

25. Protecting data

Information governance

Information governance refers to the way in which the NHS handles all information in a secure manner – in particular the personal and sensitive information of patients and employees. Effective information governance is about ensuring that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

Every year the Trust is required to submit an annual nformation governance (IG) toolkit submission. This is an online self-assessment which allows NHS and other related organisations to demonstrate whether they are compliant in basic information governance standards.

The Trust is required to upload evidence to support this assessment. Each control then scores each requirement from a Level 0 to 3. To achieve an overall 'Satisfactory' rating each control must be scored at a Level 2 or more.

For 2017/18, the Trust IG Toolkit score was 88%, achieving a satisfactory green pass rate in all IG controls. This provides the Trust Board with substantial assurance that appropriate controls are implemented and consistently applied to manage the information risks of the business.

Information governance incidents for 2017/18
The Trust is required to report any personal data incidents in our annual report at Level 1 and Level 2. Incidents designated as "pure cyber" (ie not IG related) or near misses are not required.

During 2017/18 the Trust had no serious incident at Level 2 and 97 incidents at Level 1.

Level 2 incident
There were no level 2 incidents

Level 1 incidents
A breakdown of the 97 incidents marked at Level 1 were categorised as follows:

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN (FINANCIAL YEAR)		
Category	**Breach**	**Total**
A	Corruption or inability to recover electronic data	**1**
B	Disclosed in error	**20**
C	Lost in transit	**6**
D	Lost or stolen hardware	**4**
E	Lost or stolen paperwork	**7**
F	Non-secure disposal hardware	**7**
G	Non-secure disposal of paperwork	**8**
H	Uploaded to website in error	**0**
I	Technical security failings (including hacking)	**1**
J	Unauthorised access/disclosure	**39**
K	Others	**4**
	Total	**97**

We continue to embed and improve our IG practices across the Trust, identify lessons learnt, and reflect these in future policy/procedure revisions and "Sharing the Learning" events for staff.

26. Remuneration report

Remuneration policy for directors and senior managers

Pay for executive directors is set and agreed by the Trust's remuneration Committee. Other senior managers' pay is in line with Agenda for Change pay scales.

All executive directors report to the chief executive and, like other staff, have regular appraisals to set and assess performance against objectives. There is no performance related pay within the Trust.

All our directors were appointed as permanent employees. The notice period for executive directors is six months. If applicable, termination payments would be made in line with contractual entitlements.

Remuneration for the Board

Remuneration Report : Salary and Pension Entitlements of Senior Managers - Remuneration

Name	Title	Salary	Other Remuneration	Bonus Payments	Benefits in Kind	All Pension Related Benefits	Salary	Other Remuneration	Bonus Payments	Benefits in Kind	All Pension Related Benefits	Totals	
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in Kind Rounded to the nearest £100	All Pension Related Benefits (bands of £2,500)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in Kind Rounded to the nearest £100	All Pension Related Benefits (bands of £2,500)	2017 - 2018	2015 - 2016
		£'000	£'000	£'000		£'000	£'000	£'000	£'000		£'000	£'000	£'000
1. Executive Directors													
Tim Higginson	Chief Executive	195 - 200	5 - 10	-	-	-	195 - 200	-	-	-	-	200 - 205	195 - 200
John Hennessey	Director of Finance, Information & Performance (T 01/12/17)	105 - 110	-	-	-	17.5 - 20	155 - 160	-	-	-	25-27.5	125 - 130	180 - 185
Claire Champion	Director of Nursing & Clinical Quality and Deputy CEO (T 30/04/17)	10 - 15	-	-	-	-	135 - 140	-	-	-	2.5 - 27.5	10 - 15	140 - 145
Elizabeth Aitken	Medical Director	95 - 100	105 - 110	-	-	22.5 - 25	95 - 100	90 - 95	-	-	25 - 27.5	230 - 235	215 - 220
Janet Lynch	Director of Workforce & Education	135 - 140	-	-	-	165 - 167.5	120 - 125	-	-	-	25 - 27.5	300 - 305	145 - 150
Usman Niazi *	Interim Director of Finance, Information & Performance (F 02/12/17)	40 - 45	-	-	-	280 - 282.5	-	-	-	-	-	320 - 325	-
Selina Trueman *	Interim Director Nursing and Infection Control	110 - 115	-	-	-	947.5 - 950	-	-	-	-	-	1055 - 1060	-

Name	Title	Salary	Other Remuneration	Bonus Payments	Benefits in Kind	All Pension Related Benefits	Salary	Other Remuneration	Bonus Payments	Benefits in Kind	All Pension Related Benefits	Totals	
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in Kind Rounded to the nearest £100	All Pension Related Benefits (bands of £2,500)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in Kind Rounded to the nearest £100	All Pension Related Benefits (bands of £2,500)	2017 - 2018	2015 - 2016
		£'000	£'000	£'000		£'000	£'000	£'000	£'000		£'000	£'000	£'000
2. Other Members of the Board													
Belinda Regan	* Interim Director of Governance	110 - 115	0 - 5	-	-	912.5 - 915	-	-	-	-	-	1025 - 1030	-
Lynn Saunders	Director of Business Development and Planning	80 - 85	10 - 15	-	-	-	120 - 125	-	-	-	15 - 17.5	90 - 95	135 - 140
Keith Howard	Director of Facilities & Estates	125 - 130	-	-	-	20 - 22.5	120 - 125	-	-	-	15.5 - 15	145 - 150	130 - 135
Lee McPhail	Director of Service delivery	140 - 145	-	-	-	-	140-145	-	-	-	-	140 - 145	140 - 145
3. Chairman & Non Executive Directors													
ELizabeth Butler	Chairman (T 31/05/2017)	5 - 10	-	-	-	-	40 - 45	-	-	-	-	5 - 10	40 - 45
John Ballard	Non-Executive Director	5 - 10	-	-	-	-	5 - 10	-	-	-	-	5 - 10	5 - 10
Julia Mundy	Non-Executive Director	5 - 10	-	-	-	-	5 - 10	-	-	-	-	5 - 10	5 - 10
Veronika Simons	Non-Executive Director	5 - 10	-	-	-	-	5 - 10	-	-	-	-	5 - 10	5 - 10
Henry Bright	Non-Executive Director (F 01/01/18)	0 - 5	-	-	-	-	-	-	-	-	-	0 - 5	-
Val Davison	Non-Executive Director/ Chair (F 01.06.18)	30 - 35	-	-	-	-	5 - 10	-	-	-	-	35 - 40	5 - 10
Binka Layton	Non-Executive Director (F 26/04/17)	5 - 10	-	-	-	-	-	-	-	-	-	0 - 5	-
Sukhvinder Kaur-Stubbs	Non-Executive Director	5 - 10	-	-	-	-	5 - 10	-	-	-	-	5 - 10	5 - 10
Peter Littlejohn	Non-Executive Director (F 16/01/18)	0 - 5	-	-	-	-	-	-	-	-	-	0 - 5	-

The value of the pension benefits has been calculated by taking the increase in the annual pension compared to the previous year (these figures have been inflated in line with inflation) and multiplying this by a factor of 20, plus the increase in the lump sum and minus the amount of pension contributions made by the employee during the year.

* The All Pension Related Benefits for these individual relates to their entire pension entitlement and is shown in this way as this is the first time that they have been included in the remuneration report. The pension entitlement for last year required in order to calculate the change in the year was not provided by NHSPA in error and is still awaited. The correct change in pension entitlement figures will be inserted prior to publication of the Annual Report. spective estimates are not available from

Remuneration Report : Salary and Pension Entitlements of Senior Managers - Pension Benefits 2017-18

Name	Title	Real increase/(decrease) in pension at age 60 (bands of £2500) £000	Real increase/(decrease) in pension lump sum at age 60 (bands of £5000) £000	Total accrued pension at age 60 at 31 March 2018 (bands of £5000) £000	Total accrued pension lump sum at age 60 at 31 March 2018 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension £000
Tim Higginson	Chief Executive	-	-	-	-	-	-		-
John Hennessey	Director of Finance, Information & Performance (T 01/12/17)	0 - 2.5	2.5 - 5	40 - 45	125 - 130	897	829	68	-
Claire Champion	Director of Nursing & Clinical Quality and Deputy CEO (T 30/04/17)	-	-	-	-	-	-	-	-
Elizabeth Aitken	Medical Director	0 - 2.5	-	55 - 60	90 - 95	832	768	62	-
Janet Lynch	Director of Workforce & Education	7.5 - 10	15 - 17.5	50 - 55	150 - 155	1,047	852	186	-
Usman Niazi	Interim Director of Finance, Information & Performance (F 02/12/17)	12.5 - 15	-	10 - 15	-	119	80	39	-
Selina Trueman	Interim Director Nursing and Infection Control	40 - 42.5	125 - 127.5	40 - 45	125 - 130	764	-	764	-
Belinda Regan	Interim Director of Governance	40 - 42.5	107.5 - 110	40 - 45	105 - 110	710	-	710	-
Lynn Saunders	Director of Business Development and Planning	-	-	-	-	-			-
Keith Howard	Director of Facilities & Estates	0 - 2.5	2.5 - 5	25 - 30	80 - 85	-			-

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

Board members not in the scheme in the current or previous year are not listed.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and 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.

Exit Packages for staff leaving in 2017-18			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	#	#	#
<£10,000	2	4	6
£10,000 - £25,000	1	5	6
£25,001 - £50,000	4	0	4
£50,001 - £100,000	1	0	1
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages	8	9	17
	£'s	£'s	£'s
Cost	235,224	77,841	313,065

Highest Paid Director and Median Pay of Workforce

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 Lewisham and Greenwich NHS Trust in the financial year 2017-18 was £205,252 (2016-17 £195,000). This was 5.95 times (2016-17 5.71 times) the median remuneration of the workforce, which was £34,495.20 (2016-17 £34,154). The director is the medical director and a senior academic.

In 2017-18 one employees received remuneration in excess of the highest-paid director (1 in 2016-17). Remuneration ranged from £5391.00 to £211,641.56 (2016-17 £15,081 to £209,912).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments, where appropriate. The highest paid director also has a clinical excellence award. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration Report: Median Pay & Highest Paid Director		
	2017-18	2016-17
Pay of Highest Paid Director	£205,252	£195,000
Median Pay	£34,495	£34,154
Median as Multiple of Highest Paid Director	5.95	5.71

27. Staffing report

Our staffing profile

At the time of writing (March 2017), we have 4,615 full time members of staff. In addition a total of 1,548 employees work part-time, making up 25% per cent of the Trust's permanent workforce. We have recruited 1,173 new members of clinical staff in the last year and recruitment continues to be a key priority for the Trust.

In January 2017, the Trust published a workforce equalities report, which is available on our website (www.lewishamandgreenwich.nhs.uk) or upon request (tel: 020 8333 3297). We regularly analyse our staffing profile so we can take action where there any groups are under-represented.

By gender, the breakdown of the Trust's workforce is as follows:

- Around 80 per cent of the Trust's overall workforce is female
- 65 per cent of all senior managers are female
- 56 per cent of directors in the organisation are female.

The Trust has an ethnically diverse workforce. Black and minority ethnic (BME) employees make up 46% of the Trust's permanent workforce. In general though, there is a lack of black and ethnic minority (BME) representation amongst staff at higher pay grades. This is an issue that the Trust is committed to addressing, and will continue to feature as a focus for action within our equality objectives.

Equality diversity and inclusion statement

We recognise that everyone has different needs in relation to public services, and that in both the workplace and as service users, certain individuals / groups of individuals can experience unfair and unequal outcomes. To help us understand and take action where necessary, the Trust continues to implement the Department of Health's Equality Delivery System for the NHS and the Workforce Race Equality Standard (WRES).

2017 EDI objectives included:

- Executive level commitment and accountability for specific WRES indicators enabling executives to identify and take action to address negative disparity between the experience of white and BME staff.
- Set up of self-sustaining Network(s) which act as EDI reference group to the organisation in support of improved patient care and staff experience.
- Produce and publish in January each year, an annual patient/service user profile which enables an analysis by as many of the 9 protected characteristics, experience and outcomes.
- Comply and improve on our practice and activities in relation to equalities and specifically the public sector equality duty

Implementing these has helped us to raise the profile of Equality Diversity and Inclusion and in so doing meet the commitment set out above as well as the requirements of the Equalities Act 2010.

The Trust equality steering committee actively monitors performance against the Trust equality objectives and whilst small improvements in some areas have been made throughout the year, this remains an area of focus.

Table of staffing profile

Staff Numbers & Pay	31 March 2018 #	31 March 2017 #	31 March 2018 £000	31 March 2017 £000
Medical and dental	984	933	96,640	89,102
Ambulance staff	-	-	-	-
Administration and estates	1,389	1,428	54,181	53,085
Healthcare assistants and other support staff	1,020	1,002	25,952	27,076
Nursing, midwifery and health visiting staff	2,545	2,653	125,057	122,934
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	1,108	1,122	50,394	48,355
Social Care Staff	-	-	-	-
Healthcare Science Staff	-	-	-	-
Other	6	5	234	243
Total	**7,052**	**7,143**	**352,458**	**340,795**

National NHS staff survey

The national staff survey is undertaken annually by all NHS organisations enabling comparisons between similar Trusts. The 2016 survey was carried out between late September to November 2017.

Our staff survey results for 2017 show that we have a number of improvements to make to ensure our hospitals and associated sites are places where we all want to work and where we would recommend our friends and family to receive treatment.

Our top results were:

- Quality of non-mandatory training, learning and development
- The percentage of staff able to contribute towards improvement at work
- Quality of appraisals
- The low percentage of staff experiencing physical violence from patients, relatives or the public
- The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month.

The results indicated that we need to address a number of areas including:

- The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month.
- The percentage of staff appraised in last 12 months
- The percentage of staff working extra hours
- Staff satisfaction with resourcing and support
- Organisation and management interest in and action on health and wellbeing,.

We are working with staff to explore these issues and draw up an action plan for improvement.

NHS pensions scheme

Past and present employees are covered by the provisions of the NHS pensions scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. For further detail, please refer to note 8.6 on page 18 of the annual accounts.

Staff sickness absence

Staff Sickness	31 March 2017 #	31 March 2016 #
Total Days Lost	55,764	51,760
Total Staff Years	5,636	5,600
Average working Days Lost	**9.9**	**9.2**

28. Going concern

Under accounting rules, organisations are required to report that they are able to continue for the foreseeable future in broadly the same form as at present. Doing so means that, in accounting terms, the organisation is a "going concern". The board of Lewisham and Greenwich NHS Trust has reported that the Trust is a going concern (with no plans for any substantial changes to services), although we will not be returning to financial balance in 2018/19. The auditors will also be reporting to the Secretary of State that the Trust did not meet its financial targets and recorded a deficit in 2018/19. For more information , see page xxx of the annual accounts.

29. Parliamentary Accountability and Audit Report

Lewisham and Greenwich NHS Trust does not produce a separate Parliamentary Accountability and Audit Report but has opted to include disclosures on contingent liabilities, losses and special payments, gifts and fees and charges on page xx.

An audit certificate and report is also included in this Annual Report (page xx).

30. Supplementary information

How you can get a copy of this report and accounts

If you would like a hard copy of the report or accounts, please email communications.lg@nhs.net or call 020 8333 3297 and we will send you a copy. Alternatively, you can write to Communications Department, University Hospital Lewisham, Lewisham High Street, London SE13 6LH

Whether auditors report was qualified or unqualified

The financial statements have received an unqualified opinion

Signature
Ben Travis, Chief Executive

21/5/18

Date:

Lewisham and Greenwich NHS Trust
Annual Accounts 2017-18

Contents

Independent auditor's report to the Directors of Lewisham & Greenwich NHS Trust

Report on the Audit of the Financial Statements

Opinion

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

In our opinion the financial statements:

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

Basis for opinion

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

Who we are reporting to

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

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which indicate the Trust is reliant on £53 million of financial support from Department of Health and Social Care (DHSC) in its 2018/19 operating plan. As stated in note 1.1.2, the DHSC has not, at the date of our report, confirmed this support. These events or conditions, along with the other matters explained in note 1.1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

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

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

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 25 May 2018 we referred a matter to the Secretary of State under section 30b of the Local Audit and Accountability Act 2014 in relation to the Trust's breach of its three year statutory breakeven duty arising from a predicted cumulative deficit at 31 March 2018.

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

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

In preparing the financial statements, the Directors are responsible for assessing the 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 Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

Qualified conclusion

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

Basis for qualified conclusion

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

- The Trust reported a deficit for the period of £55.6 million in its financial statements for the year ending 31 March 2018 which was a significant deterioration compared with its planned deficit position of £22.8 million.
- The Trust has not yet begun to tackle its underlying deficit and is forecasting a further deficit of £35 million for year ended 31 March 2019.
- The Trust will be reliant on further loans from the Department of Health in 2018/19. Further advances of £74,936,000 of revenue and working capital support will be sought, although accepted in principle these are not yet agreed.

The Trust's deficit financial position arose largely due to the lack of delivery of planned cost improvement savings and the loss of Sustainability and Transformational Funding from NHS Improvement. The Trust in its planning, assumed savings of £27 million from collaborative working with partners in the local health economy. These savings were not realised.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget and delivering against its savings plans and working effectively with partners in the local health economy to deliver savings. This matter is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and working effectively with partners and other third parties.

Responsibilities of the Accountable Officer

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

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

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

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

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

We have nothing to report in respect of the following matters where we are required to report to you by exception if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we issue a report in the public interest under section 24 of the Act; or
- we make a written recommendation to the CCG under section 24 of the Act.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Lewisham & Greenwich NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Darren Wells

Director
for and on behalf of Grant Thornton UK LLP
2nd Floor
St Johns House
Crawley
RH10 1HS

25th May 2018

Lewisham and Greenwich NHS
NHS Trust

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Email: ben.travis@nhs.net

Your Ref

Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG

21 May 2018

Dear Sirs

Lewisham and Greenwich NHS Trust
Financial Statements for the year ended 31 March 2018

This representation letter is provided in connection with the audit of the financial statements of Lewisham and Greenwich NHS Trust for the year ended 31 March 2018 for the purpose of expressing an opinion as to whether the Trust financial statements are presented fairly, in all material respects in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2017-18.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Group Financial Statements

i As Trust Board members, we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the Trusts' financial statements in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2017-18 (GAM); in particular the Trust financial statements are fairly presented in accordance therewith.

ii We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the Trust financial statements.

iii The Trust has complied with all aspects of contractual agreements that could have a material effect on the Trust financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the Trust financial statements in the event of non-compliance.

iv We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

vi In calculating the amount of income to be recognised in the Trust financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be derived by the Trust in accordance with the International Financial Reporting Standards and the GAM. We are satisfied that the material judgements used in the preparation of the Trust financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the Trust financial statements. There are no other material judgements that need to be disclosed.

vii We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the Trust financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

viii Except as disclosed in the Trust financial statements:

a there are no unrecorded liabilities, actual or contingent

b none of the assets of the Trust has been assigned, pledged or mortgaged

c there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

ix Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

x All events subsequent to the date of the Trust financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

xi We have considered the adjusted misclassification and disclosures changes schedules included in your Audit Findings Report. The Trust financial statements have been amended for these and are free of material misstatements, including omissions.

xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.

xiii We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the Trust financial statements.

xiv We acknowledge that, as a result of the breach in the Trust's statutory duty, the Auditor has issued a Section 30 report to the Secretary of State.

Information Provided

xv We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the Trust financial statements such as records, documentation and other matters;
b. additional information that you have requested from us for the purpose of your audit; and
c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xvi We have communicated to you all deficiencies in internal control of which management are aware.

xvii All transactions have been recorded in the accounting records and are reflected in the Trust financial statements.

xviii We have disclosed to you the results of our assessment of the risk that the Trust financial statements may be materially misstated as a result of fraud.

xix We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the Trust and involves:
a. management;
b. employees who have significant roles in internal control; or
c. others where the fraud could have a material effect on the Trust financial statements.

xx We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

xxi We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxii We have disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxiii We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the Trust financial statements.

xiv The Trust has made a number of restatements to the prior period comparators to reflect changes made to the 2017/18 disclosure requirements in accordance with the GAM. This is the only reason for the changes to comparators. We have not identified any material errors requiring a reclassification.

xxv The Trust will require additional cash loans totaling £74,936m in 2018/19 to maintain current payment performance assuming that it delivers its savings plan. Although the Trust has not received formal notification of future financing, this has always been available in the past in accordance with the need of the Trust to meet all essential liabilities and there is no indication that this will not continue. If the Trust fails to deliver its savings plan in full or its financial deficits are greater than planned in 2018/19 then further cash loans will be required. As the Trust's continuing operational stability depends on finance that has not yet been approved this represents a material uncertainty for the Trust.

Although these factors represent a material uncertainty that may cast significant doubt over the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational

Lewisham and Greenwich NHS
NHS Trust

Annual Governance Statement

Organisation Code: RJ2
1st April 2017 – 31st March 2018

1. SCOPE OF RESPONSIBILITY

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

I report to the Chair of the Trust and ensure appropriate systems exist to support the work of the Trust and the Board. I manage the executive team who have clear accountabilities and annual objectives, drawn from the annual operating plan for the Trust.

The Trust has worked in partnership with other health and social care organisations in the area, but notably the local Clinical Commissioning Groups (CCGs). The contracts between us provides clarity on our shared priorities and officers of the Trust meet regularly with our Clinical Commissioning Groups to take forward developments and monitor the delivery of our shared healthcare plans.

I also account to NHS Improvement – this body monitors the Trust and intervenes in performance management if the quarterly rating in its performance framework requires it or there is other adverse information of sufficient importance. I, and officers of the Trust, meet monthly with officers of NHS Improvement to discuss performance.

In preparing this statement I have ensured that it meets the requirements of the Corporate Governance Code (The HM Treasury/Cabinet Office Corporate Governance Code).

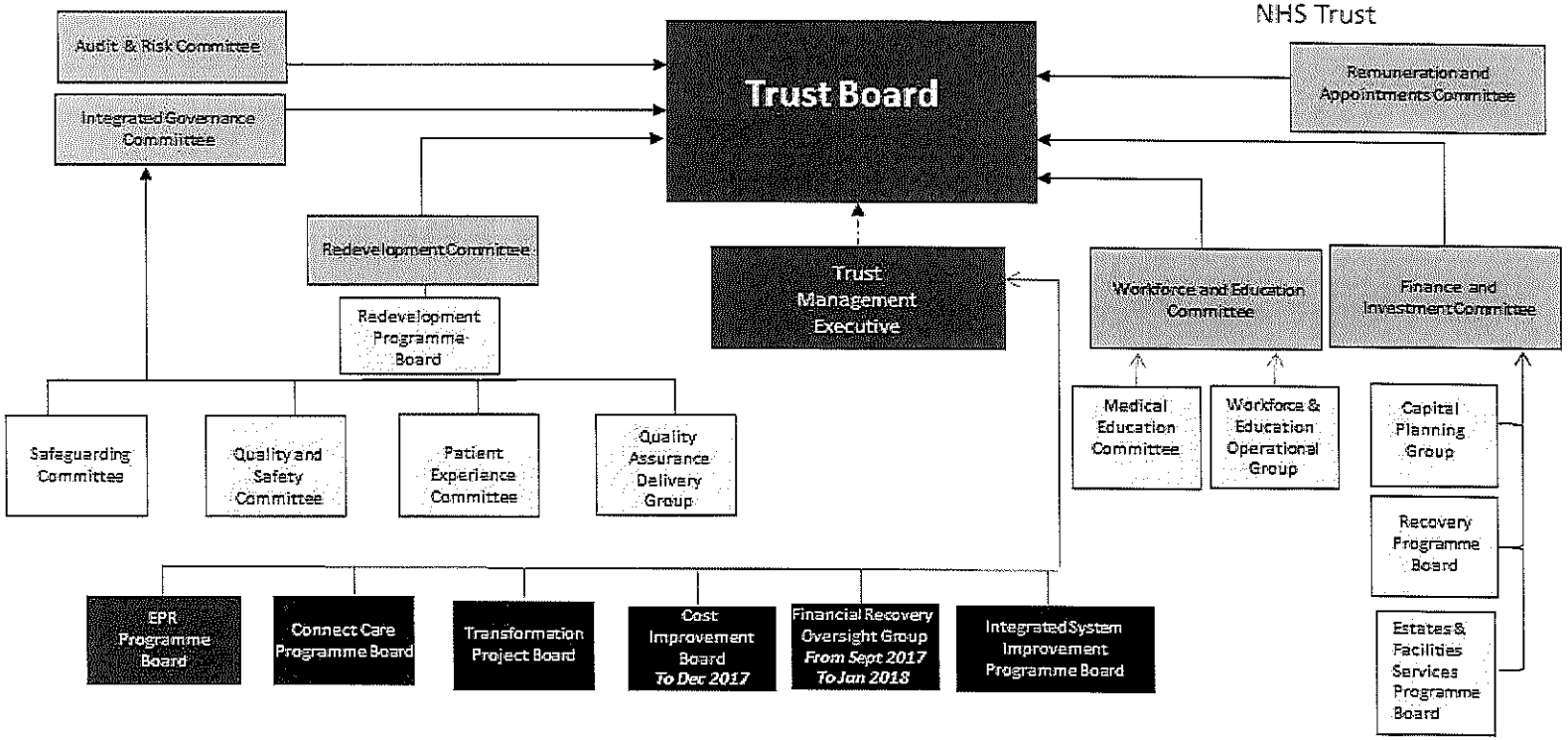
2. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

The Trust has described its corporate governance arrangements in the Corporate Governance Manual (reviewed annually) which pulls together the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation. The Board is responsible for providing effective and proactive leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed. The Board governs the Trust business, including the delivery of the strategies it sets by seeking assurance that the managerial systems that are in place deliver the desired outcomes and enable effective and timely reporting of significant issues that threaten its objectives. Accountability and decision making authorities have been delegated to the line management structures in place that deliver the day to day business.

TRUST BOARD ASSURANCE STRUCTURE 2017-18

Lewisham and Greenwich NHS

NHS Trust



KEY

Trust Board Sub-committees	Permanent committees that report to a Board Sub-committee or TME	Short life Project/ Programme Boards

April 2018

2.1 The Trust Board

The Board consists of five voting executive directors, eight non-executive directors (including the Chair) and four non-voting executive directors. The Board meets ten times a year in public, Board minutes and papers are made freely available, including on the Trust website. The Board also meets ten times a year for "Board Seminars" and twice a year for "Board Away Days". Attendance by its members has been consistently high and I am confident that the Executive Team and Board members were suitably engaged and informed in both Board and Trust management during 2017/18. The Board has reviewed its effectiveness, using external expertise in 2016 and an annual self-assessment in 2017. This year's annual Board self –assessment is in progress and the results are due to be discussed at the May 2018 Board seminar. These reviews feed into a Board development programme. This is complemented by other actions that have been taken through the appraisal of Board members by either the Trust Chair or Chief Executive, respectively.

During the year a new Chair and three Non-Executive appointments were made to the Board to replace leavers, including the University Nominated Non-Executive Director.

2.2 Summary of Public Board Activity and points of note

During the financial year the Board met ten times in public as described by the Trust Corporate Governance Manual. Standing items include a report from the Chair, improvement plan progress, patient safety, workforce, financial and performance reports, the Board assurance framework, risk management reports and my report as Chief Executive Officer. The Board received reports from its sub-committees as well as reports which are dictated by legislation or national guidance such as the annual reports for Infection Prevention and Control. The agenda regularly includes presentations or reports about clinical work in the Trust and patient safety and quality including the CQC Inspection Report and Action Plan.

The Board regularly discussed the changing local operational picture noting the capacity issues and planning for winter pressures. The Board took assurance from the implementation of the monthly "Back to the Floor' Programme" which involves Board Members visiting and observing clinical areas one day each month. Non-Executive Directors (NEDS) and Executive Directors have 'adopted' divisions and spend time visiting different areas of the hospital, taking part in quality assessments and environmental audits.

In addition, the Board has considered input from other stakeholders including

- Patients: via the Trust's Annual General Meeting and Q and A sessions before each Board meeting.
- Public/Voluntary Sector: The Trust has hosted a range of evening events for Trust Members and potential members to learn more about the Trust and to interact with Board and staff members. These include topic specific presentations on items of general health interest such as coping with diabetes and hearing loss, in addition to hosting information stalls at community events in Lewisham and Greenwich and updating members and stakeholders on current issues such as CQC inspections and future development plans.
- Staff: The Board is informed of staff views from the Staff Surveys, the staff Friends and Family test, from members of the Trust Management Executive and Clinical Leaders Group, on Board walkabouts and from discussions held by the Director of Workforce & Education with the Trust Joint Partnership Committee.
- GPs and Clinical Commissioners: The views of provider and commissioner GPs are of key importance to the Board. Through visits by the Director of Strategy Business

and Communications and members of the Business Development team the Trust has engaged with local practices giving them the opportunity to discuss the Trust and its management.

2.3 Board Committees

The Trust Board has authorised a number of committees to scrutinise aspects of the Trust's business. Each committee is chaired by a Non-Executive Director with a membership that has been discussed and agreed with the Board. The terms of reference of each committee set out the remit of responsibility delegated by the Board and are reviewed annually.

In October 2017 a Redevelopment Committee was establish to monitor progress and provide assurance to the Finance and Investment Committee and Board on the delivery of, but not limited to, the following projects: -

- Queen Elizabeth Hospital Infrastructure and Quality Improvements Programme
- Lewisham Community Programme
- QEH Greenwich Trust Wide Consolidation and Disposal
- UHL Lewisham Trust Wide Consolidation and Disposal

The Committee reports to the Finance and Investment Committee and the Board.

The Board receives an oral report from each Chair at the following public board meeting and the approved minutes and each Committee is required to submit an annual report.

3. RISK ASSESSMENT

Risk, or change in risk is identified, evaluated and controlled as described in the Trust's Risk Management Policy and Procedure. The risk evaluation and treatment model is based on a grading matrix of likelihood and consequence. This produces a risk score to enable the risk to be prioritised against other risks. The risks are also mapped to the strategic themes and objectives identified within the trust planning process along with the various other initiatives to confirm the score given to a risk.

Following the Trust CQC inspection in March 2017 and feedback from the Good Governance Institute, KPMG and EY, the process for reviewing, moderating scores, adding/removing new risks and or issues and consideration of divisional risks submitted for entry onto the corporate risk and issues register has been reviewed and restructured.

A full review of the Corporate Risk Register and Board Assurance Framework has been undertaken and all risks and issues and have been reviewed and or updated, new risks and/or issues added and some removed by the Executive Director risk owners. All Divisional risk registers have been reviewed as part of the whole Trust review and are now reviewed on a monthly basis and reported to Divisional Performance Review meetings.

The new process for the management of all divisional and corporate risks has been agreed by the Executive Team, approved by the Audit and Risk Committee and ratified by the Trust Board in September and October 2017.

To support the new approach to Risk Management, a monthly Training Programme has been implemented to ensure staff are trained and have knowledge in the Risk

Management procedures across the Trust.

Risks are identified via a variety of mechanisms:

The Board receives details of significant risks through regular Board and Audit and Risk Committee reports. The finance report records all key financial risks, the performance report records all key operational risks and performance against key clinical quality outcomes.

The Board will also identify risk through its review of the Board Assurance Framework at its meetings, the reports received from the Board sub-committees, the Trust corporate risk register and corporate issues log and any self-assessment exercise required for regulators or commissioners of service.

Reports from all external reviews and inspections is also presented to the Integrated Governance Committee and all risks, concerns and gaps in compliance are reported, together with mitigation and actions plans to meet compliance.

All areas within the Trust report incidents and near misses in line with the Trust's Incident Reporting Policy. Details of incidents are reported monthly through the Directorate Governance structure and to the Quality and Safety Committee. The Board receives a report of Serious and Red Incidents each month and on a quarterly basis a Patient Safety Report.

The Trust's Raising Concerns (Whistle-blowing) Policy enables staff to raise concerns and to ensure that they are promptly and properly investigated and dealt with appropriately. The Trust has reviewed local processes and arrangements in response to the recommendations in the 'Freedom to Speak Up' review. The Trust also has designated 'Freedom to Speak Up' Guardians to facilitate any concerns raised by staff.

Risk Assessments, including Health and Safety and Infection Control Audits are undertaken throughout the Trust. All identified risks at all levels are evaluated using a common methodology as defined in the Risk Management Policy and Procedure. The Trust's Risk Register and issues logs are generated through the assessment process of all risks at Divisional level and reviewed on a regular basis to ensure that risks are being treated and risks can be added or deleted, as necessary.

Other methods of identifying risks are:

- Complaints and Parliamentary Health Service Ombudsman Reports and recommendations
- Care Quality Commission inspections
- Inquest findings and HM Coroners' recommendations
- External reports such as the Francis Inquiry and National Confidential Inquiries
- Medico-legal claims and litigation
- Learning from Serious Case Reviews
- Incident reports and trend analysis
- Internal reports that contribute towards revalidation of doctors
- Internally generated reports from the Performance/Information Team
- Internal and external audit reports
- Performance Reviews
- Feedback from patient/public groups
- Feedback from Health Overview and Scrutiny Committees

- Patient satisfaction surveys including 'Friends and Family' test
- Chats, Queries and Concerns sessions
- Focus Groups
- Environmental Audits
- Quality and Safety visits by Executive and Non-Executive Directors
- Patient-Led Assessment of the Care Environment inspections
- Public attendance and questions at Trust Board meetings.

3.1 Capacity to handle risk

The Trust's capacity to handle risk is based around a clear Risk Management Policy and Procedure and effective leadership of the risk.

The Chief Nurse is the lead executive for the risk management structure and processes. The lead executive has continued to lead a holistic approach to risk management within the Trust by developing a new corporate risk and issues framework, re-structuring of the Board Assurance Framework with the application of the Trust Risk Appetite and strengthening reporting between the committees within the risk and governance structures, and upwards to the Trust Board.

The Medical Director is the Executive Lead for Clinical Quality, supported by the Chief Nurse. The Director of Finance and Information is the lead executive for financial risk and accountable for effective financial control and appropriate internal and external audit. The Deputy Medical Director (Professional Standards) is the responsible officer for the revalidation of doctors. This is monitored by the Workforce and Education Committee with an annual report to the Trust Board.

Trust Audit and Risk Committee
This Board sub-committee, chaired by a Non-Executive Director (NED), has delegated responsibility for the review, scrutiny and challenge of the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

Trust Management Executive (TME)
The Trust Management Executive is chaired by the Chief Executive (CEO) and membership consists of Executive Directors and Divisional Clinical Directors.
The Trust Management Executive is responsible for ensuring that there are clear and robust accountability arrangements at all levels of the organisation for risk management, including within the Divisional structure, which are explicit and understood.
The TME also has the responsibility for overview of the quarterly review and challenge of the corporate risk and issue register and Board Assurance Framework.

Executive Strategy Group
Chaired by the Chief Executive with membership of the Executive Directors, the Executive Strategy group provides assurance and a steer to the Trust Management Executive (TME) regarding high-level risks on the Board Assurance Framework, Corporate Risk Register and risks escalated by Divisions. The Group ensures that there is appropriate scrutiny and challenge associated with the review of risks prior to their inclusion onto the Trust's Corporate Risk Register/Board Assurance Framework or de-escalation to a Divisional level. The Group also ensures that adequate support is provided to Divisions through Executive Director sponsorship for each high level risk

accepted for entry onto the Corporate Risk Register from the Divisions or corporate functions.

Audit managers from KPMG (internal auditors) and Grant Thornton (external audit) attend all Audit Committee meetings and are responsible for the development of the audit reports and findings and the Annual Report to those charged with Governance. The Committee approves the annual Internal Audit Plan. This Plan is based on the Trust's Assurance and Risk Framework. The Audit and Risk Committee receives details of all the reports of the Internal Auditors and monitors the implementation of recommendations. The monitoring of the recommendations of Audit reports are reviewed at the Trust Quality & Safety and Integrated Governance Committee, through the External and Internal Review reports.
The main purposes of the audit reports are to provide Management, the Audit and Risk Committee and the Trust Board with:

- An opinion of the adequacy of internal control
- The degree to which the Trust complies with standards
- Information on significant audit findings and recommendations.

The Internal Audit Plan covers both financial and non-financial areas and includes a number of operational and support systems. Management and ownership of risk is delegated to the appropriate level from Director to local management teams through the clinical and operational management structure. All managers are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated area and scope of responsibility.

The Trust Board and the Board Sub-committees all maintain attendance records and assess their own effectiveness. The Board Sub-committees provide annual reports and committee self-assessments to the Trust Board about the coverage of their work.

Management and ownership of risk is delegated to the appropriate level from Executive Director to local management teams through the Divisional Management and Governance structure. Local risk registers are maintained and monitored through Directorate and Divisional management and Governance meetings. These are reviewed at the Divisional Governance meetings and monthly reports are presented to the Divisional performance Reviews.

A new process has been introduced to enable Divisions to escalate risks for consideration for entry onto the corporate risk register, which is overseen by the Executive Strategy Group.

Divisions have their own Risk Registers and issues logs to assist them to manage and monitor the risks they identify arising from complaints, claims, reported incidents and both clinical and non-clinical risk assessments.

Serious Incidents (SIs) are investigated through the Divisions involved, with reports generated by managers and signed-off by the Chief Executive. The Outcomes with Learning Group reviews all incidents after completion and monitors implementation of learning derived from each SI as well as delivery of action plans arising. Training in SI investigation and reporting has been carried out in 2017/18 to achieve an improvement in the timely completion of investigations and the preparation of SI reports. This will also assist the timely sharing of report outcomes and learning across the organisation.

All Divisions have a Medical quality and safety lead as well as a substantive governance

and risk lead, with responsibility for ensuring that risk management and clinical governance processes are applied consistently within their Division.

4. RISK AND CONTROL FRAMEWORK

The Trust Board is responsible for determining the strategic direction of the Trust, including that of quality governance and risk management. It is supported by the Audit and Risk Committee, which provides assurance on risk management issues. The Board reviews the interaction, ways of working, Terms of Reference, and membership of its committees.

The Trust's system of internal control is designed to manage the risks associated with achieving aims, objectives and policies to a reasonable level. The risk management process was updated and approved by the Board on 10th October 2017. It clearly defines risk management structures, accountability and responsibilities and incorporates consideration of stakeholders. The Risk Management process gives a complete overview of the risk assessment and management process, from identification to mitigation and forms the basis of the Assurance Framework and the reporting arrangements to the Trust Board. The prioritisation of risks included in the Trust Risk Register is based on a risk rating method (the Trust Risk Matrix). The Trust Risk Matrix is used to grade issues according to the impact (consequence) of the risk and the likelihood of occurrence. It is used to help prioritisation of all risk management activities, including complaints, claims and adverse incidents. It is also used to assist prioritisation of issues submitted to Risk Registers. Risks identified scoring eight or above on the Matrix (or where the issue covers more than one Division or professional group, or the Division is unable to fund the solution from existing resources) are considered by the Divisional General Managers, and / or Trust level risk managers for submission to the Corporate Risk Register. This aids consistency in the prioritisation of risks. The Trust Executive Strategy Group and Trust Management Executive reviews the Corporate Risk Register on a quarterly basis. The recommendations of national and other high-level reports are reviewed at appropriate Trust level committees and where gaps are identified, these are also submitted for consideration in the Corporate Risk Register.

4.1 Board Assurance Framework

The Board Assurance Framework (BAF) is a key support to the Trust's system of internal control. It is separate from the Trust's risk register (although the Corporate Risk Register is linked to it) and provides a clear methodology for the focused management of risks to the delivery of the Trust's strategic objectives. The BAF demonstrates clear links between the controls and assurances in place for delivery of the Strategic and Corporate Objectives. The Board now uses the risk appetite scores using the Good Governance Institute Risk Appetite for NHS Organisations (2012) matrix.

4.2 Care Quality Commission Registration

In March 2017, the Care Quality Commission (CQC) undertook a planned comprehensive inspection of all the Trust services, including our community services. The CQC gave the Trust an overall rating of requires improvement and community services received a rating of outstanding.

In their initial feedback following the visit, the CQC commented on the professionalism of staff, and on the caring attitude staff showed in ensuring that patients were treated with dignity and respect. The CQC recognised a number of areas of good practice and improvements since the last Trust-wide CQC visit in June 2016. The full inspection reports were published in November 2017

The CQC summarised their findings under three Regulation Breaches:

- Regulation 12 Safe Care and Treatment
- Regulation 17 Good Governance
- Regulation 18 Staffing.

The Trust submitted its formal action plan response to the regulation Breaches on 8th November 2017, which was presented to the Trust Board. CQC confirmed that they are satisfied with the response.

The Trust response, together with the Integrated System wide programme has been developed to address the findings within the CQC report. The Trust has an established the Quality and Assurance Delivery group (QADG) which oversee the monitoring and progress against the actions set out in the Trust's internal action plan. The QADG reports to the Integrated Governance Committee on a monthly basis and the Trust Board quarterly.

4.3 Quality Governance

As required the Trust produces an annual "Quality Account", which details the Trust's performance against a series of quality indicators and details the Trusts plans to continually improve the quality of its services. This is developed internally and shared with our local health partners before publication and submission to NHS England. The Interim Director of Governance co-ordinated the production of the Accounts with the Medical Director, as Chair of the Quality and Safety Committee, leading on the Patient Safety and Clinical Quality Sections.

The 2016/2017 Quality Account was reviewed by External Auditors Grant Thornton who confirmed that based on the results of their review, nothing had come to their attention that caused them to believe that, for the year ended 31 March 2017, the Quality Account was not prepared in all material respects in line with the criteria set out in the Regulations.

4.4 The management of incidents and identification of clinical risk

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, and the investigation of Serious Incidents and Never Events. The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the Trust. The responsibility for risk management is clearly mapped to all staff, the Trust Board, NEDs and Executive Directors, department heads, managers and senior clinicians. Risks are identified reactively and proactively. All risks are assessed against one standard tool. All risks are managed through Divisional Governance meetings; oversight is maintained by the relevant Trust Board sub-committee. High level risks are reported to and reviewed by the Trust Board quarterly.

4.5 Clinical Audit

The Trust has an established Clinical Audit programme as detailed in the Trust's Quality Account. The program aims to drive continuous improvement of services and quality of care. The Clinical Audit Programme priorities in 2017/2018 were the National Clinical Audit and Confidential Enquiries Programme, Mandatory Audits, NICE Guidance and Quality Standards, Trust Wide Governance and Risk Audits and local Clinical Specialty level Audits. The internal monitoring and reporting of Clinical Audit activity within the

Trust is established through a range of structures, systems and processes. The overall monitoring and reporting of all Clinical Audit activity is led by the Clinical Effectiveness Department supported by Directorate Level Governance and Audit Meetings, Divisional Level Governance and Risk Meetings and is overseen by the Clinical Audit and Guidelines Group

4.6 Information Governance/Data Security

Information governance is a framework for managing information, particularly personal information of patients and employees. The framework is responsible for ensuring that all personal information is handled and processed fairly and securely by the Trust to support its future regulatory, legal, risk and operational requirements. As part of this remit, the Department of Health has set a range of performance standards in a self-assessment toolkit (known as the Information Governance Toolkit (IGTK) that all NHS Health Organisations must comply with. The Trust's compliance is measured against these indicators and the Care Quality Commission (CQC) is informed of our results.

Our aim is to continually improve our compliance year on year with improved standards. A key element in achieving this is ensure that all staff undertake regular training and receive regular updates relating to Information Governance. The Trust has an established Information Governance Steering Committee (IGSC) which meets monthly that is chaired by the Trust's Senior Information Risk Officer (the Interim Director of Governance). The Trust's Caldicott Guardian is a member of this Committee. The Steering Committee reports into the Trust's Quality and Safety Committee, both through the minutes of its meetings and also on an exception-reporting basis, so that the Committee is kept informed of any risks relating to information assurance within the Trust and to ensure that mitigating action plans are in place to address such risks.

There were no Serious Incidents relating to Information Governance between 1st April 2017 and 31st March 2018 (as defined by the Trust Incident Reporting and Management policy) of which none were reported through the IGTK Incident Reporting at a level 2 or more. The Trust had one Cyber Security Related incident in this period. This incident did not affect the Trust's IT systems.

4.7 Data Quality

Ensuring that data collected and used by the Trust is accurate and complete is a key priority. The Trust Data Quality function works with Divisions and service areas to ensure that all staff are following agreed processes and that the data collected about patient activity is correct. The team carry out a number of Data Quality audits each year, as well as completing audits for the IG Toolkit submission. The Trust Information Governance Steering Committee receive these reports and where training needs are identified these are referred to the appropriate manager. The Trust also includes a review of waiting times data in its Annual Audit Programme.

Staff responsible for recording Referral to Treatment (RTT) data within Outpatient Departments and Admissions offices have both the Trust Access Policy and RTT training and awareness materials available to support their daily work. The Trust has an RTT validation team on both sites who review the regular waiting times reports produced for operational management. The Trust has worked with NHSI this year around RTT reporting Data Quality.

The risks that exist around the accuracy of waiting time data relate to the accuracy of the extracts available from the systems, the accuracy of the data recorded by staff, the availability of the required data to support pathway validation and the resources available

to complete the validation actions prior to data submission. All of these risks are mitigated through the actions detailed above.

4.8 Counter fraud

The anti-fraud, bribery and corruption work carried out during the financial year 2017/18 is currently being assessed by the Trust against the NHS Counter Fraud Authority Standards for Providers 2018/19 - Fraud, Bribery and Corruption/NHS Standard Contract. Following the annual Self-Review Toolkit return on 31st March 2017, changes to the standards were incorporated into the 2017/18 annual Counter Fraud plan to improve ratings not assessed as green. Where there was evidence of activity carried out but the Trust could not yet demonstrate that the activity had been assessed for effectiveness, the standard was rated amber

4.9 Other aspects

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. As such processes are established to manage concerns when they are identified. 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.

5. REVIEW OF EFFECTIVENESS

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways:

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

- Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

- The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

- External auditors provide me with assurances through their opinion on the financial statements, their value for money conclusion and the external auditor's report on the annual Quality Account.

- Other external organisations, including NHS Improvement, Care Quality Commission, MHRA, other agencies of the Department of Health and our commissioners, have provided me with reports about controls, compliance with standards, financial management and performance in delivering targets.

The main strategic risks to the Trusts meeting its objectives are:

- Failure to maintain Emergency Department performance because of lack of capacity in health system to manage winter pressures has a significant impact on the Trust's ability to deliver high quality care and meet national performance targets.

- Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquidity position.

The Head of Internal Audit Opinion for 2017/18 has been received and is summarised below:

The Head of Internal Audit Opinion, based on the core reviews reported to Audit Committee in year is that 'significant with minor improvements required' assurance can be given on the overall adequacy and effectiveness of the framework of governance, risk management and control.

6. SIGNIFICANT ISSUES

6.1 NHSI Investigation into Financial Governance

The Trust was notified on 24 August 2017 that NHSI intended to launch an investigation into the Trust's financial affairs. The concerns which triggered the investigation were:

- Whether appropriate steps were taken by the Trust Board and/or its sub-committees to assure itself over the credibility of its 2017/18 plan in November 2016, December 2016 and later in March 2017.
- The Trust's compliance with NHS Improvement's financial and workforce policies.
- The Trust Board's level of understanding of the drivers of the Trust's deficit and whether the Trust has a credible medium term plan to address these drivers.
- Whether the Trust has produced an appropriate plan in response to the EY financial governance report (May 2017) and is making timely progress with implementation of this.

The investigation was conducted in September and October through interviews with Board members and other senior staff, and review of information provided by the trust.

The Trust received the draft report on Friday 27th October 2017. The Trust commented on matters of factual accuracy and the final investigation response was published in November 2017.

The Trust has taken the findings of the report very seriously. The findings were reviewed at a special session of the Finance and Investment Committee on 31st October 2017 and the Board agreed an approach to its response at its meeting on 14th November 2017. A draft of the response was considered by the Finance and Investment Committee on 28th November 2017 and the final response was approved by the Board on 12th December, before submission to NHSI on 13th December 2017. The Board agreed that its response should take the form of a summary of the action it proposed to take. The plan requires a significant programme of work which will take place over the next 12-18 months. The Board will report regularly to NHSI on progress.

On 14th February 2018 NHSI wrote to the Trust to confirm their decision to close the formal investigation into the Trust's financial governance.

6.2 Quality and safety

The Trust's most significant issues relating to quality of services have been linked to bed capacity and increased levels of emergency activity. In addition, the Trust has had significant vacancy levels, particularly nursing posts within Acute and Emergency

Medicine. This had a significant financial impact throughout the year as the Trust called on bank and agency staff to ensure that safe staffing levels were maintained throughout peak periods of activity and to open escalation areas. The sustained national activity position had a similar effect on the Trust's Emergency Department standards and elective activity which affected the achievement of standards in the second half of the financial year.

Following the Trust-wide inspection from the CQC in March 2017 an Integrated System Wide Improvement Programme was developed with the Trust's partners to ensure an integrated approach, particularly with regard to the emergency care pathway. Work continues to embed the improvement plan to drive system wide performance and quality improvement. This work is overseen by the A&E Delivery Board.

The infrastructure within the PFI managed estate on the QEH site has been an area of risk since integration. In October 2016 NHS Improvement confirmed approval of the QEH Infrastructure Business Case business case for £48m of funding to address the significant infrastructure and quality and safety improvements required at QEH.

6.3 Finance

The 2017/18 financial year has been challenging for all NHS Acute providers this can clearly be seen in the financial position of a number of trusts across London. While the Trust will not achieve the originally set control total there has been an improvement in the financial position compared to the forecast made in the Q2 Returns. As at M11 the Trust is forecasting to deliver a deficit of £61.8m compared to Q2 Forecast of £65.2m, we have achieved this improvement against a backdrop of significant operational pressures and ever increasing patient volumes.

The Trust has taken the NHS Investigation into financial governance very seriously and as part of the overall Trust response the finance function has changed the way we report and monitor financial risk and will continue to implement the actions set out in our plan over the course of 2018-19. As a direct result of the investigation report the Trust will ensure that all planning assumptions made within the 2018-19 plan are within the Trust ability to control and where they are not they are limited in financial value and that appropriate monitoring is in place to ensure effective risk mitigation.

Notwithstanding the investigation the Trust has made significant progress is reducing its underlying run rate during Q3 and Q4 by implementing a range of new controls, prioritising fiscal discipline and taking a more focused approach to overall run rate as opposed to CIPs and Budget variances. As a result of this action the Trusts exit run rate in 2017-18 forecast to be £4.14m compared to an average run rate in Q1 of over £5.4m.

The 2018-19 plan has been finalised and the Trust is projecting to have a deficit of £53.1m which requires the delivery of a £25m CIP. The CIP plan is based on Trust actions and does not include any schemes over which we have limited control or ability to influence. In order to support delivery of the plan the Trust is investing in a strengthened Recovery PMO function to ensure more effective governance and oversight of the CIP programme.

6.4 Liquidity:

The Trust has historically operated on extremely low levels of cash; both in its former life as Lewisham Healthcare Trust and subsequently Lewisham and Greenwich Healthcare

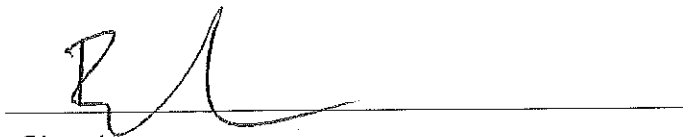
Trust.

However, there has been a significant improvement in liquidity in FY17/18. This has culminated in the Trust being able to pay its suppliers more promptly; with 67% of invoices, by number, being paid within the Better Payment Practice Code (BPPC) 30 days target compared with 44% at the start of the year.

The main reason for the improvement in liquidity has been the continuing revenue cash support from DH; which for the past two years has been funded at the same level as the adjusted retained deficit and additional amounts in respect of technical IFRIC 12 and other technical adjustments. Better overall debt management and the receipt of outstanding to Sustainability and Transformation Funding (STF) also contributed to the improvement.

7. CONCLUDING STATEMENT

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Lewisham and Greenwich NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.



Signature
Ben Travis, Chief Executive

21/5/18

Date:

Lewisham and Greenwich NHS Trust

Annual accounts for the year ended 31 March 2018

Audited 25-05-18

Statement of Comprehensive Income

	Note		2017/18 £000	2016/17 £000
Operating income from patient care activities	3		491,556	471,881
Other operating income	4		52,298	67,361
Operating expenses	5, 7		(571,742)	(549,757)
Operating surplus/(deficit) from continuing operations			**(27,888)**	**(10,515)**
Finance income	10		50	34
Finance expenses	11		(23,252)	(24,393)
PDC dividends payable			(4,427)	(6,105)
Net finance costs			**(27,629)**	**(30,464)**
Other gains / (losses)	12		(88)	(46)
Gains / (losses) arising from transfers by absorption			-	-
Surplus / (deficit) for the year from continuing operations			**(55,605)**	**(41,025)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations			-	-
Surplus / (deficit) for the year			**(55,605)**	**(41,025)**
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Impairments	6	*	(511)	-
Revaluations	16	**	21,791	(22,521)
Other recognised gains and losses			-	-
Total comprehensive income / (expense) for the period			**(34,325)**	**(63,546)**
Adjusted financial performance				
Surplus / (deficit) for the period			**(55,605)**	**(41,025)**
Add back all I&E impairments / (reversals)		***	(2,063)	178
Adjust (gains) / losses on transfers by absorption			-	-
Surplus / (deficit) before impairments and transfers			**(57,668)**	**(40,847)**
Retain impact of DEL I&E (impairments) / reversals			-	-
Remove capital donations / grants I&E impact			76	108
Prior period adjustments			-	-
IFRIC 12 adjustment (including IFRIC 12 impairments)			-	20,685
Adjusted financial performance surplus / (deficit)		****	**(57,592)**	**(20,054)**

* This is the net reduction of £511K charged to the revaluation reserve arising from the purchase 'buy-back' of medical equipment at the end of the QEH Toshiba - Managed Equipment Service (MES) contract - See Note 14.1 Property, plant and equipment - 2017/18.

** This is the net gain to the revaluation reserve from the update of the fair value of land and buildings in accordance with DHSC guidance - See Note 14.1 Property, plant and equipment - 2017/18.

*** The adjustment of £2,063K is the sum of of impairments charged to I&E and reversed out for the purposes of the financial performance 'breakeven' measure - See Note 6 Impairment of assets.

**** Adjusted financial performance has been calculated with no IFRIC 12 adjustment (including IFRIC 12 impairments) in line with the DHSC Group Accounting Manual (GAM) for 2017/18- See Note 35 Breakeven duty financial performance".

The notes on pages 6 to 55 form part of this account.

Statement of Financial Position

		Note	31 March 2018 £000	31 March 2017 £000
Non-current assets				
Intangible assets		13	27,928	27,323
Property, plant and equipment		14	359,728	335,568
Trade and other receivables		18	2,390	2,482
Total non-current assets			**390,046**	**365,373**
Current assets				
Inventories		17	5,063	5,670
Trade and other receivables		18	40,331	50,649
Cash and cash equivalents		19	8,532	5,457
Total current assets			**53,926**	**61,776**
Current liabilities				
Trade and other payables	*	20	(46,420)	(47,228)
Borrowings		22	(44,318)	(6,617)
Other financial liabilities		21	-	-
Provisions		24	(1,410)	(1,876)
Other liabilities	*	21	(8,106)	(5,761)
Total current liabilities			**(100,254)**	**(61,482)**
Total assets less current liabilities			**343,718**	**365,667**
Non-current liabilities				
Trade and other payables		20	-	-
Borrowings		22	(197,190)	(197,410)
Other financial liabilities		21	-	-
Provisions		24	(5,858)	(3,919)
Other liabilities		21	(607)	(657)
Total non-current liabilities			**(203,655)**	**(201,986)**
Total assets employed			**140,063**	**163,681**
Financed by				
Public dividend capital			198,712	188,005
Revaluation reserve			159,366	138,086
Income and expenditure reserve			(218,015)	(162,410)
Total taxpayers' equity			**140,063**	**163,681**

* Deferred income previously shown in Trade and other payables has is now included in Other financial liabilities - See Note 21 Other liabilities.

The notes on pages 6 to 55 form part of these accounts.

Name

Position Chief Executive

Date **21 May 2018**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**188,005**	**138,086**	**-**	**(162,410)**	**163,681**
Surplus/(deficit) for the year	-	-	-	(55,605)	**(55,605)**
Other transfers between reserves	-	-	-	-	**-**
Impairments	-	(511)	-	-	**(511)**
Revaluations	-	21,791	-	-	**21,791**
Public dividend capital received	10,707	-	-	-	**10,707**
Taxpayers' equity at 31 March 2018	**198,712**	**159,366**	**-**	**(218,015)**	**140,063**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**182,666**	**160,607**	**63**	**(121,448)**	**221,888**
Surplus/(deficit) for the year	-	-	-	(41,025)	**(41,025)**
Other transfers between reserves	-	-	(63)	63	**-**
Impairments	-	-	-	-	**-**
Revaluations	-	(22,521)	-	-	**(22,521)**
Public dividend capital received	5,339	-	-	-	**5,339**
Taxpayers' equity at 31 March 2017	**188,005**	**138,086**	**-**	**(162,410)**	**163,681**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

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

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note		2017/18 £000	2016/17 £000
Cash flows from operating activities				
Operating surplus / (deficit)			(27,888)	(10,515)
Non-cash income and expense:				
Depreciation and amortisation	5		25,250	23,433
Net impairments	6		(2,063)	6,421
(Increase) / decrease in receivables and other assets			9,798	(8,167)
(Increase) / decrease in inventories			607	509
Increase / (decrease) in payables and other liabilities			(106)	(11,507)
Increase / (decrease) in provisions			1,466	(302)
Net cash generated from / (used in) operating activities			**7,064**	**(128)**
Cash flows from investing activities				
Interest received			50	34
Purchase of intangible assets			(4,097)	(4,932)
Purchase of property, plant, equipment and investment property			(20,654)	(9,554)
Net cash generated from / (used in) investing activities			**(24,701)**	**(14,452)**
Cash flows from financing activities				
Public dividend capital received		*	10,707	5,339
Movement on loans from the Department of Health and Social Care		**	42,956	47,579
Capital element of finance lease rental payments			(365)	(51)
Capital element of PFI, LIFT and other service concession payments			(5,727)	(4,090)
Interest paid on finance lease liabilities			(35)	(12)
Interest paid on PFI, LIFT and other service concession obligations			(20,670)	(22,823)
Other interest paid			(2,339)	(1,558)
PDC dividend (paid) / refunded			(3,815)	(6,411)
Net cash generated from / (used in) financing activities			**20,712**	**17,973**
Increase / (decrease) in cash and cash equivalents			**3,075**	**3,393**
Cash and cash equivalents at 1 April - brought forward			**5,457**	**2,064**
Cash and cash equivalents at 31 March	19.1	***	**8,532**	**5,457**

* PDC received of £10,707K relates to DHSC funded Infrastructure works at QEH (£4,725K), QEH IT capital investment (£2,658K), Emergency Department and Wi-Fi development (£2,004K) and other cross site schemes (£1,320K).

** The net increase on loans from DHSC of £42,956K is made up of revenue cash support received during the year totalling £43,744K less capital loan repayments of £788K.

*** The closing cash balance of £8,532K includes £6,468K of Trust internally generated capital cash not utilised in year and being carried forward to 2018/19 with approval of DHSC.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 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 accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

International Accounting Standard 1 (IAS1) requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern.

In keeping with DHSC Group Accounting Manual (GAM), it is the view of the Directors that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents; such as the Trust FY18/19 operating plan and absence of any prospect of services ceasing through the dissolution of the Trust, is sufficient evidence of going concern.

It is also the case that:
- The Trust has been unable to accept its control total for 2018/19.
- DHSC has not yet confirmed that it will provide the financial support of £35,470K in the 2018/19 operating plan.
- The Trust does not presently have a plan to return to financial balance in 2019/20.
- The Trust does not presently have a plan for how it will repay revenue support loans from DHSC totalling £121,786K of which; £39,376K is repayable in 2018/19 and the remaining £82,410K in 2020/21.
- The draft operating plan assumes full, recurrent delivery of a £25,000K CIP, which it has not achieved in recent years.

Although these factors represent material uncertainties which may cast doubt upon the going concern ability of the Trust, the Directors:
- Expect the Trust to agree contracts with its main commissioners for 2018/19.
- Expect the operating plan to provide for a significant improvement in the Trust's underlying run rate.
- Are not aware of any plans which would place the future of the organisation at risk of dissolution.
- Expect DHSC confirm continuing revenue cash support in the absence of any indications to the contrary.
- Expect DHSC confirm new financing of repayable revenue support loans in the absence of any indications to the contrary.

Taking into account the GAM and the factors identified above, the Directors believe that it is a realistic expectation that the Trust will have sufficient resources to continue as a going concern for the foreseeable future.

Accordingly, as required by the GAM, the Directors have prepared the 2017/18 financial statements on a going concern basis

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

1. The Trust has used component life information provided by an independent valuer to depreciate buildings on a component basis.

2. Land and buildings have been valued on a Modern Equivalent Asset (MEA) basis using the existing site methodology in preference to an alternative location approach. This choice was predicated on the overriding practical requirement for the Trust's two hospitals to be situated in same geographical area as the populations they serve. Therefore, the existing locations were considered the most appropriate for valuation purposes. The valuer followed the latest GAM.

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

1. Property, Plant and Equipment (PPE) - PFI buildings are on the Statement of Financial Position at current value as determined by an independent professional valuer on the basis of depreciated replacement cost (DRC). The associated liability has been included using the Department of Health (DH) Universal Model.

2. The value of assets and liabilities at the year end are based on opening values with changes applied to reflect acquisitions, reclassifications, disposals, revaluations, impairments and transfers during the year as appropriate.

3. Outstanding Legal Claims - The value of reported claim is based on an estimation of the probable liabilities arising from outstanding legal claims against the Trust at the year end; having taken professional legal advice and assessment by appropriate Trust directors of the likelihood of the successful defence of the relevant cases.

4. The Trust has estimated provisions for pensions relating to former staff using information provided by the NHS pensions Agency at the time of the members' early retirement. These are updated annually and changes made where notification is received of the death of a member and resulting cessation of any continuing liability or it becomes apparent that the provision is no longer sufficient to meet the liability. Calculation of the long-term liability in respect payments to NHS Pensions Agency includes reference to Office of National Statistics (ONS) published life expectancy data.

5. The useful economic life of plant and machinery and IT equipment has been estimated on a probable life basis; consistent with actual experience inside the Trust and across similar NHS provider organisations.

Note 1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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

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 e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Note 1.4 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 period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

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

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

The Trust has no employees who are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme.

Note 1.5 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 1.6 Property, plant and equipment

Note 1.6.1 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, or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Note 1.6.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

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

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

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

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

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

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

Impairments
In accordance with the *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.

Note 1.6.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Note 1.6.4 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.

Note 1.6.5 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 IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease 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 and the charges for services.

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

Lifecycle replacement
The Trust has not capitalised lifecycle replacement costs for the PFI building (Riverside and QEH) on the basis that the costs identified in the PFI provider financial model cannot be analysed over the following headings with adequate certainty:
1. Property, plant and equipment
2. Improvement or day-to-day maintenance

However, replacement under the QEH PFI Equipment contract have been capitalised on the following basis:
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

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

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

Assets contributed by the Trust to the operator for use in the scheme
The Trust has no assets contributed to the operator for use in the scheme.
Other assets contributed by the Trust to the operator
The Trust did not contribute any assets to the operator before the PFI building came into use.

Note 1.6.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	54
Dwellings	-	-
Plant & machinery	1	9
Transport equipment	-	-
Information technology	1	7
Furniture & fittings	1	6

Finance-leased assets (including land) are depreciated over the shorter of the useful economic 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 1.7 Intangible assets

Note 1.7.1 Recognition

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

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Note 1.7.2 Measurement

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

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

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

Amortisation

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

Note 1.7.3 Useful economic lives of intangible assets

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

	Min life Years	Max life Years
Information technology	2	7

Note 1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.9 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 Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial instruments and financial liabilities
Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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

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

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

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

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

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

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

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

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

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

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

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

Note 1.11 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.

Note 1.11.1 The Trust as 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 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 is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

Contingent Rentals
Contingent rentals are recognised as an expense in the period 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.

Note 1.11.2 The Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' 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 1.12 Provisions
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 the discount rates published and mandated by HM Treasury.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016/17: positive 0.24%) in real terms.

All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A short term rate of negative 2.42% (2016/17: negative 2.70%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.85% (2016/17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.56% (2016/17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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 24.2 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 1.13 Contingencies

Contingent assets

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Note 1.14 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.

At any time, 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, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

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

Note 1.15 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 1.16 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 spot exchange rate on the date of the transaction.

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

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

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

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

Note 1.17 Third party assets

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

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

Note 1.19 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 9 Financial Instruments
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 14 Regulatory Deferral Accounts
Not yet EU-endorsed.*

Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
* The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries.

IFRS 15 Revenue from Contracts with Customers
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 22 Foreign Currency Transactions and Advance Consideration
Application required for accounting periods beginning on or after 1 January 2018.

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

IFRIC Practice Statement 2: Making Materiality Judgement
Application required for accounting periods beginning on or after 1 January 2018, it does not amend any accounting standards and adequately covered under the Trust's overview on materiality.

Note 1.21 Changes to 2016/17 comparators

The Trust has amended the following prior year comparators to reflect classification changes in the 2017/18 GAM:

Statement of Comprehensive Income
Statement of Financial Position
Statement of Cash Flows
Note 3.2 Income from patient care activities (by source)
Note 4 Other operating income
Note 5 Operating expenses
Note 7 Employee benefits
Note 12 Other gains / (losses)
Note 18.1 Trade receivables and other receivables
Note 20 Trade and other payables
Note 21 Other liabilities
Note 28.2 Carrying values of financial assets
Note 28.3 Carrying value of financial liabilities

Note 2 Operating Segments

The Trust manages all services and functions as a unified and fully integrated healthcare provider and, as such, operates one segment.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	50,186	51,996
Non elective income	135,679	122,311
First outpatient income	30,249	28,865
Follow up outpatient income	27,406	27,320
A & E income	33,123	29,765
High cost drugs income from commissioners (excluding pass-through costs)	28,673	28,876
Other NHS clinical income	122,772	122,019
Community services		
Community services income from CCGs and NHS England	25,841	26,342
Income from other sources (e.g. local authorities)	12,745	14,061
All services		
Private patient income	36	75
Other clinical income	24,846	20,251
Total income from activities	**491,556**	**471,881**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	52,847	53,462
Clinical commissioning groups	409,709	392,012
Department of Health and Social Care	-	13
Other NHS providers	9,416	8,251
NHS other	-	-
Local authorities	13,858	15,088
Non-NHS: private patients	36	75
Non-NHS: overseas patients (chargeable to patient)	4,216	2,030
NHS injury scheme	1,390	861
Non NHS: other	84	89
Total income from activities	**491,556**	**471,881**
Of which:		
Related to continuing operations	491,556	471,881
Related to discontinued operations	-	-

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

		2017/18	2016/17
		£000	£000
Income recognised this year		4,216	2,030
Cash payments received in-year	*	703	464
Amounts added to provision for impairment of receivables		2,244	1,028
Amounts written off in-year		408	312

Note 4 Other operating income

		2017/18	2016/17
		£000	£000
Research and development		513	233
Education and training		19,779	21,511
Receipt of capital grants and donations		-	-
Charitable and other contributions to expenditure		-	-
Non-patient care services to other bodies		4,618	4,944
Support from the Department of Health and Social Care for mergers		-	-
Sustainability and transformation fund income		4,252	16,746
Rental revenue from operating leases		1,530	1,530
Rental revenue from finance leases		-	-
Income in respect of staff costs where accounted on gross basis		2,093	3,167
Other income	**	19,513	19,230
Total other operating income		**52,298**	**67,361**
Of which:			
Related to continuing operations		52,298	67,361
Related to discontinued operations		-	-

* The 2016/17 comparator has been restated to exclude non-cash income contributions from commissioners under the DHSC overseas vistor income recovery scheme.

** Includes £16,440K (£16,000K in 2016/17) of financial support received under the SLHT dissolution agreement to off-set the additional cost imposed by the QEH PFI building - Reference the TDA document "Securing sustainable healthcare for the people of South East London as part of the SLHT dissolution".

Note 5 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	716	394
Staff and executive directors costs	351,287	338,268
Remuneration of non-executive directors	78	84
Supplies and services - clinical (excluding drugs costs)	44,760	44,739
Supplies and services - general	3,773	2,808
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	40,060	38,357
Inventories written down	223	76
Consultancy costs	5,842	1,762
Establishment	3,981	3,483
Premises	26,758	25,432
Transport (including patient travel)	4,785	4,554
Depreciation on property, plant and equipment	21,785	20,543
Amortisation on intangible assets	3,465	2,890
Net impairments	(2,063)	6,421
Increase/(decrease) in provision for impairment of receivables	2,601	2,338
Change in provisions discount rate(s)	(16)	315
Audit fees payable to the external auditor		
audit services- statutory audit	115	122
other auditor remuneration (external auditor only)	10	12
Internal audit costs	222	232
Clinical negligence	28,569	24,643
Legal fees	466	161
Insurance	9	45
Education and training	2,712	2,530
Rentals under operating leases	2,377	2,245
Early retirements	2,774	-
Redundancy	246	214
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	24,602	25,312
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-	-
Hospitality	52	81
Other services, eg external payroll/finance	1,169	1,158
Other	384	538
Total	**571,742**	**549,757**
Of which:		
Related to continuing operations	571,742	549,757
Related to discontinued operations	-	-

Note 5.1 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services	10	12
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**10**	**12**

Note 5.2 Limitation on auditor's liability

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

Note 6 Impairment of assets

		2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:			
Loss or damage from normal operations		-	-
Over specification of assets		-	-
Abandonment of assets in course of construction		-	-
Unforeseen obsolescence		-	-
Loss as a result of catastrophe		-	-
Changes in market price	*	(2,063)	6,421
Other		-	-
Total net impairments charged to operating surplus / deficit		**(2,063)**	**6,421**
Impairments charged to the revaluation reserve	**	511	-
Total net impairments		**(1,552)**	**6,421**

** The £2,063K is the net of impairment reversals (£4,317K) from the valuation update carried out in respect of land and buildings and loss (£2,254K) due to the reduction of the QEH Toshiba - MES mediical equipment on-balance sheet value down to the end of contract purchase "buy-back" price - See Note 14.1 Property, plant and equipment - 2017/18.

** This is the net reduction of £511K charged to the revaluation reserve as a result of the purchase 'buy-back' of medical equipment at the end of the QEH Toshiba - Managed Equipment Service (MES) contract - See Note 14.1 Property, plant and equipment - 2017/18.

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	273,745	256,366
Social security costs	28,801	27,295
Apprenticeship levy	1,341	-
Employer's contributions to NHS pensions	29,463	28,680
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	246	-
Temporary staff - agency	23,223	28,454
Total gross staff costs	**356,819**	**340,795**
Recoveries in respect of seconded staff	-	-
Total staff costs	**356,819**	**340,795**
Of which		
Costs capitalised as part of assets	1,411	1,245

Note 7.1 Retirements due to ill-health

During 2017/18 there were 5 early retirements from the Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £53k (£180k in 2016/17).

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

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Alternative pension Scheme "NEST"

The Trust had to provide a local pension scheme for staff who were unable to join the NHS Pension Scheme from 1 July 2013. NEST (National Employer Savings Trust) was chosen following advice from the Pension Advisory Service.

The specific characteristics of NEST are as follows:
- Contributions to NEST are based on 1% for employees and 1% for employers.
- Retirement age within this scheme is set at 65.
- Pensions are based on investment and growth funds.
- Employees can pay into these funds directly to top up their pension.
- Pensions can be drawn from age 55.
- At retirement employees can choose how they receive their funds – based on pension pot value.
- Cash only – cash payment up to 25% value will be tax free
- Retirement income
- Cash and retirement income – cash payment up to 25% will be tax free
- Transfer pension – open market

- Survivor's pensions are included as well as death benefits.
- Employees can choose to opt out of the scheme.
- From October 2017 employers will contribute 2%
- From October 2018 employers will contribute 3%

Contributions will be reviewed in 2018.

Note 9 Operating leases

Note 9.1 Lewisham and Greenwich NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Lewisham and Greenwich NHS Trust is the lessor.

The Trust has in place a number of operating lease arrangements under which space within the main hospitals and other sites is rented to third parties; including NHS and non-NHS organisations. The income from these leases is shown under rental revenue below.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	1,530	1,530
Contingent rent	-	-
Other	-	-
Total	**1,530**	**1,530**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	1,530	1,530
- later than one year and not later than five years;	6,120	6,120
- later than five years.	9,180	10,710
Total	**16,830**	**18,360**

Note 9.2 Lewisham and Greenwich NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Lewisham and Greenwich NHS Trust is the lessee.

The Trust has leases for various items of medical equipment and lease cars. The terms of renewal and purchase options vary between individual leases.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	2,377	2,245
Contingent rents	-	-
Less sublease payments received	-	-
Total	**2,377**	**2,245**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	2,275	2,251
- later than one year and not later than five years;	672	375
- later than five years.	1,419	1,103
Total	**4,366**	**3,729**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	50	34
Other finance income	-	-
Total	**50**	**34**

Note 11 Finance charges

Note 11.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,540	1,488
Other loans	-	-
Overdrafts	-	-
Finance leases	35	12
Interest on late payment of commercial debt	-	5
Main finance costs on PFI and LIFT schemes obligations	12,578	15,186
Contingent finance costs on PFI and LIFT scheme obligations	8,092	7,637
Total interest expense	**23,245**	**24,328**
Unwinding of discount on provisions	7	65
Other finance costs	-	-
Total finance costs	**23,252**	**24,393**

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

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	5
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(88)	(46)
Total other gains / (losses)	**(88)**	**(46)**

Note 13 Intangible assets

Note 13.1 Intangible assets - 2017/18

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**31,840**	**5,461**	**37,301**
Additions	213	3,884	**4,097**
Impairments	-	-	-
Reclassifications	2,253	(2,280)	**(27)**
Disposals / derecognition	-	-	-
Gross cost at 31 March 2018	**34,306**	**7,065**	**41,371**
Amortisation at 1 April 2017 - brought forward	**9,978**	-	**9,978**
Provided during the year	3,465	-	**3,465**
Reclassifications	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2018	**13,443**	-	**13,443**
Net book value at 31 March 2018	**20,863**	**7,065**	**27,928**
Net book value at 1 April 2017	**21,862**	**5,461**	**27,323**

Note 13.2 Intangible assets - 2016/17

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**26,540**	-	**26,540**
Additions	1,996	2,936	**4,932**
Reclassifications	3,313	2,525	**5,838**
Disposals / derecognition	(9)	-	**(9)**
Valuation / gross cost at 31 March 2017	**31,840**	**5,461**	**37,301**
Amortisation at 1 April 2016 - as previously stated	**7,090**	-	**7,090**
Prior period adjustments	-	-	-
Amortisation at 1 April 2016 - restated	**7,090**	-	**7,090**
Provided during the year	2,890	-	**2,890**
Reclassifications	-	-	-
Disposals / derecognition	(2)	-	**(2)**
Amortisation at 31 March 2017	**9,978**	-	**9,978**
Net book value at 31 March 2017	**21,862**	**5,461**	**27,323**
Net book value at 1 April 2016	**19,450**	-	**19,450**

Note 14 Property, plant and equipment

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**36,277**	**272,952**	**5,811**	**71,679**	**10**	**15,441**	**1,285**	**403,455**
Additions	-	3,869	10,648	6,911	-	1,235	-	**22,663**
Impairments	-	-	-	(511)	-	-	-	**(511)**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	8,299	-	-	-	-	-	**8,299**
Reclassifications	-	3,825	(4,210)	-	-	412	-	**27**
Disposals / derecognition	-	-	(88)	-	-	-	-	**(88)**
Valuation/gross cost at 31 March 2018	**36,277**	**288,945**	**12,161**	**78,079**	**10**	**17,088**	**1,285**	**433,845**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**-**	**-**	**55,623**	**8**	**11,264**	**992**	**67,887**
Provided during the year	-	16,617	-	3,764	-	1,257	147	**21,785**
Impairments	-	1,192	-	1,062	-	-	-	**2,254**
Reversals of impairments	-	(4,317)	-	-	-	-	-	**(4,317)**
Revaluations	-	(13,492)	-	-	-	-	-	**(13,492)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**60,449**	**8**	**12,521**	**1,139**	**74,117**
Net book value at 31 March 2018	**36,277**	**288,945**	**12,161**	**17,630**	**2**	**4,567**	**146**	**359,728**
Net book value at 1 April 2017	**36,277**	**272,952**	**5,811**	**16,056**	**2**	**4,177**	**293**	**335,568**

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**35,985**	**314,448**	**7,869**	**67,188**	**8**	**14,789**	**1,492**	**441,779**
Additions	-	2,841	4,883	4,553	2	118	-	**12,397**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	292	(44,905)	-	-	-	-	-	**(44,613)**
Reclassifications	-	568	(6,941)	-	-	535	-	**(5,838)**
Disposals / derecognition	-	-	-	(62)	-	(1)	(207)	**(270)**
Valuation/gross cost at 31 March 2017	**36,277**	**272,952**	**5,811**	**71,679**	**10**	**15,441**	**1,285**	**403,455**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**52,145**	**8**	**10,063**	**1,030**	**63,246**
Provided during the year	-	15,671	-	3,513	-	1,202	157	**20,543**
Impairments	(117)	7,055	-	-	-	-	-	**6,938**
Reversals of impairments	-	(517)	-	-	-	-	-	**(517)**
Revaluations	117	(22,209)	-	-	-	-	-	**(22,092)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	(35)	-	(1)	(195)	**(231)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**55,623**	**8**	**11,264**	**992**	**67,887**
Net book value at 31 March 2017	**36,277**	**272,952**	**5,811**	**16,056**	**2**	**4,177**	**293**	**335,568**
Net book value at 1 April 2016	**35,985**	**314,448**	**7,869**	**15,043**	**-**	**4,726**	**462**	**378,533**

Note 14.3 Property, plant and equipment financing - 2017/18

		Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018										
Owned - purchased		36,277	114,233	-	12,161	16,716	2	4,566	146	**184,101**
Finance leased		-	-	-	-	875	-	-	-	**875**
On-SoFP PFI contracts and other service concession arrangements	*	-	174,182	-	-	(4,885)	-	-	-	**169,297**
On-SoFP PFI contracts and other service concession arrangements	*	-	-	-	-	4,885	-	-	-	**4,885**
PFI residual interests		-	-	-	-	-	-	-	-	-
Owned - government granted		-	-	-	-	-	-	-	-	-
Owned - donated		-	530	-	-	39	-	1	-	**570**
NBV total at 31 March 2018		**36,277**	**288,945**	**-**	**12,161**	**17,630**	**2**	**4,567**	**146**	**359,728**

Note 14.4 Property, plant and equipment financing - 2016/17

	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 2017									
Owned - purchased	36,277	109,557	-	5,811	8,468	2	4,176	293	**164,584**
Finance leased	-	-	-	-	590	-	-	-	**590**
On-SoFP PFI contracts and other service concession arrangements	-	162,815	-	-	6,933	-	-	-	**169,748**
PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-	-
Owned - donated	-	580	-	-	65	-	1	-	**646**
NBV total at 31 March 2017	**36,277**	**272,952**	**-**	**5,811**	**16,056**	**2**	**4,177**	**293**	**335,568**

* The £4,885K is the value of QEH Toshiba - MES medical equipment previuosly on-balance under a PFI concession and subsequently purchased by the Trust, at a mutually agreed fair market value price, at the end of contract in September 2017 - See Note 16 Revaluations of property, plant and equipment.

Note 15 Donations of property, plant and equipment

No donated assets were received during the year.

Note 16 Revaluations of property, plant and equipment

Note 16.1 Land and Buildings

Summary

The Trust appointed Montagu Evans (ME), independent firm of professional valuers, to provide a report on the movement in building costs and land values during 2017-18 in order to update the fair value of land and buildings for this year.

The valuation from ME is on an Modern Equivalent Asset (MEA) basis.

ME have also applied the latest DHSC Group Accounting Manual guidance and industry best practice in carrying out the valuation.

The most significant change in approach taken this year has involved removal of contingency from the depreciated replacement cost calculation. This reflects the reduced uncertainty associated with the "instant build" under MEA - See below.

As the report from ME is an "interim valuation" only the significant parts of each property has been inspected and in a majority of cases this has been limited to an external inspection.

Basis of valuations

In the preparation of the valuation under IFRS, Montagu Evans have had regard to the Standards and in particular, reference to the following:

- IVSC: International Valuation Standards 2017 – Market Value;

- RICS: Valuation – Global Standards 2017 – Market Value (Valuation Performance Standard VPS4 – Bases of Value);
- RICS: Valuation – Global Standards 2017 – (Valuation Practice Guidance – Applications – VPGA1: Valuation for inclusion in Financial Statements);
- RICS: Valuation – Professional Standards UK January 2014 - UK Guidance Note UKGN2: Depreciated Replacement Cost Method of Valuation for Financial Reporting.

Property valuations undertaken under IFRS require the statement of assets at Fair Value. Within the UK, assets should be valued having regard to the methods of valuation defined by the RICS.

As a result, in assessing Fair Value ME have had regard to the following definitions:

- Depreciated Replacement Cost where no market exists for a property, which may be rarely sold or it is a specialised asset.
- Existing Use Value where the property is not specialised and is owner occupied;

Depreciated Replacement Cost (DRC) - Specialised Assets:

The DRC Method of Valuation for Financial Reporting is set out in UK Guidance Note UKGN2, prepared by the RICS, within which DRC is defined as;

"The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."

Valuations based on DRC are only to be used for valuing specialised property that is owner occupied for inclusion in financial statements. ME have used DRC as the basis of valuation for all of the specialised assets owner occupied by the Trust. These include all of the non-office space areas and Kaleidoscope Centre.

Existing Use Value (EUV) - Non Specialised Assets:

Existing Use Value is defined in the UK Valuation Standard UKVS1: Valuation of real property, plant and equipment for Financial Statements under UKVS1.3 as:

"The estimated amount for which an asset or liability should exchange on the valuation date between a willing buyer and a willing seller in an arm's length transaction after proper marketing and where the parties had each acted knowledgeably, prudently and without compulsion – assuming that the buyer is granted vacant possession of all parts of the asset required by the business, and disregarding any potential alternative uses and any other characteristics of the asset that would cause its market value to differ from that needed to replace the remaining service potential at least cost."

Valuations based on EUV are only to be used for valuing non-specialised property that is owner occupied for inclusion in financial statements. ME have used EUV as the basis of valuation for the following non-specialised asset owner occupied by the Trust:

- Kaleidoscope Centre, 32 Rushey Green, Catford.
- Office space on the Lewisham and Queen Elizabeth Hospital sites.

Modern Equivalent Assets

In keeping with the FReM, IFRS and RICS valuation guidelines ME have assumed that modern equivalent assets (replacement buildings) would be constructed at the date of valuation without phasing or lead in periods.

ME have taken the same approach to MEA as last year in relation to:

- Considering and applying assumptions covering the existing use, clinical and non-clinical space requirements and land requirements.
- The decision not to apply the alternative location concept and assess the land valuations and build costs on the basis of the existing hospital locations; the rationale being that the MEA should be situated in the same locality as the population served.

Further to discussions in 2017 within the RICS, the 'instant build' approach application in accordance with FReM has been reviewed where it is noted that this approach would not require a contingency allowance, which normally reflect risk of timing delays or cost overruns. As a result of this development, the 5% contingency allowance usually adopted within the DRC calculations has been omitted.

Inherent within MEA Valuations, using the DRC approach, is the BCIS Indices which provide the "mean UK new build figures per sq ft" which form the basis of the MEA calculations.

There is also a location weighting applied to construction cost to reflect regional differences in build costs. These weightings are provided by BCIS. Weightings for the London Borough of Lewisham of 17% (15% last year) and Royal Borough of Greenwich 20% (18% last year) have been applied.

The following extract from the ME valuation report summarises the overall movement in building costs during the year:

"Over the period since our last valuation we have seen a generally upward movement in build costs as they have continued their upward trajectory, albeit at a slower rate than in previous years. Similarly, the locational weightings for London have shown an increase as a result a rise in labour costs and materials. At the present time, the BCIS is forecasting that there will be a continual increase in build costs over the short to medium term as the fall in sterling and the rise in fuel prices impact on material costs."

Accounting Outcomes	**£'000**
The overall change in value from the valuation update was an increase	**24,916**
This gave rise to the following accounting changes:	
- Valuation increases to the revaluation reserve	8,299
- Valuation increases to the revaluation reserve	13,492
Total charge to revaluation reserve	21,791
- Impairment reversals	4,317
- Impairment losses	(1,192)
Total revaluation	**24,916**

Note 16.2 Plant and machinery

QEH Toshiba - MES contract

The QEH Toshiba - MES contract came to an end in September 2017. Under the deed of variation signed in April 2015, the Trust exercised the option to purchase "buy-back" the equipment at a fair market value cost.

The impact of the buy-back transaction at the end of contract was a transaction was a net impairment of £1,573K as the result of revaluing the equipment down from the carrying value to the fair market value paid to Toshiba.

Accounting Outcomes		£'000
The overall change in value from the revaluation was an impairment of		(1,573)
The changes gaving rise to the impairment included the folowing:	£'000	£'000
NBV as at 31st March 2017		6,933
Depreciation charge to September 2017		(652)
Equipment additions in year		177
		6,458
- Valuation increases to the revaluation reserve	(511)	
- Impairment losses	(1,062)	
- Net Impairment	(1,573)	(1,573)
NBV of Ex-QEH Toshiba - MES equipment in end of contract buy-back		**4,885**

Note 17 Inventories

	31 March 2018	**31 March 2017**
	£000	**£000**
Drugs	1,826	2,346
Work In progress	-	-
Consumables	3,105	3,190
Energy	132	134
Other	-	-
Total inventories	**5,063**	**5,670**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £65,040K (2016/17: £60,899K). Write-down of inventories recognised as expenses for the year were £223K (2016/17: £76K).

Note 18 Trade receivables

Note 18.1 Trade receivables and other receivables

		31 March 2018 £000	31 March 2017 £000
Current			
Trade receivables		29,811	24,193
Capital receivables (including accrued capital related income)		-	-
Accrued income		4,543	26,096
Provision for impaired receivables		(7,545)	(5,615)
Deposits and advances		-	-
Prepayments (non-PFI)		9,253	2,791
Interest receivable		-	-
Finance lease receivables		-	-
PDC dividend receivable		975	1,587
VAT receivable		3,056	1,513
Corporation and other taxes receivable		-	-
Other receivables		238	84
Total current trade and other receivables		**40,331**	**50,649**
Non-current			
Trade receivables		-	-
Capital receivables (including accrued capital related income)		-	-
Accrued income		2,390	2,482
Provision for impaired receivables		-	-
Other receivables		-	-
Total non-current trade and other receivables		**2,390**	**2,482**
Of which receivables from NHS and DHSC group bodies:			
Current	*	25,256	41,362
Non-current		-	-

* This shows that the majority of trade is with NHS and DHSC group bodies funded by Government to buy NHS patient care services and, as such, the debt is generally considered to be low risk.

Note 18.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**5,615**	**4,001**
Transfers by absorption	-	-
Increase in provision	2,601	2,338
Amounts utilised	(671)	(724)
Unused amounts reversed	-	-
At 31 March	**7,545**	**5,615**

* Receivables utilised during the year total £671K and relate entirely to outstanding sales ledger invoices. There was no movement in Injury Cost Recovery balances notified by the Compensation Recovery Unit (Department of Work and Pensions).

The amount impaired during the year is calculated in accordance with defined aged debt profile risk criteria applied consistently to all Non NHS outstanding balances as follows:

Outstanding Debt Balances - Age Profile (Days)		**Provision**
Overseas visitors		100%
All Other		
1 - 60	Days	0%
61 - 90	Days	50%
91 - 180	Days	75%
181 - 360	Days	100%
Over 360	Days	100%

Outstanding Injury cost recovery balances have been impaired at 22.84% of total notified income in line with DHSC guidance. This is only down 0.1% on last year (22.94%) and would suggest an improved outlook for the recovery of the oustanding debt.

Note 18.3 Credit quality of financial assets

	Trade and Other Receivables	
	31 March 2018	31 March 2017
Ageing of impaired financial assets	£000	£000
0 - 30 days	474	305
30-60 Days	278	173
60-90 days	455	259
90- 180 days	1,769	1,235
Over 180 days	4,569	3,643
Total	**7,545**	**5,615**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	10,737	14,528
30-60 Days	2,222	5,621
60-90 days	789	1,508
90- 180 days	3,344	1,978
Over 180 days	9,069	3,431
Total	**26,161**	**27,066**

The majority of non-impaired debt is with NHS and DHSC group bodies funded by Government to buy NHS patient care services and, as such, the debt is generally considered to be low risk - See Note 18.1 Trade receivables and other receivables.

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.

		2017/18	2016/17
		£000	£000
At 1 April		**5,457**	**2,064**
Prior period adjustments		-	-
At 1 April (restated)		**5,457**	**2,064**
Transfers by absorption		-	-
Net change in year		3,075	3,393
At 31 March		**8,532**	**5,457**
Broken down into:			
Cash at commercial banks and in hand		12	12
Cash with the Government Banking Service		8,520	5,445
Deposits with the National Loan Fund		-	-
Other current investments		-	-
Total cash and cash equivalents as in SoFP		**8,532**	**5,457**
Bank overdrafts (GBS and commercial banks)		-	-
Drawdown in committed facility		-	-
Total cash and cash equivalents as in SoCF	*	**8,532**	**5,457**

* The increase in cash held at the year end includes £6,468K of Trust internal capital funding not utilised in year which is being carried forward to 2018/19 with DHSC approval.

Note 19.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	32	26
Monies on deposit	-	-
Total third party assets	**32**	**26**

Note 20 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	21,487	27,902
Capital payables	2,106	714
Accruals	21,419	11,155
Receipts in advance (including payments on account)	-	-
Social security costs	220	3,807
VAT payables	-	-
Other taxes payable	254	3,377
PDC dividend payable	-	-
Accrued interest on loans	295	94
Other payables	639	179
Total current trade and other payables	**46,420**	**47,228**
Non-current		
Trade payables	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	4,274	6,933
Non-current	-	-

Note 21 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	8,106	5,761
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	**8,106**	**5,761**
Non-current		
Deferred income	607	657
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**607**	**657**

Note 22 Borrowings

		31 March 2018 £000	31 March 2017 £000
Current			
Bank overdrafts		-	-
Drawdown in committed facility		-	-
Loans from the DHSC - Capital Investment Loans		787	787
Loans from the DHSC - Revenue Cash Support Loans	*	39,376	-
Other loans		-	-
Obligations under finance leases		182	104
PFI lifecycle replacement received in advance		-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)		3,973	5,726
Total current borrowings		**44,318**	**6,617**
Non-current			
Loans from the DHSC - Capital Investment Loans		11,410	12,198
Loans from the DHSC - Revenue Cash Support Loans		82,410	78,042
Other loans		-	-
Obligations under finance leases		643	469
PFI lifecycle replacement received in advance		-	-
Obligations under PFI, LIFT or other service concession contracts		102,727	106,701
Total non-current borrowings		**197,190**	**197,410**
Total			
Bank overdrafts		-	-
Drawdown in committed facility		-	-
Loans from the DHSC - Capital Investment Loans	**	12,197	12,985
Loans from the DHSC - Revenue Cash Support Loans	***	121,786	78,042
Other loans		-	-
Obligations under finance leases		825	573
PFI lifecycle replacement received in advance		-	-
Obligations under PFI, LIFT or other service concession contracts		106,700	112,427
Total borrowings		**241,508**	**204,027**

* The £39,376K is historic revenue cash support received as Revolving Work Capital Facility (RWCF) monies in 2015/16 and which is repayable in 2018/19. Work is continuing with DHSC for this to be converted to Revenue Support Loan (RSL) funding during 2018/19.

** Capital Investments loans (CIL) include:

The existing loans include:.

- CIL of £8,411K relating to the construction of the Urgent Care Centre completed in April 2012.
- CIL of £3,787K relating to the creation of additional "Winter Pressure" ward capacity in 2014/15.

There were no new loans during the year.

*** Revenue Support Loans (RSL)

Total borrowings (£121,198K) includes existing loans of £78,042K and new deficit related cash support loans in year totalling £43,744K- as reflected in the Statement of Cash Flows (SoCF).

Note 23 Finance leases

Obligations under finance leases where Lewisham and Greenwich NHS Trust is the lessee.

	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	**1,067**	**704**
of which liabilities are due:		
- not later than one year;	233	127
- later than one year and not later than five years;	667	381
- later than five years.	167	196
Finance charges allocated to future periods	(242)	(131)
Net lease liabilities	**825**	**573**
of which payable:		
- not later than one year;	182	104
- later than one year and not later than five years;	643	310
- later than five years.	-	159
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

Note 24 Provisions for liabilities and charges

Note 24.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**3,514**	**746**	**-**	**-**	**214**	**1,321**	**5,795**
Change in the discount rate	52	-	-	-	-	(68)	**(16)**
Arising during the year	2,774	302	-	-	234	37	**3,347**
Utilised during the year	(550)	-	-	-	(139)	(79)	**(768)**
Reversed unused	-	(746)	-	-	(76)	(275)	**(1,097)**
Unwinding of discount	6	-	-	-	-	1	**7**
At 31 March 2018	**5,796**	**302**	**-**	**-**	**233**	**937**	**7,268**
Expected timing of cash flows:							
- not later than one year;	542	302	-	-	233	333	**1,410**
- later than one year and not later than five years;	2,153	-	-	-	-	254	**2,407**
- later than five years.	3,101	-	-	-	-	350	**3,451**
Total	**5,796**	**302**	**-**	**-**	**233**	**937**	**7,268**

Early Departure "Pensions "costs of £5,796K relate to continuing contribution payments to the NHS Pensions Agency (NHSPA) for staff that retired early . The calculation of the long-term liability in respect of future payments to NHSPA has been modified this year to factor in Office of National Statistics (ONS) published life expectancy data.

Legal Claims (£302K) are based on an assessment of all outstanding cases by solicitors acting on behalf of the Trust.

Redundancy (£233K) relates to the closure of the Trust child care nursery.

Other Provisions (£937K) comprises Injury Benefits of £710K and Employee, Public Liability claims of £227K which are handled by the NHS Litigation Authority.

Note 24.2 Clinical negligence liabilities

At 31 March 2018, £469,115K was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lewisham and Greenwich NHS Trust (31 March 2017: £419,768K).

Note 25 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(52)	(56)
Gross value of contingent liabilities	**(52)**	**(56)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(52)**	**(56)**
Net value of contingent assets	-	-

The contingent liability of £52K (£56K 2016/17K) relates to employee and public liability claims handled by the NHS Litigation Authority.

Note 26 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	4,599	1,042
Intangible assets	-	-
Total	**4,599**	**1,042**

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

Note 27.1 Imputed finance lease obligations

Lewisham and Greenwich NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

All Concessions	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**360,689**	**392,291**
Of which liabilities are due		
- not later than one year;	21,871	25,774
- later than one year and not later than five years;	94,210	93,303
- later than five years.	244,608	273,214
Finance charges allocated to future periods	(253,989)	(279,864)
Net PFI, LIFT or other service concession arrangement obligation	**106,700**	**112,427**
- not later than one year;	3,973	5,726
- later than one year and not later than five years;	20,813	18,730
- later than five years.	81,914	87,971

The Trust had three on-balance sheet service concessions at the start of the year; Queen Elizabeth Hospital Building (QEH) , Riverside Building on the Lewisham Hospital site and QEH Managed Equipment Service (Toshiba).

The QEH Managed Equipment Service (Toshiba) came to an end in September 2017.

Queen Elizabeth Hospital Building

The PFI contract transferred to the Trust under the QEH merger was entered into in January 2001 for 60 years. The contract is with Meridian Hospital Company PLC for the supply of the QEH hospital premises, maintenance and other site related services.

Under the contract, the rights and privileges of ownership of the Hospital will transfer to the NHS after 30 years (October 2030) and there is the option to terminate the concession to provide Facilities Management services from the PFI contractor at 30 and 45 years.

The Trust retains the freehold to the land on which the hospital is based. A head lease to the land was granted to Meridian Hospital Company PLC for a period of 125 years under the contract.

Riverside Building

The Riverside building is treated as an asset of the Trust under IFRIC 12; which applies to public-to-private service concession arrangements to the extent that the Trust:

- Controls or regulates what services the operator must provide within the infrastructure, whom it must provide them to, and at what price.

- Controls (through ownership, beneficial entitlement or otherwise) any significant residual interest in the infrastructure at the end of the term of the arrangement.

QEH Managed Equipment Service - Toshiba

The PFI contract transferred to the Trust under the QEH merger. The contract is with Toshiba Medical Systems for the supply, maintenance and replacement of medical equipment at QEH and was entered into in September 2001 for 15 years. A Deed of Variation was agreed in April 2015 to extend the contract by one year to the end of September 2017.

This contract formally ceased in September 2017 as planned with a final obligation payment of £2,647K and acquisition of Toshiba assets with a value of £4,885K

Queen Elizabeth Hospital Building	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**224,560**	**248,058**
Of which liabilities are due		
- not later than one year;	15,414	16,105
- later than one year and not later than five years;	67,722	67,365
- later than five years.	141,424	164,588
Finance charges allocated to future periods	(160,764)	(181,840)
Net PFI, LIFT or other service concession arrangement obligation	**63,796**	**66,218**
- not later than one year;	2,332	2,421
- later than one year and not later than five years;	13,854	11,927
- later than five years.	47,610	51,870

Riverside Building	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**136,129**	**140,696**
Of which liabilities are due		
- not later than one year;	6,457	6,132
- later than one year and not later than five years;	26,488	25,938
- later than five years.	103,184	108,626
Finance charges allocated to future periods	(93,225)	(96,303)
Net PFI, LIFT or other service concession arrangement obligation	**42,904**	**44,393**
- not later than one year;	1,641	1,489
- later than one year and not later than five years;	6,959	6,803
- later than five years.	34,304	36,101

QEH Managed Equipment Service - Toshiba	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**-**	**3,537**
Of which liabilities are due		
- not later than one year;	-	3,537
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Finance charges allocated to future periods	-	(1,721)
Net PFI, LIFT or other service concession arrangement obligation	**-**	**1,816**
- not later than one year;	-	1,816
- later than one year and not later than five years;	-	-
- later than five years.	-	-

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

All Concessions	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**652,168**	**705,782**
Of which liabilities are due:		
- not later than one year;	39,081	41,641
- later than one year and not later than five years;	166,465	166,037
- later than five years.	446,622	498,104

Queen Elizabeth Hospital Building	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**438,297**	**483,026**
Of which liabilities are due:		
- not later than one year;	30,065	30,298
- later than one year and not later than five years;	127,970	128,959
- later than five years.	280,262	323,769

Riverside Building	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**213,871**	**220,097**
Of which liabilities are due:		
- not later than one year;	9,016	8,684
- later than one year and not later than five years;	38,495	37,078
- later than five years.	166,360	174,335

QEH Managed Equipment Service - Toshiba	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**-**	**2,659**
Of which liabilities are due:		
- not later than one year;	-	2,659
- later than one year and not later than five years;	-	-
- later than five years.	-	-

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's payments in 2017/18:

All Concessions	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	44,295	44,819
Consisting of:		
- Interest charge	12,578	15,186
- Repayment of finance lease liability	5,836	4,101
- Service element and other charges to operating expenditure	17,789	17,895
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	8,092	7,637
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	6,880	7,417
Total amount paid to service concession operator	**51,175**	**52,236**

Queen Elizabeth Hospital Building	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	29,814	29,273
Consisting of:		
- Interest charge	7,484	7,746
- Repayment of finance lease liability	2,420	2,186
- Service element and other charges to operating expenditure	13,962	13,667
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	5,948	5,674
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	5,022	5,922
Total amount paid to service concession operator	**34,836**	**35,195**

Riverside Building	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	8,784	8,459
Consisting of:		
- Interest charge	2,569	2,656
- Repayment of finance lease liability	1,490	1,487
- Service element and other charges to operating expenditure	2,581	2,353
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	2,144	1,963
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	(72)	(635)
Total amount paid to service concession operator	**8,712**	**7,824**

QEH Managed Equipment Service - Toshiba	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	5,697	5,204
Consisting of:		
- Interest charge	2,525	2,901
- Repayment of finance lease liability	1,926	428
- Service element and other charges to operating expenditure	1,246	1,875
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	-	-
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	1,930	2,130
Total amount paid to service concession operator	**7,627**	**7,334**

Note 28 Financial instruments

Note 28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risk a body faces in undertaking its activities.

Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk that would be typical of listed companies. As Non-Foundation Trust, Lewisham and Greenwich NHS Trust has limited powers to borrow or invest surplus funds and, as such, financial assets and liabilities are generated by day-to-day operational activities rather than held long-term change the risks facing the Trust in undertaking its activities.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2018 is in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups (CCGs), which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

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

The Trust therefore has low exposure to interest rate fluctuations.

Currency risk

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

Note 28.2 Carrying values of financial assets

	Loans and receivables £000
Assets as per SoFP as at 31 March 2018	
Embedded derivatives	-
Trade and other receivables excluding non financial assets	22,504
Other investments / financial assets	-
Cash and cash equivalents at bank and in hand	8,532
Total at 31 March 2018	**31,036**

	Loans and receivables £000
Assets as per SoFP as at 31 March 2017	
Embedded derivatives	-
Trade and other receivables excluding non financial assets	18,662
Other investments / financial assets	-
Cash and cash equivalents at bank and in hand	5,457
Total at 31 March 2017	**24,119**

Note 28.3 Carrying value of financial liabilities

	Other financial liabilities £000
Liabilities as per SoFP as at 31 March 2018	
Embedded derivatives	-
Borrowings excluding finance lease and PFI liabilities	133,983
Obligations under finance leases	825
Obligations under PFI, LIFT and other service concession contracts	106,700
Trade and other payables excluding non financial liabilities	24,232
Other financial liabilities	-
Provisions under contract	-
Total at 31 March 2018	**265,740**

	Other financial liabilities £000
Liabilities as per SoFP as at 31 March 2017	
Embedded derivatives	-
Borrowings excluding finance lease and PFI liabilities	91,027
Obligations under finance leases	573
Obligations under PFI, LIFT and other service concession contracts	112,427
Trade and other payables excluding non financial liabilities	28,795
Other financial liabilities	-
Provisions under contract	-
Total at 31 March 2017	**232,822**

Note 28.4 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	68,551	35,412
In more than one year but not more than two years	93,539	7,495
In more than two years but not more than five years	14,261	90,797
In more than five years	89,389	99,118
Total	**265,740**	**232,822**

Note 29 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	1,377	1,136	857	1,233
Stores losses and damage to property	5	223	6	76
Total losses	**1,382**	**1,359**	**863**	**1,310**
Special payments				
Compensation under court order or legally binding arbitration award	12	5	17	9
Extra-contractual payments	-	-	-	-
Ex-gratia payments	33	9	37	17
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**45**	**14**	**54**	**26**
Total losses and special payments	**1,427**	**1,373**	**917**	**1,336**
Compensation payments received		-		-

Details of cases individually over £300k

There were no individual cases over £300K.

Note 30 Related parties

During the year none of the Department of Health Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken transactions with Lewisham and Greenwich NHS Trust.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department.

For example :

Barts Health NHS Trust
Care Quality Commission
Community Health Partnerships
Dartford and Gravesham NHS Trust
Department of Energy and Climate Change
Department of Health and Social Care
Guy's & St Thomas' NHS Foundation Trust
Health Education England
HM Revenue & Customs
King's College Hospital NHS Foundation Trust
London Borough of Bexley
London Borough of Lewisham
London Regional Office
NHS Barking and Dagenham CCG
NHS Bexley CCG
NHS Blood and Transplant
NHS Bromley CCG
NHS Croydon CCG
NHS Dartford, Gravesham and Swanley CCG
NHS England
NHS Greenwich CCG
NHS Improvement (TDA)
NHS Lambeth CCG
NHS Lewisham CCG
NHS Medway CCG
NHS NEL Commissioning Support Unit
NHS Newham CCG
NHS Pension Scheme
NHS Property Services
NHS Resolution (formerly NHS Litigation Authority)
NHS Southwark CCG
NHS Tower Hamlets CCG
NHS Waltham Forest CCG
NHS Wandsworth CCG
NHS West Kent CCG
Oxleas NHS Foundation Trust
Royal Borough of Greenwich
South London and Maudsley NHS Foundation Trust

Entities are included based on the following criteria:
- CCG where a formal service level agreement was in place during the year
- NHS, Government Department or Local Authority where the transaction exceeds £250K

The members of the Trust Board are also Trustees of the Lewisham and Greenwich NHS Trust Charitable Fund (registered Charity No. 1050522).

The Charity's objectives are to provide support both generally and in certain areas of the Trust's activities.

During the last two years the Charity contributed the following amounts:

	2017-18	2016/17
	£	£
Patient education and welfare	33,060	72,089
Staff education and welfare	42,796	37,158
New equipment	172,887	227,451
Governance	26,691	31,322
Grand Total	275,434	368,019

Note 31 Events after the reporting date

There were no events that had a material effect on the accounts after the end of the reporting period.

Note 32 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	99,507	348,223	115,841	317,919
Total non-NHS trade invoices paid within target	71,707	298,679	17,987	200,585
Percentage of non-NHS trade invoices paid within target	72.06%	85.77%	15.53%	63.09%
NHS Payables				
Total NHS trade invoices paid in the year	2,596	19,554	3,096	17,489
Total NHS trade invoices paid within target	1,543	12,471	760	5,373
Percentage of NHS trade invoices paid within target	59.44%	63.78%	24.55%	30.72%

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

Note 33 External financing

The Trust is given an External Financing Limit (EFL) against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
SoCF	**£000**	**£000**
Net cash gen from / (used in) - Operations	(7,064)	128
Net cash gen from / (used in) - Investing Activities	24,701	14,452
Net cash gen from / (used in) - Financing Activities		
Less:		
Interest paid	2,339	1,558
Interest element of fin lease	35	12
Interest element of PFI	20,670	22,823
PDC dividend (paid)/refunded	3,815	6,411
Cash flows re fin activities of discontinued ops	-	-
	44,496	45,384
Rounding	-	-
Total	44,496	45,384
Reverse Fin Leases - Additions Leased - TAC14	(617)	
Requirement Excluding - Fin Leases	43,879	45,384
	£000	£000
Total per 16. Limits - NHS Trust Only	44,496	45,384
End		
Cash flow financing	43,879	45,384
Finance leases taken out in year	617	627
Other capital receipts	-	0
External financing requirement	**44,496**	**46,011**
External financing limit (EFL)	54,501	49,245
Under / (over) spend against EFL	**10,005**	**3,234**

The undershoot of £10,005K against the target EFL is attributable to:

- Trust internal capital funding totalling £6,468K not utilised in year and being carried forward as part of the increased year end cash balance with approval of DHSC - See SoCF.

- The actual PFI (£5,727K) and finance lease rental payments (£365K) in the EFL requirement totalling £6,092K being £3,537K more than the planned amount of £2,555K in EFL limit.

Note 34 Capital Resource Limit

	2017/18	2016/17
	£000	£000
Gross capital expenditure	26,760	17,329
Less: Disposals	(88)	(46)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	26,672	17,283
Capital Resource Limit	35,611	22,418
Under / (over) spend against CRL	8,939	5,135

The undershoot of £8,939K against the target CRL is attributable to:

- Trust internal capital funding totalling £6,468K not utilised in year and being carried forward as part of the increased year end cash balance with approval of DHSC - See SoCF.
- The remaining £2,471K is CRL factored into the plan at the start of the year but did not materialise due to changes in depreciation and debt repayments.

Note 35 Breakeven duty financial performance

		2017/18	2016/17
		£000	£000
Surplus / (deficit) for the period		**(55,605)**	**(41,025)**
		£000	£000
Add back all I&E impairments / (reversals) - Non IFRIC 12		**(3,126)**	**178**
Add back all I&E impairments / (reversals) - IFRIC 12		**1,063**	**6,243**
		(2,063)	**6,421**
Surplus / (deficit) before impairments and transfers		**(57,668)**	**(34,604)**
Remove capital donations / grants I&E impact		**76**	**108**
Adjusted financial performance surplus / (deficit) (control total basis)		**(57,592)**	**(34,496)**
Remove impairments scoring to Departmental Expenditure Limit		-	-
Add back non-cash element of On-SoFP pension scheme charges		-	-
Remove CQUIN risk reserve adjustment		-	-
IFRIC 12 breakeven adjustment		7,196	14,442
Breakeven duty financial performance surplus / (deficit)	*	(50,396)	(20,054)

* The £50,396K is the representation of the 2017/18 adjusted financial deficit on a comparable basis with the breakeven performance of £20,054K in 2016/17.

Note 36 Breakeven duty rolling assessment

		2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
			£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance			6,753	1,058	1,427	1,750	242	(8,482)	(22,867)	(20,054)	(50,396)
Reversal of adjustment for dual accounting under IFRIC12	*		(1,537)	(1,405)	(1,383)	(1,574)	(3,059)	(8,957)	(11,936)	(14,442)	(7,196)
Adjusted financial performance surplus / (deficit)	**		5,216	(347)	44	176	(2,817)	(17,439)	(34,803)	(34,496)	(57,592)
Breakeven duty cumulative position		(9,337)	(2,584)	(1,526)	(99)	1,651	1,893	(6,589)	(29,456)	(49,510)	(99,906)
Operating income			188,109	222,366	229,184	241,470	382,097	517,522	518,947	539,242	543,854
Cumulative breakeven position as a percentage of operating income			(1.37%)	(0.69%)	(0.04%)	0.68%	0.50%	(1.27%)	(5.68%)	(9.18%)	(18.37%)

* Following the introduction of International Financial Reporting Standards (IFRS) accounting in FY09-10 Trust financial performance was measured in line with DHSC guidance which allowed the impact of accounting for IFRIC 12 schemes, such as PFI concessions, to be reversed out of the breakeven duty position as a technical adjustment for monitoring purposes.

** This is the adjusted financial performance surplus / (deficit) as shown on the SoCI for 2017/18 with the IFRIC 12 technical adjustment excluded.