NHS
Lewisham and Greenwich
NHS Trust

Annual report
2018/19

High quality care for every patient, **every day**


Our values
We take **responsibility** for our actions
We **work together** for patients and colleagues
We **learn**, develop and share knowledge
We treat everyone with **respect** and **compassion**
We work as a team to **improve quality**

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Dräger
Standby
Dräger
NHS

Chair's foreword

Welcome to the 2018/19 annual report – I hope you find it useful.

We celebrated two key milestones in 2018: the 70th birthday of the NHS, and the fifth anniversary of the Trust being created through the merger of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital. Both were perfect opportunities to reflect on the achievements of the NHS and of our Trust, and we held tea parties around the organisation for patients, staff, visitors and partners.

As part of the national NHS@70 celebrations, the Trust choir released a charity single to raise money for NHS Charities Together, a group of more than 100 NHS charities, and also featured in an ITV documentary that showcased the excellent work of the Trust.

This year we welcomed Ben Travis as our new Chief Executive and Angela Helleur as our new Chief Nurse. We also welcomed non-executive directors Harry Bright and Katherine Yeung and associate non-executive director Sarah Higgins to our board. In addition, we carried out work to strengthen clinical leadership in the Trust, with a restructure of our clinical divisions. It was pleasing to see that the Care Quality Commission (CQC) noted in its inspection report from September 2018 that this work was starting to have an impact, and the CQC reported on improved communication and engagement.

The CQC inspectors observed staff providing compassionate care and being attentive towards patients, who spoke positively about the care they received. So it's no surprise that we received a rating of "good" in the caring domain.

Our overall rating in the CQC inspection was "requires improvement", and last year we launched our Improving Together campaign to focus on safety and quality and help us move to an overall rating of "good". As part of the campaign, we've been running peer review assessments of all clinical and service areas so that we can see where things are going well, and where extra support is needed. The assessment teams are made up of staff at the Trust, who can look at the patient environment with fresh eyes and give feedback on what they found.

I visit services regularly and I'm always impressed by staff who take the initiative to resolve issues and develop their skills. We are now introducing a quality improvement programme that will motivate front-line staff to drive improvements, supported by the wider Trust.

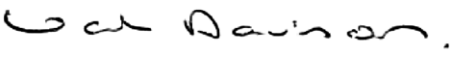
Our digital transformation programme is helping us work smarter and better, and in June 2018, after months of hard work, we brought together over a million patient records into one combined electronic system. This will enable us to introduce electronic prescribing and reduce our use of paper records later in 2019, which will be safer for patients and more efficient for staff.

We've also introduced mobile working for our community staff, which enables them to access patient records, clinical applications and more while they are out and about.

Patients are of course at the heart of everything we do, and we make sure we listen and act on what they say to us. For example, as a result of patient feedback, we now offer health visiting appointments on a Saturday, and we provide iPads for new mothers whose babies are in the special care unit so that they can see their babies using FaceTime. We're also offering more virtual and flexible clinics to reduce waiting times.

I'm extremely proud of our hard-working staff, and one of the highlights of my calendar is the annual staff awards, which last year took place at the beautiful Blackheath Halls. It is an absolute honour to present the awards and celebrate the achievements of staff at all levels and from all areas of the Trust.

Thank you for your ongoing support, and we will continue to focus on our improvement journey over 2019/20.



Val Davison, Chair
May 2019

Highlights of the year

1. **Celebrity photographer Tom Oldham** captures photos of dads in the UHL birth centre before and after the birth of their baby for his portrait series Becoming a Father
2. **The Trust celebrates Nurses' Day** with drop in events at both hospitals
3. **The Trust features in The big NHS singalong** on ITV with Ashley Banjo and Sara Cox
4. **The NHS celebrates its 70th birthday**

5. **1 October 2018 marked the fifth anniversary of the Trust** being formed from the merger of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital
6. **Members of Charlton Athletic FC** visit wards at Queen Elizabeth Hospital
7. **Members of Millwall football team** visit wards at University Hospital Lewisham
8. **New mental health café The Harbour** is opened by Dr Alex George, A&E doctor at the Trust and former Love Island contestant
9. **The new clinical facility at QEH** is officially opened by broadcaster Richard Bacon, who credits the Trust with saving his life when he was an inpatient in the summer
10. **A new renal dialysis centre opens** at University Hospital Lewisham, a joint venture with Guy's and St Thomas' NHS Foundation Trust

About us

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

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

Vision, values and priorities

Last year we worked with staff and patients to refresh our vision and values. Our vision sets out what we are all working towards and is a short and concise statement of our aspirations. Our values are at the heart of everything we do and set out how we should all behave towards colleagues, patients, visitors and partners to make the Trust a caring and great place to work.

They were developed through staff workshops, after which more than 950 members of staff and patients took part in an online vote.

We also agreed our priorities. These are closely linked to the vision and outline what we all need to focus on to ensure we provide high quality care for every patient, every day.

Our vision

To work together to provide high-quality care for every patient, every day

Our values

- We treat everyone with respect and compassion
- We work as a team to improve quality
- We take responsibility for our actions
- We work together for patients and colleagues
- We learn, develop and share knowledge

Our priorities

Quality Continually improve safety and quality

Patients Put patients at the heart of everything we do

People Support and develop our workforce to live our values every day

Partnership Work effectively with partner organisations

Money Ensure we spend every penny wisely.

What patients say about us

The NHS Friends and family test shows that a high percentage of patients would recommend the Trust as place to receive treatment.

Friends and family test 2018/19

Patients	% who would recommend the Trust to friends and family
Inpatients	94%
ED patients	97%
Community	97%
Maternity	94%
Outpatients	95%

The Trust in numbers*

- 6,500 members of staff
- 567,040 outpatients appointments
- 301,930 A&E attendances
- 8,000 births
- 21,625 patients treated in our theatres
- 567,040 community contacts with patients
- 20 operating theatres
- 13 community sites in Lewisham
- 901 beds

*2018/19

The populations we serve

We provide a comprehensive range of high quality hospital services to more than 666,000 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 in line with the London average (83.1 years for women, 79.5 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 per cent of Bexley's population is expected to be over 65 by 2036, compared to 13 per cent in Lewisham and 14 per cent in Greenwich.

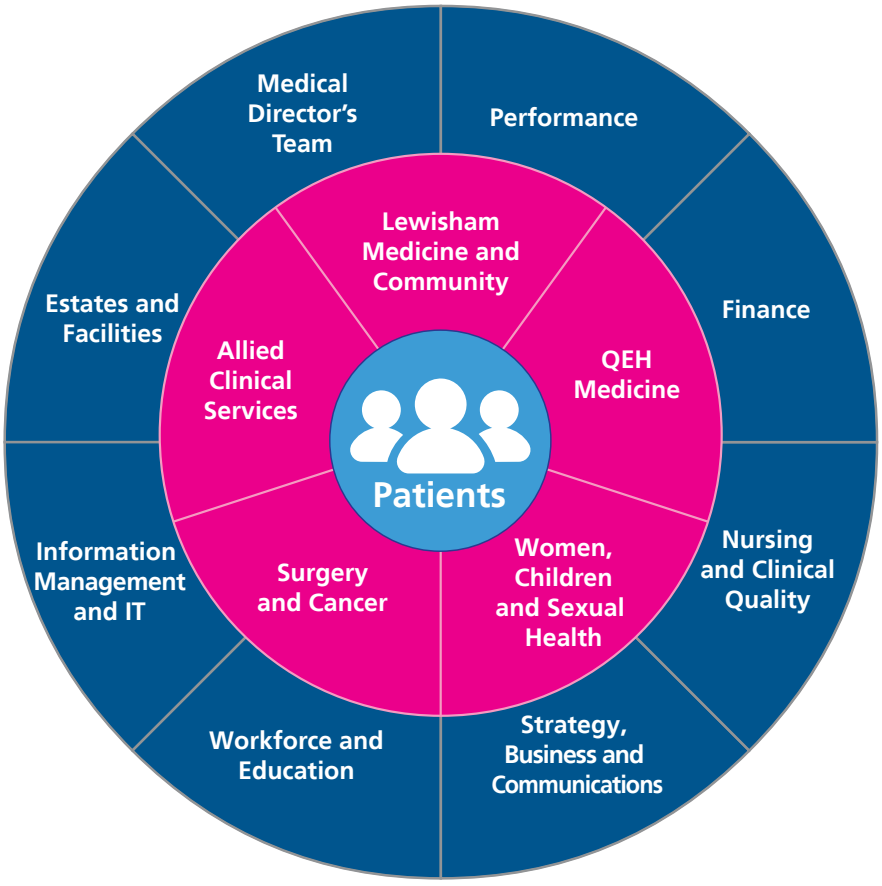
Lewisham has the highest proportion of children (29.6 per cent) and older people (25.7 per cent) in economic deprivation in England.

Ethnicity

In Lewisham, 46 per cent of the overall population are from black, asian and minority ethnic (BAME) groups, compared to 38 per cent in Greenwich and 18 per cent in Bexley (2011 census data). Bexley is becoming more diverse – BAME groups are expected to account for 27 per cent of the population by 2030.

How we are set up

We have around 6,500 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 page 41).



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. We are a training centre for nurses, midwives and allied health professionals and are pioneering new roles that will support the changing needs of our patients.

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, the community head and neck team, podiatry 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).

Equality and human rights

The Trust is committed to promoting equality, valuing diversity and protecting human rights. We do not tolerate any form of discrimination against employees, patients, services users or carers.

We recognise that everyone has different needs and that some people can experience unfair and unequal outcomes. We are committed to creating and sustaining fully inclusive and accessible services to better meet the needs of patients and staff.

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.

Changes to our structure

During 2018 we reviewed our divisional structure and senior roles to make sure that we are truly clinically led and are set up in the right way to support patients and staff.

Following a consultation with affected staff, we agreed to make changes from 1 November to strengthen our clinical leadership. The rationale is to:

- Ensure that our clinical divisions are of a consistent size in terms of budgets and staffing numbers – reducing variation
- Ensure that each division is properly resourced to deliver improvements. Each division now has its own support function, led by a divisional business manager
- Create a clear leadership structure. Each clinical division is now led by:
  - A divisional director of operations
  - A divisional medical director
  - A divisional director of nursing/midwifery/professions.

We have introduced more protected time to the clinical leaders to enable them to fulfil their administrative roles as well as their clinical roles. We introduced a new role, director of integrated care, to work across the Trust and our partners. We also created a director of corporate affairs role to strengthen our corporate governance.

New divisions

We decided to split acute and emergency medicine into two separate divisions at the two hospitals. This was a large division, and each hospital has quite different relationships with its external partners. University Hospital Lewisham runs community services, whereas Queen Elizabeth Hospital doesn't, and QEH has two local authorities – Greenwich and Bexley – whereas UHL has only one. We now have five patient facing divisions:

- UHL Medicine and Community
- QEH Medicine
- Women, Children and Sexual Health
- Surgery and Cancer
- Allied Clinical Services

Our award-winning staff

"Our staff are committed to giving the best care for our patients. Many go above and beyond and it is fantastic when this is recognised."

Angela Helleur, Chief Nurse

Nursing Times Awards

Surgical nursing

Practice development nurse, Fiona Bernard, was a finalist in the 2018 Nursing Times awards in the Surgical Nursing category.

Together with Nour Makour, Fiona has worked tirelessly in the pursuit of excellence in training resources for our surgery division.

Fiona also won this year's Doreen Norton award, an internal award at the Trust, for her work on developing a surgical nursing course, which was the first surgical nursing course in the country, accredited with the University of Greenwich.

Fiona Bernard (left)

Student Nursing Times awards

We had two finalists in the 2018 Student Nursing Times Awards in 2018. Lydia Gray was a finalist in the 'mentor of the year' category and Sarah Joy Owen in the 'student midwife of the year' category.

NHS70 Parliamentary Awards

Older Persons' Assessment and Liaison (OPAL) Nurse Specialist, Tempie Mambiravana, and the children's community nursing team (CCNT) were chosen from hundreds of entries to represent London in the prestigious NHS70 Parliamentary awards to mark the 70th birthday of the NHS.

Tempie was successful in the Person Centred Care Champion category and the CCNT team in the Excellence in Cancer Care category. They joined other regional winners from across England at a special ceremony in the Palace of Westminster on 4 July, the day before the NHS70 big birthday celebrations.

The NHS70 Parliamentary Awards recognise the massive contribution made by the individuals who work in and alongside the NHS. Launched in February 2018, it asked the region's MPs to find and nominate those individuals or teams they thought have made the biggest improvements to health services in their constituencies across ten categories. Our champions were nominated by local MPs Matthew Pennycook, Ellie Reeves, Heidi Alexander and James Brokenshire.

Tempie Mambiravana

Our award-winning maternity team

Midwife scholarships

Midwives Gayani Raheem and Claire Axcell were awarded scholarships last year by the Iolanthe Midwifery Trust, a registered charity set up to support midwifery education, practice and research.

Gayani Raheem is using her £1,500 funding to develop antenatal education classes for teenage parents. Claire Axcell, student award winner, will use her £1,000 to train as a Mellow Parenting practitioner to support local vulnerable populations.

British Journal of Midwifery Practice

Our brilliant maternity team scooped two awards in February 2019 at the British Journal of Midwifery Practice Awards 2019. Verity Lancaster, second year student midwife based at University Hospital Lewisham, won Student Midwife of the Year.

Her nomination was for contributing to and leading on a new way of caring for women whose babies have been diagnosed with Down's syndrome. This has involved engaging with women and professionals at all levels in her own time.

Jo Frame, practice development midwife at UHL, came second in the Technology in Midwifery category.

Jo was nominated for leading the development of the maternity social media accounts, posting as Edie the E-Midwife (twitter @e_midwife). This has included information on services and facilities on offer and responding to private messages to give advice and support.

Edie's Twitter, Facebook and Instagram accounts saw a dramatic increase in engagement with the introduction of Edie's Elf through December, where the Elf got into lots of mischief in our maternity units and provided daily snippets of advice and support.

Jo Frame (left) and Verity Lancaster

Leadership scholarship

In December 2018, Giuseppe Labriola, Head of Midwifery at University Hospital Lewisham, was awarded a prestigious leadership scholarship by the Florence Nightingale Foundation. This will provide him with opportunities to learn at Harvard and with the leadership team at Disney.

Pharmacy team awards

LIMOS team

A team of pharmacists and pharmacy technicians at University Hospital Lewisham helped a local care home achieve a 'good' rating in their CQC inspection.

The Lewisham Integrated Medicines Optimisation Service (LIMOS) works across the hospital, local care homes and community settings to ensure a seamless approach to managing medications, which ensures that transfers from one setting to another are smooth and trouble free.

Their work helped Manley Court Care Home in New Cross to achieve a 'good' rating in their CQC inspection, an improvement on their previous rating of 'requires improvement'.

The CQC report says: "Each person had a medicines care plan that was robust and individualised because of the LIMOS work and multi-disciplinary team (MDT) working practices to enhance safety." The report also quotes a member of staff at the care home, who says: "Since we have had the support of the pharmacist there has been a reduction in problems with the administration of drugs".

Lead Pharmacist Kath Howes says: "We are very proud to have helped the care home achieve a 'good' rating. We have proved that working across organisations in an integrated way keeps patients safe, avoids unnecessary hospital admissions and saves money, and we hope this model of working will be adopted more widely across the health and social care sector.

The Trust also won the Primary Care Pharmacy Association (PCPA) Award for best poster at a care home symposium. The poster described how patient feedback about LIMOS could be used to measure the quality of the service.

The PCPA award was presented to Jacqui Williams, LIMOS care home pharmacy technician.

Health visiting service accredited by Unicef

The health visiting service in Lewisham was re-accredited by UNICEF UK in 2018 as Baby Friendly Level 3 for supporting breastfeeding mothers.

The 'Stage 3 Baby Friendly Award' is given after re-assessment of the care and support received by mothers from the health visiting service. The committee commended all staff involved for their hard work over the last two years in continuing to support mothers.

The report stated that it was clear to the assessment team that pregnant women and new mothers received a high standard of care. The assessors also commended the service on developing a comprehensive peer support training programme and praised Ade Olotu, Neighbourhood Health Visitor Lead, who has worked really hard to create this.

Performance report

Chief Executive's statement on performance

There have been many highlights during my first year at the Trust - including the opening of a new clinical facility at Queen Elizabeth Hospital, a new mental health café at University Hospital Lewisham, the bringing together of 1 million patient records, mobile working for community staff, new CT and MRI scanners and four upgraded theatres. It's been a huge boost to everyone involved to see their projects, some of which have been years in the planning, come to life.

All of these achievements will help us improve patient care but, like most trusts, we struggled to meet the national standard that says 95% of patients should be treated within four hours of entering our emergency departments. We agreed a local target with our commissioners and NHS England, but performance was affected by a growth in attendances (we saw an additional 7,491 patients compared with the previous year). Over the coming year we will continue to work with our partners to make improvements and expand the range of services we provide to reduce the need for a stay in hospital.

I'm pleased that we have consistently achieved the two-week wait and 31-day standards for cancer this year. However, meeting the national standard to ensure all patients start treatment within 62 days of referral remains a significant challenge nationally and across the whole of south east London. We are investing in diagnostic services and working with our partners to improve performance.

We reached our key financial targets in 2018/19 and reported a reduced deficit, which makes our financial position much more stable going forward. For 2019/20 we plan to report a smaller deficit, while at the same time continuing to focus on improving the quality and safety of our services.

During the year, we engaged with staff, patients and partners to agree five key priorities for the organisation: quality (improve safety and quality); patients (put patients at the heart of everything we do), people (support and develop our workforce), partnership (work effectively with partner organisations) and money (ensure we spend every penny wisely). These are central to achieving our vision, which is to work together to provide high quality care for every patient, every day.

We also refreshed our values, which are at the heart of everything we do – how we behave at work and how we treat our colleagues, patients and visitors. On that subject, while it's clear that some staff have a great experience of working here, this isn't the case for everyone, and we have developed a detailed plan to ensure that all staff feel respected, valued and supported.

I've made a point of visiting as many different services as I can during my first year at the Trust to gain an understanding of the challenges we face, both in our hospitals and in our community services. I hold regular drop in sessions and invite staff to email me with their concerns. One of our major challenges has been a shortage of staff, so I'm pleased to report that this year we've reduced vacancy rates from 17.5 per cent in April 2018 to 13 per cent at the time of writing. We've also introduced new roles to the Trust – apprentice nursing associates and physician associates – to support patient care.

In January 2019 we produced a road map for the future, which outlines where we are now as an organisation, the challenges we face and where we want to be in three years' time. During 2019/20 we will develop an overall Trust clinical strategy.

The CQC inspected the Trust in September 2018 and, although the overall rating was "requires improvement", the inspectors found many improvements since their previous inspection in March 2017. We aim to achieve an overall rating of "good" when the CQC next inspects our services.

Finally, I'd like to say thank you to all of our staff for their continuing commitment and hard work.

Ben Travis, Chief Executive
May 2019

Performance overview

Our performance against NHS standards and 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 on pages 22 and 23.

An overview of our performance against financial targets is included on page 38.

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.

The challenges to providing timely emergency care in the NHS are well documented. In 2018/19, it was recognised that it was not realistic for us to deliver the 95 per cent national standard throughout the year, given the volume of patients who come through our emergency departments. We agreed a local trajectory with our commissioners and NHS England to improve performance over the year and to meet the national 95 per cent standard by March 2019.

While we met the local trajectory over the first four months of 2018/19, performance for the rest of the year was affected by a growth in attendances (as we saw an additional 7,491 patients compared with the previous year) and by the winter pressures faced by hospitals throughout the country.

For 2018/19, we have agreed a trajectory of 89.2 per cent for performance against the four hour target, as the pressures we face mean that 95 per cent is not achievable. Dr Elizabeth Aitken, Medical Director, commented: "While it's disappointing we didn't meet our trajectory for emergency care, we did make a number of improvements for our patients in 2018/19. This includes the development of a new clinical facility at Queen Elizabeth Hospital (QEH), opening a mental health café at University Hospital Lewisham (UHL) and improving the discharge of patients from hospital (see below).

"Over 2019/20, we will build on the good work over the last year, and look to expand the range of services we provide that reduce the need for a stay in hospital."

New clinical facility at QEH

In December 2018 we opened a brand new building next to the emergency department at Queen Elizabeth Hospital with two new short-stay wards (Wards 22 and 23). The new wards, which provide 47 new beds, provide treatment for patients who don't require specialist care but need a short stay in hospital (of up to 72 hours). This frees up beds in the hospital over winter, helping us to provide more timely care in the right environment.

We also moved the surgical assessment unit (SAU) into the new building so that patients coming through our emergency department can be reviewed by a senior clinician more quickly.

New clinical facility at QEH

Dr Alex George opens the new mental health cafe at UHL

Improving mental health care

We have seen an increase in the number of our patients who present to our emergency departments with mental health problems. It is essential that we treat these patients, who are often in crisis, in a timely and compassionate manner. This remains difficult for us to deliver at all times. However, this year we welcomed the national focus on crisis care with the Mental Health Crisis Care Concordat. This gives us a framework to improve care for our patients. We have started working more closely with our system partners and have introduced a Mental Health Board, chaired by our Chief Nurse, which has a focus on more responsive and appropriate support in crisis and ongoing care to prevent re-attendance.

In January 2019 we opened The Harbour, a brand new mental health crisis café, at University Hospital Lewisham. The Harbour provides peer support to people experiencing a mental health crisis, and offers people feeling distressed someone to talk to in a relaxed and calm non-clinical setting. This will help them avoid spending extended time in A&E or as an inpatient. For more information, see page 17.

We owe it to our patients to work to improve care both by our emergency department staff and to push for better mental health care services in and out of hours. Current systems especially for out-of-hours services, can lead to delays for patients with mental health issues, who often then spend time in a non-therapeutic and potentially harmful environment. There is a lot to do, but we are committed to working with partners to address these issues.

Working with providers of mental health services, we have developed better communication networks with the London Ambulance Service, charities, the Metropolitan Police, local councils and primary sector colleagues.

Earlier hospital discharge

A key priority over 2019/20 is freeing up hospital beds by enabling patients who are ready to leave hospital to be discharged earlier in the day. As part of this work, we are producing clear guidance to enable senior nursing staff and therapists to lead on discharges for patients who do not have complex needs – as long as a defined set of criteria are met.

We aim for 30 per cent of these "simple" discharges to happen before 12 midday, as well as increasing our use of the discharge lounges at our hospitals to free beds up earlier for new patients. The aim is to ensure that patients can return home as safely and as quickly as possible, and that beds are freed up for other patients.

We are also working closer with our health and social care partners to improve discharges for patients with more complex needs to ensure that they leave hospital with a comprehensive package of care in place. This is achieved through regular meetings between health and social care professionals to plan the discharge of patients who may need rehabilitation, extra care, or to move into a care home, for example. Packages of care are put in place well ahead of time to speed up the discharge process and free up beds for patients who need them.

Cancer targets

We have consistently achieved the two-week wait and 31 day standards. However, meeting the national standard to ensure all patients start treatment within 62 days of referral remains a significant challenge nationally and across the whole of south east London. We continue to invest in diagnostic services and work jointly with our partners to improve performance. We have agreed a local trajectory to improve performance and to meet the 62-day target consistently from October 2019.

Meeting the 62 day target is a key area of focus over 2019/20.

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 every month following a referral for any type of cancer but missed the standard slightly in two months for patients with symptoms of breast cancer.

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 2018/19.

62-day standard
The NHS standard is that at least 85 per cent of 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 and will be implementing a local cancer action plan. The priorities for the action plan are to improve diagnostic performance, increase consultant capacity and improve cancer pathways.

New CT scanner for faster cancer diagnosis

In October 2018 we officially opened our new CT scanner at Queen Elizabeth Hospital. With state-of-the-art technology, the new scanner plays a critical role in the diagnosis of our patients, and will support the delivery of key cancer standards.

The scanner is faster than our old scanner and produces clearer images. It will be running seven days a week to improve efficiency and patient experience.

The new technology on the scanner will also really help us to further develop our highly skilled staff.

Developing endoscopy services

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 work to upgrade our endoscopy suite at Queen Elizabeth Hospital will be completed in summer 2019. 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. We will be able to do more tests, with shorter waiting times and a better patient environment. We are also planning to expand endoscopy services at University Hospital Lewisham.

Gold standard in cancer biopsies

We have become the first district general hospital provider in the UK to phase out standard biopsies for prostate cancer ("TRUS" biopsies") and roll out the gold standard in cancer biopsies – "template prostate biopsies".

Mr Mohamed Hammadeh, Consultant Urology Surgeon and clinical director of urology, said: "It is wonderful that we can offer patients this service. Template biopsies take targeted samples from the prostate following an MRI scan. This is a more accurate way of testing for cancer than the standard TRUS biopsies, which we have phased out. We can now offer template biopsies under local or sedation anaesthesia, depending on the patient's preference."

Mr Hammedeh added: "This development is thanks to great work from our staff, our management team in the surgery division, our partners in the South East London Cancer Network, and the urology department at Guys and St Thomas' NHS Foundation Trust, who provided training for our staff."

Official unveiling of new MRI scanner

University Hospital Lewisham's new MRI scanner was unveiled in September 2018.

The use of MRI for diagnosis has increased in recent years and the addition of a third scanner to the Trust gives us an increased capacity for inpatients and outpatients on both sites.

Dr Fatima Shah, Consultant Radiologist and Clinical Director for radiology at UHL said: "It is fantastic the MRI unit at UHL has now achieved its full potential, offering two scanners next door to one another with inpatient and outpatient waiting areas, changing facilities and a recovery area."

New MRI scanner

Chief Executive Ben Travis at the relaunch of the surgery day care unit

Referral to treatment targets

The NHS standard remains that 92 per cent of patients should be treated either as an inpatient or as a day case within 18 weeks of referral. However, for 2018/19, NHS England changed the performance focus away from the 92 per cent standard to reducing the number of active (open) pathways to below the number in March 2018, and reducing the number of patients waiting over 52 weeks before starting treatment.

During 2018/19, we did not meet the 92 per cent standard. However, while the number of open pathways (ie patients waiting for treatment) in March 2019 at 38,866 is above the agreed trajectory of 38,575, it is below the March 2018 figure of 39,924. During 2018/19 there were twelve 52 week breaches. The national priorities remain the same for 2019/20, and we have agreed a trajectory to reduce the number of open pathways to 38,800 and to deliver performance of 84.8 per cent against the 92 per cent standard by March 2020. From April to June we expect to report up to fifteen 52 week breaches due to a specific pathway issue for paediatric ophthalmology patients. This is being addressed and we will have no 52 week breaches from July.

Improvements to day surgery at QEH

In September 2018 we re-launched the surgery day care unit at Queen Elizabeth Hospital (QEH) to provide a safe environment for patients to recover after planned surgery – reducing last minute cancellations and delays.

Mr Paolo Sorelli, Consultant Colorectal Surgeon, said: "The day care surgery unit now has ring-fenced beds for patients to recover from their planned surgery. In the past, we've often had to make last minute cancellations and delay planned surgery – as the beds in the unit were used for emergency patients when the hospital was busy.

"The changes to the surgery day care unit have been made as part of a major improvement plan, which includes setting up a new surgical service in the QEH ambulatory care unit. This means that patients who come through the emergency department with surgical issues, such as abdominal pain, can see a senior surgical consultant sooner. This reduces the amount of time that these patients need to stay in hospital, with early treatment to promote recovery."

Upgraded theatres at UHL

Over the past year we have upgraded four of our theatres at University Hospital Lewisham. Two of the theatres have had laminar flow air conditioning systems installed, which provide the optimum conditions for orthopaedic surgery such as hip replacements.

Infection control

We have continued with our zero tolerance approach to ensure that no patient acquires an MRSA bacterial infection at the Trust. During 2018/19 the Trust reported one case of MRSA bacteraemia, which was investigated thoroughly; this represents an improvement over the four cases reported in 2017/18. Where learning is identified, the clinical teams lead on making sure that actions are 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. During 2017/18 we reported 16 cases of C. difficile and in 2018/19 this has reduced to 12 cases against a ceiling of no more than 38. Over the past five years the trust has seen a total reduction of 68 per cent in Trust attributable C. difficile cases. Although we are pleased to have reduced the number of cases and come in well below our target, we continue to investigate each case of C. difficile to prevent more patients developing the infection.

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 2018/19 and actively continue to recruit and retain high quality staff. Nursing vacancies remain a significant challenge for the Trust and, while the overall Trust vacancy rate has improved from 17 per cent in June 2018 to 13 per cent in June 2019, this remains a priority for us. In particular, we are looking at how we improve our staff retention rates and make the Trust a fantastic place to work for all our staff.

VTE

The national standard is that 95 per cent 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 2018/19.

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 in reception class (aged four to five years) and again in year 6 (aged 10 to 11 years) to assess the percentage of children who are overweight or very overweight 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. In Greenwich, community services are provided by Oxleas NHS Foundation Trust.

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 Lewisham health visiting services gained Stage 3 UNICEF Baby Friendly accreditation in July 2018. This is a fantastic and very prestigious achievement for the Trust. 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. This is not a target for us in Greenwich, as the Trust only directly provides community services in Lewisham.

Mortality data

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 1. A score below 1 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 2018/19, Lewisham and Greenwich NHS Trust score was "as expected" (Band 2) in the SHMI indicating that our care is safe.

Performance table

National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
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)	87.6%	90.1%	90.0%	90.4%	89.1%	87.5%	88.6%	86.3%	86.3%	83.8%	81.6%	84.9%
Infection control: the Trust should have no cases of MRSA bacteraemia	0	0	0	0	0	0	1	0	0	0	0	0
Infection control: the Trust should have no more than 38 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 15 cases over the year).	3	0	1	1	1	2	1	2	0	2	0	2
Cancer: patients should wait no more than two weeks for an urgent referral. The standard is 93%	94.7%	96.1%	96.9%	95.5%	95.4%	95.5%	96.8%	95.1%	97.4%	94.5%	96.9%	96.7%
Cancer: Patients with symptoms of breast cancer should wait no more than two weeks for treatment following an urgent referral. The standard is 93%	91.2%	94.8%	97.0%	94.5%	96.6%	93.6%	96.0%	94.3%	97.0%	92.2%	95.2%	98.4%
Cancer: patients should not wait more than 31 days from confirmed diagnosis to treatment. The standard is 96%	99.1%	97.9%	100%	99.0%	96.8%	96.5%	99.2%	97.9%	96.0%	93.2%	99.1%	97.1%
Cancer: patients should not wait more than 62 days for treatment from GP referral. The standard is 85%	85.4%	82.4%	80.9%	72.2%	84.3%	84.8%	76.0%	75.5%	72.5%	70.7%	70.1%	73.6%
Cancer 62 day performance excluding shared pathway patients	92.8%	89.1%	90.4%	84.5%	92.1%	94.0%	86.4%	85.7%	81.7%	80.0%	75.4%	81.5%

National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
18 weeks target: patients who have not been treated yet should not have waited longer than 18 weeks. The standard is 92%.	88.2%	87.0%	86.8%	87.0%	86.3%	85.2%	86.1%	85.9%	85.7%	85.5%	85.7%	85.2%
18 weeks target: number of open pathways	40761	40537	40194	40861	41115	39821	39591	37471	38126	39152	39017	38866
18 weeks target: patients waiting longer than 52 weeks	0	0	0	0	0	0	1	0	1	0	0	10
Safer staffing: we should be meeting 90% of staffing requirements	96.7%	99.3%	100.4%	100.3%	98.6%	98.4%	100.2%	101.4%	99.3%	101.1%	101.7%	101.2%
95% of inpatients should receive a VTE assessment	96.5%	96.6%	96.3%	95.8%	96.6%	96.9%	96.5%	96.4%	96.2%	95.9%	96.8%	96.3%
Breastfeeding: ensure the feeding status of 95% of infants is checked within 6-8 weeks after birth	99.1%			98.7%			99.1%			99.44%		
Breastfeeding: ensure that 72.5% of infants are fully or partially breast fed at 6-8 week check	79.2%			79.3%			81.5%			80.0%		
Childhood obesity: ensure that 87% of children in Reception are measured as part of the Government's National Childhood Measurement Programme - Academic year 2017-18	89.2%											
Childhood obesity: ensure that 87% of children in Year 6 are measured - academic year 2017-18	91.0%											
Standardised Hospital Mortality Indicator (SHMI)	0.97			0.97			0.98			0.97		

The view from our regulators

The Care Quality Commission (CQC) inspected the Trust in September 2018 and published its report in January 2019. The Trust's overall rating was "requires improvement", but the CQC found many improvements since their previous inspection in March 2017. They also commented on how caring they found our staff, with the Trust's rating in the caring domain improving to "good".

While the CQC noted there is more to do, they said that there are positive signs that we are addressing the challenges we face. The report shows that we are moving in the right direction.

The Trust's community services weren't inspected this time and retain their rating of "outstanding". Key points from the inspection report include:

- The Trust has achieved an overall rating of "good" for caring
- Urgent and emergency care at University Hospital Lewisham (UHL) improved from "requires improvement" to "good"
- Maternity services at UHL have moved up from "requires improvement" to "good", with maternity services at Queen Elizabeth Hospital (QEH) retaining their rating of "good"
- End of life care at QEH, which had been rated "inadequate" in the last inspection, has moved up to "requires improvement".

Overall, across the core services and hospital sites inspected, we have seen an improvement in ratings in 12 service area domains and deterioration in just one area/domain rating (surgery, effectiveness). No services were rated as "inadequate", reflecting improvements since the last inspection.

Inspectors noted that the appointment of a new chief executive and chief nurse at the Trust last year had resulted in improved communication and engagement. Inspectors could also see that recent changes to strengthen clinical leadership were already having an impact.

They observed staff providing compassionate care and being attentive towards patients, who spoke positively about the staff and the care they received. They said staff were friendly and helpful. Response from the Friends and Family test showed that patients would generally recommend the Trust.

The inspectors saw areas of outstanding practice, for example the excellent education strategy in the emergency department at QEH and the "education trolley bus" in maternity, which senior staff use to discuss key issues and best practice with staff. Another area of outstanding practice was the bereavement service in maternity at UHL, which provides support to women and families who have lost babies at all stages of pregnancy.

There were areas where the Trust needs to improve, including medicines management and staffing. In response, we have provided more training to staff on medicines management and we have increased the number of internal audits we carry out to monitor progress and address any issues. We have been carrying out a major recruitment drive and have succeeded in reducing vacancy rates from 17 per cent in June 2018 to 13 per cent in June 2019. We have recently completed two international recruitment drives for nursing staff, offering positions to a further 187 qualified nurses. More international recruitment for key roles is planned in 2019/20.

The inspectors noted that the emergency department at QEH was often overcrowded, but acknowledged that the new clinical facility (see page 16) would provide increased capacity.

The 2018 inspection did not inspect the following hospital services, and therefore the ratings have remained as they were in the 2017 report:

UHL: Critical care, services for children and young people, outpatients and diagnostics

QEH: Medical care, services for children and young people, outpatients and diagnostics.

Getting to "good"

Following the CQC inspection, divisions throughout the Trust drew up plans to make the improvements the CQC asked for. Our aim is to move from a rating of "requires improvement" to "good", and we have invited the CQC to reinspect our services during 2019/20. See page 27 for more information.

Ratings for Queen Elizabeth Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency care	Requires improvement →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018
Medical care (including older people's care)	Requires improvement Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Surgery	Requires improvement ↑ Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018
Critical care	Requires improvement →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018
Maternity	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Services for children and young people	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
End of life care	Requires improvement →← Sept 2018	Requires improvement ↑ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Good ↑↑ Sept 2018	Requires improvement ↑ Sept 2018
Outpatients and diagnostic imaging	Good Aug 2017	Not rated	Good Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017

Ratings for University Hospital Lewisham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency care	Requires improvement →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Medical care (including older people's care)	Requires improvement Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Surgery	Requires improvement →← Sept 2018	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018
Critical care	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Good Aug 2017
Maternity	Good ↑ Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Services for children and young people	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
End of life care	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Requires improvement →← Sept 2018
Outpatients and diagnostic imaging	Requires improvement Aug 2017	Not rated	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017


Chloe
CHARTERED
PHYSIOTHERAPIST

Quality: continually improve safety and quality

"We aim to provide the best evidence-based care for all our patients whenever and wherever they are treated. We want to be a learning organisation with a culture of quality improvement, and make the best use of digital technologies."

Dr Elizabeth Aitken, Medical Director

Improving Together

In the summer of 2018 we launched our "Improving Together" campaign to focus on safety and quality throughout the organisation. Following the Care Quality Commission (CQC) inspection in September 2018, divisions throughout the Trust drew up plans to make the improvements the CQC asked for. Our aim is to move from a rating of "requires improvement" to "good", and we have invited the CQC to reinspect our services during 2019/20.

Peer reviews

As part of the campaign, we have been running peer review assessments of all clinical and service areas. The aim of the peer reviews is to support improvements and to raise the profile of quality and safety in all areas. The assessment teams consist of staff at the Trust, who visit different areas of the hospital, make notes on what they see and speak to staff. They then give feedback on what they found.

Angela Helleur, Chief Nurse, commented: "These peer reviews have helped us to celebrate success where things are going well, and offer a bit of extra support where it is needed. We've been able to make a number of improvements to the patient environment through the reviews, which help us to look at our workplace with a fresh pair of eyes."

Providing training to empower our staff

We are launching a quality improvement training programme for our staff in 2019/20. This will provide training to frontline staff on how to deliver major improvements to quality and safety. Angela Helleur, Chief Nurse, explains: "This is about empowering our staff, giving them the tools they need to deliver improvements, so we can build on the progress we have made over the last year. Other NHS trusts have been able to deliver significant improvements by training staff in quality improvement methodology, and we are really excited about launching our own programme."

In addition, we are also launching a separate training programme to support our staff in displaying the Trust's values (see page 9) at all times. Fay Blackwood, Associate Director of Education and Development, said: "This is about getting the right culture across the whole Trust. We have appointed a company to deliver training on the Trust values – and what they mean – to all 4,000 staff in supervisory roles."

Getting it right First Time (GIRFT)

Getting It Right First Time (GIRFT) is a national NHS programme to help improve the quality of medical and clinical care by identifying and reducing unnecessary variations in service and practice. Led by frontline clinicians, it is a partnership between the Royal National Orthopaedic Hospital NHS Trust (RNOH) and NHS Improvement (NHSI).

The aim is to improve the quality of medical and clinical care within the NHS by analysing data across a range of metrics. GIRFT encourages the sharing of best practice between trusts and proposes improvements within specialties to help improve patient outcomes and make savings that can be invested into services.

The Trust received 11 visits in 2018/19 from the national GIRFT team to review different areas including surgery, maternity and radiology. The team has investigated data and put forward their recommendations, which the Trust will be putting into practice throughout 2019/20.

Seven day hospital services

The national seven day working programme aims to reduce variations in service at weekends. NHS England assesses trusts against four clinical standards:

- Time to consultant review
- Access to diagnosics
- Access to consultant-led interventions
- Ongoing daily consultant-led review

We have continued to make improvements and have met all of these standards for 2018/19. The work done so far has seen an increase in weekend discharges and decrease in length of stay through greater use of ambulatory and emergency day care services.

During 2019/20, we will work to improve performance, particularly for the daily review at weekend (currently at 78 per cent) and information given to patients within 48 hours.

End of life care

In March 2018 the Trust's specialist palliative care team relaunched their document - "The principles of care for dying patients" to help medical, nursing and allied health care professionals identify and assess dying patients and plan their care.

The document guides staff to achieve excellent care for dying patients and is placed in patients' medical and nursing notes once it has been recognised that the patient is dying.

The team also produced a podcast and video to help staff understand more about the principles of care for dying patients.

As a result of this work, the Trust's rating for end of life care moved from "inadequate" to "requires improvement".

Making the best use of technology

Dr John O'Donohue, Associate Medical Director for IT, commented: "We've introduced lots of ways to work more efficiently with the help of technology. When we're always so busy, technology can help us maximise our time with patients and communicate more effectively with each other. These smarter ways of working benefit our patients and our colleagues."

Merged patient record system

Our two hospitals used to have separate patient record systems. In June 2018, we safely brought together over one million patient records into one combined system. This is now used by both our hospitals. At the same time, we also set up a system to record cancer treatment. All this work was on time and within budget.

Our new merged system will enable us to introduce electronic prescribing and reduce our use of paper records in 2019. These new developments will be safer for patients and much more efficient for staff.

Health visitors and district nurses go digital

The Trust's new mobile working system, "LGT anywhere", was rolled out to 100 health visitors, district nurses and other community staff in December 2018.

Using a secure Trust laptop or tablet, these staff can use the LGT anywhere platform to access patient records, clinical applications, shared drives, e-rostering and more while they are out and about. Whether they're in a patient's home, in a school, at a conference or in a council building, they'll be able to easily access the tools that enable them to do their jobs.

The new system will later be rolled out to 600 more community staff, who will pioneer this new way of providing high quality services to our patients.

Community nurse Antonia Vasileva said: "I'm really excited about mobile working – it saves me so much time and makes my work so much easier. Not only can I input patient notes directly into the system, I can also take photographs for wound care using the tablet and save them with the notes."

Video consultations for cardiology patients

In February 2018 we became the first NHS Trust in the country to offer video consultations for cardiology patients – enabling them to get the specialist advice they need without the hassle of travelling to hospital.

Hospital appointments will continue to be provided for patients who are required to see a healthcare professional in person, if they don't have a smartphone or would prefer an on-site appointment.

David Meynell, one of the first patients to benefit from the service, explains what it means to him: "It was incredibly convenient. I have multiple sclerosis and coming to hospital is a hassle; I have to get a cab and it is quite expensive. Phone calls feel very impersonal, but a video appointment felt just like I was talking to my consultant in person, which really put me at ease. I just used my smartphone and it was great getting all the advice I needed without making a trip to the hospital."

Dr Zeeshan Khawaja, the consultant cardiologist trialling the new service, said: "This is a fantastic service for patients who have been discharged from A&E and referred for a follow-up cardiac appointment."

Patient Portal

We have built a new Patient Portal to enable patients to see some of the key information from their electronic healthcare record whenever they want to. We are trialling it with a small number of patients to help us make sure that it is easy to use and meets our patients' needs.

These patients are able to log in and see results of blood tests, letters from us to their GP and any future appointments. This is a free secure online service to give our patients easy access to important information about their health.

Radiology goes digital

This year we upgraded all of our X-ray equipment from plain film to digital, which means that X-rays can be viewed on computer screens at our hospitals, or remotely at home, and can be easily shared between teams.

Apps for staff

There are never enough hours in the day for our busy staff so we've developed several apps this year to help make some of their regular tasks easy to do on the go.

In September we introduced an app for staff to quickly look up treatment guidelines for antibiotics. In January we launched an app that enables staff to keep up to date with compulsory training. And our new app for junior doctors means they can see when they're on the roster, request leave and swap shifts from their phone or PC.

Free unlimited Wi-Fi for patients, visitors and staff

In May 2018 the Trust made free Wi-Fi available for patients and visitors, under the name NHS Wi-Fi. This is a public unsecured service. There are no time limits, although bandwidth restrictions mean that it is not suitable for video streaming.

Our staff can log use Govroam Wi-Fi, a secure government network, in our buildings and when visiting other NHS and council buildings to check emails or use the internet.

Patients: put patients at the heart of everything we do

"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

Listening to patients

As well as receiving feedback through formal routes – such as our Patient Advice and Liaison (PALS) and complaints services, 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 including:

- Providing iPads for new mothers whose babies are in the special care unit so that they can see their babies using FaceTime.
- Employing flow coordinators to speed up discharge from surgery so that patients don't have to wait so long to go home
- Offering health visiting appointments on a Saturday.

Improving patient experience

Chemotherapy bells unveiled at both hospitals

In October 2018, chemotherapy bells were installed at both our chemotherapy units. Donated by patients and families, the idea is that patients ring the bell at significant moments during their treatment.

The bell at Queen Elizabeth Hospital was unveiled by BBC TV News presenter Asad Ahmad. Asad said: "It was my great pleasure to unveil the new chemotherapy bell, a superb idea which will really give hope and courage to the patients who come here and the fantastic staff who help them through some of the trickiest periods in their life."

Broadcaster Asad Ahmad unveils the new chemotherapy bell

Exercise bikes for ICU

Two specialised exercise bikes worth £10,000 were donated last year to our intensive care unit (ICU) at Queen Elizabeth Hospital (QEH) by the League of Friends QEH. The bikes will help critically ill patients to recover faster in hospital, as early rehabilitation can help shorten the length of time patients spend in intensive care.

Amy Collins, sister for ICU at QEH explains: "We cannot thank the League of Friends QEH enough for this generous donation. These exercise bikes will make a significant difference to the lives of our patients.

"Patients in critical care often develop muscle weakness. Using these bikes at an early stage definitely helps to preserve ICU patients' muscle mass and also helps them to keep moving. It will also enable us to conduct our own research study which will help shape future care at the Trust."

Early referrals to the falls team

For patients who come to the emergency department at Lewisham after a fall, we now make early referrals to the falls team, who offer support and advice to reduce the chances of further falls. The team is made up of physiotherapists, occupational therapists and social workers who work together to assess, treat and discharge patients with mobility problems.

This means that social worker assessments can take place sooner and packages of care set up more quickly to allow the patient to be discharged home.

Virtual and flexible clinics

A number of departments including gynaecology, cardiology and fracture clinic have introduced virtual clinics to reduce the wait times for follow up. Health visiting, ear nose and throat (ENT) and maternity have introduced weekend clinics and the sexual health team offer evening appointments so patients have more choice and flexibility.

Working with patient groups

Patient Welfare Forum, University Hospital Lewisham

Jan Ferrari, PWF chair, said: "During 2018/19, PWF members visited all of the wards and outpatient clinics at 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 continued to contribute to improvements across the hospital. For example, we recommended that some additional equipment was provided in cardiac physiology, and that consulting areas were rearranged to improve privacy for patients. Repairs and redecorations are underway in Suite 1 and dermatology, improving the environment for patients and staff. And we were pleased to see the appointment of a play worker in children's outpatients.

"Our members continue to represent the patient voice at Trust-wide committees, such as patient experience, complaints and catering, and this year PWF members took part in stakeholder and interview panels for the recruitment of senior staff."

Patient User Group, Queen Elizabeth Hospital

Judy Lyons, PUG chair, says: "The Patient User Group has continued to support the welfare of inpatients and outpatients at Queen Elizabeth Hospital.

"This year we have participated in inspection regimes including patient-led assessments of the care environment (PLACE) and peer reviews, working with other volunteers and clinicians.

"We have carried out observations of different parts of the hospital, including various outpatient clinics, A&E and ambulatory care. We remain committed to the Food Focus Group, through which we are able to report our findings from our food tasting experiences on the wards.

"Several members of PUG sat on the working groups involved with the tendering of the soft services facilities management contract, due to be decided later this year. We were also involved in the consultation process and preparation of the opening of Lloyds Pharmacy."

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 2018/19 we received more than 6,577 contacts through PALS and 742 formal complaints; this is an increase from 2017/18 when we received more than 5,500 contacts through PALS and 610 formal complaints.

Complaint themes over 2018/19

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

People: support and develop our workforce to live our values every day

"We are committed to supporting our staff to develop in their roles and reach their full potential. We offer personal and professional development, career clinics, flexible working and many other staff benefits to ensure that our Trust is a great place to work."

Fay Blackwood, Associate Director of Education and Development

Award winners Bromley stroke rehabilitation team

We are planning more international recruitment campaigns for areas where we have shortages. We have recruited 21 physician associates and 18 apprentice nursing associates, which are new roles for the NHS, and around 30 apprentices into a wide range of roles.

To improve staff retention, we have set up regular career clinics to make it easier for nursing staff to move within the organisation without having to go through the recruitment process. We have introduced a "bank to permanent" initiative, enabling bank staff who have been in the same vacant post for six months or more to move smoothly into the role without going through the recruitment process. We have also set up a flexible working group to promote the different types of flexible working available to help staff improve their work-life balance.

Celebrating our staff

In November 2018, we held our annual staff awards at Blackheath Halls to celebrate and recognise our staff. A huge congratulations to all of our 2018 award winners.

Recruitment

We have been carrying out a major recruitment drive and have succeeded in reducing vacancy rates from 17.5 per cent in April 2018 to 13.9 per cent in January 2019. Our recruitment drive has included open days, stalls in local shopping centres, work with our universities, international recruitment and more digital and online promotion. More international recruitment is planned in 2019/20.

- In November 2018, we carried out a nursing recruitment campaign in India and made 91 offers for nurses to join us.
- In March 2019 we completed a nursing recruitment campaign in the Philippines, where we made 96 offers for nursing staff.
- In March 2019 we completed a successful specialist recruitment campaign in India, where we made offers for 10 doctors to join us. They will work across both sites in emergency and acute medicine.

The Trust choir at the staff awards

Supporting newly qualified nurses

In February 2019 we were awarded the CapitalNurse Preceptorship Quality Mark, which means that our preceptorship (newly qualified) nurses are well supported during their first year of work. The Trust achieved 100 per cent of the criteria in terms of allocating protected time for learning, providing individual support, and setting up regular review meetings. This all helps our newly qualified nurses develop confidence and skills and feel valued at work.

Research shows that trusts that run a good preceptorship programme are much more likely to retain their staff. CapitalNurse is run by Health Education England with a remit to 'get nursing right for London'.

Gill Berry, the Trust's preceptorship lead, said: "I'm delighted that we've been awarded this quality mark, which shows that our preceptorship programmes in ED, adult nursing and midwifery are of the highest standard. I look forward to welcoming our next cohort of newly qualified nurses to the Trust, and hope that many of them will choose to stay on and develop their careers with us."

New roles at the Trust

Nursing associates

The nursing associate is a new national role that bridges the gap between healthcare assistants (HCAs) and registered nurses. Training takes the form of a two year apprenticeship and is a combination of academic study and work-based learning.

In December 2018 our first group of apprentice nursing associates started work on wards at Queen Elizabeth Hospital and University Hospital Lewisham, having begun their university studies in November.

At the time of writing we have 18 apprentice nursing associates at the Trust, and will be recruiting our next cohort in June 2019.

Physician associates

In 2018 we welcomed our first physician associates to our medical, care of the elderly and surgical wards. Dr Jacqueline Simms, consultant physician in geriatric and general medicine, said: "This is a really exciting role, which has been developing in the NHS for a number of years now and is one of the fastest growing healthcare professions in the UK.

"Physician associates are graduates who have undergone intense training to gain key medical skills – such as gathering a patient's history and taking blood. They work alongside our medical and surgical teams, helping to support patient care. They play a key role in engaging with families and patients and helping smooth the patient's journey from admission to discharge."

Physician associates

Nursing associates

NHS staff survey

All NHS organisations take part in the national NHS staff survey. The 2018 survey was carried out between September and November 2018 and the results were published in February 2019.

The survey consisted of 52 questions split across 10 themes and it showed a number of improvements when compared to our results from the 2017 survey:

- Staff participation was up by 4 per cent
- We significantly improved in five of the 10 themes (quality of appraisals, quality of care, immediate managers, safety culture and staff engagement)
- In four themes, we stayed the same, and one wasn't applicable as there wasn't a comparable survey question the previous year.
- 58.4 per cent of staff would recommend the Trust as a place to work (friends and family test), an increase from 51.5 per cent of staff in the previous year's survey.

As part of the survey, we are benchmarked against similar combined acute and community trusts so that we can see how we compare against a national average. We did well in five areas: we rated 'above average' in two of the themes, quality of appraisals and quality of care and we rated 'average' in three themes, immediate managers, safe environment – violence and staff engagement. However, in five of the themes, including morale and safe environment – bullying and harassment – we scored below average.

We know that we have a lot more to do and we will continue to work with our staff to develop a positive and open culture. This will include work to ensure that our values are embedded across the Trust. We have developed an action plan to ensure that all staff are treated with respect and compassion (see below), and on other key initiatives to make the Trust a welcoming and rewarding place to work for everyone.

Improving staff experience

Treating all staff with respect and compassion

Ben Travis, Chief Executive, commented: "I know from discussions with colleagues that many are really happy working at the Trust. But that's not the case with everyone, and we need to do more to get the culture right for everyone.

"Previous staff surveys showed a higher than average number of staff reporting bullying and harassment, and we commissioned and published an independent report into this issue in 2018. Importantly, the report gave us clear recommendations on what we need to do to ensure that all members of staff are treated in the right way – so we've been putting into place our action plan to address all these issues."

Work over 2018/19 includes:

- Changing how we do our annual appraisals – known as Personal Development Reviews (PDRs) – so that it's clear that, whatever someone's role, demonstrating our values is key to doing the job in the right way
- Setting up a comprehensive training programme, which will start in June 2019, providing training to over 4,000 staff in management and supervisory roles over 2019/20 to strengthen leadership and embed our values
- Improving our processes for reviewing cases where staff have reported issues with not being treated in the right way. We have prioritised completing investigations of longstanding cases in a more timely manner. To carry out this work, we have strengthened our Employee Relations team by appointing a new Head of Employee Relations and two other new members staff, so the team is fully staffed with nine members of staff
- Agreeing the criteria for new investigations to be undertaken where repeated concerns have been raised. We have written to the people who are affected by this, and appointed an external company we've not worked with before, TCM, to investigate the matters that have been drawn to our attention. We expect all matters in relation to these investigations to be concluded by the end of June
- Settting up a monthly programme board to oversee this work, chaired by the Chief Executive, and involving staff-side (trade unions) and the Trust's equality , diversity and inclusion (EDI) network.

We have also set up an oversight group to offer advice, represent staff and hold us to account on this work. We are delighted to announce that Roger Kline and Sir Steve Bullock have agreed to act as joint chairs to this group. Roger Kline is a research fellow from Middlesex University who specialises in diversity, inclusion and tackling bullying. Sir Steve Bullock has played a major role in the local community over the last four decades, and served as Mayor of the Borough of Lewisham for 16 years.

Manisha Patel, Lead for the Bromley Stroke Rehabilitation Team and chair of the Trust's equality, diversity and inclusion (EDI) network, said: "The equality, diversity and inclusion network was set up to give all staff a voice – so we are all treated equally, in the right way. It is great to see the Trust leadership asking staff how we can get the culture right for everyone and taking action to deliver the improvements. We were involved in selecting Sir Steve Bullock and Roger Kline as joint chairs of the oversight group, and look forward to working with them."

Core members of the equality, diversity and inclusion (EDI) network

Freedom to Speak up Guardians

In 2017 the Trust appointed seven Freedom to Speak up Guardians to help staff raise concerns to prevent incidents and improve services. Guardians don't get involved in investigations or complaints – rather, they help people raise concerns through the Trust's processes and ensure they are listened to and acted upon.

Our Guardians are all independent of the Trust, but have worked here in the past, so have a good understanding of the Trust. They are also representative of all the main staff groups in the Trust.

Improving diversity and inclusion

The equality, diversity and inclusion (EDI) network was set up in 2017 to support the Trust in promoting, delivering and embedding EDI in the everyday work of the Trust. Everyone who works at the Trust is automatically a member of the network.

Manisha Patel, chair of the network, says: "The vision is to create a workplace that is accessible, inclusive and innovative, enabling the Trust to deliver fair and equitable outcomes for staff, patients and carers."

The EDI network's core members are a group of staff with different skills who share common, positive values. The aim of the group is to use their collective knowledge, experience and expertise to improve the working environment.

The EDI network prioritises areas where the Trust appears to be underperforming in terms of inclusivity – recruitment, bullying and harassment, staff disciplinary outcomes and senior level BAME representation at Band 8 and above.

To address the latter, when recruiting to senior posts, all interviewing panels now include at least one person from a BAME (black and minority ethnic) group.

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 to conduct investigations.

Training

New elearning system for the trust

In April 2018, the education and development department introduced an easy-to-use e-assessment system, which enables staff to complete their mandatory training quickly online. Staff can also download an app on to their smartphones to complete their training.

The system is flexible and accessible any time and anywhere with internet connection. It is easy to register and learners can learn at their own pace and receive immediate feedback. The system has already had an impact on improving our mandatory training rates, which in March 2019 were at 86 per cent compared to 82 per cent last year.

Partnership: work effectively with partners organisations

"We are committed to working closely with our partners, including clinical commissioning groups (CCGs), local authorities, other NHS trusts and charities, to provide more coordinated care for local residents across the whole health and social care system."

Jim Lusby, Director of Integrated Care

Our Healthier South East London (OHSEL)

The Trust is a member of OHSEL, South East London's Sustainability and Transformation Partnership (STP), which brings together our health and social care partners to ensure we are doing all we can to get the best health outcomes for our populations. The partnership includes all of the hospitals, CCGs and councils in south east London.

The aim of the partnership is to work together to help local people lead healthier, longer lives and ensure that they have equal access to high quality healthcare. Current areas of focus include orthopaedics, maternity care, cancer diagnosis and advice, and mental health. OHSEL engages extensively with patients and the public when developing new models of care.

The NHS Long Term Plan, published in January 2019, says that, by 2021, all STPs will be known as Integrated Care Systems (ICS).

Improving community care

We are working closely with the other health and social care organisations in Lewisham – which are responsible for NHS community services – to transform community services and provide the best care for local people. The Trust is part of Lewisham Health and Care Partners, which also includes NHS Lewisham Clinical Commissioning Group, Lewisham Council, One Health Lewisham (a GP federation of 37 General Practices), South London and Maudsley NHS Foundation Trust and Lewisham Local Medical Committee.

Jim Lusby, Director of Integrated Care for Lewisham and Greenwich NHS Trust, said: "Developments over the last year include improving how we plan hospital discharges, with a joint team of health and care professionals helping patients to return home sooner. Over 2019/20 we will also be focusing on providing early treatment closer to home to keep people healthy and reduce the need for a stay in hospital. This includes the development of community hubs, where health and care professionals will be located together. Lewisham CCG is carrying out a major refurbishment of the Waldron Health Centre in New Cross to set up a hub there, supported by £1m of Government funding."

The development of the community hubs follows successful work in 2018/19 in expanding specialist outpatient care (also known as ambulatory care) at University Hospital Lewisham – including setting up a GP hotline, so GPs can get advice from hospital consultants on managing patients, and can book them in for appointments if needed.

Over 2019/20, Lewisham Health and Care partners is also looking at providing more timely treatment out of hospital for those most in need, including older patients who may have a range of health conditions. This work includes setting up joint community teams to carry out home visits.

Mental health café at UHL

In January 2019 we opened The Harbour, a new mental health crisis café, at University Hospital Lewisham. The Harbour is a joint venture between the Trust, South London and Mausdsley NHS Trust (SLaM) and Certitude, a mental health charity.

It provides peer support to people experiencing a mental health crisis, and offers people feeling distressed someone to talk to in a relaxed and calm non-clinical setting. This will help them avoid spending extended time in A&E or as an inpatient. It is not a walk-in service but takes hospital and community referrals for those aged 18 and over. The café is open from 2pm to 6am, seven days a week.

New renal dialysis centre at UHL

The Trust has worked with Guy's and St Thomas' Hospital (GSTT) to build a state-of-the art renal dialysis unit at University Hospital Lewisham.

Previously, GSTT, which runs the renal dialysis service along with specialist providers Diaverum, provided dialysis at a satellite unit in Forest Hill. The new unit at the hospital has 15 outpatient dialysis stations in a modern, spacious environment, which is important for patients who require dialysis three times a week. The new unit also has five inpatient dialysis stations, which means that inpatients will no longer have to be transferred to Guy's Hospital for dialysis, a round trip that could take up to eight hours. The new unit will also provide emergency dialysis, which was previously provided in UHL's intensive care unit, freeing up beds in the ICU.

The new renal dialysis centre

Ensuring better continuity of care enables patients to recover faster and return home sooner – reducing length of stay and freeing up hospital beds.

Red bag scheme

In May 2018 we introduced the red bag scheme to enable smoother transfers of care between care homes and hospital. The red bag contains vital information about the patient's health, such as any medication they are taking, as well as details such as what they like to be called, their personal preferences, their interests and history.

This key information allows all of those caring for the person to get to know the patient well in a short space of time.

The bag is kept with the patient throughout their hospital stay and is returned with them when they are discharged.

The red bag scheme is a collaboration between care homes for older adults in Lewisham, Bexley and Greenwich, Lewisham and Greenwich NHS Trust, London Ambulance Service, and Lewisham, Bexley and Greenwich CCGs. It originated in Sutton, where it was shown to lead to smoother transfers of care, increased communication between care homes and hospitals, better patient care and reduced length of hospital stay for care home residents.

Addressing high levels of falls in patients with dementia

In October 2018, the falls team at University Hospital Lewisham won a grant to address the high level of falls amongst residents with dementia in Lewisham care homes.

Occupational therapist Vicky Shaw was presented with the award at the South London Innovation Awards, run by Health Innovation Network in partnership with Health Education England.

The team is working with South London and Maudsley NHS Foundation Trust (SLAM) to train care home staff in assessing the risk of falls and managing residents with dementia. The aim is to produce and deliver a joint falls training programme that looks at falls from both a physical and psychological perspective.

Lewisham integrated medicines optimisation service

The Lewisham Integrated Medicines Optimisation Service (LIMOS) works across the University Hospital Lewisham, local care homes and community settings to ensure a seamless approach to managing medication, which ensures that transfers from one setting to another are smooth and trouble free.

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, and we hope this model of working will be adopted more widely across the health and social care sector."

Pathology to develop partnership with Barts and Homerton

NHS trusts are now required by NHS Improvement (NHSI) to consolidate pathology services into 29 'hub and spoke' networks across the country. The aim is for trusts to work together to improve services and save money. Initially, Lewisham and Greenwich NHS Trust was part of the south east London pathology procurement network, but the situation was complicated by the fact that King's and Guy's and St Thomas' have a commercial arrangement for their pathology services.

In July 2018, our Trust Board made the decision to exit the south east London pathology procurement network to pursue an NHS-only pathology partnership. After a detailed evaluation process, the Trust Board has agreed to enter a partnership with Barts Health NHS Trust and Homerton University Hospital to form a three-way equal partnership.

We will now work with our partners to agree a framework and set of principles before looking at the configuration of services and developing an operating model.

Money: Ensure we spend every penny wisely

"We worked hard to reduce our deficit in 2018/19, and I'm pleased to report that we achieved our target. For 2019/20 we plan to report an even smaller deficit while at the same time investing in our services for the future."

Seb Nai, Interim Chief Financial Officer

One of our key priorities is to manage our resources effectively and work in new and innovative ways to make the best use of taxpayers' money.

In 2018/19, we achieved our key financial targets in terms of the breakeven control total, external financing limit and capital resource limit. Most importantly, the adjusted deficit of £30.6m is an improvement of £27m on the £57.6m achieved last year.

The improvement was due, in large part, to additional provider sustainability funding from DHSC for improved performance; together with the initiatives introduced to control and push down expenditure, in all but essential areas, by process of better monitoring, scrutiny and approval of spending at every level across the Trust.

Next year we have signed up to a control total deficit of £43.6m. If we achieve this, we will receive more national funding, which will bring our deficit down to £14.8m. This would be an improvement of £15.8m on 2018/19 (£30.6m).

Building on our performance last year, we will not only continue to deliver improvements in our finances, but also invest in our services to support our long term recovery. This includes investing in urgent care, outpatients, quality improvement processes and the leadership team in order to transform our services and ensure they are fit for the future.

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 has reported that the Trust is a going concern (with no plans for any substantial changes to services), even though we will not be returning to financial balance in 2019/20. The auditors will also be reporting to the Secretary of State that the Trust did meet its financial targets in 2018/19.

Sustainability report

Reducing our carbon footprint

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 per cent (from a 1990 baseline). This is equivalent to a 28 per cent 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 for consideration by the board.

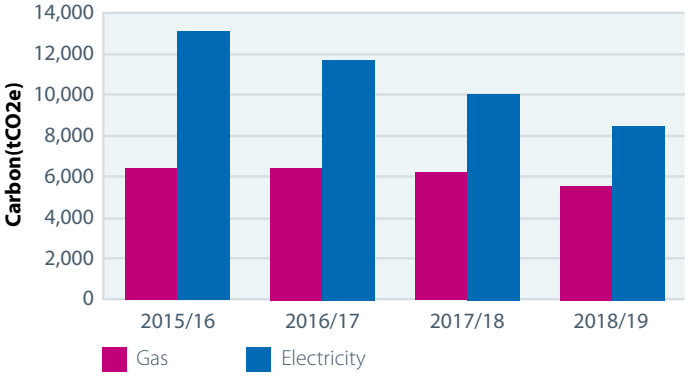
As an organisation we acknowledge our responsibility towards creating a sustainable future. To help us achieve that goal we run awareness campaigns that promote the benefits of sustainability to our staff.

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 heatwaves, 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 2018/19

Lewisham and Greenwich NHS Trust spent £3,990,370 on energy in 2018/19, which is 2 per cent higher than we spent on energy last year. The table below shows a 13 per cent reduction in CO2 emissions from 2017/18.

Carbon emissions



Carbon(tCO2e)	Gas	Electricity
2015/16	6,443	13,143
2016/17	6,457	11,766
2017/18	6,250	10,078
2018/19	5,607	8,514

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.

Planning for the future

Road map

During 2018 we consulted with staff and partner organisations to develop a road map for the future. The road map, published in January 2019, outlines where we are now as an organisation, the challenges we face and where we want to be in three years' time. We have set out our priorities and the programme of work that we believe will be needed to deliver on these. We have included details on how we will measure success and we will be reporting back to staff and partners on a regular basis. This includes engaging with staff, partners and patients to develop an overall Trust strategy by December 2019.

Our priorities

Quality
Continually improve safety and quality

Patients
Put patients at the heart of everything we do

People
Support and develop our workforce to live our values every day

Partnership
Work effectively with partner organisations

Money
Ensure we spend every penny wisely

Challenges to achieving success

We are proud of our organisation and our hard-working staff but we recognise that we face significant workforce challenges, including staff shortages. Overcoming these challenges will be a critical success factor in delivering our plans. We see many examples of great care on a daily basis but we also recognise that there is always room for improvement. Over the next three years, we want to improve how we support our staff to get it right for all patients consistently. This means continuing our drive to improve quality and improving how we listen to patients and staff to put them at the heart of how we work. It also means that we all work together to make sure that we provide our services within the finances available to us.

Improving recruitment and retention will help us to reduce our reliance on expensive external agency staff. We are also investing in our leadership team so that we can work more efficiently and mitigate financial risks. We recognise that we are on a journey and to get to where we want to be, we need to work closely with our staff, patients and partners.

Accountability report

Directors' report

Role of the Trust Board

Our Board plays a key role in shaping the strategy, vision and purpose of the organisation. Board members 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 2018/19 are listed below.

Voting

Ms Val Davison, Trust Chair
Mr John Ballard, non-executive director
Mr Harry Bright, non-executive director
Ms Sarah Higgins, associate non-executive director
Ms Sukhvinder Kaur-Stubbs, non-executive director
Ms Binka Layton, non-executive director
Prof Peter Littlejohns, non-executive director
Dr Julia Mundy, non-executive director
Ms Katherine Yeung, non-executive director
Dr Elizabeth Aitken, Medical Director
Mr Ben Travis, Chief Executive
Ms Angela Helleur, Chief Nurse
Ms Janet Lynch, Director of Workforce and Education/ Deputy Chief Executive
Mr Seb Nai, Interim Chief Financial Officer – from February 2019
Mr Usman Niazi, Interim Director of Finance and Information – until August 2018

Non-voting

Ms Kate Anderson, Interim Director of Corporate Affairs – from August 2019
Mr Keith Howard, Director of Estates, Facilities and Redevelopment
Ms Ann Johnson, Interim Director of Finance and Recovery – from September 2018 until February 2019
Mr Nigel Kee, Interim Director of Service Delivery – from February 2019
Mr Jim Lusby, Director of Integrated Care – from November 2018
Mr Lee McPhail, Chief Operating Officer – left July 2018
Mr Usman Niazi, Interim Director of Performance and Recovery – from August 2018 until February 2019
Ms Lynn Saunders, Director of Strategy, Business and Communications

How the Board is appraised

The Chief Executive is appraised by the chair who also appraises the non-executive directors. A senior non-executive director undertakes the Chair's appraisal, which is then reviewed by NHS Improvement. The Chief Executive 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 and risk committee, which meets five times a year and approves the annual accounts and annual report. Over 2018/19, membership of the audit committee included:

- John Ballard, audit and risk committee chair until September 2018
- Binka Layton, audit and risk committee chair from September 2018
- Peter Littlejohns
- Julia Mundy
- Katherine Yeung

The other Board committees are the finance and performance committee, remuneration committee, workforce and education committee, strategic projects committee and quality governance committee.

Details of company directorships and other significant interests

The register of interests for Board members is in the table below, as of March 2019:

Name	Declaration
Dr Elizabeth Aitken	Nil
Ms Kate Anderson	Chair of Healthcare Financial Management Association London Branch
Mr John Ballard	Nil
Mr Harry Bright	Nil
Ms Val Davison	Director of Dulwich Consulting Ltd Undertakes consultancy for NHS organisations and organisations doing business with the NHS
Ms Angela Helleur	Various clinical negligence and litigation teams Expert witness midwifery No formal connection but undertakes services as an independent expert witness in an advisory role.
Ms Sarah Higgins	Nil
Mr Keith Howard	Nil
Ms A Johnson	Nil
Ms Sukhvinder Kaur-Stubbs	MD of Engage-Us Ltd Member, London Legacy Development Corporation CEO of Citizens Advice Lewisham (CAL) – local charity providing information and advice that sometimes relates to health and social care
Mr Nigel Kee	Nil
Ms Binka Layton	Nil
Mr Peter Littlejohns	Nil
Mr Jim Lusby	Married to a civil servant in the Department of Health
Ms Janet Lynch	London Vice President of Healthcare People Management Association
Mr Lee McPhail	Nil
Dr Julia Mundy	Employee of University of Greenwich Audit & Risk Committee of the UK Statistics Authority (from June 2018)
Mr Seb Nai	Nil
Mr Usman Niazi	Partner works as Deputy Director of the SEL Commissioning Support Unit, SEL team
Ms Lynn Saunders	Nil
Mr Ben Travis	Director (appointed by Oxleas) of SARD JV Ltd, which sells medical revalidation software to the NHS, including LGT. Stood down as director in June 2018. No current involvement in the company
Ms Katherine Yeung	Employee, BT Group Ltd

Statement of the Chief Executive's and directors' responsibilities

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

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

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

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

Ben Travis, Chief Executive
28 May 2019

Statement of directors' responsibilities in respect of the accounts

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

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

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

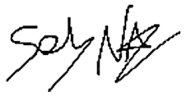
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

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

The directors confirm to the best of their knowledge and belief that there is no relevant audit information of which the entity's auditors are unaware, and the Accounting Officer has taken all the steps they ought to have taken to make themselves aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

By order of the Board

Ben Travis, Chief Executive
28 May 2019



Seb Nai, Interim Chief Financial Officer
28 May 2019

Governance statement signed by accountable officer

1. Scope of responsibility

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

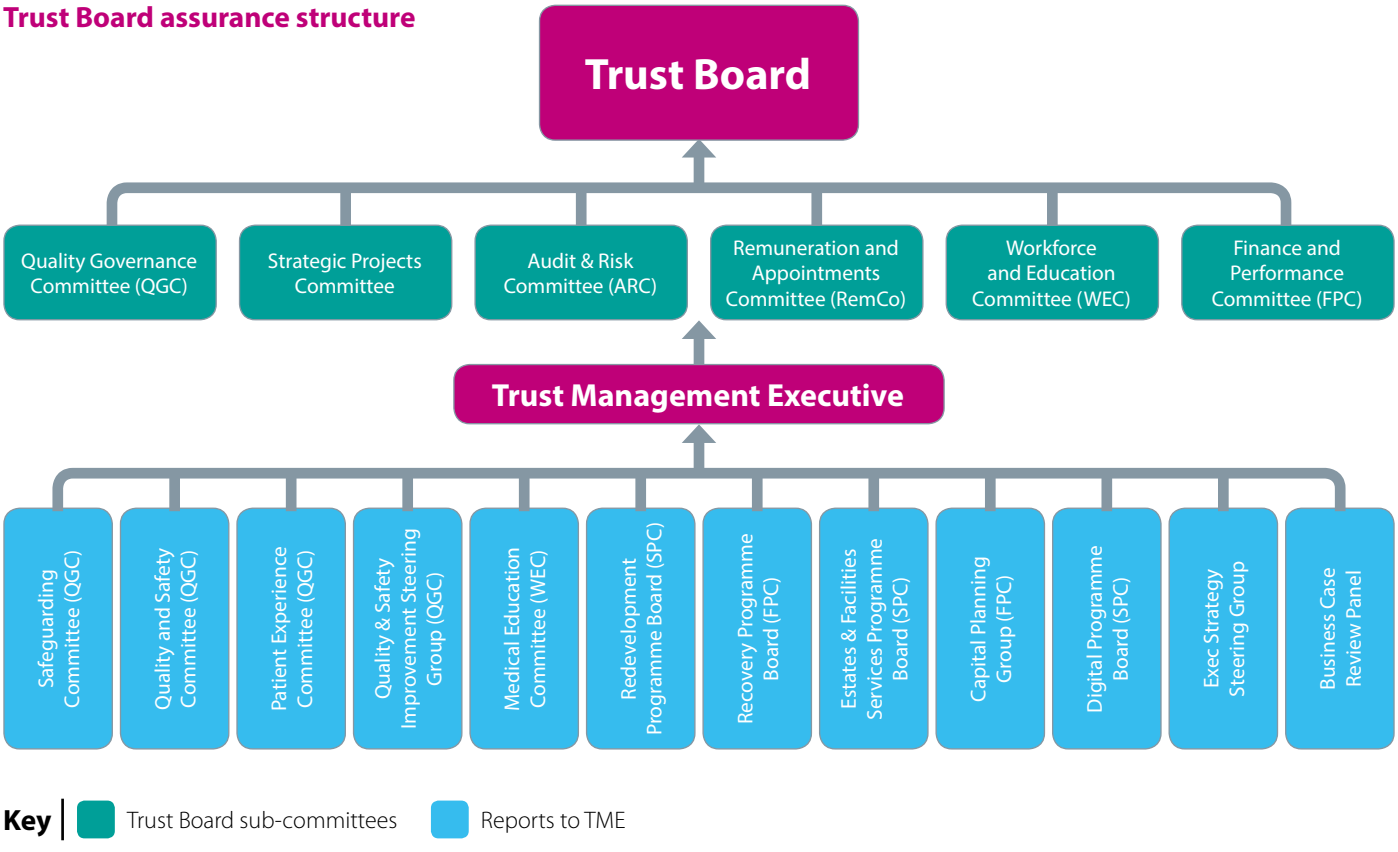
I report to the Chair of the Trust and ensure appropriate systems exist to support the work of the Trust and the Board. I manage the executive team who have clear accountabilities and annual objectives, drawn from the annual operating plan for the Trust which sets out our approach to planning and the delivery of agreed priorities and how we will work with partner provider and commissioning organisations across the South East London Sustainability and Transformation Partnership.

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Trust Board assurance structure



3. The governance framework of the organisation

The Trust has described its corporate governance arrangements in the Corporate Governance Manual 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 risks 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.

4. The Trust Board

The Trust Board consists of five voting executive directors, eight voting non-executive directors (including the Chair), one non-voting associated non-executive director and five non-voting executive directors. The Trust Board meets ten times a year in public, with minutes and papers available on the Trust's website. The Board also meets four times a year for Board seminars, and twice a year for Board away days. Attendance at Trust Board meetings by Board 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 2018/19.

Following previous self-assessment exercises in 2016 and 2017, in 2018 the effectiveness of the Board was considered as part of the Care Quality Commission's 'well led' assessment. The Board plans to follow this up by undertaking a further self-assessment in the 2019/20 period.

In 2018/19 the Trust entered into a partnership arrangement with NHS Providers to develop a comprehensive Board Development programme, which is being delivered from February 2019 over a period of 12–18 months.

During the 2018/19 period, two non-executive appointments were made to the Board to replace leavers, including an associate non-executive director. There were also a number of changes to the Executive team. These changes included the appointment of a new Chief Nurse, and a number of Interim arrangements put in place to cover the director roles for finance, workforce and education, service delivery, performance and corporate affairs. These posts will be substantively recruited to during the 2019/20 period.

Summary of public Board activity and points of note

During the 2018/19 period, the Board met ten times in public as described by the Trust's 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 routinely received reports from its committees, as well as reports that are required by legislation or national guidance. The Board agenda regularly included a patient or staff story, presentations or reports about clinical work in the Trust, and reports relating to patient safety and quality including the CQC Inspection Report and resulting action plan.

The Board regularly discussed the changing local operational picture noting developments in the South East London Sustainability and Transformation Partnership, current capacity issues and planning for winter pressures. The Board also took assurance from the implementation of the programme of visibility visits – which has involved Board members visiting and observing clinical areas. Working in pairs, non-executive and executive directors have 'adopted' divisions for a twelve-month period, spending time visiting different areas of the hospital, to understand the challenges faced by each area, and taking part in quality assessments and environmental audits.

During 2018/19, the Board has considered input from a range of stakeholders including:

- **Patients:** Via the Trust's Annual General Meeting and question and answer sessions before each Board meeting. The Trust also engages with patient groups – including Healthwatch, the Patient Welfare Forum and the Patient User Group – through the Patient Experience Committee.
- **Public/voluntary sector:** During 2018/19, the Trust ran a campaign to recruit lay members for Committees of the Board, the Strategic Projects, Workforce and Education, and Quality Governance Committees all now have appointed lay members. A further campaign for the Finance and Performance and Audit and Risk Committees will be undertaken in 2019/20. In addition to the appointment of lay members to Board Committees, the Trust has hosted information stalls at community events across the boroughs of Lewisham and Greenwich, and organised membership events, including patient workshops (on topics such as developing the Trust's values and improving facilities management). The Trust has also undertaken wider public surveys to influence key workstreams, including the development of the organisation's values.
- **Staff:** The Board is informed of staff views from the staff surveys, the Staff Friends and Family test, by members of the Trust management, on Board walkabouts and visibility visits and by discussions during the monthly Trust Joint Partnership Committee. The Trust also holds regular staff feedback and engagement events.
- **GPs and clinical commissioners:** The views of provider and commissioner GPs are of key importance to the Board. The Trust engages with GP commissioning, provider and educational leads in a number of ways to ensure it responds to the needs of our local population and to the views and expectations of those responsible for commissioning services for them. In practice these relationships are maintained through daily dialogue, as well as more formal interaction with CCG governing bodies and clinical committees. Good relationships are also being developed with the GP federations in each borough

and the Trust is participating proactively in discussions around the development of Primary Care Networks at neighbourhood level. The Trust is engaged in the development of place-based governance at borough level as part of the development of Integrated Care Systems across South East London. Increasingly this will provide the framework through which partnerships will evolve and be strengthened between the Trust and local GPs as well as with other providers.

In 2018 the Board governance structure was reviewed, with the following changes made to the committee structure from September 2018:

- The Redevelopment Committee was disbanded and a Strategic Projects Committee was established as a formal committee of the Trust Board;
- The Integrated Governance Committee was renamed the Quality Governance Committee;
- The Finance and Investment Committee was renamed the Finance and Performance Committee, and the remit of this committee was refocused to more explicitly include consideration of performance.
- Workforce and Education Committee was made a monthly meeting, having previously met bi-monthly.

The remit, membership and Terms of Reference for all Board committees were updated as part of this review.

The Board receives a written summary report from each committee chair at the following public board meeting and each Committee is required to submit an annual report.

5. 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.

All Trust divisions maintain risk registers which are now reviewed on a monthly basis and reported through Divisional Governance Boards, with top divisional risks being reported to the Trust Management Executive.

Risks are escalated to the Board via a variety of mechanisms:

- The Audit and Risk Committee and Trust Board receive details of significant risks through the quarterly presentation of the Corporate Risk Register and Board Assurance Framework.
- All Board committees review the corporate risks related to the committees on a monthly basis where they are reviewed.

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

Reports from all external reviews and inspections are also presented to the Trust Management Executive and Quality Governance Committee – with any identified risks, concerns and gaps in compliance considered, together with appropriate mitigation and actions plans to address identified deficiencies.

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 Divisional 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 which contains the themes, root causes and learning from incidents.

The Trust also produces quarterly thematic reviews of complaints, claims and litigation and areas of risks associated with the themes are reported and detailed in the reports. These are presented quarterly to the Trust Management Executive, the Quality Governance Committee and Trust Board on a quarterly basis.

The Trust's Raising Concerns (whistleblowing) Policy has been reviewed and updated and the draft policy is currently out to consultation with a view that it will be finalised early in the 2019/20 period. The Trust has reviewed local processes and arrangements in response to the CQC feedback on the Trust's Freedom to Speak Up framework and has an action plan in place to implement recommendations. The Trust has designated 'Freedom to Speak Up' Guardians to facilitate any concerns raised by staff and also has in place a Guardian of Safe Working Hours for junior doctors.

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 is generated through the assessment process of all risks at divisional level, and is 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 include:

- 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 / Visibility visits by Executive and Non-Executive Directors
- Patient-Led Assessment of the Care Environment inspections; and
- Public attendance and questions at Trust Board meetings.

6. 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 Medical Director is the executive lead for patient safety, supported by the Chief Nurse. 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 provided to the Trust Board.

The Chief Financial Officer is the lead executive for financial risk and accountable for effective financial control and appropriate internal and external audit.

Trust Audit and Risk Committee

This Board 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 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 TME is chaired by the Chief Executive and membership consists of Executive Directors, Divisional Medical Directors, Divisional Directors of Operations and Divisional Directors of Nursing and Governance. The TME 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.

Audit managers from KPMG (internal audit) and Grant Thornton (external audit) attend all Audit and Risk 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 for quality and safety are reviewed at the Trust Quality & Safety and Quality 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.

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 on top risks are presented to the TME and divisional operating plan reviews.

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 2018/19 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.

7. Risk and control framework

The Trust Management Executive reviews the Corporate Risk Register on a monthly 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.

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 establishes basis of 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. During 2018/19 processes for the management of all divisional and corporate risks were updated to reflect the revised sub-board committee structure. As a result of this, a revised risk management policy was approved by the Audit and Risk Committee in December 2018.

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.

8. Care Quality Commission

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

In September 2018, the CQC undertook a planned focused inspection, as well as 'use of resources' and 'well led' assessments following the Trust wide inspection undertaken in March 2017. The CQC awarded the Trust an overall rating of 'requires improvement'. Although the overall rating for the Trust has not changed since the previous inspection, it was noted that there had been many improvements across the core services and hospital sites.

Compared to the March 2017 Inspection report, an improvement has been achieved in the ratings of 11 service area domains, and a deterioration noted in one area/domain rating (surgery, effectiveness).

This inspection also resulted in the removal previous 'Inadequate' ratings – in particular the inadequate end of life care ratings at the QEH site.

The CQC issued two Requirement Notices for breaching the statutory regulations;

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (related to Medicines Management)
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

The Trust submitted its formal action plan response to the regulation breaches in February 2019, which was presented to the Trust Board.

The Trust's response, articulated via the Board approved action plan, has been developed to address the findings within the CQC report. The Trust has an established the Quality and Safety Improvement Group which oversee the monitoring and progress against the actions set out in the Trust's internal action plan. The Quality and Safety Improvement group reports to the Quality & Safety Executive Steering Group, chaired by the Chief Executive, which in turn reports through to the Quality Governance Committee on a monthly basis and the Trust Board quarterly.

9. Review of economy, efficiency and effectiveness of the use of resources

As noted above, the CQC undertook an assessment of the Trust's Use of Resources in September 2018. There are a number of processes used by the Trust to deliver economy, efficiency and effectiveness of the use of resources. These include:

- Use of standing financial instructions;
- Efficient use of electronic procurement with workflow;
- Regular, systematic and risk based Internal audit;
- Detailed bottom-up process for budget setting and business cases; and
- Financial and efficiency benchmarking at Trust level against other NHS trusts, in recent periods this has been facilitated by the development and use of the 'Model Hospital' database.

10. Annual Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Quality Accounts detail the Trust's performance against a series of quality indicators and detail the Trust's plans to continually improve the quality of its services. The Quality Accounts are developed internally, and shared with local health partners before, review by the Trust's external auditors (Grant Thornton), and submission to the Secretary of State by uploading it to the NHS website.

The Deputy Director of Governance co-ordinates the production of the Trust's Quality Account, with the Medical Director, as Chair of the Quality and Safety Committee, leading on the patient safety and clinical quality sections patient experience and infection control areas

11. 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.

12. Clinical Audit

The Trust has an established Clinical Audit programme as detailed in the Trust's Quality Account. The programme aims to drive continuous improvement of services and quality of care. The Clinical Audit Programme priorities in 2018/2019 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 both the Quality & Safety and Quality Governance Committees.

13. 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, and in May 2018, the new legislation for GDPR Regulations came into force and introduced a new set of performance standards/ regulations. The new regulations have been implemented across the Trust and are subject to a new self-assessment toolkit (known as the Data Security Protection Toolkit) which all health and social care organisations must comply with. The Trust's compliance is reviewed on an annual basis through our internal audit programme and is reviewed by the Care Quality Commission (CQC) as part of CQC well led inspection.

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 and Data Protection. The Trust has an established Information Governance Steering Committee (IGSC) which meets monthly and is chaired by the Head of Information Governance. The Trust's Caldicott Guardian is a member of this Committee. The Steering Committee reports into the Trust's Digital 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 and or Data Protection between 1st April 2018 and 31st March 2019 (as defined by the Trust Incident Reporting and Management policy).

14. Data quality

Poor data quality affects all aspects of the Trust – patient safety, performance against national targets, Income and reputation, improving the quality of Trust data is a key priority for the coming year.

Over the past year a number of data quality audits have been completed looking at data recording and data quality issues across wards, Emergency Departments (ED) and outpatient areas (OPDs), with the audit reports being shared with the Division for them to identify improvement actions. The DQ audit programme is a mix of revising areas already audited to confirm improvements in DQ have taken place as well as looking at new areas.

Daily analysis of all patients with current activity or on the Trust waiting lists are being carried out to confirm that the main demographic details match the NHS Spine and the main patient systems are synchronised with the Spine for these patients. Daily reports are also being sent out to service staff identifying data quality issues that require immediate action.

In addition to the Information Steering Committee receiving a monthly Data Quality scorecard and being briefed on data quality issues and risks, a new body (The Data Assurance Committee (DAC) is being established to co-ordinate and monitor improvement actions. The DAC will look at data quality across clinical and corporate areas, and be led by a member of Trust Management Executive (TME) with membership drawn from clinical divisions and corporate areas who will be responsible for leading the improvement agenda in their areas.

The move to using live data for reporting across ED, bed occupancy and RTT highlights where data is not being updated in a timely manner. This is clearly an issue when data is being used to manage live situations where patient flow data (ED arrivals, inpatient admission and discharges) does not reflect the situation on the ground.

The Data Quality team has communicated the importance of recording data accurately via a screensaver and staff updates. Whilst this has been well received, further work through 2019/20 is required to increase the understanding of the wide-ranging and serious effects of poor data quality.

15. Counter fraud

The anti-fraud, bribery and corruption work carried out during the financial year 2018/19 is currently being assessed by the Trust against the NHS Counter Fraud Authority Standards for Providers 2019/20 - Fraud, Bribery and Corruption/NHS Standard Contract. Following the annual Self-Review Toolkit return on 31st March 2018, changes to the standards were incorporated into the 2018/19 annual counter fraud plan to improve ratings not assessed as green.

16. Register of interests

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. This is published annually on the Trust's website.

17. Workforce

The Workforce Committee endorsed the Trust's two-year Workforce Strategy to 2021 which focuses on four main themes: staff satisfaction and retention, recruitment, leadership and improving our collective workforce processes with 11 key goals. As part of the wider development of the strategy the key challenges and risks the Trust faces have been acknowledged with clear goals identified. The committee agreed a new reporting format to update the committee monthly on key progress.

Workforce planning is undertaken with active engagement and in collaboration with services, professional leads, finance and workforce. Workforce plans are reviewed and risk-adjusted to ensure that they are able to meet the Trust's key workforce targets, including reductions in vacancies and temporary staffing spend. Reviews of the workforce and establishments take place throughout the year with services with key stakeholders for the process in attendance, including at bi-monthly workforce review meetings, quarterly Operating Plan Review meetings where divisional performance against these trajectories is monitored and any associated risks for delivery are identified. Plans are submitted to the Board annually, and we intend to present at our Workforce and Education Committee on a six-monthly basis. We will be working over the course of 2019/20 to ensure that all the recommendations within the 'Developing Workforce Safeguards' are in place and embedded.

We expect teams to have effective operational controls. Rosters (non-medical) are published in advance to allow managers and staff to be assured of staffing levels and service needs on an operational level through the year. We monitor vacancy levels at directorate and staff group level to ensure that any risks are anticipated and mitigated. Induction and appraisal processes are in place and are tracked and monitored on a monthly basis to ensure that staff are supported at work. There are clear processes to support services with temporary staff of the appropriate levels of skills and competencies should the need arise and to ensure that patient care is prioritised at all times.

We review our safe staffing levels by triangulating a range of quantitative and narrative sources of information that are tracked over time, including benchmarking data, average fill rates for RNs and HCAs, turnover, sickness, bank and agency staff usage, incidents, compliments and complaints, roster KPIs, and PDR reviews and professional judgement reviews. We are currently reviewing rostering practice within the medical workforce with a view to ensuring that good practice identified in other staff groups is replicated and embedded.

18. Sustainable development

The Trust has undertaken risk assessments and a sustainable development management plan is being developed by the Trust which takes account of UK Climate Projections 2018 (UKCP18). As a public organisation the Trust acknowledges its 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. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

19. Other aspects

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

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

20. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed 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. The 2018/19 Head of Internal Audit opinion is one of: 'Significant assurance with minor improvements required: Our work has confirmed that there is generally a sound system of internal control which is designed to meet the Trust's objectives and that controls in place are being consistently applied in all key areas reviewed'. During the period KPMG completed 12 reviews. Of these, 10 reviews received an overall assurance rating of 'significant assurance with minor improvement opportunities', and two reviews received an overall assurance rating of 'partial assurance with improvements required' (Health and Safety and Child Safeguarding).
- The findings and recommendations detailed within reports of the Care Quality Commission. As noted above, in 2018/19 the CQC undertook a planned focused inspection, as well as 'use of resources' and 'well led' assessments following the Trust wide inspection undertaken in March 2017. The CQC awarded the Trust an overall rating of 'Requires Improvement'. In this report the CQC issued the Trust with two Requirement Notices for breaching statutory Regulations;
  - Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (related to Medicines Management)
  - Regulation 18 HSCA (RA) Regulations 2014 Staffing.

- 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 provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation in achieving its strategic objectives have been regularly reviewed.
- The Trust's committee structures ensure sound monitoring and review mechanisms to make certain that the systems of internal control are working effectively.
- External auditor assurances provided through the annual opinion on the financial statements, a value for money conclusion and the external auditor's report on the annual Quality Accounts.
- Clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.
- Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports and mortality monitoring; reports from external assessments.

21. Concluding statement

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Risk Committee and other Committees of the Trust Board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

This report sets out an open and balanced reflection of the Trust's progress over the past year. The Board and Executive have a clear understanding of the significant issues facing the Trust to address its workforce, financial and performance challenges and the work it must focus on during the 2019/20 and beyond to address these.

During 2018/19, the Trust has received two requirement notices from the CQC during the period (relating to medicines management and staffing), and two 'partial assurance' Internal Audit assurance reports (relating to audits of Health and Safety and Child Safeguarding). In response to these adverse findings, I am satisfied that appropriate action plans are in place to address the deficiencies identified, and improve the effectiveness of the system of internal control in place for these areas. With these exceptions, 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.

Ben Travis, Chief Executive
28 May 2019

Protecting data

Information governance

Information governance (IG) refers to the way in which the NHS handles all data in a secure and confidential manner – in particular the personal and sensitive data of patients and employees. Effective information governance is about ensuring that personal confidential data 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 data security and protection toolkit assessment. This is an online self-assessment which allows NHS and other related organisations to demonstrate whether they are compliant in data security and data protection standards.

The new Data Security and Protection Toolkit came into force in July 2018 and the Trust is required to upload evidence to support this assessment. The new toolkit gives the auditors, who review the toolkit, extra powers to ensure the Trust is compliant with the standards.

The auditors have given the Trust "substantial assurance with minor amendments". Therefore the toolkit has published that all the 10 standards have been met.

Information governance incidents for 2018/2019

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

From April 2019, as directed by the Department of Health and NHS Digital, the IG incident matrix will be redesigned in line with the standard Trust risk matrix. However, any incidents above Level 12 will be reported to the Information Commissioner's Office (ICO) and any incidents above Level 15 will be reported to NHS Digital as well as the ICO.

During 2018/19 the Trust had no serious incident at Level 2 and 111 incidents at Level 1.

Level 2 incident

There were no level 2 incidents.

Level 1 incidents

A breakdown of the 111 incidents marked at Level 1 were categorised as follows:

Level 1 personal data related incidents 2018/2019	
Breach	**Total**
Access issues	1
Confidentiality issue	1
Disclosed in error	1
Documentation issue	32
Identifiable issues	1
Inappropriate photo taken	2
Lost or stolen hardware	1
Lost or stolen hardware	3
Non secure disposal	7
Other IG breaches (near miss)	45
Unauthorised disclosure	16
Upward to website in error	1
Total	111

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.

Also for 2019/20, IG training at the Trust will focus on incidents as well as the legalities of information governance.

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.

Salary and pension entitlements of senior managers - remuneration - audited

Name		Title	Salary (bands of £5,000)	Expense payments (Taxable) Nearest £100	Performance pay and related bonuses (bands of £5,000)	Long term performance related pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	2018/19 Total (a-e) (bands of £5,000)	2017/18 Total (bands of £5,000)
1. Executive Directors									
Ben Travis		Chief Executive	185-190	-	-	-	90-92.5	275-280	-
Sebastian Nai	(1)	Interim Chief Financial Officer from 07 Feb 19	-	-	-	-	-	-	-
Usman Niazi	(2)	Interim Director of Finance to 31 Jul 18	110-115	-	-	-	75-77.5	190-195	320-325
Elizabeth Aitken	(3)	Medical Director	205-210	-	-	-	50-52.5	260-265	230-235
Janet Lynch		Director of Workforce and Education and Deputy Chief Executive to 28 Feb 19	140-145	-	-	-	32.5-35	175-180	300-305
Angela Helleur		Chief Nurse	130-135	-	-	-	62.5-65	195-200	-
2. Other members of the Board									
Ann Johnson		Interim Director of Finance from 01 Aug 18 to 07 Feb 19	190-195	-	-	-	-	190-195	-
Lynn Saunders	(4)	Director of Strategy, Business and Communications	90-95	-	-	-	-	90-95	90-95
Keith Howard		Director of Estates and Facilities	130-135	-	-	-	52.5-55	185-190	145-150
Kate Anderson		Interim Director of Corporate Affairs from 13 Aug 18	60-65	-	-	-	22.5-25	85-90	-
Nigel Kee		Director of Service Delivery from 11 Feb 19	20-25	-	-	-	-	20-25	-
James Lusby	(5)	Director of Integrated Care Development from 26 Nov 18	25-30	-	-	-	-	25-30	-
Lee McPhail		Chief Operating Officer to 06 Sep 18	60-65	-	-	-	-	60-65	140-145
3. Chair & non executive directors									
Val Davison		Chair	35-40	-	-	-	-	35-40	35-40
John Ballard		Non-Executive Director	5-10	-	-	-	-	5-10	5-10
Sukhvinder Kaur-Stubbs		Non-Executive Director	5-10	-	-	-	-	5-10	5-10
Harry Bright		Non-Executive Director	5-10	-	-	-	-	5-10	0-5
Binka Layton		Non-Executive Director	5-10	-	-	-	-	5-10	0-5
Julia Mundy		Non-Executive Director	5-10	-	-	-	-	5-10	5-10
Peter Littlejohns		Non-Executive Director	5-10	-	-	-	-	5-10	0-5
Katherine Yeung		Non-Executive Director	5-10	-	-	-	-	5-10	-
Sarah Higgins		Associate Non-Executive Director (non-voting)	5-10	-	-	-	-	5-10	-
4. Payments to past directors and senior managers									
John Hennessey	(6)	Past Director for the period from 01 Apr 18 to 30 Jun 18	45-50	-	-	-	-	45-50	125-130
Lee McPhail	(6)	Past Director for the period from 07 Sep 18 to 31 Mar 19	80-85	-	-	-	-	80-85	-

(1) Sebastian Nai is seconded from NHSI, his pay and pension information was not received in time from NHSI to be included in the table above.

(2) Usman Niazi was Interim Director of Performance & Recovery from 01 Aug 2018 to 11 Feb 2019 as a non-voting member on the board. During this time his salary was £65K-70K which is included in the above figures.

(3) Elizabeth Aitken's salary includes both Clinical and Medical Director earnings

(4) Lynn Saunders is part time

(5) James Lusby's employment is part of a shared arrangement with the South East London Sustainability and Transformation Partnership (hosted by Southwark CCG), 50% of his remuneration is recharged to Southwark CCG. His total remuneration was £50K-£55K.

(6) During the noted periods both directors were seconded to other NHS organisations.

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.

Salary and pension entitlements of senior managers - pension benefits - audited

Name		Title	Real increase/(decrease) in pension at age (bands of £2,500)	Real increase/(decrease) in pension lump sum at age (bands of £5,00)	'Total accrued pension at age 31 March 2019 (bands of £5,000)	'Lump sum at pension age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018 £000s	Real Increase in Cash Equivalent Transfer Value £000s	Cash Equivalent Transfer Value at 31 March 2019 £000s	Employers Contribution to Stakeholder Pension £000s
Ben Travis		Chief Executive	5-7.5	5-7.5	30-35	60-65	382	131	524	-
Usman Niazi		Interim Director of Finance to 31 Jul 18 and Interim Director of Performance & Recovery to 11 Feb 19	2.5-5	0-2.5	15-20	-	119	72	195	-
Sebastian Nai	(1)	Interim Chief Financial Officer from 07 Feb 19	-	-	-	-	-	-	-	-
Angela Helleur		Chief Nurse	2.5-5	10-12.5	50-55	160-165	1,029	183	1,243	-
Elizabeth Aitken		Medical Director	2.5-5	0-2.5	60-65	95-100	832	155	1,012	-
Janet Lynch		Director of Workforce and Education and Deputy Chief Executive to 28 Feb 19	2.5-5	0-2.5	55-60	155-160	1,047	156	1,235	-
Kate Anderson		Interim Director of Corporate Affairs from 13 Aug 18	0-2.5	0-2.5	5-10	-	-	59	59	-
Nigel Kee		Director of Service Delivery from 11 Feb 19	(2.5)-0	(2.5)-0	35-40	110-115	723	86	831	-
Keith Howard		Director of Estates and Facilities	2.5-5	7.5-10	30-35	95-100	-	-	-	-

(1) Sebastian Nai is seconded from NHSI, his pay and pension information was not received in time from NHSI to be included in the table above.

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.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Exit packages 2018/19 - audited								
Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £	Number of other departures agreed Number	Cost of other departures agreed £	Total number of exit packages Number	Total cost of exit packages £	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £000s
<£10,000	1	3,742	11	60,244	12	63,986	0	0
£10,000 - £25,000	0	0	5	63,352	5	63,352	0	0
£25,001 - £50,000	1	32,718	1	27,283	2	60,001	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	2	36,460	17	150,878	19	187,338	0	0

Analysis of other departures - audited		
	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	17	151
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	17	151

Highest paid director and median pay of workforce

Audited

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, full time equivalent, annualised total remuneration of the highest paid director in Lewisham and Greenwich NHS Trust in the financial year 2018/19 was £365K-£370K (2017/18 £205K-210K). This was 10.06 times (2017/18 6.02 times) the median remuneration of the workforce, which was £36,536 (2017/18 £34,495). The change arises from the highest paid director last year being the Medical Director, this year with the appointment of an Director of Finance on an interim basis from 1 August 2018 to 7 February 2019 resulted in the increase.

In 2018/19 no employees received remuneration in excess of the highest-paid director (one in 2017/18). Remuneration ranged from £10K-£15K to £365K-£370K (2017/18 £5-10 to £210K-£215K).

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

Median pay and highest paid director			
		2018/19	2017/18
Pay of highest paid director (Bands of £5,000)	*	365-370	205-210
Median pay		£36,536	£34,495
Median as multiple of highest paid director		10.06	6.02

* The highest paid director (£365K-£370K) is the annualised costs - based on actual cost to the Trust for the 6 month period from 01-Aug-18 to 07-Feb-19. 2017/18 has been amended to disclose the highest paid director salary in bands of £5,000.

Off-payroll engagements

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

Off-payroll engagements longer than six months	
	Number
Number of existing engagements as of 31 March 2019	-
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	-
for between two and three years at the time of reporting	-
for between three and four years at the time of reporting	-
for four or more years at the time of reporting	-

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

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

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Off-payroll board member/senior official engagements	
	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	21

Staffing report

Our staffing profile

At the time of writing (March 2019), we have 4,739 full time members of staff. In addition a total of 1,662 employees work part-time, making up 26 per cent of the Trust's permanent workforce. We have recruited 1,282 new members of staff in the last year and recruitment continues to be a key priority for the Trust.

The Trust's most recent workforce equalities report is available on our website (www.lewishamandgreenwich.nhs.uk/equality) or on request (tel: 020 8333 3297). We regularly analyse our staffing profile so we can take action where any groups are under-represented.

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

- 80 per cent of the Trust's overall permanent workforce is female
- 74 per cent of all senior managers are female. This represents a 9 per cent increase since the last report
- 58 per cent of directors in the organisation are female. This represents a 2 per cent increase since the last report.

The Trust has an ethnically diverse workforce. Black and minority ethnic (BAME) employees make up 49 per cent of the Trust's permanent workforce. In general though, there is a lack of BAME representation amongst staff at higher pay grades. This is an issue that the Trust is committed to addressing, and continues to feature as a focus for action within our equality objectives.

The disability breakdown of the trust's permanent workforce is as follows:

- 3 per cent of permanent staff have stated they have a disability
- 82 per cent have stated they do not have a disability
- 15 per cent of staff have chosen not to disclose information with regards to disability

Equality, diversity and inclusion

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 (EDS) for the NHS, the Workforce Race Equality Standard (WRES) and from April 2019 the Workforce Disability Equality Standard (WDES).

The WRES and WDES seek to ensure that black and minority ethnic (BME) and disabled staff are treated fairly within NHS organisations.

The EDS is a tool designed to support NHS commissioners and providers to deliver better outcomes for patients and communities, and better working environments for staff. It provides a framework for assessing performance and setting equality objectives. The trust is currently engaging with staff and service users to review its overall performance on equality matters, using the EDS framework. It is anticipated that this work will be complete by June 2019 and will inform the equality objectives for the next two years.

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 9 on page 79 of the annual accounts.

Staff costs - audited				
	Permanent	Other	2018/19 Total	2018/18 Total
	£000	£000	£000	£000
Salaries and wages	240,307	44,211	284,518	273,740
Social security costs	26,369	3,583	29,952	28,801
Apprenticeship levy	1,397	-	1,397	1,341
Employer's contributions to NHS pensions	28,823	2,181	31,004	29,463
Pension cost - other	9	4	13	5
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	151	-	151	246
Temporary staff	-	23,887	23,887	23,223
Total gross staff costs	**297,056**	**73,866**	**370,922**	**356,819**
Recoveries in respect of seconded staff	(3,580)	-	(3,580)	-
Total staff costs	**293,476**	**73,866**	**367,342**	**356,819**
Of which				
Costs capitalised as part of assets	894	841	1,735	1,411

Average number of employees (WTE basis) - audited				
	Permanent	Other	2018/19 Total	2018/18 Total
	Number	Number	Number	Number
Medical and dental	918	118	1,036	984
Ambulance staff	-	-	-	-
Administration and estates	1,188	213	1,401	1,389
Healthcare assistants and other support staff	788	247	1,035	1,020
Nursing, midwifery and health visiting staff	2,092	487	2,579	2,545
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	1,016	104	1,120	1,108
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	5	-	5	6
Total staff costs	**6,007**	**1,168**	**7,175**	**7,052**
Of which				
Costs capitalised as part of assets	16	20	35	26

Staff sickness absence

Staff sickness - audited		
	2018/19	2017/18
	Number	Number
Total days lost	60,771	55,764
Total staff years	5,715	5,636
Average working days lost	10.6	9.9

Ben Travis, Chief Executive
28 May 2019

Parliamentary accountability and audit report

Parliamentary accountability

Lewisham and Greenwich 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 99.

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

Report on the audit of the financial statements

Opinion

We have audited the financial statements of Lewisham and Greenwich NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 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 2018-19; 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.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates the Trust has agreed a deficit control total of £14.751 million for 2019/20 and that a corresponding level of revenue cash support is shown in its 2019/20 operating plan submission. The Department of Health and Social Care (DHSC) has not confirmed that it will provide this support.

As stated in note 1.2, the Trust does not presently have a plan for how it will repay DHSC revenue support loans totalling £157.654 million, of which £45.555 million is repayable in 2019/20.

These events or conditions, along with the other matters as set forth in note 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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

We have nothing to report in respect of the above matters except on 15 May 2018 we referred a matter to the Secretary of State under section 30a of the Local Audit and Accountability Act 2014 in relation to the Trust's setting of a deficit budget for the year ended 31 March 2019 and ongoing breach of its three-year statutory break-even duty.

Responsibilities of the directors and those charged with governance for the financial statements

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

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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 matters 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 2019.

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 year of £38.5 million in its financial statements for the year ending 31 March 2019 after receipt of £23.3 million of additional income from the Provider Sustainability Fund. This deficit exceeded the Trust's control total for the year agreed with NHS Improvement by £0.8 million.
- The Trust delivered 20 percent less Cost Improvement Plans (CIPs) in 2018/19 than planned and achieved £19.7m of its revised £25.3 million target. 67.6 percent of the savings delivered were recurrent in nature.
- The Trust has not yet begun to tackle its underlying deficit, which equates to approximately £42.5 million. It is forecasting a further deficit of £43.5 million for the year ended 31 March 2020 prior to receipt of Provider Sustainability Funding, Financial Recovery Funding and Marginal rate emergency tariff (MRET) funding. Its planned deficit for 2019/20 after inclusion of this additional funding is £14.7 million.

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.

They are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities.

Responsibilities of the Accountable Officer

The Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

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

Use of our report

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

Darren Wells
Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
Crawley
28 May 2019


Edson

Accounts

Statement of comprehensive income	Note		2018/19 £000	2017/18 £000
Operating income from patient care activities	3		501,042	493,677
Other operating income	4		73,499	50,177
Operating expenses	6, 8		(588,528)	(571,742)
Operating surplus/(deficit) from continuing operations			**(13,987)**	**(27,888)**
Finance income	11		114	50
Finance expenses	12		(21,532)	(23,252)
PDC dividends payable			(3,075)	(4,427)
Net finance costs			**(24,493)**	**(27,629)**
Other gains / (losses)	13		-	(88)
Share of profit / (losses) of associates / joint arrangements			-	-
Gains / (losses) arising from transfers by absorption			-	-
Corporation tax expense			-	-
Surplus/(deficit) for the year from continuing operations			**(38,480)**	**(55,605)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	-		-	-
Surplus/(deficit) for the year			**(38,480)**	**(55,605)**
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Impairments	7		(17,207)	(511)
Revaluations	17	*	6,270	21,791
Other recognised gains and losses			-	-
Total comprehensive income / (expense) for the period			**(49,417)**	**(34,325)**
Adjusted financial performance (control total basis)				
Surplus / (deficit) for the period			(38,480)	(55,605)
Remove impact of consolidating NHS charitable fund			-	-
Remove all I&E impairments / (reversals)	7	**	7,808	(2,063)
Remove (gains) / losses on transfers by absorption			-	-
Remove I&E impact of capital grants and donations			71	76
Prior period adjustments			-	-
Remove non-cash element of on-SoFP pension costs			-	-
Adjusted financial performance surplus / (deficit)			**(30,601)**	**(57,592)**

* This is the net reduction to the revaluation reserve from the update of the current "fair" value of land and buildings in accordance with Department of Health and Social Care (DHSC) guidance - See Note 15.1 Property, plant and equipment 2018/19.

** The adjustment of £7,808K is the sum of of impairments charged to I&E and reversed out for the purposes of the financial performance 'breakeven' measure - See Note 7 Impairment of assets.

The notes on pages 67 to 101 form part of this account.

Statement of financial position	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	29,250	27,928
Property, plant and equipment	15	344,526	359,728
Investment property		-	-
Investments in associates and joint ventures		-	-
Other investments / financial assets		-	-
Receivables	19	2,943	2,390
Other assets		-	-
Total non-current assets		**376,719**	**390,046**
Current assets			
Inventories	18	4,412	5,063
Receivables	19	49,997	40,331
Other investments / financial assets	17	-	-
Other assets		-	-
Non-current assets held for sale / assets in disposal groups		-	-
Cash and cash equivalents	20	2,064	8,532
Total current assets		**56,473**	**53,926**
Current liabilities			
Trade and other payables	21	(47,177)	(46,420)
Borrowings	23	(51,135)	(44,318)
Other financial liabilities		-	-
Provisions	25	(3,277)	(1,410)
Other liabilities	22	(10,507)	(8,106)
Liabilities in disposal groups		-	-
Total current liabilities		**(112,096)**	**(100,254)**
Total assets less current liabilities		**321,096**	**343,718**

Statement of financial position	Note	31 March 2019 £000	31 March 2018 £000
Non-current liabilities			
Trade and other payables	21	-	-
Borrowings	23	(222,313)	(197,190)
Other financial liabilities	-	-	-
Provisions	25	(5,457)	(5,858)
Other liabilities	22	(557)	(607)
Total non-current liabilities		**(228,327)**	**(203,655)**
Total assets employed		**92,769**	**140,063**
Financed by			
Public dividend capital		200,835	198,712
Revaluation reserve		148,429	159,366
Financial assets reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(256,495)	(218,015)
Total taxpayers' equity		**92,769**	**140,063**

The notes on pages 67 to 101 form part of these accounts.

Ben Travis
Chief executive
28 May 2019

Statement of changes in equity for the year ended 31 March 2019	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 - brought forward	**198,712**	**159,366**	**-**	**(218,015)**	**140,063**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	(38,480)	(38,480)
Other transfers between reserves	-	-	-	-	-
Impairments	-	(17,207)	-	-	(17,207)
Revaluations	-	6,270	-	-	6,270
Public dividend capital received	2,123	-	-	-	2,123
Taxpayers' equity at 31 March 2019	**200,835**	**148,429**	**-**	**(256,495)**	**92,769**

Statement of changes in equity for the year ended 31 March 2018	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £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**

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 DHSC. A charge, reflecting the cost of capital utilised by the trust, is payable to the DHSC as the PDC 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 flow	Note		2017/18 £000	2016/17 £000
Cash flows from operating activities				
Operating surplus / (deficit)			(13,987)	(27,888)
Non-cash income and expense				
Depreciation and amortisation	6		26,840	25,250
Net impairments	7		7,808	(2,063)
Income recognised in respect of capital donations	4		-	-
Amortisation of PFI deferred credit			-	-
Non-cash movements in on-SoFP pension liability			-	-
(Increase) / decrease in receivables and other assets			(10,367)	9,798
(Increase) / decrease in inventories			651	607
Increase / (decrease) in payables and other liabilties			1,768	(106)
Increase / (decrease) in provisions			1,450	1,466
Tax (paid) / received			-	-
Operating cash flows from discontinued operations			-	-
Other movements in operating cash flows			-	-
Net cash generated from / (used in) operating activities			**14,163**	**7,064**
Cash flows from investing activities				
Interest received			114	50
Purchase and sale of financial assets / investments			-	-
Purchase of intangible assets			(5,670)	(4,097)
Sales of intangible assets			-	-
Purchase of property, plant, equipment and investment property			(24,400)	(20,654)
Sales of property, plant, equipment and investment property			-	-
Cash movement from acquisitions / disposals of subsidiaries			-	-
Net cash generated from / (used in) investing activities			**(29,956)**	**(24,701)**
Cash flows from financing activities				
Public dividend capital received		*	2,123	10,707
Public dividend capital repaid			-	-
Movement on loans from the Department of Health and Social Care		**	34,683	42,956
Movement on other loans			1,000	-
Other capital receipts			-	-
Capital element of finance lease rental payments			(182)	(365)
Capital element of PFI, LIFT and other service concession payments			(3,974)	(5,727)
Interest on loans			(2,954)	(2,339)
Other interest			-	-
Interest paid on finance lease liabilities			(50)	(35)
Interest paid on PFI, LIFT and other service concession obligations			(18,394)	(20,670)
PDC dividend (paid) / refunded			(2,927)	(3,815)
Financing cash flows of discontinued operations			-	-
Cash flows from (used in) other financing activities			-	-
Net cash generated from / (used in) financing activities			**9,325**	**20,712**
Increase / (decrease) in cash and cash equivalents			**(6,468)**	**3,075**
Cash and cash equivalents at 1 April - brought forward			**8,532**	**5,457**
Prior period adjustments				-
Cash and cash equivalents at 1 April - restated			**8,532**	**5,457**
Cash and cash equivalents transferred under absorption accounting			-	-
Unrealised gains / (losses) on foreign exchange			-	-
Cash and cash equivalents at 31 March	20.1		**2,064**	**8,532**

* The PDC dividend capital received of £2,123K relates to DHSC funded Infrastructure works at QEH (£916K), Health Service Lead Investment - Provider Digitalisation schemes (£750K) for self check-in and bedside monitoring, UHL Mental Health Cafe (£400K) and a number of other smaller projects (£57K).

** The net increase on loans from DHSC of £34,683K is made up of deficit revenue cash support received during the year totalling £35,470K less capital loan repayments of £787K.

Notes to the accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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 1.2 Going concern

These accounts have been prepared on a going concern basis.

International Accounting Standard 1 (IAS1) requires management to assess 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 2019/20 operating plan submission to NHS Improvement (NHSI) and together with the absence of a notification from DHSC or any other relevant national body of the intention for the dissolution of the Trust, is sufficient evidence of going concern.

The current situation is that:

- The Trust has been able to agree with NHSI its control total deficit target of £14,751K for 2019/20
- DHSC has not yet confirmed that it will provide the corresponding revenue cash support of £14,751K shown in the FY19/20 operating plan submission.
- The Trust does not presently have a plan to return to financial balance in 2020/21
- The Trust does not presently have a plan for how it will repay DHSC revenue support loans totalling £157,654K; of which £45,555K is repayable in 2019/20 and the remaining £112,099K by 2021/22.
- The operating plan assumes full, recurrent delivery of a £21,126K CIP, which is considered a more achievable than targets set in recent years.

However, although these factors include and reflect some material uncertainties which may cast a significant degree of doubt on the going concern capability of the Trust for 2019/20, the Director's expectation is that:

- The contracts agreed with commissioners will provide the Trust with a sound level income.
- The operating plan will produce a significant improvement in the Trust's underlying run rate.
- DHSC will, as in previous years, continue to provide revenue cash support
- DHSC is committed to helping the Trust to find a sustainable solution for the repayment of outstanding revenue cash support loans.
- Neither DHSC or any other relevant national body will seek to dissolve the Trust in the foreseeable future.

Taking account of the GAM and the factors outlined 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 through to the 31st March 2020 and beyond.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15 (2017/18 comparator was prepared under IAS 18). The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

This also includes income for education and training (excluding notional apprenticeship levy income).

Revenue from NHS contracts:

Commissioners

The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patients. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Provider Sustainability Funding

The Provider Sustainability Funding (PSF) enables NHS providers to earn income linked to the achievement of financial controls and performance targets. Access to both the general and targeted elements of PSF are unlocked as NHS providers meet their financial control totals. At each quarter, a minimum of 70% of allocated funding will be released upon achievement of the financial control total, with up to a further 30% released where a provider also meets its agreed trajectories for delivery of operational standards.

PSF is accounted for as a variable consideration in line with IFRS 15.

Private Finance Initiative Funding

DHSC provides Private Finance Initiative (PFI) funding to the Trust as additional support to cover the excess cost of the Queen Elizabeth Hospital contract on an annual basis until the contracts are modified or end.

Receipt of the funding by the Trust is assurance by virtue of the operation of the contract as set out in the TSA 2013 report "Securing sustainable healthcare for the people of South East London" and is recognised on this basis.

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. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

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

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

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.

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, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful 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. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period.

As such, all land and buildings are subject to a quinquennial "full revaluation" supplemented by annual indexation or professional "desk top" valuation updates.

Current values in existing use are determined as follows:

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

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

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

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

Subsequent expenditure

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

Depreciation

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

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

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 De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned 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 useful 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 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

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.

Note 1.6.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	60
Dwellings	-	-
Plant & machinery	1	12
Transport equipment: Nil (Fully depreciated)	1	1
Information technology	1	7
Furniture & fittings	1	6

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

Note 1.7 Intangible assets

Note 1.7.1 Recognition

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

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

- the 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."

Note 1.7.2 Measurement

Valuation

Intangible assets are initially recognised 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.

All assets are subsequently valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Amortisation

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

Note 1.7.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Information technology	1	10
Development expenditure	-	-
Websites	-	-
Software licences	1	10

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

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 Recognition

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

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

The note has been prepared under IFRS 9 (2017/18 IAS 39).

Note 1.10.2 Classification and measurement

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

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

Financial assets and financial liabilities at amortised cost

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

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

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

The adoption of IFRS 9 has had the effect of increasing the level of reported financial liabilities for the amount of interest payable on borrowings accrued at the end of the year.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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

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

The amount impaired during the year for expected losses 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 21.89% of total notified oustanding debt line with DHSC guidance. This is only down 0.95% on last year (22.84%) and would suggest a more pessimistic outlook for the successful recovery of the oustanding debt.

Note 1.10.3 Derecognition

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

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

Note 1.11 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 charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. 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 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's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

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

Note 1.12 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 costs

The provision is discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) 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 nominal short term rate of 0.76% (2017-18: negative 2.42% in real terms) for expected cash flows up to and including 5 years
- A nominal medium term rate of negative 1.14% (2017-18: negative 1.85%in real terms) for expected cash flows over 5 years up to and including 10 years
- A nominal long term rate of 1.99% (2017-18: negative 1.56% in real terms) for expected cash flows over 10 years.

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 25.2 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 (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 26 where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in Note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability."

Note 1.14 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 PDC 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.

(iv) PSF Incentive payments receivable.

In accordance with the requirements laid down by the DHSC (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 of 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 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 1.17 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.18 Critical judgements in applying accounting policies

No critical judgements, apart from those involving estimations (see below), have been made in the process of applying the Trust accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Note 1.18.1 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. 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.

Given the areas and nature of assumptions made it is not practical to disclose the extent of the possible effects of the assumptions or another source of estimation uncertainty as at the end of the financial year. Therefore, on the basis of existing knowledge, it is reasonably possible that outcomes within the next financial year that are different from the assumptions could require a material adjustment to the carrying amount of the relevant asset or liability affected.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

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

IFRS 14 Regulatory Deferral Accounts

Not EU endorsed. Applies to first time adopters of IFRS after 1 January 2016. therefore not applicable to DHSC group bodies

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. Financial Reporting Advisory Board has confirm that it will be applicable for public sector bodies from 2020/21.

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 therefore not permitted.

IFRS 23 Uncertainty over Income Tax Treatments

Application required for accounting periods beginning on or after 1 January 2019.

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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Acute services		
Elective income	50,234	50,186
Non elective income	142,632	135,679
First outpatient income	32,199	30,249
Follow up outpatient income	34,151	27,406
A & E income	35,529	33,123
High cost drugs income from commissioners (excluding pass-through costs)	25,611	28,673
Other NHS clinical income	123,781	122,772
Community services		
Community services income from CCGs and NHS England	26,726	25,841
Income from other sources (e.g. local authorities)	8,028	12,745
All services		
Private patient income	-	36
Agenda for Change pay award central funding	4,715	-
Other clinical income	17,436	26,967
Total income from activities	**501,042**	**493,677**

Note 3.2 Income from patient care activities (by source)

		2018/19 £000	2017/18 £000
Income from patient care activities received from:			
NHS England		52,434	52,847
Clinical commissioning groups	*	413,376	405,614
Department of Health and Social Care	**	4,727	-
Other NHS providers		5,144	9,416
NHS other		-	-
Local authorities		11,707	13,858
Non-NHS: private patients		171	36
Non-NHS: overseas patients (chargeable to patient)		4,148	4,216
Injury cost recovery scheme		1,517	1,390
Non NHS: other	*	7,818	6,300
Total income from activities		**501,042**	**493,677**
Of which			
Related to continuing operations		501,042	493,677
Related to discontinued operations		-	-

* The 2017/18 comparator has been restated by £6,226K to include patient care contract income previously classified as CCG (£4,095K) and non-patient care services to other bodies (£2,131K) - See Note 4 Other operating income.

** The DHSC income is one-off payaward funding provided in year.

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

	2018/19 £000	2017/18 £000
Income recognised this year	4,148	4,216
Cash payments received in-year	528	703
Amounts added to provision for impairment of receivables	3,267	2,244
Amounts written off in-year	994	408

Note 4 Other operating income

		2018/19 £000	2017/18 £000
Other operating income from contracts with customers:			
Research and development (contract)		1,096	513
Education and training (excluding notional apprenticeship levy income)		20,162	19,779
Non-patient care services to other bodies	*	8,870	2,561
NHS Provider sustainability / sustainability and transformation fund income (PSF / STF)		23,311	4,252
Income in respect of employee benefits accounted on a gross basis	**	-	2,029
Other contract income	***	18,530	19,513
Other non-contract operating income			
Research and development (non-contract)		-	-
Education and training - notional income from apprenticeship fund		-	-
Receipt of capital grants and donations		-	-
Charitable and other contributions to expenditure		-	-
Support from the Department of Health and Social Care for mergers		-	-
Rental revenue from finance leases		-	-
Rental revenue from operating leases		1,530	1,530
Amortisation of PFI deferred income / credits		-	-
Other non-contract income		-	-
Total other operating income		**73,499**	**50,177**
Of which			
Related to continuing operations		73,499	50,177
Related to discontinued operations		-	-

* The 2017/18 comparator has been restated by £2,131K to exclude patient care contract income now reported as Non NHS: other under Note 3.2 Income from patient care activities (by source).

** The 2018/19 balance is nil due to income from staff recharges, which is now reported gross rather than net in line with the new GAM guidance. The prior year comparator has not been restated.

*** Includes £16,440K (£16,440K in 2017/18) of financial support received under the SLHT dissolution agreement to off-set the additional cost imposed by the QEH PFI building - Reference the TSA 2013 report "Securing sustainable healthcare for the people of South East London".

Note 5 Additional information on revenue

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	8,106
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**31 March 2019 £000**
within one year	-
after one year, not later than five years	-
after five years	-
Total revenue allocated to remainig performance obligations	**-**

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

Note 6 Operating expenses

		2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies		-	-
Purchase of healthcare from non-NHS and non-DHSC bodies		530	716
Purchase of social care		-	-
Staff and executive directors costs		364,384	351,287
Remuneration of non-executive directors		94	78
Supplies and services - clinical (excluding drugs costs)		46,822	44,760
Supplies and services - general		2,965	3,773
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		36,151	40,060
Inventories written down		70	223
Consultancy costs		729	5,842
Establishment		6,410	3,981
Premises		28,764	26,758
Transport (including patient travel)		4,605	4,785
Depreciation on property, plant and equipment		22,492	21,785
Amortisation on intangible assets		4,348	3,465
Net impairments		7,808	(2,063)
Movement in credit loss allowance: contract receivables / contract assets		2,068	
Movement in credit loss allowance: all other receivables and investments		-	2,601
Increase/(decrease) in other provisions		-	-
Change in provisions discount rate(s)		(64)	(16)
Audit fees payable to the external auditor			
audit services- statutory audit		97	115
other auditor remuneration (external auditor only)		10	10
Internal audit costs		222	222
Clinical negligence		28,523	28,569
Legal fees		864	466
Insurance		12	9
Research and development		-	-
Education and training		2,249	2,712
Rentals under operating leases		1,414	2,377
Early retirements		214	2,774
Redundancy		36	246
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)		25,062	24,602
Charges to operating expenditure for off-SoFP PFI / LIFT schemes		-	-
Car parking & security		-	-
Hospitality		51	52
Losses, ex gratia & special payments	*	16	14
Grossing up consortium arrangements		-	-
Other services, eg external payroll		1,128	1,169
Other	*	454	370
Total		**588,528**	**571,742**
Of which			
Related to continuing operations		588,528	571,742
Related to discontinued operations		-	-

* The 2017/18 comparator has been restated by £14K previously disclosed as Other.

Note 6.1 Other auditor remuneration

Other auditor remuneration paid to the external auditor	2018/19 £000	2017/18 £000
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	10	10
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**	**10**

Note 6.2 Limitation on auditor's liability

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

Note 7 Impairment of assets

Net impairments charged to operating surplus / deficit resulting from	2018/19 £000	2017/18 £000
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	7,808	(2,063)
Other	-	-
Total net impairments charged to operating surplus / deficit	**7,808**	**(2,063)**
Impairments charged to the revaluation reserve	17,207	511
Total net impairments	**25,015**	**(1,552)**

Note 8 Employee benefits

		2018/19 £000	2017/18 £000
Salaries and wages		284,518	273,740
Social security costs		29,952	28,801
Apprenticeship levy		1,397	1,341
Employer's contributions to NHS pensions		31,004	29,463
Pension cost - National Employer Savings Trust (NEST)	*	13	5
Other post employment benefits		-	-
Other employment benefits		-	-
Termination benefits		151	246
Temporary staff (including agency)		23,887	23,223
Total gross staff costs		**370,922**	**356,819**
Recoveries in respect of seconded staff		(3,580)	-
Total staff costs		**367,342**	**356,819**
Of which			
Costs capitalised as part of assets		1,735	1,411

Reconcilation to employee benefits in Note 6 Operating expenses	2018/19 £000	2017/18 £000
Total staff costs	**367,342**	**356,819**
Costs capitalised as part of assets	(1,735)	(1,411)
Education and training	(973)	(1,101)
Redundancy	(36)	(246)
Early retirements	(214)	(2,774)
Total staff and executive directors costs as per Note 6 Operating expenses	**364,384**	**351,287**

* The 2017/18 comparator has been restated by £5K, previously disclosed as salaries and wages.

Note 8.1 Retirements due to ill-health

During 2018/19 there were 4 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £157k (£53k in 2017/18).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

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 3% for employees and 2% 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 April 2019 employees will contribute 5%
- From April 2019 employers will contribute 3%

Contributions will be reviewed in 2019.

Note 10 Operating leases

Note 10.1 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.

Operating lease revenue	2018/19 £000	2017/18 £000
Minimum lease receipts	1,530	1,530
Contingent rent	-	-
Other	-	-
Total	**1,530**	**1,530**

Future minimum lease receipts due	31 March 2019 £000	31 March 2018 £000
- 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.	7,650	9,180
Total	**15,300**	**16,830**

Note 10.2 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.

Operating lease expense	2018/19 £000	2017/18 £000
Minimum lease payments	1,414	2,377
Contingent rents	-	-
Less sublease payments received	-	-
Total	**1,414**	**2,377**

Future minimum lease payments due	31 March 2019 £000	31 March 2018 £000
- not later than one year;	2,226	2,275
- later than one year and not later than five years;	570	672
- later than five years.	1,280	1,419
Total	**4,076**	**4,366**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2018/19 £000	2017/18 £000
Interest on bank accounts	114	50
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total finance income	**114**	**50**

Note 12 Finance charges

Note 12.1 Finance expenditure

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

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	3,072	2,540
Other loans	-	-
Overdrafts	-	-
Finance leases	50	35
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	9,699	12,578
Contingent finance costs on PFI and LIFT scheme obligations	8,695	8,092
Total interest expense	**21,516**	**23,245**
Unwinding of discount on provisions	16	7
Other finance costs	-	-
Total finance costs	**21,532**	**23,252**

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

	2018/19 £000	2017/18 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	-	5
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

Operating lease expense	2018/19 £000	2017/18 £000
Gains on disposal of assets	-	-
Losses on disposal of assets	-	(88)
Total other gains / (losses)	**-**	**(88)**

Note 14 Intangible assets

Note 14.1 Intangible assets - 2018/19

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost			
Valuation / gross cost at 1 April 2018 - brought forward	**34,306**	**7,065**	**41,371**
Additions	5,214	456	5,670
Reclassifications	6,561	(6,561)	-
Disposals / derecognition	-	-	-
Valuation / gross cost at 31 March 2019	**46,081**	**960**	**47,041**
Amortisation			
Amortisation at 1 April 2018 - brought forward	**13,443**	**-**	**13,443**
Provided during the year	4,348	-	4,348
Reclassifications	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2019	**17,791**	**-**	**17,791**
Net book value at 31 March 2019	**28,290**	**960**	**29,250**
Net book value at 1 April 2018	**20,863**	**7,065**	**27,928**

Note 14.2 Intangible assets - 2017/18

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost			
Valuation / gross cost at 1 April 2017	**31,840**	**5,461**	**37,301**
Additions	213	3,884	4,097
Reclassifications	2,253	(2,280)	(27)
Disposals / derecognition	-	-	-
Valuation / gross cost at 31 March 2018	**34,306**	**7,065**	**41,371**
Amortisation			
Amortisation at 1 April 2017	**9,978**	**-**	**9,978**
Provided during the year	3,465	-	3,465
Transfers to / from assets held for sale	-	-	-
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 15 Property, plant and equipment

Note 15.1 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost								
Valuation/gross cost at 1 April 2018 - brought forward	**36,277**	**288,945**	**12,161**	**78,079**	**10**	**17,088**	**1,285**	**433,845**
Additions	-	15,552	5,907	2,883	-	1,314	379	26,035
Impairments	(8,359)	(8,848)	-	-	-	-	-	(17,207)
Reversals of impairments	-	-	-	-	-	-	-	-
Revaluations	(2,198)	(16,243)	-	-	-	-	-	(18,441)
Reclassifications	-	7,845	(9,612)	1,179	-	580	8	-
Disposals / derecognition	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2019	**25,720**	**287,251**	**8,456**	**82,141**	**10**	**18,982**	**1,672**	**424,232**
Accumulated depreciation								
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**60,449**	**8**	**12,521**	**1,139**	**74,117**
Provided during the year	-	16,903	-	4,030	-	1,486	73	22,492
Impairments	2,198	6,948	-	-	-	-	-	9,146
Reversals of impairments	-	(1,338)	-	-	-	-	-	(1,338)
Revaluations	(2,198)	(22,513)	-	-	-	-	-	(24,711)
Reclassifications	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**64,479**	**8**	**14,007**	**1,212**	**79,706**
Net book value at 31 March 2019	**25,720**	**287,251**	**8,456**	**17,662**	**2**	**4,975**	**460**	**344,526**
Net book value at 1 April 2018	**36,277**	**288,945**	**12,161**	**17,630**	**2**	**4,567**	**146**	**359,728**

Note 15.2 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost								
Valuation / gross cost at 1 April 2017	**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								
Accumulated depreciation at 1 April 2017	**-**	**-**	**-**	**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 15.3 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019								
Owned - purchased	25,720	118,925	8,456	16,946	2	4,974	460	175,483
Finance leased	-	-	-	693	-	-	-	693
On-SoFP PFI contracts and other service concession arrangements	-	167,884	-	-	-	-	-	167,884
Owned - donated	-	442	-	23	-	1	-	466
NBV total at 31 March 2019	**25,720**	**287,251**	**8,456**	**17,662**	**2**	**4,975**	**460**	**344,526**

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

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £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	-	-	-	-	-	174,182
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 16 Donations of property, plant and equipment

No donated assets were received during the year.

Note 17 Revaluations of property, plant and equipment

Note 17.1 Land and Buildings

Summary

The last full "fair value" revaluation was carried out in FY15/16 under the quinquennial programme of valuations.

Therefore, 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 2018/19 in order to update the fair value of land and buildings.

The valuation from ME is on an Modern Equivalent Asset (MEA) basis as at 28th February 2019. This was followed up with a letter from the valuer confirming no material change in the valuation through to the 31st March 2019.

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

As an interim valuation ME have not inspected the properties on this occasion but have worked with the Trust in updating floor area details and any changes in use across each of the sites.

VAT has been excluded when considering the value of PFI buildings.

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 – UK National Supplement (Valuation Practice Guidance – Applications – VPGA1: Valuation for Financial Reporting; VPGA6 Local Authority and Central Government Accounting: Existing Use Value (EUV) Basis of Value);
- RICS UK Guidance Note, Depreciated Replacement Cost Method of Valuation for Financial Reporting, 1st Edition.

In assessing Fair Value ME have had regard to the following definitions:

- Depreciated Replacement Cost where the Trust owned property is a specialised operational asset with no perceived market;
- Existing Use Value where the Trust owned property is a non-specialised operational asset and can be 'compared to other assets in the market.

Depreciated Replacement Cost (DRC) - Specialised Assets:

The RICS UK Guidance Note, Depreciated Replacement Cost Method of Valuation for Financial Reporting 1st Edition November 2018 sets out the definition of DRC 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 the Lewisham and Queen Elizabeth Hospitals (excluding office space), Hither Green (Synergy) site and four health centres considered as specialised assets owner occupied by the Trust.

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:

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

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.

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% (17% last year) and Royal Borough of Greenwich 20% (20% 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. At the present time, the BCIS is forecasting that there will be a continual, but steady, increase in build costs over the short to medium term with the falls in sterling, rising fuel and labour costs all having an adverse impact. This may increase more rapidly once the UK eventually leaves the EU."

Accounting outcomes	£000
The overall change in value from the valuation update was an decrease	(1,538)
This gave rise to the following accounting changes:	
- Valuation increase / (decrease) charged to the revaluation reserve - Gross	(18,441)
- Valuation increase / (decrease) charged to the revaluation reserve - Accumulated Depn	24,711
Total charge to revaluation reserve	**6,270**
- Impairment losses	(9,146)
- Impairment reversals	1,338
Total revaluation	**(1,538)**

Note 18 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	1,332	1,826
Work In progress	-	-
Consumables	3,073	3,105
Energy	7	132
Other	-	-
Total inventories	**4,412**	**5,063**
Of which		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £55,566k (2017/18: £65,040k). Write-down of inventories recognised as expenses for the year were £70k (2017/18: £223k).

Note 19 Trade receivables and other receivables

Note 19.1 Trade receivables and other receivables

		31 March 2019 £000	31 March 2018 £000
Current			
Contract receivables	*	44,742	
Contract assets	*	-	
Trade receivables	*		29,811
Capital receivables		-	-
Accrued income	*		4,543
Allowance for impaired contract receivables / assets	*	(8,535)	
Allowance for other impaired receivables		-	(7,545)
Deposits and advances		-	-
Prepayments (non-PFI)		6,995	9,253
Interest receivable		-	-
Finance lease receivables		-	-
PDC dividend receivable		827	975
VAT receivable		5,798	3,056
Other receivables		170	238
Total current trade and other receivables		**49,997**	**40,331**
Non-current			
Contract receivables		2,943	
Contract assets		-	
Trade receivables			-
Capital receivables		-	-
Accrued income			2,390
Other receivables		-	-
Total non-current trade and other receivables		**2,943**	**2,390**
Of which receivables from NHS and DHSC group bodies:			
Current	**	35,704	25,256
Non-current		-	-

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

** This shows that the majority of trade receivables is with NHS and DHSC group bodies (£35,704K) funded by Government to buy NHS patient care services and, as such, the debt is generally considered to be low risk.

Note 19.2 Allowances for credit losses - 2018/19

	31 March 2019 Contract receivables and contract assets £000	31 March 2018 All other receivables £000
Allowances as at 1 Apr 2018 - brought forward		
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	7,545	-
Transfers by absorption	-	-
New allowances arising	2,068	-
Changes in existing allowances	-	-
Reversals of allowances	-	-
Utilisation of allowances (write offs)	(1,078)	-
Changes arising following modification of cotractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2019	**8,535**	**-**

Outstanding Injury cost recovery balances have been impaired at 21.89% of total notified oustanding debt line with DHSC guidance. This is only down 0.95% on last year (22.84%) and would suggest a more pessimistic outlook for the successful recovery of the oustanding debt.

Note 19.3 Allowances for credit losses - 2017/18

Accounting outcomes	All receivables £000
Allowances as at 1 Apr 2017	**5,615**
Transfers by absorption	-
Increase in provision	2,601
Amounts utilised	(671)
Unused amounts reversed	-
Transfer to FT upon authorisation	-
Allowances as at 31 Mar 2018	**7,545**

Note 19.4 Credit quality of financial assetss

Outstanding Debt Balances - Age Profile (Days)		31 March 2019 £000	31 March 2018 £000
Ageing of impaired financial assets			
0 - 30	Days	667	474
30-60	Days	322	278
60-90	Days	521	455
90- 180	Days	1,118	1,769
Over 180	Days	5,907	4,569
Total		**8,535**	**7,545**
Ageing of non-impaired financial assets past their due date			
0 - 30	Days	11,847	10,737
30-60	Days	2,615	2,222
60-90	Days	1,144	789
90- 180	Days	1,978	3,344
Over 180	Days	8,378	9,069
Total		**25,962**	**26,161**

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 19.1 Trade receivables and other receivables.

Note 20 Cash and cash equivalents

Note 20.1 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.

		2018/19 £000	2017/18 £000
At 1 April		**8,532**	**5,457**
Prior period adjustments		-	-
At 1 April (restated)		**8,532**	**5,457**
Transfers by absorption		-	-
Net change in year		(6,468)	3,075
At 31 March		**2,064**	**8,532**
Broken down into:			
Cash at commercial banks and in hand		13	12
Cash with the Government Banking Service		2,051	8,520
Deposits with the National Loan Fund		-	-
Other current investments		-	-
Total cash and cash equivalents as in SoFP		**2,064**	**8,532**
Bank overdrafts (GBS and commercial banks)		-	-
Drawdown in committed facility		-	-
Total cash and cash equivalents as in SoCF	*	**2,064**	**8,532**

* The reduction in tne amount of cash held at the year-end reflects the £6,468K of Trust internal capital funding carried forward from 2017/18 having been utilised in 2018/19.

Note 20.2 Third party assets held by the trust

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

	31 March 2019 £000	31 March 2018 £000
Bank balances	19	32
Monies on deposit	-	-
Total third party assets	**19**	**32**

Note 21 Trade and other payables

		31 March 2019 £000	31 March 2018 £000
Current			
Trade payables		24,289	21,487
Capital payables		3,741	2,106
Accruals		13,683	21,419
Receipts in advance (including payments on account)		-	-
Social security costs		4,456	220
VAT payables		-	-
Other taxes payable		146	254
PDC dividend payable		-	-
Accrued interest on loans	*		295
Other payables		862	639
Total current trade and other payables		**47,177**	**46,420**
Non-current			
Trade payables		-	-
Capital payables		-	-
Accruals		-	-
Receipts in advance (including payments on account)		-	-
VAT payables		-	-
Other taxes payable		-	-
Other payables		-	-
Total non-current trade and other payables		**-**	**-**
Of which payables from NHS and DHSC group bodies:			
Current		4,375	4,274
Non-current		-	-

* Following the adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within Note 23. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 22 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	10,507	8,106
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Other deferred income	-	
Total other current liabilities	**10,507**	**8,106**
Non-current		
Deferred income: contract liabilities	557	607
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**557**	**607**

Note 23 Borrowings

		31 March 2019 £000	31 March 2018 £000
Current			
Bank overdrafts		-	-
Drawdown in committed facility		-	-
Loans from the DHSC - Capital Investment Loans	*	802	787
Loans from the DHSC - Revenue Support Loans	**	45,555	39,376
Other loans		-	-
Obligations under finance leases		182	182
PFI lifecycle replacement received in advance		-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)		4,596	3,973
Total current borrowings		**51,135**	**44,318**
Non-current			
Loans from the DHSC - Capital Investment Loans		10,623	11,410
Loans from the DHSC - Revenue Support Loans		112,099	82,410
Other loans		1,000	-
Obligations under finance leases		461	643
PFI lifecycle replacement received in advance		-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)		98,130	102,727
Total non-current borrowings		**222,313**	**197,190**
Total			
Bank overdrafts		-	-
Drawdown in committed facility		-	-
Loans from the DHSC - Capital Investment Loans	***	11,425	12,197
Loans from the DHSC - Revenue Support Loans	****	157,654	121,786
Other loans		1,000	-
Obligations under finance leases		643	825
PFI lifecycle replacement received in advance		-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)		102,726	106,700
Total borrowings		**273,448**	**241,508**

* The capital investment loans repayable in 2019/20 of £802K includes £15K of accrued interest charges following the application of IFRS 9. The comparator for 2017/18 has not been restated to reflect the IFRS 9 change in 2018/19.

** The revenue support loans reyable in 2019/20 of £45,555K comprises actual funding received in 2015/16 of £39,376K and 2016/17 of 5,781K and, in line with IFRS 9, including accrued interest of £66K and £3K respectively. The comparator for 2017/18 has not been restated to reflect the application of IFRS 9 in 2018/19.

The £39,376K loan from 2015/16 was originally due for repaymemt in 2018/19 as reported last year. However, DHSC has approved a loan maturity extension for repayment to be made in 2019/20.

*** Capital Investments loans (CIL) include:
The total capital investment loans of £11,425K include £15K of accrued interest charges following the application of IFRS 9.

The existing loans include:.
- CIL of £7,952K, relating to the construction of the Urgent Care Centre completed in April 2012.
- CIL of £3,473K 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)
The total borrowings of £157,654K includes new deficit related cash revenue support loans in year totalling £35,470K- as reflected in the Statement of Cash Flows (SoCF).

They include £398K of accrued interest charges following the application of IFRS 9.

Note 23.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	**133,983**	**-**	**825**	**106,700**	**241,508**
Cash movements:					
Financing cash flows - payments and receipts of principal	34,683	1,000	(182)	(3,974)	31,527
Financing cash flows - payments of interest	(2,954)	-	(50)	(9,699)	(12,703)
Total cash movements	**31,729**	**1,000**	**(232)**	**(13,673)**	**18,824**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	295	-	-	-	295
Transfers by absorption	-	-	-	-	-
Additions	-	-	-	-	-
Application of effective interest rate	3,072	-	50	9,699	12,821
Change in effective interest rate	-	-	-	-	-
Changes in fair value	-	-	-	-	-
Other changes	-	-	-	-	-
Total non-cash movements	**3,367**	**-**	**50**	**9,699**	**13,116**
Carrying value at 31 March 2019	**169,079**	**1,000**	**643**	**102,726**	**273,448**

Note 24 Finance leases

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

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**835**	**1,067**
of which liabilities are due:		
- not later than one year;	233	233
- later than one year and not later than five years;	556	667
- later than five years.	46	167
Finance charges allocated to future periods	(192)	(242)
Net lease liabilities	**643**	**825**
of which payable:		
- not later than one year;	182	182
- later than one year and not later than five years;	461	643
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

Note 25 Provisions for liabilities and charges

Note 25.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	NHS injury benefits scheme £000	Legal claims £000	Re-structuring £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	Other £000	Total £000
At 1 April 2018	**5,796**	**666**	**302**	**-**	-	**233**	**271**	**7,268**
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	(64)	-	-	-	-	-	-	(64)
Arising during the year	214	-	1,352	869	-	-	107	2,542
Utilised during the year	(545)	(62)	-	-	-	(54)	(64)	(725)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	-	-	(100)	-	-	(179)	(24)	(303)
Unwinding of discount	16	1	-	-	-	-	(1)	16
At 31 March 2019	**5,417**	**605**	**1,554**	**869**	**-**	**-**	**289**	**8,734**
Expected timing of cash flows:								
- not later than one year;	540	63	1,554	869	-	-	251	3,277
- later than one year and not later than five years;	2,129	262	-	-	-	-	22	2,413
- later than five years.	2,748	280	-	-	-	-	16	3,044
Total	**5,417**	**605**	**1,554**	**869**	**-**	**-**	**289**	**8,734**

Early Departure Pensions costs of £5,417K relate to continuing contribution payments to the NHS Pensions Agency (NHSPA) for staff who retired early.
The calculation of the long-term liability in respect of future payments to the NHSPA is based on information provided by the NHS Pensions Agency and makes use of National Statistics (ONS) published life expectancy data. The provision is 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.

NHS injury benefits relate to the cost of payments to people who sustained an injury or contracted a disease wholly or mainly due to their NHS employment The reported cost of £605K would previously have been included within other provisions.

Legal Claims of £1,554K are based on an assessment of all outstanding cases by solicitors acting on behalf of the Trust and other potential claims. The value of reported claims 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.

Restructuring costs of £869K relate to the re-organisation of management structures and processes across the Trust following the Leader Capacity Review and are specifically linked to the strategic / operational leadership and values based education programme designed to change how the Trust works.

Other Provisions of £289K include a general provision of £224K and Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) claims handled by the NHS Litigation Authority totalling £65K.

Note 25.2 Clinical negligence liabilities

At 31 March 2019, £481,228k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lewisham and Greenwich NHS Trust (31 March 2018: £469,115k).

Note 26 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(52)	(52)
Gross value of contingent liabilities	**(52)**	**(52)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(52)**	**(52)**
Net value of contingent assets	**-**	**-**

The contingent liability of £52K (£52K 2017/18K) relates to employee and public liability claims handled by the NHS Litigation Authority.

Note 27 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
Property, plant and equipment	941	4,599
Intangible assets	218	-
Total	**1,159**	**4,599**

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

Note 28.1 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:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**346,030**	**360,689**
Of which liabilities are due		
- not later than one year;	23,332	21,871
- later than one year and not later than five years;	98,386	94,210
- later than five years.	224,312	244,608
Finance charges allocated to future periods	(243,304)	(253,989)
Net PFI, LIFT or other service concession arrangement obligation	**102,726**	**106,700**
- not later than one year;	4,596	3,973
- later than one year and not later than five years;	22,613	20,813
- later than five years.	75,517	81,914

The Trust had two on-balance sheet service concessions at the start of the year; Queen Elizabeth Hospital Building (QEH) and the Riverside Building on the Lewisham Hospital site.

Although the QEH Managed Equipment Service (Toshiba) came to an end in September 2017, the financial impact of the contract is still reflected in the 2017/18 comparators under Note 28.3 Analysis of amounts payable to service concession operator.

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). 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.

Queen Elizabeth Hospital building	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**215,099**	**224,560**
Of which liabilities are due		
- not later than one year;	16,789	15,414
- later than one year and not later than five years;	71,427	67,722
- later than five years.	126,883	141,424
Finance charges allocated to future periods	(153,635)	(160,764)
Net PFI, LIFT or other service concession arrangement obligation	**61,464**	**63,796**
- not later than one year;	2,944	2,332
- later than one year and not later than five years;	15,506	13,854
- later than five years.	43,014	47,610

Riverside building	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**130,931**	**136,129**
Of which liabilities are due		
- not later than one year;	6,543	6,457
- later than one year and not later than five years;	26,959	26,488
- later than five years.	97,429	103,184
Finance charges allocated to future periods	(89,669)	(93,225)
Net PFI, LIFT or other service concession arrangement obligation	**41,262**	**42,904**
- not later than one year;	1,652	1,641
- later than one year and not later than five years;	7,107	6,959
- later than five years.	32,503	34,304

Note 28.2 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 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	626,681	652,168
Of which liabilities are due		
- not later than one year;	41,033	39,081
- later than one year and not later than five years;	174,764	166,465
- later than five years.	410,884	446,622

Queen Elizabeth Hospital building	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	419,837	438,297
Of which liabilities are due		
- not later than one year;	31,688	30,065
- later than one year and not later than five years;	134,873	127,970
- later than five years.	253,276	280,262

Riverside building	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	206,844	213,871
Of which liabilities are due		
- not later than one year;	9,345	9,016
- later than one year and not later than five years;	39,891	38,495
- later than five years.	157,608	166,360

Note 28.3 Analysis of amounts payable to service concession operator

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

All Concessions	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	40,018	44,295
Consisting of:		
- Interest charge	9,699	12,578
- Repayment of finance lease liability	3,974	5,836
- Service element and other charges to operating expenditure	17,650	17,789
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	8,695	8,092
- Addition to lifecycle prepayment	-	-
Amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	7,412	6,880
Total amount paid to service concession operator	**47,430**	**51,175**

Queen Elizabeth Hospital building	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	30,915	29,814
Consisting of:		
- Interest charge	7,219	7,484
- Repayment of finance lease liability	2,332	2,420
- Service element and other charges to operating expenditure	15,067	13,962
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	6,297	5,948
- Addition to lifecycle prepayment	-	-
Amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	7,387	5,022
Total amount paid to service concession operator	**38,302**	**34,836**

Riverside building	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	9,103	8,784
Consisting of:		
- Interest charge	2,480	2,569
- Repayment of finance lease liability	1,642	1,490
- Service element and other charges to operating expenditure	2,583	2,581
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	2,398	2,144
- Addition to lifecycle prepayment	-	-
Amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	25	(72)
Total amount paid to service concession operator	**9,128**	**8,712**

Toshiba	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	-	5,697
Consisting of:		
- Interest charge	-	2,525
- Repayment of finance lease liability	-	1,926
- Service element and other charges to operating expenditure	-	1,246
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	-	-
- Addition to lifecycle prepayment	-	-
Amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	1,930
Total amount paid to service concession operator	**-**	**7,627**

Note 29 Financial instruments

Note 29.1 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 a 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 through its day-to-day operational activities and with little scope to manage any associated risks over the longer- term.

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 29.2 Carrying values of financial assets

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

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values as at 31 March 2019 under IFRS 9				
Trade and other receivables excluding non financial assets	39,320	-	-	39,320
Other investments / financial assets	-	-	-	-
Cash and cash equivalents at bank and in hand	2,064	-	-	2,064
Total at 31 March 2019	**41,384**	**-**	**-**	**41,384**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Carrying values as at 31 March 2018 under IAS 39					
Trade and other receivables excluding non financial assets	29,437	-	-	-	29,437
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	8,532	-	-	-	8,532
Total at 31 March 2018	**37,969**	**-**	**-**	**-**	**37,969**

Reconciliation of Financial Instruments as in SoFP	2018/19		
	Current £000	Non Current £000	Total £000
Financial Instruments Receivables			
Contract receivables	44,742	2,943	47,685
Allowance for impaired contract receivables / assets	(8,535)	-	(8,535)
Other receivables	170	-	170
Total Receivables	**36,377**	**2,943**	**39,320**
Total cash and cash equivalents as in SoCF	2,064	-	2,064
Total Financial Instruments	**38,441**	**2,943**	**41,384**
Non-Financial Instruments Receivables			
Prepayments (non-PFI)	6,995	-	6,995
PDC dividend receivable	827	-	827
VAT receivable	5,798	-	5,798
Corporation and other taxes receivable	-	-	-
Total Non-Financial Instruments	**13,620**	**-**	**13,620**
Total Receivables and cash and cash equivalents as in SoFP	**52,061**	**2,943**	**55,004**

Note 29.3 Carrying value of financial liabilities

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

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	169,079	-	169,079
Obligations under finance leases	643	-	643
Obligations under PFI, LIFT and other service concession contracts	102,726	-	102,726
Other borrowings	1,000	-	1,000
Trade and other payables excluding non financial liabilities	42,575	-	42,575
Total at 31 March 2019	**316,023**	**-**	**316,023**

	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Carrying values as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	133,983	-	133,983
Obligations under finance leases	825	-	825
Obligations under PFI, LIFT and other service concession contracts	106,700	-	106,700
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	45,651	-	45,651
Total at 31 March 2019	**287,159**	**-**	**287,159**

Note 29.4 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	94,210	89,970
In more than one year but not more than two years	124,704	93,539
In more than two years but not more than five years	14,979	14,261
In more than five years	82,130	89,389
Total	**316,023**	**287,159**

Reconciliation of Financial Instruments as in SoFP	2018/19 Current £000	Non Current £000	Total £000
Financial Instruments Payables			
Trade payables	24,289	-	24,289
Capital payables	3,741	-	3,741
Accruals	13,683	-	13,683
Other payables	862	-	862
Total Payables	**42,575**	**-**	**42,575**
Loans from the DHSC - Capital Investment Loans	802	10,623	11,425
Loans from the DHSC - Revenue Support Loans	45,555	112,099	157,654
Other loans	-	1,000	1,000
Obligations under finance leases	182	461	643
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	4,596	98,130	102,726
Total Borrowings	**51,135**	**222,313**	**273,448**
Total Financial Instruments	**93,710**	**222,313**	**316,023**
Non-Financial Instruments Payables			
Social security costs	4,456	-	4,456
Other taxes payable	146	-	146
Total Non-Financial Instruments	**4,602**	**-**	**4,602**
Total payables and borrowings as in SoFP	**98,312**	**222,313**	**320,625**

Note 30 Losses and special payments

	2018/19 Total number of cases £000	Total value of cases £000	2017/18 Total number of cases £000	Total value of cases £000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	394	1,078	1,377	1,136
Stores losses and damage to property	3	70	5	223
Total losses	**397**	**1,148**	**1,382**	**1,359**
Special payments				
Compensation under court order or legally binding arbitration award	13	5	12	5
Extra-contractual payments	-	-	-	-
Ex-gratia payments	21	11	33	9
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**34**	**16**	**45**	**14**
Total losses and special payments	**431**	**1,164**	**1,427**	**1,373**
Compensation payments received		-		-

Details of cases individually over £300k

There were no individual cases over £300K.

Note 31 New standards

Note 31.1 Initial application of IFRS 9

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

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

Under IFRS 9, borrowings from the DHSC, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £295k, and trade payables correspondingly reduced.

The overall impact from the application of IFRS 9 is a net increase in DHSC total borrowings as follows: - See Note 23 Borrowings:	£000
Loans from the DHSC - Capital Investment Loans	15
Loans from the DHSC - Revenue Support Loans	398
Total IFRS15 Impact	**413**

Note 31.2 Initial application of IFRS 15

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

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

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

There was no financial impact from the application of IFRS 15.

Note 32 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 within Lewisham and Greenwich NHS Trust.

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

Details of related party transactions with individuals are as follows:

Barts Health NHS Trust
Bexley London Borough Council
Care Quality Commission
Community Health Partnerships
Dartford and Gravesham NHS Trust
Department of Health and Social Care
Greenwich London Borough Council
Guy's & St Thomas' NHS Foundation Trust
Health Education England
HM Revenue & Customs
King's College Hospital NHS Foundation Trust
Lewisham London Borough Council
NHS Barking and Dagenham CCG
NHS Bexley CCG
NHS Blood and Transplant
NHS Bromley CCG
NHS City and Hackney CCG
NHS Croydon CCG
NHS Dartford, Gravesham and Swanley CCG
NHS England
NHS Greenwich CCG
NHS Hammersmith and Fulham CCG
NHS Improvement (TDA legal entity)
NHS Lambeth CCG
NHS Lewisham CCG
NHS Medway CCG
NHS Newham CCG
NHS Pension Scheme
NHS Property Services
NHS Resolution (formerly NHS Litigation Authority)
NHS Southwark CCG
NHS Tower Hamlets CCG
NHS Wandsworth CCG
NHS West Kent CCG
Oxleas NHS Foundation Trust
Oxleas NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
St George's University Hospitals 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:

	2018-19 £	2017-18 £
Patient education and welfare	33,240	33,060
Staff education and welfare	20,289	42,796
New equipment	29,912	172,887
Governance	30,893	26,691
Grand Total	**114,334**	**275,434**

Note 33 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 34 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 £000	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	83,147	335,151	99,507	348,223
Total non-NHS trade invoices paid within target	75,927	319,600	71,707	298,679
Percentage of non-NHS trade invoices paid within target	**91.3%**	**95.4%**	**72.1%**	**85.8%**
NHS Payables				
Total NHS trade invoices paid in the year	2,541	16,976	2,596	19,554
Total NHS trade invoices paid within target	1,846	12,147	1,543	12,471
Percentage of NHS trade invoices paid within target	**72.6%**	**71.6%**	**59.4%**	**63.8%**

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 35 External financing

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

SoCF	2018/19 £000	2017/18 £000
Net cash (gen from) / used in - Operations	(14,163)	(7,064)
Net cash gen from / (used in) - Investing Activities	29,956	24,701
Net cash gen from / (used in) - Financing Activities		
Less:		
Interest paid	2,954	2,339
Interest element of fin lease	50	35
Interest element of PFI	18,394	20,670
PDC dividend (paid)/refunded	2,927	3,815
Total	**40,118**	**44,496**
Reverse Fin Leases - Additions Leased	-	(617)
Requirement Excluding - Fin Leases	**40,118**	**43,879**

	2018/19 £000	2017/18 £000
Cash flow financing	40,118	43,879
Finance leases taken out in year	-	617
Other capital receipts	-	-
External financing requirement	**40,118**	**44,496**
External financing limit (EFL)	41,119	54,501
Under / (over) spend against EFL	**1,001**	**10,005**

The undershoot of the target EFL by £1,001K is attributable

- A re-instatement of PDC totalling £764K by DHSC.
- A £238K increase actioned by DHSC in respect of cancelled loan repayments (£625K) and a reduction in forecast depreciation (£387K).

Note 36 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	31,705	26,760
Less: Disposals	-	(88)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**31,705**	**26,672**
Capital Resource Limit	32,759	35,611
Under / (over) spend against CRL	**1,054**	**8,939**

The undershoot of £1,054K against the target CRL is attributable to:

- A re-instatement of PDC totalling £764K by DHSC.
- A £238K increase actioned by DHSC in respect of cancelled loan repayments (£625K) and a reduction in forecast depreciation (£387K).
- An actual underspend against the Trust internal capital plan of £52K.

Note 37 Breakeven duty financial performance

	2018/19 £000	2017/18 £000
Surplus / (deficit) for the period	**(38,480)**	**(55,605)**
Remove all I&E impairments / (reversals) - Non IFRIC 12	7,808	(3,126)
Remove all I&E impairments / (reversals) - IFRIC 12	-	1,063
	7,808	**(2,063)**
Surplus / (deficit) before impairments and transfers	**(30,672)**	**(57,668)**
Remove capital donations / grants I&E impact	71	76
Adjusted financial performance including PSF	**(30,601)**	**(57,592)**
Less: Provider Sustainability Funding (PSF)	(23,311)	(4,252)
Adjusted financial performance excluding PSF	**(53,912)**	**(61,844)**
Adjusted financial performance surplus / (deficit) (control total basis) - including PSF	**(30,601)**	**(57,592)**
Remove impairments scoring to Departmental Expenditure Limit	-	-
Add back non-cash element of On-SoFP pension scheme charges	-	-
IFRIC 12 breakeven adjustment	8,370	7196
Breakeven duty financial performance surplus / (deficit)	**(22,231)**	**(50,396)**

Note 38 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Breakeven duty in-year financial performance		6,753	1,058	1,427	1,750	242	(8,482)	(22,867)	(20,054)	(50,396)	(22,231)
Breakeven duty cumulative position	(9,337)	(2,584)	(1,526)	(99)	1,651	1,893	(6,589)	(29,456)	(49,510)	(99,906)	(122,137)
Operating income		188,109	222,366	229,184	241,470	382,097	517,522	518,947	539,242	543,854	574,541
Cumulative breakeven position as a percentage of operating income		**(1.4%)**	**(0.7%)**	**(0.0%)**	**0.7%**	**0.5%**	**(1.3%)**	**(5.7%)**	**(9.2%)**	**(18.4%)**	**(21.3%)**

Glossary

Financial statements – glossary

The accounts have been produced in line with the **International Financial Reporting Standards (IFRS)**. The main features of IFRS, as compared with the previously applied UK GAAP rules, are that fixed assets are valued at fair value; normally existing use value (EUV) or depreciated replacement cost (DRC) in the case of most Trust assets, assets covered by finance leases such as the Riverside (PFI) building are shown on balance sheet and potential staff costs relating to untaken annual leave are included in expenditure.

The **Statement of Comprehensive Income (SoCI)** records the income and the costs incurred by the Trust during the year in the course of running its operations. It includes cash expenditure on staff and supplies as well as non-cash expenses such as depreciation (a charge that reflects the consumption of assets used to deliver services). It is the equivalent of what may be referred to as the "profit and loss account" in the private sector. If income exceeds expenditure, the Trust has a surplus that can be re-invested in new equipment or services. Conversely, if expenditure exceeds income, a deficit is incurred which the Trust will have to recover. Unrealised gains and losses from changes in the value assets during the year which have not yet had any cash consequences, such as those arising from the revaluation of property, are now also summarised here as part of Other Comprehensive Income.

The **Statement of Financial Position (SoFP)** provides a balance sheet snapshot of the Trust's financial condition at the end of the financial year. It summarises assets held (everything the Trust owns that has monetary value), liabilities (money owed to external parties) and taxpayers' equity (public funds invested in the Trust). The sum of assets less liabilities is matched by an equal amount of taxpayers' equity.

The **Statement of Cash Flows (SoCF)** summarises the amount of cash received and paid out by the Trust during the year in the delivery of its operational services, investment activities, capital transactions and payment of financing cost. A surplus in the SoCI will not always lead to an increase in cash. Similarly, a deficit would not necessarily translate into a reduction in cash held. This is because the SoCI has expenditure in the form depreciation which does not involve actual cash payments, and cash flow includes payments for investments, capital and financing cost that are not shown in the SoCI because they are non-operational (greater than one year). The impact of an organisation's operating performance on its cash position can only be gleaned from the SoCF and SoFP.

Revenue from patient care activities relates primarily to income for services commissioned by CCGs. It also includes income received for joint care arrangements with local authorities or for delayed discharges, and income from treating overseas visitors from countries where there is no reciprocal healthcare agreement in place. Reciprocal arrangements exist with most European countries – meaning healthcare is delivered free to patients and costs funded by the Department of Health via CCGs. The NHS Injury Costs Recovery Scheme enables trusts to recover the cost of treating patients injured in a road traffic accident by charging a standard fee for an accident and emergency attendance or claiming actual costs (up to a set limit), through the private insurance system, if inpatient care was provided.

Other operating income includes education, training and research funding, income from non-patient care services to other bodies, and rental income from other NHS and Non NHS bodies that use Trust property to deliver patient care related services. Funds to cover the costs of providing education and training come from Medical and Professional Education and Training (MPET) levies. The levies comprise Service Increment for Teaching undergraduate medical students (SIFT), Medical and Dental Education Levy for postgraduate medical training (MADEL) and Non Medical Education and Training for nursing and other professional staff training (NMET). These funds are generally allocated by the Department of Health via Health Education England (HEE). Organisations undertaking research can also receive funding through a research and development levy.

Non patient care services to other bodies – examples include laundry and pathology.

Income generation is income from non patient care activities such as car parking, pharmacy and accommodation charges.

Other income covers income not reported in the categories above and include Riverside PFI support.

Operating expenses

Establishment includes items such as printing, postage, telephone, advertising and travel expenses.

Transport includes vehicle insurance, fuel and oil, maintenance equipment and hire of transport.

Premises include all the trust's utility costs, furniture and other property related revenue expenditure such as rates, rent and insurance.

Provision for impairment of receivables is the amount of outstanding non NHS debt charged to expenditure on the basis that it is unlikely to be recovered. These debts are pursued and only written-off after they are three years old.

Depreciation is an accounting charge recognising that capital assets are 'consumed' over their useful lives. For instance, IT equipment may be depreciated over five years on a straight line basis, meaning one fifth the purchase cost is assigned to each of the 5 years of the assumed asset life.

Impairments of property, plant and equipment is where the Net Book Value of an asset is charged to expenditure due to the consumption of economic benefit in full or a reduction in value not matched a positive revaluation reserve balance. The Department of Health excludes the impact of impairments from a trust's breakeven duty.

Clinical negligence is the annual premium payment to the NHS Litigation Authority (NHSLA) as part of the Clinical Negligence Scheme for Trusts. Premium levels are influenced by a range of factors, including the type of trust, the specialties it provides and the number of clinical staff it employs. Discounts are available to those trusts that achieve the relevant NHSLA risk management standards and to those with a good claims history.

Employee benefits are the total employment costs. These are analysed into:

1. 'Employee benefits excluding board members'. This includes employer's national insurance, pension contributions, early retirement, termination and agency staff costs.

2. 'Directors' costs'. This is the total paid to Executives including employer's national insurance and employer's pension costs.

Revaluation – Existing Use Value for non-specialised properties is 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.

Revaluation – Depreciated Replacement Cost (DRC) is 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.

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