Lincolnshire Community Health Services NHS Trust

Annual Report and Accounts

2017-18

Great care, close to home

Contents

Trust Purpose

Great care, close to home

Strategic objectives

Strategic aims	Strategic objectives
Providing high quality, safe, personalised care	1. To deliver safe services
	2. To deliver service improvement that stems from feedback from partners, patients and carers.
	3. Become a CQC-rated Outstanding Trust by 2019/20
Delivering value for money and financial sustainability	4. Sustaining service viability while demonstrating the value of our services
	5. Real time business intelligence demonstrating productivity and value for money
	6. Deliver 2018/19 Financial Plan and control total
Building a quality, productive and supported workforce	7. Right people, right skills, right place, right time
Strengthening our positive reputation	8. Build positive relationships with all stakeholders
	9. Play a leading role in the delivery of Lincolnshire STP, while demonstrating the value and impact of our contribution to system transformation
Leading integration and innovation	10. HomeFirst – With partners lead the implementation of healthcare change and improvement across Lincolnshire.

LCHS Way

The LCHS Way is “We listen, we care, we act, we improve”

We listen: we engage with everyone we work with | we are united | we are always positive

We care: everyone is valued, respected and developed | knowledge and skills are nurtured | success is celebrated

We act: Clear goals and the right resources | freedom coupled with accountability | emphasis on simplicity

We improve: we are creative, resourceful and innovative | integration & collaboration is the way forward | we’re always striving to do better

Introduction

Elaine Baylis QPM, chair of Lincolnshire Community Health Services NHS Trust

Welcome to the Annual Report and Accounts 2017/18 for Lincolnshire Community Health Services NHS Trust.

Lincolnshire Community Health Services NHS Trust (LCHS) provides community healthcare services for the population of Lincolnshire.

The philosophy of the trust is to deliver great care, close to home; putting itself at the forefront of providing good quality out of hospital care to avoid admissions into acute hospitals.

Working in partnership with other health and social care bodies, the trust delivers care in community settings across a range of services including; community nursing and therapy services, end of life care, urgent care, public health, children's health and social care services; all supporting a shift to care outside of a hospital setting.

The trust prides itself on delivering clinical practice that is safe for patients, is effective and delivers a great patient experience. LCHS measures the quality of its services through a series of metrics that are presented on a monthly basis to the LCHS trust board and its assurance committees. This includes feedback from those who use our services.

Although this annual report concentrates on LCHS and the quality of the services it delivers, it is important to stress that LCHS does not exist in a vacuum. The Lincolnshire Sustainability and Transformation Partnership (STP) is a collaboration of provider and commissioner NHS organisations and Lincolnshire County Council all working together to address the health and social care needs of the population of Lincolnshire both now and in the future.

LCHS remains at the forefront of the whole system approach. The Lincolnshire coordinating board is chaired by Elaine Baylis, chair of LCHS and the system executive team is chaired by LCHS chief executive, Andrew Morgan. Both the STP programme board and the programme management office have a high level of participation from LCHS staff.

Changes to the Trust Board

In May 2017, Liz Libiszewski joined the trust as a non-executive director. Liz brings a wealth of NHS experience, having held a combination of senior operational management positions and board level nursing posts. Liz is chair of the trust's quality and risk committee.

Dr Neal Parkes left the trust at the end of June 2017, having served as interim medical director since January 2017. Neal was not directly employed by the trust, instead having worked as part of an arrangement between LCHS and Lincolnshire and District Medical Services.

At the end of September 2017, David Woodward's term of office as a non-executive director came to an end. David, who has been with the trust since October 2012, has extensive experience within financial services and was the chair of the trust's Audit Committee.

Dr Sue Elcock joined LCHS as interim medical director in November 2017. Sue is the substantive medical director at Lincolnshire Partnership Foundation Trust, the mental health provider organisation in Lincolnshire and holds both posts concurrently.

In January 2018, Alan Kent joined the trust as associate non-executive director. Alan brings more than 30 years' financial expertise to the role, having worked both within the NHS and the private sector. As a qualified accountant and management consultant, he has worked with most types of NHS trusts, including provider and commissioning organisations, and is also currently a lay member with South Norfolk Clinical Commissioning Group.

Highlights and performance

The trust continues to perform in a sustainable manner with clinical services that have attained an overall rating of "good" from the Care Quality Commission (CQC) and strong financial performance that once again saw the trust report a surplus against its control total.

In August and September 2017, the trust's GP Out of Hours Service received a planned inspection by the CQC. This included a series of announced and unannounced visits at sites across Lincolnshire.

The trust was delighted when the service received an overall rating of good. A summary of the CQC inspection report can be found here.

One of the greatest challenges to the sustainability of a trust is losing the services it delivers. In October 2016, Lincolnshire County Council took the decision to deliver health visiting and school nursing services in house.

On October 1, 2017 the service transferred to Lincolnshire County Council. The staff who delivered the service also transferred across and they go with the very best wishes of everyone within the trust.

In February 2018 the Lincoln Walk-in Centre closed its doors for the last time. The commissioners, Lincolnshire West Clinical Commissioning Group, made the decision to decommission the service to support the provision of alternative primary care services in the area.

At the end of February 2018, the worst of the weather brought out the best in the trust's staff. Examples of this selfless attitude include therapists from the Assisted Discharge Stroke Service who were unable to complete their own visits, supporting colleagues from the local acute trust on the stroke unit at Lincoln County Hospital and nursing teams caring for their most vulnerable patients via specially commissioned 4x4 vehicles.

It never comes as a surprise to the senior leaders' within LCHS that the staff always put the needs of their patients above their own needs and comfort. These are just some of the examples of the attitudes and behaviours embodied within the LCHS Way: "We listen, we care, we act, we improve".

LCHS has created an initiative to showcase the positive impact its staff has on the lives of the people it cares for. Titled "Ordinary Day, Extraordinary People", this initiative highlights to staff the remarkable effect their everyday actions have on the lives of the people in the communities served by the trust.

On behalf of the Trust Board I am pleased to present this annual report.

Overview of quality performance

The trust's quality improvement priorities for 2018/19 are set out in its quality account including:

- **leg ulcers** - improving outcomes for patients with leg ulcers, 50% of patients healed within a 12 week pathway
- **falls** - falls prevention priority to reduce falls with harm rates in our community hospitals by 25%
- **pressure ulcers** - further reducing harm from preventable pressure damage by 50%
- **medicines management** - Improving medicines safety for our patients by 25% against a baseline of 213 errors

The trust delivered a range of CQUIN programmes during 2017/18 as agreed with commissioners agreed with commissioners, these include:

- **improving staff health and wellbeing** - the trust introduced 'Physio for you', mindfulness, menopause support, wellbeing sessions, sugar awareness. The trust's flu vaccination programme for 2017/18 achieved 71.9%
- **supporting proactive and safe discharge** - joint working with acute partners, extension of 'home first' initiatives, refresh of transitional care pathways across the system, bespoke actions to address delayed transfers of care working with all partners, continuation of HART service, shared workshops with partners to understand system flow and community hospitals discharge with safer bundles
- **preventing ill health by risky behaviours** - particularly tobacco and alcohol - screening, advice and referral
- **improving the assessment of wounds** - diagnostic treatment and formulary management and wound photography
- **personalised care and support planning** - focussed on specialist teams, accessing training, four teams on personalised activation

Further development of care pathways in line with the system transformation plan

The trust introduced frailty and long term conditions and a stroke pathway in partnership with the acute trust for patients to have their first seven days in acute care and then transfer back into a community setting.

The trust has undertaken significant work on improving clinical audit, identifying and implementing practice changes and providing examples for

board assurance. Planned improvements will include closer monitoring and closure of actions.

The trust has led in the development of the single system plan for Lincolnshire and will continue to be taking a leading role in the delivery of key pathways to improve outcomes for patients. The trust will be developing new partnerships and working closely with the acute trust and primary care to ensure that patients receive the right care in the right place at the earliest opportunity.

Following patient feedback the trust has introduced changes within services by taking a "you said, we did" approach. The trust aims to increase Friends and Family Test feedback by the increased use of text messaging (SMS). SMS will now be rolled out across all services.

The trust has received very positive feedback from staff in the NHS Staff Survey and is now in the upper quartile for positive responses. The feedback has been reviewed and shared with the Trust Board and there are plans in place to further improve the health and wellbeing offer for staff to ensure that they are motivated and positive in their delivery of patient care.

LCHS staff spend a significant amount of time in their cars and sometimes in difficult conditions. The trust is exploring provision of driver awareness training.

Integrated neighbourhood working in partnership with general practice, adult social care, mental health and the third sector

The plan is to identify patients with a health and care need in their locality and plan care as part of a multi-disciplinary team to ensure self-management and ill-health prevention.

Work streams include:

- primary care streaming has been established at the front of each acute site. The plan is to extend this to a multi-disciplinary team offer to manage patients and avoid A&E attendance and admission. Patients will then be signposted back to their primary care practice or neighbourhood team for future management.
- access to the Clinical Assessment Service will be extended to direct calls from care homes and neighbourhood teams to ensure clinical

decision making for patients with an urgent need to prevent A&E attendance and admissions.
- extending the leadership development programme to corporate as well as front line clinical staff and extending to other providers as an offer.
- taking a leading role in delivery of the Sustainability and Transformation Partnership
- governance and risk management

Highlights and innovation

Donna Phillips, clinical nurse lead of Scotter Ward at John Coupland Hospital was nominated for and won 'Nurse of the Year at the first ever Lincolnshire Health Awards in November 2017.

Donna was nominated by several members of the team and staff she had worked with in the past. She was nominated for her can do attitude, her supportive nature as a leader, going the extra mile for staff and patients, supporting the staff to raise money for the palliative care suite and engaging in activities to do this in her own time to name a few things.

HSJ Value Awards 2018 – Operations Centre shortlisted

The Operations Centre was opened in December 2016 and provides a 24/7 multi-disciplinary team for LCHS. It was developed on the principle of a ‘one call does it all’ model and is a critical service that glues the trust’s services together e.g. community nursing, community hospitals, urgent care, transitional care and our Clinical Assessment Service. There were three phases to the development of the Operations Centre; estates conversation and workforce re-alignment, a review of standard operating procedures, pathways and patient flow and finally around support to the wider healthcare system and future innovations. One of the core functions of the Operations Centre is to be the centralised referral management hub for the trust, support with transitional care bed flow and home visiting teams dispatch.

HSJ Value Awards 2017 and 2018 – Clinical Assessment Service shortlisted

The Clinical Assessment Service (CAS) is an alliance with East Midlands Ambulance Service NHS Trust which has been in operation since August 2016. CAS is a triage service which directs patients to primary care centres; dispatches home visiting teams, offers planned call backs to those with less urgent needs and is supported by multi-skilled clinical staff including GPs, urgent care practitioners and pharmacists.

Family members being trained to give pain-relieving injections to dying loved-ones

This innovative scheme developed by LCHS in collaboration with St Barnabas Hospice has been featured in the Telegraph as an example of direct choice and control of self-care being offered to patients. Described by the newspaper as a scheme which 'empowers nominated carers' by allowing them to administer drugs with the prior approval of two clinicians, it is applauded for the dignity, choice and of course, relief on the system it provides.

Full article here: http://www.telegraph.co.uk/news/2016/12/11/family-members-trained-give-pain-relieving-injections-dying

Frailty

In response to an ageing population with increasingly complex needs LCHS has started to embed a patient-centred approach that articulates dependency and need. Rather than looking at symptoms and treating separately; for example falls and pressure damage. LCHS has turned this around to focus on the cause. LCHS consulted widely with system partners on a new pathway and a range of support tools including facilitating a three-day consultation event in December 2017 to showcase the pathway and toolkit.

The event was attended by over 300 people from LCHS and beyond.

Diabetes 100 days challenge

Through the 100 days challenge and some transformation funding the Diabetes Service has been able to trial a number of innovative practice developments including:

- virtual clinics (consultants and specialist nurses triaged all referrals during the pilot period to ensure they were only referred to secondary care where appropriate)
- single referral point (all referrals from three participating practices were directed to a specialist nurse for an assessment and directed to the most appropriate service)
- a caseload review with secondary care.

These initiatives highlighted that more patients could be managed in the community, allowing secondary services to focus their resources on more complex cases. Diabetes innovation activity has strong partnership engagement including with patients, who led an engagement event in April

2018 looking at how services can be improved, and academics from Lincoln University who are helping with the analysis.

Digby 'Home First' Community Ward

A real time, fast and effective innovation, in partnership and at the request of the acute trust in Lincolnshire. To support winter transitional care and multi-disciplinary team, with both therapists and nurses to release acute sector beds and resource to deal with the winter pressures. Real partnership working resulted in the setup of the Digby 'Home First' Community Ward.

At very short notice to support transitional care needs. This can be best summed up by the following sentence. The 100 patients LCHS discharged stayed in hospital and average of 2 days, 10 days less than those remaining on an acute ward. Those 100 patients saved the system £2 million.

Performance report

Performance overview

Purpose of this section

The aim of this performance report is to provide a summary of:

- the purpose and activities of the trust
- the main objectives and strategies
- the principal risks faced by the trust
- the trust's operational and financial performance

A statement from the chief executive providing his perspective on the performance of the trust during 2017/18

Andrew Morgan, chief executive
Lincolnshire Community Health Services NHS Trust

Lincolnshire Community Health Services NHS Trust (LCHS) provides community healthcare services for the population of Lincolnshire. The trust has an annual turnover of c. £95m, employs c. 2,000 members of staff and was last inspected by the CQC in December 2014, gaining an overall rating of 'Good'.

Working in partnership with other health and social care bodies, the trust delivers care in community settings across a range of services including; community nursing and therapy services, end of life care, urgent care, public health and children's health and social care services; all supporting a shift to care outside of a hospital setting.

The trust's stated purpose is to deliver great care, close to home. This puts it at the heart of the Lincolnshire healthcare economy and it is vital that LCHS' services continue to be aligned to the needs of the county as a whole.

During the year the trust has continued to develop its services in line with the needs of the Lincolnshire healthcare community. With the launch of the Urgent Care Streaming Service at Lincoln County Hospital and Pilgrim Hospital, Boston, working in tandem with the Clinical Assessment Service,

the Urgent Care Streaming Service has been working well to divert patients away from the emergency departments at both hospitals.

In February 2018, LCHS launched the Digby 'Home First' Community Ward, based at Lincoln County Hospital. This was a joint pilot project between LCHS and United Lincolnshire Hospitals NHS Trust (ULHT), during February and March 2018. The actions of the staff on Digby Ward made a significant contribution to patient flow at Lincoln County Hospital during a particularly busy period, with more than 100 discharges in six weeks.

LCHS continues to perform well and in addition to the positive CQC inspection result the trust is one of only 37 trusts in segment 1 of the Single Oversight Framework, out of the 232 trusts operating under the framework.

The Single Oversight Framework is used by NHS Improvement to identify NHS providers' potential support needs and to segment trusts according to the level of support required.

Financial performance

LCHS has a legal and moral obligation to manage the money it receives from the public purse each year and deliver quality healthcare services that represent good value for money. Although the trust continues to have strong financial performance, LCHS operates within the Lincolnshire healthcare system and the system as a whole faces significant financial pressures.

During 2017/18, LCHS posted a year-end financial surplus of £4.823m, £1.508m higher than the planned surplus of £3.315m. Within the outturn position, the trust has received Sustainability and Transformation Fund (STF) income of £1.357m (planned allocation) and a further "bonus" allocation of £1.447m for achievement beyond NHS Improvement expectation.

Purpose and activities of the organisation

LCHS is the primary community healthcare provider in Lincolnshire. The trust delivers a broad range of community nursing, therapy, urgent care, reablement, palliative care, public health, children's health and social care services.

By providing community-based services aimed at preventing health problems from getting worse, LCHS helps to reduce the need for people to go into hospital. We are working closely with other health and social care services to support a shift from care in acute hospitals, into more joined-up care in the community, closer to home.

The trust has a wide portfolio of healthcare services that includes:

- general and specialist integrated community nursing and therapy healthcare services
- inpatient beds in four community hospitals
- emergency care services, including:
  - two urgent care centres, one in Skegness and one in Louth
  - two minor injuries units, one in Gainsborough and one in Spalding
  - a minor illness and injury unit at the city care centre in Peterborough
- GP out of hours services
- Sexual health and contraceptive health services
- podiatry service
- children's and young people's services, including:
  - vulnerable children and young people
  - children's therapy services
- safeguarding services for both children and adults

Service developments in 2017/18 include:

- the introduction of urgent care streaming at Lincoln County Hospital and Pilgrim Hospital in Boston, in partnership with United Lincolnshire Hospitals NHS Trust (ULH)
- enhanced Clinical Assessment Service for care homes
- outpatient antibiotic therapy

Business environment

Key challenges for Lincolnshire's health and care system

Deteriorating quality

- ULH is in Quality Special Measures
- The system is in Category 4 (this is the lowest category) for urgent and emergency care
- The system is in escalation for not achieving constitutional standards for cancer
- CCGs are a long way from Right Care upper quartile performance

Significant staffing challenges

- The Lincolnshire healthcare system has a recruitment challenge with a high vacancy rate of 9%
- As a consequence, the system has very high use of agency/locum staff (average 400 whole time equivalent each month)
- The system has been more successful with GP international recruitment. An extra 26 GPs were recruited through international recruitment and 24 remain (now) in post compared to this time last year.

Deteriorating finances

- Month seven showed a system deficit of £70million with an additional £26million financial risk identified
- ULH is in Financial Special Measures
- All CCGs are carrying significant financial risk

There is shared acceptance that Lincolnshire is a challenged health economy and the status quo is neither safe nor sustainable.

System working and commissioning

Both national policy, as described in the Five Year Forward View and the 2018/19 NHS Mandate, and local commissioning intentions, as articulated in the Lincolnshire Single System Plan, are focussed on addressing three key objectives:

- **improving health and wellbeing:** radical upgrade in prevention, patient activation, choice and control and community engagement
- **driving transformation:** development of new care models, improvement against clinical priorities and rollout of digital healthcare

- **closing the finance and efficiency gap:** achieving financial balance across the local health system and improving the efficiency of NHS services

The commissioning and provider NHS organisations in Lincolnshire have committed to:

- system working, with common purpose, standards and outcomes.
- the development and delivery of the single system plan for 2018/19 for the benefit of the Lincolnshire population.
- applying all the collective resources to deliver better outcomes, while living within the funds available across the system.

Planning has been reframed in line with the Sustainability and Transformation Partnership (STP). A single system plan has been developed and this has been disaggregated to the seven individual organisations for delivery. The objectives of this plan are:

- achieving the 'triple aim': closing the care and quality gap, health and wellbeing and funding and efficiency gaps
- maximising the available capacity, capability and funding of the NHS in Lincolnshire
- clarifying system accountability, while ensuring leaders have the autonomy to act across organisations
- having a concurrent focus on 18/19 and developing the planning pipeline for 2019/20 and beyond

Lincolnshire's single system plan has four priorities:

System Priorities	2018/19 programmes of work
System Working Commitment to system working, with common purpose, standards and outcomes for the benefit of the Lincolnshire population. Application of all of our collective resources to deliver better outcomes, while ensuring that we live within the funds available	• System coordination • Meeting national STP requirements • Strategic planning • System finance • Analytics and performance • Diagnostics • Transport • Large scale change and organisational development • IM&T & information governance • Estates and capital

System Priorities	2018/19 programmes of work
across the system	• Workforce • Communications and engagement • System equality and diversity assessment • System Programme Management Office
Out of Hospital Delivery Ensuring out-of-hospital care becomes a much larger part of what the NHS in Lincolnshire does: moving care and resources from acute hospitals to neighbourhood networks providing care closer to home.	• **Out of Hospital Delivery Programme:** align and design; population health management • **Integrated Neighbourhood Working and Self Care**: developing core teams, clear pathways including frailty; care home support; neighbourhood networks; strengthen transitional care; determine the role of community hospitals • **Primary Care:** delivering GP Five Year Forward View • **Cancer:** supporting people living with & beyond cancer • **Urgent and emergency care**: supporting self-care; extended use of CAS; commission integrated CAS, OOH and streaming; develop Urgent Treatment Centres • **Planned care:** demand and referral management; community pain management service • **Mental Health:** transforming community services • **Women and children:** redesigning community paediatrics; delivering Better Births standards • Continuing healthcare
Acute Services Delivery Developing a smaller but more resilient acute hospital sector: considering current and projected future needs for	• **Acute Services Review (ASR):** engagement; developing the pre-consultation business case for the new models of care; consultation • **Delivering 2018/19 ASR priorities:** Increase elective activity at Louth and

System Priorities	2018/19 programmes of work
hospital services, taking into account planned developments in prevention, supported self-care and out of hospital care in line with the STP.	elective orthopaedics and general surgery at Grantham; enhance ambulatory pathways at Lincoln PAU; seven day acute stroke community rehabilitation • **Urgent and emergency care:** A&E redesign • **Planned care:** MSK pathway service redesign • **Women and children:** redesigning acute paediatrics; delivering the Better Births standards • **Mental health:** reducing out of area placements
Operational Efficiencies Maximising NHS service efficiency to increase resources available for frontline services: reducing management costs, increasing the use of technology, procuring more effectively, reducing costly duplication and maximising the benefits of scale.	• **Pharmacy and prescribing:** countywide QIPP pharmacy and prescribing programme; rationalisation of prescribable products and Off FP10 supply; Electronic Prescribing and Robotic Dispensing in Acute Care; Clinical Pharmacists in Primary Care; Repeat Prescription Management – Prescription Ordering Direct • **Procurement transformation:** maximising procurement efficiencies • **Estates efficiency:** review of estate by corporate functions • **Workforce efficiency** • **Corporate services transformation:** review and implementation of shared services arrangements

LCHS Business Model

In 2017/18, the trust's clinical services have been split into two divisions:

Neighbourhood Teams

- **General and specialist integrated community nursing and therapy services** – supporting people with long term conditions; frailty and end of life care

- **Community hospitals** – health and wellbeing hubs provide a range of ambulatory and inpatient services, which can either prevent admissions into acute hospital or support timely discharge from acute hospitals
- **Supporting children with complex needs** - specialist therapy and social care services
- **Electronic assistive technology service** – supporting people with significant physical disabilities to regain or retain their independence

Urgent Care & Flow

- **Urgent care:** clinical assessment; urgent care treatment centres; home visiting service providing a responsive network of community-based services for people with urgent but non-life threatening needs
- **Transitional care:** rehabilitation and support for older people and adults with long term conditions at times when they need some extra help to manage their recovery. These services will be time limited and complement the teams that work with people on an ongoing, longer term basis
- **Sexual health and contraceptive health services**
- **Operations centre**: referral handling and capacity management ensuring the right care, first time

These services are managed by the deputy director of operations, with heads of clinical services and integrated services clinical leads providing clinical and professional support.

The trust is managed through organisational directorates, namely:

- chief executive
- nursing and operations
- medical
- workforce and transformation
- finance and strategy

The corporate services directorates support the work of the operations directorate, to ensure delivery of the best possible services. All services work closely together and report to the Trust Board through a dedicated director.

Key issues and risks to achieving the trust's objectives

Providing high quality, safe, personalised care

- **Harm-free care:** lack of relationship with partners; lack of identification of acquired harm incidents of admitted patients
- **Compliance with statutory safeguarding duties:** continued compliance with the Mental Capacity Act; lack of training around safeguarding and competency testing; lack of assurance around Section 11 HR processes
- **Co-production and co-design:** lack of patient engagement and transformation of skills
- **Delivery of quality priorities:** lack of staffing capacity; increasing levels of acuity of patients and demand; increasing complexity of patients co-morbidities; increases in the competing priorities resulting in a lack of delivery

Delivering value for money and financial sustainability

- **Selling the LCHS proposition:** lack of understanding or consistency around contractual obligations; inability to evidence or showcase outstanding performance; competition from other providers; commissioners have not commissioned the organisation to deliver the STP through the single plan; the level of maturity of the CCGs in their commissioning intentions; lack of capacity and capability to safely implement different contracting approaches
- **Developing innovative contracting solutions:** lack of engagement from stakeholders in reviewing and considering other contracting approaches
- **Business partnering:** inability to integrate corporate teams to deliver a full business partnering offer; insufficient capacity and capability within corporate functions to support a full business partnering offer; inability to articulate and implement a collaborative leadership model to maximise the performance improvement potential of this model
- **Business intelligence:** lack of organisational capacity and capability; organisational culture regarding quality of information may not be embedded; existing hardware and software may limit ability to develop real time business intelligence
- Inability to evidence performance, value for money and quality, hindering appropriate management of the trust's service portfolio
- **Inability to deliver to Productivity and Efficiency Strategy, target reduction in corporate costs and control total:** service development that does not realise required savings; lack of sophistication of the business planning process; insufficient detailed efficiency schemes in place to deliver savings required; identified efficiency schemes are not

implemented in a timely or recurrent way; inability to manage currently unknown cost pressures; adverse resolution to the HMRC dispute

Building a quality, productive and supported workforce

- **Recruitment and talent management pipeline:** lack of candidates to fill difficult to recruit to posts
- **Improved staff health and wellbeing:** lack of operational capacity and capability in order to proactively manage attendance
- **Improved staff experience:** lack of staff buy-in to use and promote fab-o-meter
- **Promoting and endorsing professional standards and behaviours:** lack of credible appraisal in capturing learning requirements in line with the Training Needs Analysis reporting
- **Maximise utilisation and efficiency of trust estate:** lack of clinical and corporate buy in to vacate premises; lack of pace of achieving rationalisation plan by third parties
- **E-rostering implementation to enable more productive and flexible staffing:** Risk operational workforce does not fully engaged with the full system capabilities
- **Understand the need for and radically shift the use of technology to support care delivery and business function:** risk of delivering at pace due to competing demands, resource, third party

Strengthening the positive reputation of the trust

- Commissioners continue to buy LCHS services: lack of understanding or consistency around contractual obligations; inability to evidence or showcase outstanding performance; competition from other providers; commissioners have not commissioned the organisation to deliver the STP through the single plan; the level of maturity of the CCGs in their commissioning intentions; lack of capacity and capability to safely implement different contracting approaches

Leading integration and innovation

- Integrated neighbourhood working: failure to maximise the opportunities to lead and participate in neighbourhood teams
- Urgent care: commissioners changing their commissioning approach and re-tendering urgent care provision

Relevant controls and mitigation are included within the trust's Board Assurance Framework, and these are monitored on a regular basis.

Going concern basis

After making enquiries, the directors have a reasonable expectation that the trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Quality account priorities

The quality account priorities for 2017/18 were discussed and agreed with the LCHS Trust Board, Quality and Risk Committee and staff groups. They were chosen in consideration of the national audit recommendations, local prevalence, feedback from Healthwatch Lincolnshire and input from commissioners.

All quality priorities have been monitored throughout the year via the trust's Quality and Risk Committee, and the LCHS operational plan.

The following extract from the quality account describes how the trust performed against each of those quality priorities. LCHS made significant progress with three of the quality targets during 2017/18 and failed to meet the other one.

Priority 1: Improving patient experience, care and outcomes for insulin dependent diabetes patients on the caseloads of community teams
Senior Lead: Head of Clinical Services East **Progress – not on target**
Why did the trust choose this priority? Lincolnshire has one of the highest rates of diabetes and LCHS undertakes an increasing number of community visits to support administration of insulin and support to diabetic patients. Diabetes UK has undertaken a piece of work which reviewed a cohort of diabetics on insulin, implemented a wider lifestyle and co-morbidity impact assessment and then developed focussed individual support. The outcomes were astounding, both qualitatively and quantitatively. In line with the clinical strategy and the Lincolnshire Sustainability and Transformation Partnership (STP) principles of increasing and promoting self-care, LCHS is repeating a similar programme of work. Outcomes cited included that many patients were able to stop taking insulin and many were

able to take control of their medicine administration. There were also notable wider health outcomes to general fitness, nutrition, mobility and mental health which positively impacted on long-term condition management and complications.

How did the trust plan to address this priority?

The activity associated with this priority was to:

- undertake an assessment of all those patients within community caseloads on insulin as our baseline cohort
- reduce the number of patients on insulin
- increase the number of insulin dependent patients who are able to self-administer

This work was to be supported by the Diabetes Clinical Nurse Specialist Team. As a new piece of work there was no existing baseline data but the trust believed there to be 235 patients across community teams receiving daily or twice daily visits.

How has the trust measured progress?

Quarter 1: The programme was established which included revision of policies and guidelines to support change in practice, revising templates on SystmOne, engagement across clinical teams and development of an e-learning package for staff.

Quarter 2: Implementation included wider engagement with United Lincolnshire Hospital Trust (ULHT) colleagues and GPs to support the programme and the establishment of two pilot sites in Gainsborough and Skegness.

The training was rolled out and included all team staff both registered and unregistered. This quarter also saw a supported review by the Information Management & Technology Team (IMT) of the care plans and templates to ensure they were fit for purpose.

All caseloads were reviewed for all teams by the diabetes specialist nurses. Patients identified were discussed at the caseload review with teams and a program of management agreed.

Quarter 3 - Involved caseload reviews and the roll out of the project incorporating lessons learned from the pilot. Standardisation of the meters used to test the patient's blood sugar levels and continuing to implement

best practice for the care of all LCHS patient with diabetes by access up to date guidance.

Quarter 4 – Continued roll out and evaluation.
The two pilot sites of Gainsborough and Skegness have been established but due to operational priorities and winter pressures this priority will not be achieved within the planned timescales. This work is linked to the 100 day challenge in Lincolnshire on diabetes. Outcomes are similar but again noted not to be within timescales. Before end of Q4 the two programmes will be reviewed.

The Diabetes Specialist Nurse Teams have therefore continued to work on caseload review support processes and increased the training offer for later in 2018.

The trust's ongoing aims:
Improvements will be taken forward in two ways. Community specialist diabetes nurses will continue to work with patients prescribed insulin in attempts to support self-care and ensure patients are on optimum treatment plans. In addition the diabetes 100 day challenge for diabetes as part of the wider work with all partners will also support on going focus.

Priority 2: Improving the knowledge and skills of staff to better manage a rising number of patients whose care may be compromised by self-neglect issues

Senior Lead: Head of Clinical Services West
Progress – target achieved

Why did the trust choose this priority?
It has become widely recognised in recent years that health and social care practitioners find it difficult to respond to self-neglect. Managing long term problems is often complex, and practitioners can be torn between respecting the right of the individual to make choices and their duty of care to protect themselves from harm (Braye et al 2013).

A failure to engage with individuals who are self-neglecting may have a serious impact on the health and wellbeing of not only themselves, but also others.

The main aims of improving the knowledge and skill of our staff in this area

are to prevent death or serious harm to self-neglecting individuals and in turn improve their health and wellbeing.

Nurses and primary care staff are essential in the detection and management of self-neglect and must be aware of its causes and risk factors (Lauder et al, 2006).

There is no one accepted definition of self-neglect; the Care Act 2014 defines it as:
"Self-neglect- this covers a wide range of behaviours neglecting to care for one's personal hygiene, health, or surroundings and includes behaviour such as hoarding."

How did the trust plan to address this priority?

The activity LCHS committed to undertake was:

- development and adoption of a self-neglect toolkit and staff guidance
- data capture of self-neglect patients through the 'vulnerable patient' domains on SystmOne.
- development of e-learning resource for staff to access when required or indicated.
- quarter four audit and reflection on case reviews undertaken during the year.

How has the trust measured progress?

The self-neglect tool kit has been developed and shared and reviewed by staff. The tool kit is now available as a resource on the staff website. Self-neglect has now been added to the trust mandatory training programme.

The e-learning resource for staff has been adopted from the Lincolnshire Safeguarding Board and is now available for staff to use across all organisations in Lincolnshire.

45 staff or teams have downloaded the guidance document between July 1, 2017 and January 1, 2018 and many more have accessed it.

An audit has been completed on caseload numbers of complex self-neglect/ hoarding issues being managed and included a multi-disciplinary team (MDT) led approach. In 2016 when LCHS developed the guidance there were three identified patients. There are now 19 identified complex patients and many lower level, less complex patients being supported.

A case study has been produced to demonstrate how the lessons learned have influenced practice. Two further cases have been added to the safeguarding training as examples of practice.

Safeguarding training forms part of the trust's mandatory training programme. 179 staff members have also completed supplementary e-learning through the Lincolnshire Safeguarding Board since it was made available in June 2017.

The trust's ongoing aims:
Skills and knowledge gained over the year in relation to self-neglect will ensure assessment and support for patients can now become embedded.

The awareness levels raised throughout 2017-18 will continue now that this topic is included within staff mandatory training.

Working closely with partners through the multi-disciplinary team approach should ensure the community is aware of patients who may self-neglect and enable wider needs to be met i.e. fire safety.

Priority 3: Improving end of life pain management experience through increased and more effective pre-emptive prescribing

Senior Lead: Clinical pathway lead for frailty/palliative care and respiratory services
Progress – target acheived

Why did the trust choose this priority?
Planning ahead for palliative and end of life patients continues to be the key to achieving good patient outcomes as the patient deteriorates. Having the appropriate medication available and ready for use for these patients provides timely relief in symptom management and reduces anxiety caused by possible delay.

How did the trust plan to address this priority?
LCHS committed to work with partner organisations and commissioners to increase the planning and provision of pre-emptively prescribed medications supported by an existing Lincolnshire End of Life Care Strategy and countywide SystmOne templates - Electronic Palliative Care Co-ordination Systems (EPaCCS).

The trust's aim was to:

- increase numbers of pre-emptive prescribing
- increase awareness and collaborative working to achieve compliance across all provider services including primary care, Marie Cure and St Barnabas services
- improve end of life experience for our patients through better and more timely pain control
- reduce delay in receiving medications, particularly during the out of hours (OOH) period

How has the trust measured progress?

There has been a considerable drive across community teams, supported by palliative care specialists to increase and improve availability of pre-emptive medicines for end of life patients.

- A collaborative task and finish group established by LCHS and involving membership from wider Lincolnshire partners has met and reviewed availability and planning of pre-emptive medications. The new 'authority to administer' form has been approved and is currently awaiting approval from ULHT. Symptom management guidance has been updated and agreed countywide.
- All organisations, with the exception of ULHT, are now using the same palliative care template in clinical records which acts as a prompt for anticipatory prescribing.
- Work continues to be led by LCHS engaging with ULHT medical leads to improve the take up of the 'authority to administer' as part of discharge planning.
- Underpinning this is the ongoing Macmillan 'Care to Learn' training and the frailty training which work on identification of patients needing palliative care support. The End of Life Care Conference held in October 2017 was well attended and received excellent feedback from clinicians including:

''a well-structured informative day giving perspectives not just clinically, but from family and patients which gave extra weight to impact of the day. The small break out groups generated great discussion.''

- LCHS participated in the STP palliative care pathway development held in February 2018. Delivery of the education programme has been agreed and a podcast broadcast approach with participation from all STP members will be implemented.

The trust's ongoing aims:

LCHS continues to support and manage end of life patients including supporting patients to choose their preferred place of death. Community teams, Macmillan specialist teams, inpatient palliative beds and partnership hospice beds strive to work in partnership with other agencies to ensure seamless 24 hour care across seven days.

Patients being able to have their pain managed within the community, as well as having an effective anticipator plan continues to be a projected outcome of care planned.

The reduction of barriers to assessment and prescribing as well as proactive planning being undertaken with patients and their families ensures patients are aware of medication and support is available if needed.

Positive outcomes for patient will continue through the wider adoption of the Electronic Palliative Care Co-ordination Systems (EPaCCS). Medicines management remains a high priority and features within the trust's 2018/19 quality priorities.

Priority 4: Supporting carers of patients by signposting to available support services

Senior Lead: Head of Clinical Services South
Progress – target acheived

Why did the trust choose this priority?

Often carers do not receive the recognition and support they need and deserve from the NHS. LCHS is committed to identifying and supporting the vital roles that carers undertake and recognising that helping carers to provide better care and to stay well themselves will contribute to better lives for those needing care and more effective use of NHS resources.

How did the trust plan to address this priority?

- Quantify the number of patients on caseloads with significant carer input and use the 'relationship field' on SystmOne to record carer numbers.
- Signpost the carers who were identified to existing carer support services and networks siting support services.
- Work with Lincolnshire County Council leads to support increased signposting and distribution of materials.

How has the trust measured its progress?

- Carers First is the LCC led ‘umbrella’ network for carers’ networks and groups. The network includes 23 individual and different support groups. The Carers First lead has attended operational and clinical meetings with LCHS services including Neighbourhood Team leads. LCHS has also invited the LCC lead to discuss access and the resources that are available.
- Carers First has provided leaflets / referral cards and posters to support the teams in raising awareness of the available resource.
- Carers First has taken up the offer to have a presence in many LCHS community bases either for hot desking or as a main site.
- Carers First has been participating in the MDT ward round on Digby Ward visiting the ward daily to offer advice and support to patients.

The trust’s ongoing aims:

LCHS teams have worked on the identification of careers of patient on the trusts caseloads. Relationships built over 2017/18, particularly with carers first, will ensure carers continue to be signposted to wider services to provide help and support.

Understanding the complex needs of patients and ensuring those with carers are supported remains a high priority for the trust. All patients on referral into LCHS services receive a holistic assessment and information about care needs. This enables the trust to understand the full needs of its patients and where appropriate signpost them to further areas of wider support.

Members of Carers First are now working alongside LCHS teams within given neighbourhoods.

Performance analysis

Statement of comprehensive income for year ended 31st March 2018

	2017-18 £000s	2016-17 £000s	Description
Gross employee benefits	(63,738)	(69,268)	The amount we spend on pay costs for our staff groups.
Other operating costs	(35,943)	(36,231)	Our non-pay costs for supplies, services and operational costs.
Revenue from patient care activities	94,643	100,096	Income received for provision of services from our commissioning and contractual partners.
Other operating revenue	7,010	7,004	Income received for providing services to other bodies, education and training income and other non-healthcare related income.
Sustainability & Transformation Fund allocations	2,804	2,236	In 2016/17, Trusts achieving their underlying financial performance targets became eligible for additional funding from NHS England. This continued in the 2017/18 financial year.
Operating surplus/(deficit)	4,776	3,837	
Investment revenue	47	25	Income generated from the interest on our cash balances.
Other gains and (losses)	0	0	
Finance costs	0	0	Costs associated with borrowing or financing arrangements.
Surplus/(deficit) for the financial year	4,823	3,862	
Public dividend capital dividends payable	0	0	
Transfers by absorption - gains	0	0	
Transfers by absorption - (losses)	0	0	
Net Gain/(loss) on transfers by absorption	0	0	
Retained surplus/(deficit) for the year	4,823	3,862	Our overall reported surplus/(deficit) for the year

Statement of financial position as at 31st March 2018

	31 March 2018 £000s	31 March 2017 £000s	Description
Non-current assets:			
Property, plant and equipment	4,615	4,063	The value of our buildings, equipment and physical IT.
Intangible assets	518	295	The value of software licences purchased by the Trust.
Investment property	0	0	
Other financial assets	0	0	
Total non-current assets	5,133	4,358	Total value of assets owned and used by the Trust
Current assets:			
Inventories	0	0	
Trade and other receivables	8,485	9,266	Outstanding balances of money due to the Trust from its operating activities.
Other financial assets	0	0	
Other current assets	0	0	
Cash and cash equivalents	21,260	13,806	The balance of cash held by the Trust at the end of the period.
Sub-total current assets	29,745	23,072	
Non-current assets held for sale	0	0	
Total current assets	29,745	23,072	The total debts to the Trust which are expected to be settled in the next 12 months.
Total assets	34,878	27,430	
Current liabilities			
Trade and other payables	(12,890)	(11,869)	Outstanding balances of money owed by the Trust at the end of the period through its operating activities.
Other liabilities	(518)	0	
Provisions	(2,570)	(2,362)	Balance of estimates included for future settlements which the Trust may incur.
Borrowings	0	0	
Other financial liabilities	0	0	
Total current liabilities	(15,978)	(14,231)	The total liabilities of the Trust expected to be settled in the next 12 months.
Net current assets/(liabilities)	13,371	8,841	
Total assets less current liabilities	18,900	13,199	
Non-current liabilities			
Trade and other payables	0	0	

	31 March 2018 £000s	31 March 2017 £000s	Description
Provisions	(396)	0	
Borrowings	0	0	
Other financial liabilities	0	0	
Total non-current liabilities	0	0	
Total assets employed:	18,504	13,199	
FINANCED BY:			
Public Dividend Capital	381	0	
Retained earnings	17,213	12,375	The accumulated surpluses/(deficit) balances which the Trust has generated over the period it has operated.
Revaluation reserve	910	824	Balances relating to increases in values of the asset the Trust owns.
Other reserves	0		
Total Taxpayers' Equity:	18,504	13,199	

Statement of cash flows for the year ended 31 March 2018

	31 March 2018 £000s	31 March 2017 £000s
Cash Flows from Operating Activities		
Operating surplus/(deficit)	4,776	3,837
Depreciation and amortisation	878	755
Impairments and reversals	63	38
Donated Assets received credited to revenue but non-cash	(24)	0
Government Granted Assets received credited to revenue but non-cash	0	0
Interest paid	0	0
PDC Dividend (paid)/refunded	0	0
(Increase)/Decrease in Inventories	0	0
(Increase)/Decrease in Trade and Other Receivables	781	(3,346)
Increase/(Decrease) in Trade and Other Payables	878	694
Provisions utilised	0	(31)
Increase/(Decrease) in movement in non-cash provisions	604	2,353
Increase/(decrease) in other liabilities	157	0
Net Cash Inflow/(Outflow) from Operating Activities	**8,113**	**4,300**
Cash Flows from Investing Activities		
Interest Received	47	25
(Payments) for Property, Plant and Equipment	(742)	(983)
(Payments) for Intangible Assets	(369)	(85)
(Payments) for Investments with DH	0	0

	31 March 2018 £000s	31 March 2017 £000s
(Payments) for Other Financial Assets	0	0
Proceeds of disposal of assets held for sale (PPE)	0	23
Rental Revenue	0	0
Receipt of cash donations to purchase capital assets	24	0
Net Cash Inflow/(Outflow) from Investing Activities	**(1,040)**	**(1,020)**
Net Cash Inflow/(Outflow) before Financing	**7,073**	**3,280**
Cash Flows from Financing Activities		
Public dividend capital received	381	0
Loans received from DH - New Capital Investment Loans	0	0
Loans received from DH - New Revenue Support Loans	0	0
Other Loans Received	0	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal	0	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans	0	0
Other Loans Repaid	0	0
Net Cash Inflow/(Outflow) from Financing Activities	381	0
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**7,454**	**3,280**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	13,806	10,526
Cash and Cash Equivalents (and Bank Overdraft) at year end	21,260	13,806

Statement of changes in taxpayers' equity for the year ending 31 March 2018

	Retained earnings	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Changes in taxpayers' equity for 2017-18				
Balance at 1 April 2017	**0**	**20,873**	**1,762**	**13,199**
Retained surplus/(deficit) for the year		4,823		**4,823**
Net gain / (loss) on revaluation of property, plant, equipment			101	**101**
Net gain / (loss) on revaluation of intangible assets				**0**
Net gain / (loss) on revaluation of financial				**0**

	Retained earnings	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
assets				
Net gain / (loss) on revaluation of available for sale financial assets				**0**
Impairments and reversals				**0**
Other gains/(loss) (provide details below)				**0**
Transfers between reserves		15	(15)	**0**
Reclassification Adjustments				**0**
Transfers between Reserves in respect of assets transferred under absorption				**0**
On disposal of available for sale financial assets				**0**
Reserves eliminated on dissolution				**0**
Originating capital for Trust established in year				**0**
Public Dividend Capital Received	381			**381**
Permanent PDC received – cash				**0**
Permanent PDC repaid in year				**0**
PDC written off				**0**
Transfer due to change of status from Trust to Foundation Trust				**0**
Other movements				**0**
Net actuarial gain/(loss) on pension				**0**
Other pensions re-measurement				**0**
Net recognised revenue/(expense) for the year	**381**	**4,838**	**86**	**5,305**
Balance at 31 March 2018	**381**	**25,711**	**1,848**	**18,504**
Changes in taxpayers' equity for 2016-17				
Balance at 1 April 2016	**0**	**8,498**	**938**	**9,436**
Retained surplus/(deficit) for the year		3,862		**3,862**
Net gain / (loss) on revaluation of property, plant, equipment			(99)	**(99)**
Net gain / (loss) on revaluation of intangible assets				**0**
Net gain / (loss) on revaluation of financial assets			0	**0**
Net gain / (loss) on revaluation of available for sale financial assets			0	**0**
Impairments and reversals			0	**0**
Other gains/(loss) (provide details below)				**0**
Transfers between reserves		15	(15)	**0**
Reclassification Adjustments				**0**
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	**0**
On disposal of available for sale financial assets			0	**0**

	Retained earnings	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Reserves eliminated on dissolution	0	0	0	**0**
Originating capital for Trust established in year				**0**
Permanent PDC received – cash	0			**0**
Permanent PDC repaid in year	0			**0**
PDC written off	0	0		**0**
Transfer due to change of status from Trust to Foundation Trust	0	0	0	**0**
Other movements	0	0	0	**0**
Net actuarial gain/(loss) on pension				**0**
Other pensions remeasurement				**0**
Net recognised revenue/(expense) for the year	**0**	**12,375**	**824**	**3,763**
Balance at 31 March 2017	**0**	**20,873**	**1,762**	**13,199**

Single Oversight Framework

The aim of the Single Oversight Framework is to help providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding'. The framework was introduced from 1st October 2016, at which point the Monitor 'Risk Assessment Framework' and NHS Trust Development Authority's 'Accountability Framework' ceased to apply.

Each trust is segmented into one of the following four categories:

Segment	Description
1	Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.
2	Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
3	Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.
4	Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.

Full details are available on the NHS Improvement website: https://improvement.nhs.uk/resources/single-oversight-framework/#h2-what-is-the-single-oversight-framework-sof

The framework is used to identify NHS providers' potential support needs and to segment trusts according to the level of support required, with signposting and offer (or mandate) of tailored support as appropriate. This segmentation is informed by data monitoring and judgement of providers' circumstances

against five themes, however only three of the themes have indicators relating to LCHS (Leadership and Improvement, Quality of Care and Finance and Use of Resources). Each of the themes has trigger points, which impact on the segmentation of the trust. NHSI publish segmentation outcomes on a monthly basis (see most recently published performance below), and have consistently assessed the trust as 1 – "no evident concerns". As such, review meetings with NHSI are held on quarterly basis.

Of the 232 trusts operating under the framework, the overview of segmentation by type is as below; LCHS is one of only 37 trusts in segment 1 (the top 16%).

	Segment 1	**Segment 2**	**Segment 3**	**Segment 4**
Acute	10	71	53	17
Ambulance	2	5	1	2
Care Trust	1	4	0	0
Community	**9**	**6**	**3**	**0**
Mental Health	15	27	5	1
Total	**37**	**113**	**62**	**20**

Info about care trusts
http://www.legislation.gov.uk/ukpga/2001/15/section/45

Performance data presented to Trust Board throughout the year

Performance metrics are based around the CQC domains of safe, effective, caring, responsive and well led. The trust's key performance indicators (KPIs) are held to account via the Finance, Performance and Investment Committee (FPIC). These performance metrics are reported to the Trust Board on a monthly basis via the Integrated Performance Report and the data presented below is a full year representation of the monthly reports.

Safe

Patient falls per 1,000 occupied bed days

To provide a stable and accurate measure of falls within its community hospitals, the trust calculates falls on an average titled 'rate per 1,000 occupied bed days'. This allows performance comparison month on month within the trust, but cannot be used to compare against other community hospitals. Staff in other community trusts might report falls in different ways, and their patients may be more or less vulnerable to falling than those treated by LCHS.

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
8.98	7.5	6.39	7.25	4.73	4.25	3.75	7.2	4.95	8.67	6.87	3.26	4.34	2.83

Medication errors resulting in serious harm

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	0	0	0	0	0	0	0	0	0	0	0	0	0

Completion of annual mandatory training

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb -18	Mar -18
90%	95%	91.5%	90.6%	90.6%	91.3%	90.9%	91.2%	92.9%	93.8%	93.8%	92.7%	93.2%	92.6%

Central Alerting System (CAS) alerts open beyond timescale

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	0	0	0	0	0	0	0	0	0	0	0	0	0

Serious untoward incidents (SUIs) reported (excluding pressure ulcers)

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
		0	4	2	1	2	2	2	5	2	2	3	2

Venous thromboembolism (VTE)

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
95%	95%	94.4%	100%	96.3%	100%	100%	95.65%	100%	100%	95%	96%	100%	100%

Completion of root cause analyses within 60 days

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

MRSA

Infection prevention data is now supplied quarterly

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
		0	0	0	0	0	0			0			0

MRSA screening

Infection prevention data is now supplied quarterly

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	100%	100%	96.22%	98%	97%	100%	100%	100%	96%	100%			98%

C Difficile

Infection prevention data is now supplied quarterly

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan -18	Feb - 18	Mar - 18
0	N/A	0	1	2	0	0	0	1	0	0			1

E Coli

Infection prevention data is now supplied quarterly

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
0	N/A	1	0	0	0	0	0	0	0	0			0

MSSA

Infection prevention data is now supplied quarterly

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan -18	Feb - 18	Mar - 18
0	N/A	0	0	0	0	0	0	0	0	0			0

Ward cleanliness

Infection prevention data is now supplied quarterly

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
0	>95%	>95%	>95%	>95%			>95%			<95%			>95%

Effective

Harm free care rate

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
95%	95%	95.64%	97.15%	97.00%	97.19%	98.01%	96.54%	97.05%	95.51%	96.56%	95.13%	97.28%	96.05%

Rate of avoidable grade 3 or 4 pressure ulcers in the community per 1000 contacts

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
4.6	0.32	0.16	0.06	0.18	0.07	0.13	0.14	0.13	0.14	0.14	0.16	0.13	0.14

Rate of avoidable grade 3 or 4 pressure ulcers in the community hospitals per occupied bed dates

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
0.9	0.07	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.19	0.18	0

Clinical supervision

Since April 2017 a new system to record clinical supervision has been introduced with access available via the staff intranet. This system has been well received by staff and recording compliance has improved month on month. A trajectory of 70% was set by the director of nursing and operations for the end of July 2017, increasing to 80% by the end of September 2017, which is in line with the target of the Quality Account. Both of these targets have been achieved and continue to be sustained.

Compliance figures are monitored weekly and overall compliance is achieved when supervision has been undertaken once every three months, with many staff recording much more than this.

Clinical supervision forms part of the performance dashboard in order that the trust can monitor service area compliance. Now that target has been reached, there is the requirement to ensure that this is maintained.

The next challenge in relation to clinical supervision will be to ensure that staff have evidence to support their session and that supervision undertaken is of high quality.

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	80%	51.9%	50.4%	69.0%	77.5%	79.1%	87.0%	89.1%	85.7%	85.3%	88.7%	85.9%	88.1%

Patient facing time

Completeness and quality of data input on SystmOne impacts the trust's ability to accurately report patient facing time (PFT). Review of data demonstrates that some staff are not including activity length for clinically relevant activity. For example, 9% of clinically relevant contacts in November 2017 were recorded with an activity length of 0.

The PFT indicator definition is as follows:

- Telehealth and patient related clinical documentation as part of the PFT calculation
- record patient facing time for nursing staff only undertaking nursing specific activities
- include all activity regardless of how many minutes are recorded as this is more reflective of recorded activity on Systm1 and drives data quality improvements
- a move from calculating PFT as a % of contracted hours to a % of total available hours – allowing a more accurate recording taking account of absence and actual activity recording behaviours

PFT continues to improve in most teams. The capture of PFT is dependent on clinicians recording behaviours in SystmOne. The management analysts continue to work with staff and SystmOne trainers.

Work is ongoing to understand any complex problems; the plan will include:

- Accurate training on induction
- Task force approach to training groups of staff in the 12 teams
- 1-1 training of individuals requiring it
- Performance management of individuals not complying post training
- Annual training

The plan will be submitted to senior operations and performance against the plan, to be monitored at local operations, performance meetings, and performance management reviews.

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	65%	59.63%	56.15%	57.46%	60.03%	60.66%	57.87%	56.87%	53.82%	58.79%	56.75%	57.5%	57.81%

Average length of stay

The agreed sustainability and transformation fund (STF) key performance indicator (KPI) is to remain below the national benchmark of 28 days.

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
28 days	16 days	17.8	16.3	16.7	11.3	12.4	12.5	13.3	11.1	11.1	12.1	10.9	11.2

Bed occupancy

Bed occupancy rates are monitored to establish the utilisation of community hospital beds against the benchmark set by the community trust benchmarking group is 90%.

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
85-95%	86% (+-2)	86.9%	83.8%	73%	81%	85%	85.6%	88.1%	81.5%	85.8%	87.30%	85.1%	94.9%

Delayed transfers of care (DTOC)

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	<=3.5%	12.36%	14.27%	10.38%	9.65%	10.61%	8.50%	6.53%	7.04%	5.06%	3.73%	3.88%	6.88%

Chlamydia screening

The target is for 25% (21,519) of the population aged 15 to 24 to receive a chlamydia screen by year end. Following the transfer of the service from Lincolnshire County Council (LCC) it was established that the recording of chlamydia screens included an element of double counting. This has been addressed, however has impacted on the ability to deliver against an anomalous baseline. Although activity levels are below target, positivity rates remain high and a quality review undertaken by commissioners in June gave an overall ‘Good’ rating, with an outstanding rating for clinical effectiveness.

The following actions are in place to increase activity levels:

- communications to pharmacies and GPs promoting the Lincolnshire Integrated Sexual Health (LISH) service and the C-Card Scheme (the Lincolnshire C-Card Scheme provides free condoms and sexual health information to young people aged 13 – 19 years old.)
- review of the C-Card service locations and quality of delivery, including review by ‘Young Inspectors’

- sub-contract with Terence Higgins Trust reviewed and updated
- extended use of mobile unit

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18	Total
	21,519	1,121	1,439	1,292	1,320	1,522	1,892	1,998	1,872	1,445	1,739	1836	1691	19167

Caring

Mixed sex accommodation

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
0	0	0	0	0	0	0	0	0	0	0	0	0	0

Friends and family test (net promoter score)

April and October 2017 data unavailable

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
89.84	94.2		95%	91%	93%	90%	90%		90%	89%	88%	89%	86%

Number of complaints

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
		10	13	15	17	8	10	18	7	4	11	9	10

Total complaints – rate per 100 whole time equivalents

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	5.0	6.12	7.9	8.02	10.46	4.9	5.97	12.08	4.69	2.68	7.29	5.92	6.61

Well led

CQC conditions or warning notices

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	0	0	0	0	0	0	0	0	0	0	0	0	0

Completion of a valid NHS number for A&E data sets

April 2017 and March 2018 data unavailable

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
95.7%	95%		99%	99%	98.9%	98.9%	98.9%	98.9%	99.0%	98.90%	99%	99%	

Ethnicity reporting in A&E data sets

April 2017 and March 2018 data unavailable

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
94.3%	95%		91.3%	91.6%	91.4%	91.1%	91.2%	91.3%	91.40%	91.50%	91.7%	91.8%	

Data completeness: community services (R) comprising: referral information

January, February and March 2018 data unavailable

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	50%	87.97%	87.90%	88.16%	88.27%	88.17%	87.97%	87.94%	88.03%	88.16%			

Data completeness: community services (R) comprising: treatment activity information

January, February and March 2018 data unavailable

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	50%	73.96%	73.98%	74.02%	74.20%	74.12%	74.17%	74.20%	74.25%	75.04%			

Data completeness: community services (R) comprising: RTT information

No data available for this measure

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
	50%												

Sickness rates (long and short term)

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
5.31%	4%	4.95%	4.96%	5.51%	5.08%	4.05%	3.54%	3.95%	4.43%	4.66%	5.23%	4.16%	4.12%

Percentage staff appraisal

Data for April and May 2017 was not RAG rated

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
90%	95%	4.30%	21.40%	85.90%	89.60%	91.00%	91.00%	94.60%	94.90%	95.20%	95.50%	95%	94.9%

Staff turnover (rolling 12 month)

Data was not RAG rated

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
12.6-29.8%		20.84%	21.09%	20.59%	19.30%	18.52%	28.10%	28.23%	26.36%	26.01%	25.66%	24.79%	24.56%

Staff turnover excluding TUPE (rolling 12 month)

Data was not RAG rated

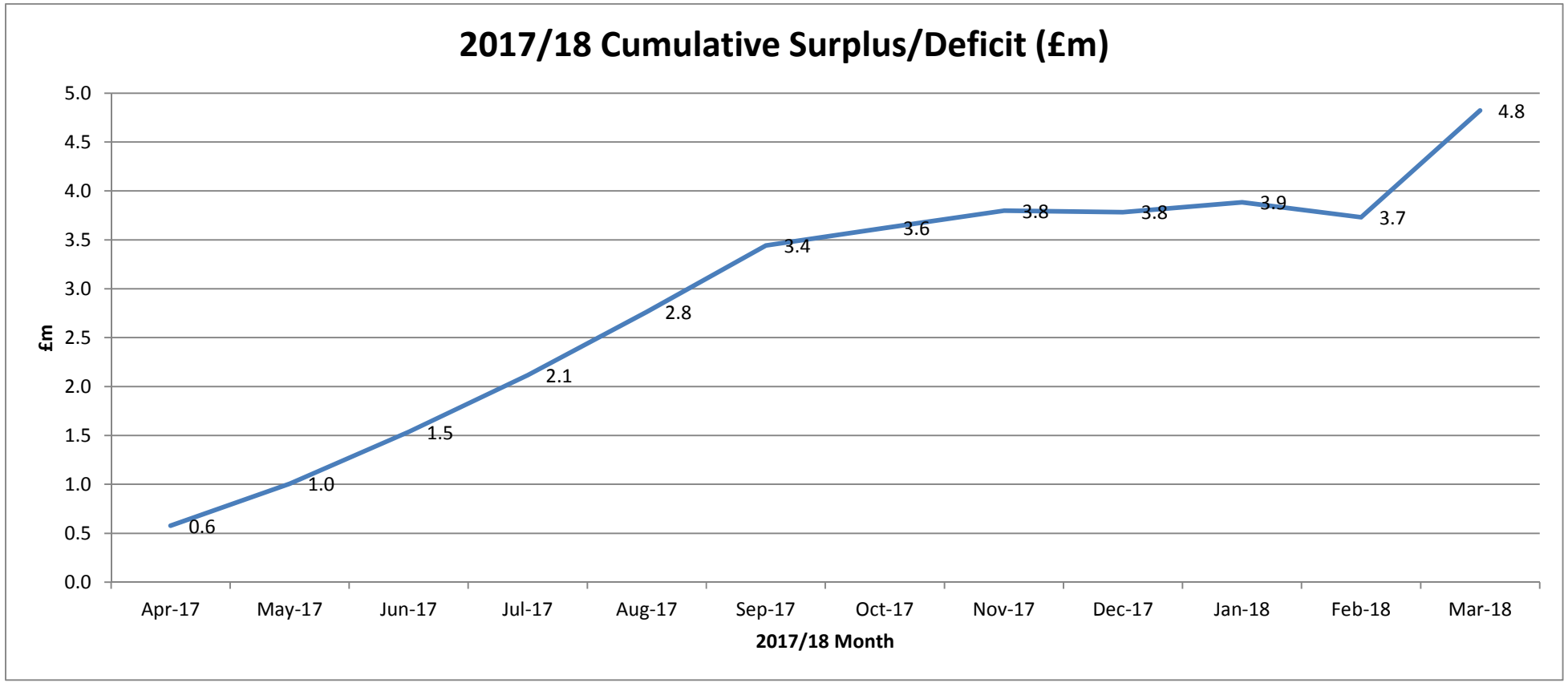
Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
12.6-29.8%		22.01%	22.48%	22.27%	21.23%	20.39%	19.66%	19.39%	17.11%	16.64%	16.04%	15.36%	14.09%

Percentage of vacancies

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
8%		8.46%	8.80%	15.12%	12.40%	12.07%	9.82%	8.79%	10.46%	7.50%	6.35%	3.46%	3.7%

Proportion of temporary staffing (costs)

Benchmark	Target	Apr -17	May -17	Jun -17	Jul - 17	Aug -17	Sep -17	Oct - 17	Nov -17	Dec -17	Jan - 18	Feb - 18	Mar - 18
5%		4.47%	3.37%	3.48%	3.16%	4.04%	3.09%	6.05%	5.33%	6.39%	5%	4%	9.91%


2017/18 Cumulative Surplus/Deficit (£m)
£m
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
0.6
1.0
1.5
2.1
2.8
3.4
3.6
3.8
3.8
3.9
3.7
4.8
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
2017/18 Month

Capital expenditure

Month	Amount
April 2017	£106,000
May 2017	£170,000
June 2017	£209,000
July 2017	£218,000
August 2017	£218,000
September 2017	£265,000
October 2017	£266,000
November 2017	£436,000
December 2017	£505,000
January 2018	£655,000
February 2018	£926,000
March 2018	£1,615,000
Total	£1,615,000

Better payment practice code compliance

Target is compliance

Month	Amount
April 2017	Non-compliant
May 2017	Non-compliant
June 2017	Non-compliant
July 2017	Non-compliant
August 2017	Non-compliant
September 2017	Non-compliant
October 2017	Non-compliant
November 2017	Non-compliant
December 2017	Non-compliant
January 2018	Non-compliant
February 2018	Non-compliant
March 2018	Non-compliant
Total	Non-compliant

Single oversight framework financial rating

Benchmark	Target	Apr - 17	May – 17	Jun - 17	Jul - 17	Aug - 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	Jan - 18	Feb - 18	Mar - 18
	1	1	1	1	1	1	1	1	1	1	1	1	1

Cash Flow (rolling and current balance)

Month	Amount
April 2017	£16,726,664
May 2017	£17,043,585
June 2017	£17,449,205
July 2017	£18,421,603
August 2017	£21,826,000
September 2017	£21,220,233
October 2017	£22,144,766
November 2017	£19,200,000
December 2017	£20,100,000
January 2018	£20,452,995
February 2018	£21,700,000
March 2018	£21,300,000
Total	£21,300,000

Responsive

Genito urinary medicine (GUM) patients seen within 48 hours

Benchmark	Target	Apr - 17	May - 17	Jun - 17	Jul – 17	Aug - 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	Jan - 18	Feb - 18	Mar - 18
	80%	91.8%	92.1%	93.6%	93.88%	87.06%	81.09%	84.27%	85.29%	82.29%	84.76%	85.05%	85.34%

18 week referral to treatment

Benchmark	Target	Apr - 17	May - 17	Jun - 17	Jul - 17	Aug - 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	Jan - 18	Feb - 18	Mar - 18
95%	100%	100%	99.76%	100%	99.8%	99.7%	99.7%	99.9%	99.5%	100%	100%	99.38%	99.4%

A&E four hour target

Benchmark	Target	Apr - 17	May - 17	Jun - 17	Jul - 17	Aug - 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	Jan - 18	Feb - 18	Mar - 18
	95%	99.41%	98.92%	99.42%	99.31%	99.31%	99.24%	99.24%	99.11%	98.41%	98.96%	98.69%	98.34%

Community nursing responsiveness

The community nursing responsiveness indicators measure the time from referral to contact. The percentage compliance reflects those patients seen within two full working days for routine referrals and one working day for urgent referrals.

The community nursing indicators were brought in by the NHS Improvement within their oversight model. When this model was superseded, the decision was taken to retain these two indicators. Since the oversight model was superseded the efficacy of these indicators have been called into question.

- The indicators measure performance against urgent and routine response at one working day and two working days respectively, however they do not include a category for referrals which are appropriate to see outside of a two day timescale e.g. planned response for patient to be seen in one week for dressing change.
- Referrals are inappropriately classified as urgent and not subsequently altered to routine, therefore performance is reported against an inappropriate timescale. Targets should be appropriate to clinical need determined on receipt of referral.
- A review of breaches was undertaken, which demonstrated that in the majority of cases patients are contacted by telephone and the visit prioritised appropriately. This is not reflected in the existing measure.

An alternative measure is being piloted which utilises a RAG (red/amber/green) rating to demonstrate the outcome of the intervention delivered. A process has been established for this to be recorded on Systmone and weekly reporting will commence for the specialist nursing services from March 2018.

Community nursing responsiveness (NON urgent)

Benchmark	Target	Apr - 17	May - 17	Jun - 17	Jul - 17	Aug - 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	Jan - 18	Feb - 18	Mar - 18
	90%	80.55%	77.61%	77.99%	76.55%	76.10%	75.90%	76.98%	77.40%	77.30%	78.39%	82.49%	78.32%

Community nursing responsiveness (urgent)

Benchmark	Target	Apr - 17	May - 17	Jun - 17	Jul - 17	Aug - 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	Jan - 18	Feb - 18	Mar - 18
	95%	96.13%	91.87%	94.72%	92.10%	91.98%	95.08%	94.89%	92.76%	96.50%	94.78%	96.41%	97.67%

NQRS12

National quality requirements in the delivery of out of hours (OOH) services came into effect on January 1, 2005. All those who provide OOH services have to meet the requirements and report compliance to their commissioners. LCHS is consistently compliant with all of the 13 indicators which apply to it with the exception of NQRS12:

Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- **Emergency:** Within one hour
- **Urgent:** Within two hours
- **Less urgent:** Within six hours

To achieve full compliance average performance of 95% or higher must be achieved.

Benchmark	Target	Apr - 17	May – 17	Jun - 17	Jul - 17	Aug - 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	Jan - 18	Feb - 18	Mar - 18
	Full compliance	Non-compliant	Non-compliant	Non-compliant	Non-compliant	Non-compliant	Partially-compliant	Partially-compliant	Partially-compliant	Non-compliant	Partially-compliant	Non-compliant	Non-compliant

Sustainability

LCHS has an ongoing commitment to support sustainability through the provision of effective and efficient health and social care in partnership with local communities. This commitment is supported by the clinical and estates strategies which encourage partnership working and the provision of care closer to home. LCHS is increasing the efficiency of services through transformational change and the rationalisation of its operational sites, the majority of which are owned by NHS Property Services.

All LCHS premises receive utility services through the government procurement service framework which allows the trust to achieve the best value for money in regard to its utility contracts and agreements. LCHS is currently working with partner organisations, such as Lincolnshire Partnership NHS Foundation Trust (LPFT) to review these contracts and achieve further efficiencies.

The trust is actively involved in the wider STP programme, progressing partnership working initiatives. The estates and facilities teams of LCHS and LPFT are now working together and a new joint appointment for an energy, environmental and sustainability manager post has been proposed.

Performance on other matters

Health and safety

This year, the trust began to give greater consideration to the level of harm caused by the accidents reported, as by far the majority involve no or minor harm. For the year (up until March 20, 2018) there were 83 incidents involving staff that resulted in injury. Of these only 7% resulted in moderate harm, the rest being minor. The biggest causes being manual handling and needlestick. Improvements to training and data collection and analysis have been implemented that should provide in a reduction in these incidents.

There were 96 reported incidents resulting in injury to patients, the majority resulting minimal harm and 5% involved moderate short term harm. The largest cause here is slips trips and falls. This is consistent with the previous year. Falls are being closely monitored and addressed through the patient safety groups.

At the start of the year the trust identified issues with the levels of fire compartmentation on its inpatient wards at community hospitals and took various steps to keep patients and staff safe including agreed actions to

improve the compartmentation with the landlord NHS Property Services. These works have been ongoing throughout the year. John Coupland Hospital in Gainsborough and Johnson Community Hospital in Spalding are now complete. Skegness Hospital will be completed by end of April 2018 and the more extensive project at County Hospital, Louth has commenced and is programmed for a late summer 2018 completion. These works provide Lincolnshire with some of the best fire protection in hospitals in the country.

Handling of Complaints

LCHS takes a proactive approach to the management of complaints and considers them to be a vital source of information and learning from patients and service users. LCHS is committed to the effective and timely investigation and response to any complaints received.

During 2017/18 the trust received 139 formal complaints (this figure may differ from the figure stated within the performance analysis due to informal concerns being translated into formal complaints), 140 compared to 168 during 2016/17. The trust also responded to a further 204 informal concerns, compared to 316 during 2016/17. LCHS also handled 16 professional to professional complaints.

Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) received a total of 172 contacts relating to LCHS services during 2017/18 compared to 171 during 2016/17. The PALS team also handles calls for commissioners, receiving 789 contacts during 2017/18 and sign posted 447 contacts to other organisations.

Accountable Officer:
Andrew Morgan
Organisation: Lincolnshire Community Health Services NHS Trust

Signature:

Date: May 24, 2018

Accountability report

Corporate governance report

The governance framework of the trust

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure in order 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 LCHS, 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 LCHS utilises has been in place for the year ended March 31, 2018 and up to the date of approval of the annual report and accounts.

The Trust Board is responsible for the management of key risks. The key areas of those risks are managed through:

- Combined Corporate Risk Register
- Board Assurance Framework
- financial risk management
- compliance with targets
- Single Oversight Framework
- Operational Delivery Plan

The Trust Board receives updates of the Board Assurance Framework quarterly and the Combined Corporate Risk Register monthly. The Trust Board also receives details of key risks through regular board reports. The monthly Integrated Quality, Performance and Finance Board Report records performance against key clinical quality indicators and all key operational performance and financial risks on a monthly basis.

The Combined Corporate Risk Register provides the Trust Board with an awareness and understanding of the major risks faced by the organisation. This allows the Trust Board to monitor and challenge the effectiveness of controls and ensure a more focused approach to its risk management strategy.

The Board Assurance Framework describes the strategic objectives and identifies the associated principal risks as well as any potential gaps in either assurance or control. The Board Assurance Framework processes and control framework issues are reviewed quarterly by the Audit Committee. Issues will be escalated to the Trust Board as appropriate.

The Trust Board meets monthly and consists of a chair, five non-executive directors (excluding the chair) and five voting executive directors (including the chief executive). The trust board secretary is also in attendance.

Directors' report

Trust Board

Chair:
Elaine Baylis QPM

Chief executive:
Andrew Morgan

Executive directors
Director of workforce and transformation/deputy chief executive:
Marie Fosh

Director of nursing and operations:
Lisa Stalley Green

Director of finance and strategy:
Danielle Cecchini

Interim medical director:
Dr Neal Parkes (01-01-2017 to 30-06-2017)

Interim medical director:
Dr Sue Elcock (14-11-2017 to 31-04-2018)

Director of strategy:
Dr Carol Brady (to 30-09-2017)

Non-executive directors
Liz Libiszewski (started 01-05-2017)

Kevin Lockyer
Murray Macdonald
David Woodward (to 30-09-2017)

Associate director
Alan Kent (started 05-02-2018)

The Trust Board meets monthly and consists of a chair, five non-executive directors (excluding the chair) and five voting executive directors (including the chief executive). The trust board secretary is also in attendance.

During the year the Trust Board has held 10 meetings with 93% attendance from non-executive directors.

Trust Board Committees

Audit Committee	
Chair	David Woodward, non-executive director (to 30-09-2017)
Membership	Non-executive director (Chair) One non-executive directors Also in attendance: Representative from KPMG 2 x representatives from 360 assurance Representative from PWC counter fraud Director of workforce and transformation Director of finance and strategy Trust board secretary/trust board business manager Director of nursing and operations
Purpose	The purpose of this committee is to: • ensure the establishment of effective governance, risk management and internal control • ensure the effectiveness of internal audit functions • review the work of the external auditor and the organisational response • review of other structural assurance functions and control frameworks
Frequency of meetings	Quarterly

Finance, Performance and Investment Committee	
Chair	Murray Macdonald, non-executive director
Membership	Non-executive director (chair) One non-executive director Chief executive Director of finance and strategy Director of workforce and transformation
Purpose	The purpose of the committee is to consider, monitor and review the following: • financial strategy, policy, management and reporting • performance management and reporting of key performance indicators investment policy, management & reporting • integrated business planning preparation and delivery procurement strategy delivery • estates strategy delivery • information management and technology strategy delivery • to make arrangements as necessary to ensure that all members of the board, and senior officers of the trust, maintain an appropriate level of knowledge and understanding of key financial issues affecting the trust.
Frequency of meetings	Monthly

Quality and Risk Committee	
Chair	Liz Libiszewski, non-executive director (from 01-05-2017)
Membership	Non-executive director (chair) One non-executive director (deputy chair) Director of nursing and operations (Caldicott guardian and director of infection, prevention and control) Deputy director of nursing Deputy director of operations Medical director (Accountable Officer for Controlled Drugs) Trust board secretary/trust board business manager Head of safeguarding Deputy director of workforce and transformation Quality governance manager

Purpose	The quality and risk committee is established to provide assurance to the board of directors that appropriate and effective governance mechanisms are in place for all aspects of clinical governance and risk including safety of clinical services, patient experience, health outcomes and compliance with national, regional and local requirements.
Frequency of meetings	Monthly

Trust and Charitable Funds Committee	
Chair	Philip Jackson, non-executive director (LPFT)
Membership	Non-executive director (chair) Charitable funds manager – Lincolnshire Community Health Services NHS Trust Head of treasury services - Lincolnshire Partnership NHS Foundation Trust Clinical representatives from Lincolnshire Community Health Services NHS Trust Communications leads/managers from both Lincolnshire Partnership NHS Foundation Trust and Lincolnshire Community Health Services NHS Trust
Purpose	The committee is responsible for governing, controlling and overseeing the administration of the charitable funds held by the Lincolnshire Community Health Services NHS Trust charitable funds.
Frequency of meetings	Quarterly

Remuneration and Terms of Service Committee	
Chair	Elaine Baylis, chair and non-executive director
Membership	Trust chair (chair) All five non-executive directors
Purpose	The purpose of the committee is to agree appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other directors including all aspects of salary, provisions for other benefits, arrangements for termination of employment and other contractual terms.
Frequency of meetings	At least annually

Register of interests

Entry Number	Name of Employee	Official Appointment in LCHS	Nature of Interest (Pecuniary or Non-Pecuniary) declared	Current Interest	Date interest declared	Date Recorded	Date interest ceased
1	E Baylis	Chair	Owner of Baylishill, a performance development coaching and consultancy business, operated as a sole trading company from my home address.	Yes	13/4/11	13/4/11	
			Director and trustee (deputy chair) Lincolnshire Action Trust. This is a registered charity and limited company that seeks to improve the skills and employability of offenders and prisoners	Yes	24/4/11	24/4/11	
			Interim chair United Lincolnshire Hospitals NHS Trust	Yes	1/1/2018	9/2/2018	
2	A Morgan	Chief executive	Board governor – The Gainsborough Academy	Yes	26/03/15	26/03/15	
			Board member – East Midlands Leadership Academy	Yes	26/03/15	26/03/15	
3	M Fosh	Director of workforce and transformation	Nil	Yes	10/03/14	10/03/14	
4	D Woodward	Non-executive director	Non-executive director of Hinckley & Rugby Building Society	No	17/01/15	23/01/15	30/09/17
			Director – Hinckley & Rugby Building Society	No	09/05/17	11/05/17	30/09/17
5	M Macdonald	Non-executive director	CEO - Boston Mayflower Ltd Boston Mayflower are a member of Lincolnshire Independent Living Partnership which is a consortium of Lincolnshire Charities working across the areas of Housing, Health and Social Care	No	02/07/13	19/07/13	16/04/18
			Chair - Manby Scout Association	Yes	14/04/15	14/04/15	

Entry Number	Name of Employee	Official Appointment in LCHS	Nature of Interest (Pecuniary or Non-Pecuniary) declared	Current Interest	Date interest declared	Date Recorded	Date interest ceased
			CEO – Shoreline Housing Partnership Ltd	No	14/11/17	16/11/17	10/04/18
			CEO – Lincolnshire Housing Partnership (following merger of Boston Mayflower Ltd and Shoreline Housing Partnership Ltd)	Yes	10/04/18	16/04/18	
6	C Brady	Director of strategy	Private practice – provision of psychological therapy services for trauma and pain management	No	17/02/15	20/02/15	30/09/17
7	K Lockyer	Non-executive director	Director, KML Consulting Ltd	Yes	26/07/15	30/09/15	
			Managing Partner, Adaptus Consulting LLP	Yes	26/07/15	30/09/15	
8	L Stalley Green	Director of nursing and operations	Trustee, Lincolnshire HealthWatch	Yes	12/01/16	15/01/16	
9.	D Cecchini	Director of finance and strategy	Nil	Yes	12/01/16	15/01/16	
10	N Parkes	Interim medical director	Senior Partner – Newmarket Medical Practice	No	10/01/17	12/01/17	30/06/17
			CEO – Lincolnshire and District Medical Services (LADMS)	No	10/01/17	12/01/17	30/06/17
			Director – Quine Medical Services	No	10/01/17	12/01/17	30/06/17
			Chairman – TWMe8 (software company) (sub directorate of LADMS)	No	14/03/17	14/03/17	01/04/17
			Partner, Crossroads Medical Practice (Sub Directorate of LADMS)	No	14/03/17	14/03/17	30/06/17
11	E Libiszewski	Non-executive director	Elizabeth Libiszewski Consulting	Yes	09/05/17	11/05/17	
			Non-executive director - United Lincolnshire Hospitals	Yes	13/03/18	13/03/18	

Entry Number	Name of Employee	Official Appointment in LCHS	Nature of Interest (Pecuniary or Non-Pecuniary) declared	Current Interest	Date interest declared	Date Recorded	Date interest ceased
			NHS Trust Husband is a non-executive director at St Barnabas Hospice	 Yes	 13/03/18	 13/03/18	
12	S Elcock	Interim medical director	Medical director – Lincolnshire Partnership Foundation Trust	No	14/11/17	16/11/17	30/04/18
13	A Kent	Associate non-executive director	Director and shareholder of Litmus Health Limited Lay member of South Norfolk CCG Governing Body	Yes Yes	31/01/18 31/01/18	02/02/18 02/02/18	

Information governance

Information Governance (IG) is a high priority for the trust. The Information Governance Management Assurance Group (IGMAG) oversees all IG issues and reports to the Quality and Risk Committee (Q&R). The IGMAG is chaired by the Caldicott Guardian who is the medical director and membership includes; senior information risk owner (SIRO) and other subject matter experts from information governance.

The IGMAG provides quarterly assurance reports and updates risks and work-plans to Q&R. The Quality Scrutiny Group (QSG) receive quarterly assurance reports and submissions of any new risks identified according to the risk assessment process.

The SIRO is responsible for overseeing the development and implementation of the trust's Information Risk Management Strategy and IG risks are managed in accordance with the Risk Management Strategy and where appropriate, recorded on the risk register.

Staff are encouraged to report IG risks and incidents and seek further advice and guidance.

Each IT system, whether corporate or clinical, has a designated service lead SIRO with defined responsibilities; including risk management and responsibility for identifying IG risks. These are supported by information asset owners (IAO) and information asset administrators (IAA) who provide support at local level.

All staff are governed by a code of confidentiality and access to data held on IT systems is restricted to authorised users through access control procedures either with a smartcard or secure login.

IG training is incorporated into the mandatory annual training and follows the Core Skills for Health Framework. IG is also part of the induction training for new starters. Dedicated specialised training for SIRO, IAO and IAA is available as e-learning through the e-learning for health platform, delivered in-house utilising accredited e-learning material provided by NHS Digital (NHSD). Ad-hoc training is provided on request or individual need.

The annual IG self-assessment exercise has taken place using the Information Governance Toolkit (IGT) provided by NHSD. The trust has achieved all of the 39 key standards for the IGT.

During the last year there has been one reported SIRI (Serious Incident Requiring Investigation) through the IG Incident Reporting Tool which automatically triggered a notification to the Information Commissioner's Office (ICO) in accordance with reporting guidelines.

Cyber Security remains a high priority for the trust and continues to review and strengthen existing arrangements and infrastructure.

False or misleading information

The Care Act 2014 has put in place a new criminal offence to publish, or otherwise make available, certain types of information that is either false or misleading. The offence came into force on April 1, 2015, under Section 92 of the Care Act and specifies that an offence has been committed if the trust supplies, publishes or otherwise makes available information of a specified description, that is required under enactment or other legal obligation, and is false or misleading in a material respect.

LCHS is committed to taking all reasonable measures to ensure that all information provided by, or on behalf of the trust is both accurate and factual. The trust has a number of measures in place to check the consistency and accuracy of data being published and ensure that staff are fully aware of their responsibilities under the Act.

Statement as to disclosure to auditors

All directors have confirmed that so far as they are aware, there is no relevant audit information of which the auditor is not aware and that they have taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS trust's auditor is aware of that information.

All directors understand that it is their responsibility to prepare the annual report and accounts, and that they consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable, and to provide the information necessary for patients, regulators and other stakeholders to

assess the performance of Lincolnshire Community Health Services NHS Trust, including its business model and strategy.

Accountable Officer:
Andrew Morgan
Organisation: Lincolnshire Community Health Services NHS Trust

Signature:

Date: May 24, 2018

Annual Governance Statement 2017-18

Lincolnshire Community Health Services NHS Trust

Governance Statement

Scope of Responsibility

The Trust Board is accountable for internal control. As chief executive of this Trust Board, I am the accountable officer for the trust with 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 the organisation's assets for which I am personally responsible. I have an understanding of propriety and accountability issues and am responsible for ensuring that the organisation is administered prudently and economically, and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

The trust has a Risk Management Strategy which is endorsed by the Trust Board annually, presented to staff at annual mandatory training sessions and is available on the website. The purpose of the strategy is to ensure that risks to the quality and delivery of patient services and care are minimised, to protect the services, reputation and finances of the trust, to create a culture where staff acknowledge risk as the responsibility of everyone and to ensure that the trust meets its statutory obligations. The strategy defines the structures for the management, ownership, review of risks and risk criteria, control and gaining assurance of risk, and the methods in which risk issues are considered and assessed.

There is a robust Board Assurance Framework in place, which sets out the key controls and assurances on controls to safeguard against the key risks to the achievement of the strategic objectives. In addition, there are formal risk management procedures in place with effective review and management procedures, which incorporate both a controls assurance and a risk assessment.

The trust's approach to corporate governance is rooted within best practice and regularly reviewed and assessed through internal processes. The Combined Corporate Risk Register and Board Assurance Framework are both reviewed and reported to the Trust Board at regular intervals.

Fulfilling the wider objectives of the trust requires effective partnership working, in addition to the internal governance and control framework. As the chief executive I am accountable to the Trust Board, the chair, and NHS Improvement. I am also accountable, along with the Trust Board, to the Secretary of State via NHS Improvement.

I ensure that the trust works effectively in partnership across the wider health community in Lincolnshire. Key partnerships include:

- executive groups of Clinical Commissioning Groups (CCGs) in Lincolnshire and adjoining counties
- health commissioners
- Health Scrutiny Committee
- Joint Staff Consultation and Negotiation Committee
- Lincolnshire County Council
- Lincolnshire HealthWatch
- NHS Improvement (NHSI)
- NHS Providers
- Sustainability and Transformation Partnership (STP)
- System Executive Team (SET)

The governance framework of the trust

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 Lincolnshire Community Health Services NHS Trust (LCHS), 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 LCHS has been in place for the year ended March 31, 2018 and up to the date of approval of the annual report and accounts.

The Trust Board is responsible for the management of key risks. The key areas of those risks are managed through:

- Combined Corporate Risk Register
- Board Assurance Framework
- financial risk management
- compliance with targets
- Single Oversight Framework
- Operational Delivery Plan

The Trust Board receives updates of the Board Assurance Framework monthly and the Combined Corporate Risk Register monthly. The Trust Board also receives details of key risks through regular board reports. The monthly Integrated Quality, Performance and Finance Board Report records performance against key clinical quality indicators and all key operational performance and financial risks on a monthly basis. Operational plans are also monitored on a monthly basis by both the Quality and Assurance Committee, the Finance, Performance and Investment Committee and the Trust Board.

The Combined Corporate Risk Register provides the Trust Board with an awareness and understanding of the major risks faced by the organisation. This allows the Trust Board to monitor and challenge the effectiveness of controls and ensure a more focused approach to its risk management strategy.

The Board Assurance Framework describes the strategic objectives and identifies the associated principal risks as well as any potential gaps in either assurance or control. The Board Assurance Framework processes and control framework issues are reviewed quarterly by the Audit Committee. Issues will be escalated to the Trust Board as appropriate.

The Trust Board meets monthly and consists of a chair, five non-executive directors (excluding the chair) and five voting executive directors (including the chief executive). The trust board secretary is also in attendance.

During the year the Trust Board has held 10 meetings with 93% attendance from non-executive directors.

The Trust Board has continued to develop its focus on strategic issues, as well as strengthening its processes for gathering assurance from across the organisation. It has achieved this through:

- periodic assessment of the Trust Board's effectiveness during board development sessions
- the chair continues to conduct reviews of governance processes
- strengthening the skills of the Trust Board
- appointment of an interim medical director
- strengthened business planning processes which have supported the continued development of the clinical and commercial strategies to inform the strategic objectives and Board Assurance Framework
- consideration of internal and external environmental factors and performance, particularly significant leadership of the STP process
- reinforcement of more robust confirm and challenge processes
- implementation of a comprehensive board development programme with a focus upon strategy development
- review and realignment of the performance management framework with the Single Oversight Framework
- well led self-assessment

The trust has been awarded segment one status via the Single Oversight Framework and the Trust Board is compliant with the HM Treasury/Cabinet Office Corporate Governance Code.

The trust remains committed to partnership working and its role as part of the wider health community in support of the five year STP plan. LCHS has taken a lead role in the development of plans and currently chair the System Executive Team (SET) and Lincolnshire Coordinating Board (LCB). The STP

plan aims to improve the quality of healthcare services across Lincolnshire whilst bringing the system back into financial balance by 2021.

To support the Trust Board in carrying out its duties effectively and to ensure the organisation remains legally compliant, there were four formal committees – Finance, Performance and Investment Committee, Quality and Risk Committee, Audit Committee and Remuneration Committee. The Finance, Performance and Investment Committee and the Quality and Risk Committee each provide supports the Trust Board and ensures effective assurance to the Board on the performance of the Trust. The Audit Committee monitors accountability arrangements on the systems of internal control.

The remit and terms of reference of these committees were reviewed during the year to ensure that compliance arrangements are in place for the discharge of statutory functions with robust governance and assurance. Each committee receives a set of regular reports, as outlined within their terms of reference and provides summary reports to the Trust Board after each meeting. Performance of the Trust Board and its formal sub committees are continually assessed for their own effectiveness against the national priorities set out in the Single Oversight Framework, with regular meetings held with the local branch of NHSI overseeing and monitoring this performance.

The Trust Board committees are described below.

Audit Committee

The Audit Committee reviews the adequacy of all risk and control related disclosure statements together with any accompanying head of internal audit statement, prior to endorsement by the Trust Board. The committee also has responsibility for overall assurance of the internal control systems/processes as monitored and validated through the internal and external audit cycles.

The Audit Committee held five meetings during the financial year, with 100% attendance from non-executive directors.

Committee minutes are submitted to the Trust Board following each meeting where any issues that require disclosure to the full Trust Board, or require executive action, will be highlighted. The committee will report to the Trust

Board annually on its work in support of the Annual Governance Statement on Internal Control, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against any key self-assessment declarations.

In addition to a number of issues being reviewed on a continuous basis, the Audit Committee has undertaken specific reviews during 2017/18 incorporating reviews of cyber security, risk management strategies, STP governance, key financial systems and payroll expenditure.

During February 2018, KPMG ran a development workshop at the request of the Audit Committee, to provide committee members with an update on the role of Audit Committees and highlight new practice for year end audit.

The committee will continue to develop and enhance mechanisms to gain assurance on all areas that come within its terms of reference over the forthcoming year. It will approve a programme of work by internal audit, external audit and counter fraud, based on a risk analysis with a number of new and more in-depth clinical assurance mechanisms being introduced, to allow it to provide the necessary assurance to the Trust Board on an on-going basis.

Quality and Risk Committee

The Quality and Risk Committee has the responsibility for leadership and strategic development, implementation, and oversight of the risk register and its impact on clinical delivery. It also oversees clinical governance with a key focus on quality of clinical care across the whole trust and actions taken to share standards; guidance and best practice and ensure that lessons learned are embedded. This includes ensuring actions are taken to address issues of poor quality and performance. It monitors progress on delivery of the Clinical Strategy taking regular updates from key service lines.

The Quality and Risk Committee has met monthly during the year with 100% attendance from non-executive directors. The meeting in December 2017 was utilised for a committee development session to improve overall performance.

There have been a number of achievements over the past year including the achievement of an overall 'Good' rating from the Care Quality Commission for the Out of Hours Service, improvement in delayed transfers of care and achievement of over 80% compliance with clinical supervision.

In July 2016, NHSI wrote to all provider organisations lending their support in the approach of deciding staffing levels based upon needs, acuity and risks. As part of the National Safer Staffing Review, an action was agreed to devolve responsibility and accountability for safe staffing numbers to directors of nursing. This allowed organisations to make an appropriate judgement in the delivery of safe, sustainable and productive staffing.

LCHS has worked with commissioners to review all staffing structures and models using best practice tools available and national benchmarking. The outcome has been a locally developed workforce model providing quality outcomes for patients within available resource, which aligns to the development of countywide neighbourhood teams and supports a care delivery focus of care closer to home and in the community where possible.

The Quality and Risk Committee receives monthly reports on how the trust is achieving the mandate from NHSI.

A number of community hospital beds have been closed due to fire safety risks and the remedial work required. Staffing levels have been reviewed to ensure safe evacuation can be delivered in the event of a fire.

The focus on the trust's quality agenda has been evident in continued achievement of over 95% for the safety thermometer.

There has been a significant focus on improving safeguarding; including new leadership and team structure, positive feedback from external reviews and an increased focus on staff training in particular the Mental Capacity Act.

As a member of the Lincolnshire wide STP, the trust has contributed significantly to ensuring best practice in the management of long term

conditions and frailty and achieved a marked reduction in delayed transfers of care.

Effective practice improvements include the launch and adoption of the Edmonton Assessment Tool. Ensuring the trust makes best use of its resources efficiently and effectively whilst maintaining and improving the quality of its services remains a key priority for LCHS this year and one in which it has been successful.

Focus for the coming year will be reflected in the trust's quality account priorities in improving patient safety through reducing harm from pressure damage, falls and medicines errors.

Internal Audit undertook a review of the Quality and Risk Committee and was able to provide significant assurance on their systems and processes.

Finance, Performance and Investment Committee

The Finance, Performance and Investment Committee has the responsibility for leadership and strategic development, implementation and monitoring of financial strategy, business planning, operational performance and investment.

The Finance, Performance and Investment Committee has met monthly during the year and had a 90% attendance. Each meeting was led by a non-executive director.

The committee reports to the Trust Board on key issues from its work programme and other emerging issues within its terms of reference.

The following areas were reviewed on a monthly basis during the year:

- financial and operational strategy, policy, management and reporting
- key issues arising from the Workforce and Transformation Executive Group and Health and Safety Committee
- performance management and reporting
- investment policy, management and reporting
- integrated business planning
- cyber security

- Combined Corporate Risk Register
- Board Assurance Framework

The committee also routinely considered:

- trust strategies (commercial, people, estates, IM&T, performance, financial management and procurement)
- updates on service line reporting
- oversight of the trust's business planning and the two-year integrated operational plan 2017-19.

One of the key matters raised during 2015/16 and that continued to be considered by the committee during 2017/18, was an issue raised by HM Revenue and Customs (HMRC) as described below:

Since 2014/15, Lincolnshire Community Health Services NHS Trust has been engaged in discussions with HMRC with regard to potential liabilities due in respect of pay-as-you-earn tax and national insurance contributions. These relate to individuals engaged by the trust in the delivery of its services (specifically the GP Out-of-Hours services), since the trust's inception in 2011. The arrangements were inherited from the trust's predecessor organisation (Lincolnshire Primary Care Trust). In February 2017, HMRC issued the trust with a computation of its assessment of total liabilities. The trust has concluded the formal mediation process and HMRC continues to pursue its position. The trust is in the process of setting out an appeal which will be served in early 2018/19.

The committee will continue to develop and enhance mechanisms to gain assurance on all areas that come within its terms of reference.

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee ratifies appointments and agrees appropriate remuneration and terms of service for the chair, chief executive and executive directors; including all aspects of salary, provisions for other benefits, arrangements for termination of employment and other contractual terms.

In addition the committee monitors and evaluates the performance of the chief executive, executive directors and other senior employees, and oversees and advises on termination payments, such as redundancy or early retirement provisions, to ensure that any payments are exceptional and only made where payment is in the public interest and represents value for money.

The committee has held eight meetings during the year with 100% attendance from non-executive directors.

Charitable Funds Committee

The trust has a Corporate Trustee who has overall responsibility for the charitable funds. The Charitable Funds Committee provides the day to day management of the charitable funds held by the trust, including the approval of expenditure within the purposes of the funds, and to supervise the operation of the funds.

The committee has met four times during the year with 100% attendance from members of the committee.

The committee reports to the Corporate Trustee on key issues following each committee meeting and at the end of the financial year submits an annual report which includes summarised financial statements.

There have been a number of successful charitable fund raising events over the past year such as the Johnson Community Hospital Annual Ball. Scotter Ward at John Coupland Hospital has been very active over the past 12 months and is now looking to begin work on its palliative care suite.

Moving forward, in the next twelve months the committee will be continuing to engage staff with its the “#makingadifference” campaign using social media, supporting staff with fundraising and encouraging spending on projects to benefit patients and staff.

Risk assessment

The ethos of the trust is that risk management is an explicit process in every activity the trust and its employees take part in. As accountable officer, the chief executive has overall responsibility for risk management in the trust and

this is discharged through clearly focusing executive responsibility for all clinical governance and risk management with the respective executive directors, who have responsibility for all trust activities and supporting corporate functions.

The Risk Management Strategy clearly outlines the leadership, responsibility and accountability arrangements. These responsibilities are then taken forward through the Board Assurance Framework, risk registers and business planning and performance management processes enabling the coherent and effective delivery of risk management throughout the organisation. The Quality and Risk Committee and Trust Leadership Team have the primary responsibility for the development and implementation of risk management throughout the trust, and seek to ensure that the trust learns from its processes and strengthens its governance accordingly. The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal controls across all the trust's activities.

Capacity and capability is developed across the trust through training events commensurate with staff duties and responsibilities and includes risk management training for all new staff.

Sharing the learning through risk related issues, incidents, complaints and claims is an essential component to maintaining the risk management culture within the trust. Learning is shared through service line structures and trust wide forums such as the Quality and Risk Committee, Infection Control Committee, Emergency Planning Committee, Information Governance Committee, Safeguarding and Patient Safety Group, Effective Practice Assurance Group, Mortality Review Panel and Health and Safety Committee.

Learning is acquired from a variety of sources which include:

- analysis of incidents, complaints, claims and acting on the findings of investigations
- external Inspections
- internal and external audit reports
- clinical audits
- outcome of investigations and inspections relating to other organisations

The trust has established the posts of trust board secretary, two corporate assurance managers, and three quality assurance managers who are responsible for providing advice and support to all staff within the organisation in identifying and managing risk. They ensure that robust systems are in place to capture all risks on the LCHS Combined Corporate Risk Register, monitor progress on mitigating actions and provide regular reports to the Quality and Risk Committee. Each service area has identified a lead to act as a point of contact on risk issues. In addition risk is managed through the Incident Reporting Policy.

All systems use the same risk grading process, an assessment of their likelihood and consequence using a 5 x 5 risk matrix in accordance with the Risk Management Strategy. These arrangements apply to all aspects of risk, including clinical risk.

Over the past year the Combined Corporate Risk Register was reviewed on a regular basis, with new risks being added and removed as appropriate. The Combined Corporate Risk Register identified the following risks at the start of April 2017, including three which were added following the publication of the previous Annual Governance Statement.

Theme	Risk
Providing high quality, personalised care	Causing harm to patients through poor safety practices
	Failure to act on lessons learnt with regard to all safeguarding reviews, root cause analysis investigations, serious incidents and high risk incidents
	Risk during transition of 0-19 services to new provider (New)
	Lack of stakeholder confidence impacted by weakened GP relationships
	If the total transformation approach required to achieve an increase in patient facing time is not

	cohesively implemented then the required target will not be achieved
	Ineffective collaborative working arrangements
	Adverse outcome from planned or unplanned CQC inspections
	Seasonal pressures
	Flexibility of services within financial envelopes
Delivering value for money and financial sustainability	Service line reporting information by commissioner may impact on investment priorities by CCGs
	Failure to deliver IM&T Strategy in line with existing contractual arrangements
	Failure to deliver on financial duties including financial balance and financial targets
	Historic employment status legacy issues
	Risk of non-delivery of trust wide QIPP Programme
Strengthening our positive reputation	Variation in practice leading to poorer outcomes for patients
	Lack of embedded systems for stakeholder engagement
	Failure to develop Trust Board capability and capacity
	Current transformation programme including service line restructures may impact on the workforce health and wellbeing and overall resilience levels (New)
Leading integration and innovation	Non-achievement of operational division QIPP targets
	Lack of Lincolnshire County Council engagement
	Failure to engage with CCG/STP
	IR35 – off payroll workers (New)

	Lack of effective leadership during periods of change
	If suitable controls and support are not in place then Nursing and Operations will fail to meet the bank and agency cap target
	Failure to provide a clear plan of proactive and urgent care services on a site by site basis may result in failure to meet the demands of commissioners and potential loss of business

In August 2017, the corporate and operational risk registers were merged to form one Combined Corporate Risk Register. This continued to be reviewed monthly.

In May 2017, the trust was subject to a cyber-attack. The trust responded by implementing its business continuity plans including using paper to present the virus spreading across the network. Community staff were able to continue to use electronic reporting as their mobile units were able to work without being connected to the network.

Since the cyber-attach the rust has undertaken the following actions:

- Reviewed and amended all business continuity plans.
- Ensured there is robust monitoring and reporting of security patches.
- Taken part in national and local lessons learned workshops.
- Joined the NHS Digital CareCERT schemes for information and early warning of potential threats.
- Aligned to the Data security and protection for health and care organisations standards set by NHS England.
- Had a NHS Digital cyber assessment (penetration test) and a remediation plan is in place to resolve the issues.
- Updated all information governance and cyber training.

During 2018 the trust will:

- Undertake an Emergency planning exercise scheduled to test plans
- Develop a plan to be Cyber Essentials certified by December 2018.

Information governance

Information Governance is a high priority for the trust. The Information Governance Management Assurance Group (IGMAG) oversees all information governance (IG) issues and reports to the Quality and Risk Committee (Q&R). The IGMAG is chaired by the Caldicott Guardian who is the medical director and membership includes; senior information risk owner (SIRO) and other subject matter experts from information governance.

The IGMAG provides quarterly assurance reports and updates risks and work-plans to Q&R. The Quality Scrutiny Group (QSG) receive quarterly assurance reports and submission of any new risks identified according to the risk assessment process.

The SIRO is responsible for overseeing the development and implementation of the trust's Information Risk Management Strategy and information governance risks are managed in accordance with the Risk Management Strategy and where appropriate, recorded on the risk register.

Staff are encouraged to report IG risks and incidents and seek further advice and guidance.

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All staff are governed by a code of confidentiality and access to data held on IT systems is restricted to authorised users through access control procedures either with a smartcard or secure login.

IG training is incorporated into the mandatory annual training and follows the Core Skills for Health Framework. IG is also part of the induction training for new starters. Dedicated specialised training for SIRO, IAO and IAA is available as e-learning through the e-learning for health platform, delivered in-house utilising accredited e-learning material provided by NHS Digital (NHSD). Ad-hoc training is provided on request or individual need.

The annual IG self-assessment exercise has taken place using the Information Governance Toolkit (IGT) provided by NHSD. The trust has achieved all of the 39 key standards for the IGT.

During the last year there has been one-reported SIRIs (Serious Incident Requiring Investigation) through the IG Incident Reporting Tool which automatically triggers notification to the Information Commissioner's Office (ICO) in accordance with reporting guidelines.

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LCHS is committed to taking all reasonable measures to ensure that all information provided by, or on behalf of the trust is both accurate and factual. The trust has a number of measures in place to check the consistency and accuracy of data being published and ensure that staff are fully aware of their responsibilities under the Act.

The risk and control framework

The trust has in place a comprehensive structure for governance and through this structure the trust identifies, evaluates and controls its risks. The trust embeds risk management through:

- committees and assurance groups of the Trust Board
- Combined Corporate Risk Register
- Board Assurance Framework
- Care Quality Commission registration compliance
- NHS Resolution Safety and Learning Service

- staff training
- internal performance management processes
- policies and procedures
- Standing Financial Instructions and Standing Orders
- IG toolkit compliance and IG toolkit incident reporting tool

The trust takes all reasonable measures to prevent risks from occurring. However, where risks are identified action plans are put in place to remove, mitigate or minimise the risk as much as reasonably practicable. Progress on action plans is monitored and reported through the relevant sub committees of the Trust Board and any identified learning is disseminated across the organisation through service scrutiny groups.

The trust continues to make progress creating strong, strategic and sustainable governance arrangements. Specifically, during 2017/18, the trust continues to have a clear published statement of the vision and values for the whole organisation.

In addition, the trust:

- is compliant with local counter fraud and security management services requirements.
- has in place an established and experienced senior management team.
- has in place a robust information governance framework.
- has standing orders, standing financial instructions and scheme of delegation in place.

The trust has in place a comprehensive review, approval and dissemination process for policies and procedures. The process to ensure all policies and procedures remain current and valid has been strengthened and a review has been undertaken.

The trust continues to be a member of the NHS Resolution (NHSR) risk pooling schemes for clinical negligence, third party liability and property expenses. The NHSR has now ceased its discounts and assessments for trusts against the risk management standards, with a greater focus being placed on an outcome based approach to reducing claims through the NHSR Safety and Learning Service. The trust monitors its claim profile through the

Audit Committee and the trust's other formal committees, with lessons being identified and shared throughout the trust.

Quality assurance of the trust's QIPP programmes has been strengthened with processes for impact assessment and corporate confirm and challenge are signed off by the Medical Director, Director of Nursing and Operations.(I don't think this sentence is quite right – this used to be the case but its changed in year) In addition these are also subject to further confirm and challenge by the Business Planning.

Board Assurance Framework

The Board Assurance Framework provides the trust with a comprehensive method for the effective and focussed management of the principal risks to meeting its strategic objectives. The Board Assurance Framework has been in place throughout the year which is designed and operating to meet the requirements of the Audit Committee Handbook. The framework is underpinned by risk management which maps the trust's principal objectives to risk, controls and assurances. Any gaps in control or assurances have an action plan which is reviewed by executive leads prior to detailed scrutiny by the Audit Committee.

A separate Trust Board paper summarising the assurance work of the Audit Committee, Finance, Performance and Investment Committee and Quality and Risk Committee and highlighting key issues is presented to the Trust Board after each meeting.

The trust's Board Assurance Framework provides reasonable assurance that there is an effective system of governance and internal control to manage the principal risks identified by the trust.

To further strengthen the system of governance and internal control, strategic objectives and the Board Assurance Framework are continually assessed. This ensures that there is a focus on strategic and operational risk and the key controls and assurances to manage and monitor risks relating to the trust's strategic objectives.

During 2017/18 an external audit was carried out by KPMG, following which a Trust Board workshop was held on April 28, 2017, facilitated by KPMG. In addition 360 Assurance (the trust's internal auditors) carried out a risk workshop on July 20, 2017 to further strengthen and improve development and understanding of risk management principles.

Internal audit

The trust is subject to a number of internal audit visits throughout the year and received a statement from its internal auditors that, based on the work undertaken in 2017/18, action plans have been agreed to address any recommendations. This proactive approach for identifying areas for improvement has been supported by internal audit and through this work the trust has agreed actions to make the necessary improvements. A culture and approach to addressing weaknesses and ensuring continuous improvement of the system is in place.

Care Quality Commission registration

The trust holds registration with the Care Quality Commission.

The trust has 20 locations registered with the Care Quality Commission under the Health and Social Care Act 2008. A framework is in place to provide assurance on the registration requirements and the Essential Standards of Quality and Safety which underpins this.

The trust is currently registered to carry out the following activities:

- personal care
- treatment of disease, disorder or injury
- diagnostic and screening procedures
- nursing care

The Quality and Risk Committee regularly reviews compliance and the Audit Committee reviews this process.

Management of incidents

The trust reports and manages serious incidents in accordance with the National Patient Safety Agency recommendations and the previous Trust Development Authority Accountability Framework. These incidents are reported to, investigated and managed through service line governance

groups and the Safety and Patient Safeguarding Group, with an action plan review and final sign off being obtained through the trust's Effective Practice Assurance Group and Quality and Risk Committee.

The number of serious incidents reported this year has been consistent with last year. All trust serious incident (SI) reports are reviewed quarterly by a CCG SI scrutiny group and have been influenced this year by focussed training programmes and LCHS has demonstrated a marked improvement in the quality of serious incident reporting.

No 'Never Events' have occurred during the year, however other incidents have been reported and investigated and no significant control issues have been identified.

Annual quality account

The trust is required, under the Health Act 2009, to prepare a quality account for each financial year. This demonstrates the achievements in quality improvements over the past twelve months and details the priorities that the trust intends to focus on during the next year.

The quality priorities which were agreed last year in the '2016/17 quality account' for implementation during 2017/18, were agreed in consultation with patients, public, staff and other stakeholders.

These quality priorities were agreed as:

Improving care and outcomes for insulin dependent diabetes patients on the caseloads of community teams

Assessment of all patients on community caseloads on insulin as the baseline cohort, reducing the number of patients on insulin and increasing the number of insulin dependent patients who are able to self-administer.

Improving the knowledge and skills of LCHS staff to better to manage a rising number of patients whose care may be compromised by self-neglect issues

Development and adoption of a self-neglect toolkit and staff guidance. Data capture of self-neglect patients through the 'vulnerable patient' domains on electronic patient record. Development of an e-learning resource for staff to access as required.

Improving end of life pain management experience through increased and more effective pre-emptive prescribing

- LCHS will work with partner organisations and commissioners to increase the planning and provision of pre-emptively prescribed medications.
- Increase numbers of pre-emptive prescribing. Improve end of life experience for our patients through better and more timely pain control through collaborative working with other providers. Reduce delay in receiving medications, particularly during the Out of Hours period.

Supporting carers of LCHS patients by signposting to available support services

- Ensure the trust takes every opportunity to identify the carers of its patients, and understand the very important role they play in supporting the patients we care for.
- Signpost carers to existing carer support services and network support services.
- Work with Lincolnshire County Council to signpost to services and existing valuable reading and support materials.
- Quantify the number of patients on our caseloads with significant carer input.

Feedback on improvements against these priorities will be detailed in the 2017/18 quality account which is due to be published in June 2018, together with the new priorities outlined for 2018/19.

The information contained in the quality account is reviewed by the Quality and Risk Committee prior to it going to Trust Board for final approval.

Review of the effectiveness of risk management and internal control

As accountable officer I have responsibility for reviewing the effectiveness of the system of internal control and to ensure that arrangements are in place in order to discharge the trust's statutory functions, which have been checked for irregularities and that they are legally compliant.

My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls

reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence of the effectiveness of controls that manage risks to the organisation.

My review was also informed by:

- delivery of audit plans by external and internal auditors
- unconditional registration with the Care Quality Commission

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the internal mechanisms of the trust, which includes the oversight by the Trust Board, the work of the Audit Committee and the Quality and Risk Committee and appropriate sub-committee structure. Plans to address weaknesses and ensure continuous improvement of the trust's system are in place.

The head of internal audit is required to provide an annual opinion on the systems and processes of internal control employed in the trust. The Head of Internal Audit Opinion provided a significant assurance opinion for 2017/18. In reaching this opinion, the head of internal audit identified one high-risk area, Management of Projects and Business Case Review. It was recommended that the business-planning framework be updated to ensure financial considerations are documented using the 'scoping document'. All submissions include an assessment of financial assumptions, financial risks, sources of funding, workforce resource assessment. Introduction of a quality assurance process to ensure financial assumptions are robust. The agreed action has an implementation date of 30th June 2018.

Significant Issues

There have been no significant control issues in the trust during 2017/18.

During the year the trust has made real and sustainable improvements to its governance arrangements. It has embedded further structure and guidance in relation to the management of risk and clinical audit. Following on from wider structural changes, further improvements to re-align and enhance its governance arrangements were undertaken.

Accountable Officer:

Andrew Morgan

Organisation: Lincolnshire Community Health Services NHS Trust

Signature:

Date: May 24, 2018

Modern slavery statement

Lincolnshire Community Health Services NHS Trust (LCHS) response to the requirements of the Modern Slavery Act 2015

Definition of offences

Slavery, servitude and forced or compulsory labour.

A person commits an offence if:

- the person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude, or;
- the person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

Human trafficking

A person commits an offence if:

- the person arranges or facilitates the travel of another person (victim) with a view to being exploited.
- it is irrelevant whether the victim consents to travel and whether or not the victim is an adult or a child.

Exploitation

A person is exploited if one or more of the following issues are identified in relation to the victim:

- slavery, servitude, forced or compulsory labour
- sexual exploitation
- removal of organs
- securing services by force, threats and deception
- securing services from children, young people and vulnerable persons

In accordance with the Modern Slavery Act 2015, LCHS makes the following statement regarding the steps it has taken in the financial year 2015/16 to ensure that modern slavery i.e. slavery and human trafficking, is not taking place in any part of its supply chains.

LCHS is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. We are committed to social and environmental responsibility and have zero tolerance

for modern slavery and human trafficking. Any identified concerns regarding modern slavery and human trafficking are escalated as part of the organisational safeguarding process working in conjunction with our partner agencies.

- The trust adheres to the National NHS Employment Checks/Standards (This includes employees UK address, right to work in the UK and suitable references).
- LCHS has systems to encourage the reporting of concerns and the protection of whistle blowers.
- A review is undertaken of all safeguarding referrals via LCHS incident reporting system and presentation of data is shared at LCHS Safeguarding Governance and Patient Safety Committee.
- The LCHS Safeguarding Adult Policy (P_SG_02) identifies and defines human trafficking and the response, which will be co-ordinated under the safeguarding adults process and the led by the police who are the lead agency (A national framework is in place to assist in the formal identification and help to coordinate the referral of victims to appropriate services, known as the National Referral Mechanism).
- The referral process for adults/children at risk links to both the Lincolnshire Safeguarding Adult Board and the Lincolnshire Safeguarding Children Board.
- NHS employment checks and payroll systems (i.e. people bought into the country illegally will not have a National Insurance Number)

LCHS aims to be as effective as possible in ensuring that modern slavery and human trafficking is not taking place in any part of its business or supply chains, and in addition to the above actions, measure its performance against the following indicators:

- The trust endeavours to build long standing relationships with our suppliers and make clear our expectations of business behaviour. Where national or international supply chains are used, we expect these suppliers to have suitable anti-slavery and human trafficking policies and procedures and where there is a risk of slavery and human trafficking taking place, steps have been taken to assess and manage that risk.
- Develop a level of communication with the next link in the supply chain and their understanding of, and compliance with, our expectations in relation to the NHS terms and conditions. These conditions relate to issues such as bribery, slavery and other ethical considerations.

- Working with partners throughout Lincolnshire, LCHS is represented on the Lincolnshire Safeguarding Adult Board Modern Slavery Sub-Committee.
- Modern slavery and human trafficking training is available to all LCHS staff and it is the specialist topic provided as part of the trust's mandatory annual update safeguarding day. In addition, all new members of staff receive safeguarding training which includes modern slavery. Additional training is available via the local Safeguarding Adult's and Children's Boards.

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and constitutes our trust's Modern Slavery and Human Trafficking statement for the financial year 2017/18.

Remuneration and staff report

Remuneration Policy

LCHS has a Remuneration and Terms of Service Committee. The purpose of the committee is to agree appropriate remuneration and terms of service for the chief executive, executive directors and other directors including all aspects of salary, provisions for other benefits, arrangements for termination of employment and other contractual terms working to the NHS Improvement.

Remuneration report

Board members and senior management remuneration

Salaries and allowances for the year ending 31 March 2018 (subject to audit)

Name and Title	Period of Office	17/18 Salary	Expense Payments Taxable	Performance pay and bonuses	Long term performance pay and bonuses	17/18 Pension Benefits**	17/18 Total		Actual 17/18 Remuneration Received
		(Bands of 5k)	(Nearest hundred)	(Bands of 5k)	(Bands of 5k)	(Bands of 2.5k)	(Bands of 5k)		(Bands of 5k)
		£000s	£00s	£000s	£000s	£000s	£000s		£000s
Mr AJ Morgan, chief executive	Full Year	145-150	74	0	0	20 - 22.5	175 - 180		150-155
Ms DD Cecchini, director of finance and strategy	Full Year	105-110	55	0	0	15 - 17.5	130 - 135		110-115
Mrs ME Fosh, director of workforce & transformation	Full Year	105-110	79	0	0	25 - 27.5	140 - 145		115-120
Mrs LM Stalley Green, director of nursing and operations	Full Year	100-105	49	0	0	55 - 57.5	160 - 165		105-110

Name and Title	Period of Office	17/18 Salary	Expense Payments Taxable	Performance pay and bonuses	Long term performance pay and bonuses	17/18 Pension Benefits**	17/18 Total		Actual 17/18 Remuneration Received
		(Bands of 5k)	(Nearest hundred)	(Bands of 5k)	(Bands of 5k)	(Bands of 2.5k)	(Bands of 5k)		(Bands of 5k)
		£000s	£00s	£000s	£000s	£000s	£000s		£000s
Dr S Elcock, medical director *	07/11/17 - present	40-45	0	0	0	0 - 5	40 - 45		40-45
Mrs E Baylis, chair	Full Year	25-30	16	0	0		30 - 35		30-35
Mr MA MacDonald, non-executive director	Full Year	5-10	11	0	0		5 - 10		5-10
Mr KM Lockyer, non-executive director	Full Year	5-10	10	0	0		5 - 10		5-10
Mrs E Libiszewski, non-executive director	01/05/17 - present	5-10	0	0	0		5 - 10		5-10
Mr DP Woodward, non-executive director	01/04/16-30/09/17	0-5	12	0	0		0 - 5		0-5
Mr AJ Kent, non-executive director	01/02/18 - present	0-5	0	0	0		0 - 5		0-5

*Dr S Elcock costs recharged from Lincolnshire Partnership NHS Foundation Trust based on 4 PA's

Salaries and allowances for the year ending 31 March 2017

Name and Title	Period of Office	16/17 Salary	Expense Payments Taxable	Performance pay and bonuses	Long term performance pay and bonuses	16/17 Pension Benefits**	16/17 Total		Actual 16/17 Remuneration Received****
		(Bands of 5k)	(Nearest hundred)	(Bands of 5k)	(Bands of 5k)	(Bands of 2.5k)	(Bands of 5k)		(Bands of 5k)
		£000s	£00s	£000s	£000s	£000s	£000s		£000s
Mr A Morgan, chief executive	Full Year	145-150	69.0	0	0	30-32.5	180-185		150-155
Dr P Mitchell, medical director	Full Year	110-115	71.0	0	0	22.5-25	140-145		115-120
Dr C Brady, director of strategy*	Full Year	100-105	58.0	0	0	22.5-25	130-135		105-110
Mrs M Fosh, director of workforce & transformation	Full Year	105-110	71.0	0	0	52.5-55	165-170		115-120
Ms D Cecchini, director of finance and strategy	Full Year	105-110	50.0	0	0	65-67.5	175-180		110-115
Mrs E Baylis, chair	Full Year	30-35	14.0	0	0	0***	30-35		30-35
Ms L Green, director of nursing and operations	Full Year	90-95	43.0	0	0	105-107.5	200-205		95-100
Dr M Fairman, non-executive director	Full Year	5-10	16.0	0	0	0***	5-10		5-10
Mr D Woodward, non-executive director	Full Year	5-10	15.0	0	0	0***	5-10		5-10
Mr M Macdonald, non-executive director	Full Year	5-10	16.0	0	0	0***	5-10		5-10
Mrs V Risk, non-executive	Full Year	5-10	7.0	0	0	0***	5-10		5-10

Name and Title	Period of Office	16/17 Salary	Expense Payments Taxable	Performance pay and bonuses	Long term performance pay and bonuses	16/17 Pension Benefits**	16/17 Total		Actual 16/17 Remuneration Received****
		(Bands of 5k)	(Nearest hundred)	(Bands of 5k)	(Bands of 5k)	(Bands of 2.5k)	(Bands of 5k)		(Bands of 5k)
		£000s	£00s	£000s	£000s	£000s	£000s		£000s
director									
Mr K Lockyer, non-executive director	Full Year	5-10	10.0	0	0	0***	5-10		5-10

Pension Benefits for the year ending 31 March 2018 (subject to audit)

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000s	£000s	£000s	£000s
Mr AJ Morgan, chief executive	0 - 2.5	5 - 7.5	65-70	195-200	1263	106	1369	0
Ms DD Cecchini, director of finance and strategy	0 - 2.5	2.5 - 5	30-35	100-105	626	64	690	0

Mrs ME Fosh, director of workforce & transformation	0 - 2.5	0 - 2.5	15-20	0-5	130	28	158	0
Mrs LM Stalley Green, director of nursing and operations	2.5 - 5	0 - 2.5	25-30	20-25	265	58	323	0

Pension Benefits for the year ending 31 March 2017 (subject to audit)

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000s	£000s	£000s	£000s
Mr A Morgan, Chief Executive	0 - 2.5	5 - 7.5	60-65	185-190	1169	81	1250	0
Miss L Green, Director of Nursing and Operations	5 - 7.5	2.5 - 5	20-25	20-25	190	73	262	0
Ms D Cecchini, Director of Finance	2.5 - 5	10 - 12.5	30-35	95-100	537	83	620	0
Mrs M Fosh, Director of Workforce & Transformation	2.5 - 5	0 - 2.5	10-15	0-5	94	35	129	0

Dr P Mitchell, Medical Director	0 - 2.5	0 - 2.5	5-10	5-10	68	26	94	0
Dr C Brady, Director of Strategy	0 - 2.5	2.5 - 5	35-40	110-115	714	56	770	0

Pension Benefit Notes

The above information is based on data provided by the NHS Pensions Agency.
The employer's contribution rate to pension benefits is 14.3% of pensionable pay (2016/17: 14.3%).
Staff are able to make additional voluntary contributions alongside their regular contributions.
Non-Executive members do not receive pensionable remuneration.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Compensation on early retirement or for loss of office (subject to audit)

Reporting of compensation schemes - exit packages 2017/18								
	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
Exit package cost band (including any special payment element)	**Number**	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£s**
<£10,000	2	7,802	7	13,719	9	21,521	-	-
£10,001 - £25,000	2	29,747	-	-	2	29,747	-	-
£25,001 - £50,000	1	36,667	-	-	1	36,667	-	-
£50,001 - £100,000	-	-	-	-	-	-	-	-
£100,001 - £150,000	1	127,564	-	-	1	127,564	-	-
£150,001 - £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Total number of exit packages by type	**6**	**201,780**	**7**	**13,719**	**13**	**215,499**	**-**	**-**

Redundancy and other departure costs have been paid in accordance with the provisions of NHS Agenda for Change. Exit costs in this note are the full costs of departures agreed in the year. Where Lincolnshire Community Health Services NHS Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Reporting of compensation schemes - exit packages 2016/17								
	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
Exit package cost band (including any special payment element)	**Number**	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£s**
<£10,000	12	57,375	13	13,719	25	75,437	-	-
£10,001 - £25,000	10	175,206	1	-	11	188,500	-	-
£25,001 - £50,000	5	157,817	-	-	5	157,817	-	-
£50,001 - £100,000	5	393,423	-	-	5	393,423	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 - £200,000	1	160,000	-	-	1	160,000	-	-
>£200,000	-	-	-	-	-	-	-	-
Total number of exit packages by type	**33**	**943,821**	**14**	**13,719**	**47**	**975,177**	**-**	**-**

Exit packages: other (non-compulsory) departure payments (subject to audit)

	2017/18		2016/17	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**Total value of agreements**
	Number	Number	Number	Number
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	7	14	14	31
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	7	14	14	31
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Payments to past directors

There were no payments to past directors doing the reporting period.

Fair pay disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Lincolnshire Community Health Services NHS Trust in the financial year 2017/18 was £140-145k (2016/17: £140-145k). This was 5.58 (2016/17: 5.21) times the median remuneration of the workforce, which was £25,551 (2016/17: £27,361).

In 2017/18 and 2016/17 no employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £1,150 to £144,515 (2016/17: £959 to £143,084).

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

	2017-18	2016-17
Highest paid director's remuneration £'000	140-145	140-145
Median total £	£25,551	£27,361
Ratio	5.58	5.21

Staff report

The number of senior managers by band

- four of the six (66.7%) executive directors are female
- two of the six (33.3%) non-executive directors are female

Analysis of staff numbers and costs (subject to audit)

Staff costs

			2017/18	2016/17
	Permanent	**Other**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	47,127	174	47,301	51,959
Social security costs	4,411	-	4,411	4,808
Apprenticeship levy	224	-	224	-
Employer's contributions to NHS pensions	6,509	-	6,509	6,926
Pension cost - other	10	-	10	7
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	216	-	216	975
Temporary staff		5,067	5,067	4,593
Total gross staff costs	58,497	5,241	63,738	69,268
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	58,497	5,241	63,738	69,268

Staff composition

Average number of employees (WTE basis)

			2017/18	2016/17
	Permanent	**Other**	**Total**	**Total**
	Number	**Number**	**Number**	**Number**
Medical and dental	6	3	10	19
Ambulance staff	-	-	-	-
Administration and estates	323	1	324	328
Healthcare assistants and other support staff	338	-	338	375
Nursing, midwifery and health visiting staff	668	2	670	807
Nursing, midwifery and health visiting learners	-	0	0	-

			2017/18	2016/17
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Scientific, therapeutic and technical staff	244	-	244	212
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	0	-	0	59
Total average numbers	1,580	6	1,586	1,800
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	-

Sickness absence data

Data supplied is for the 2017 calendar year.

Average FTE 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
1,608	17,335	10.8	586,809	28,121

The table below shows the data that are presented to the LCHS Trust Board each month and cover the 2017/18 financial year.

Benchmark	5.31%
Target	4%
Apr-17	4.95%
May-17	4.96%
Jun-17	5.51%
Jul-17	5.08%
Aug-17	4.05%
Sep-17	3.54%
Oct-17	3.95%
Nov-17	4.43%
Dec-17	4.66%
Jan-18	5.23%

Feb-18	4.16%
Mar-18	4.12%
Total	4.55%

Staff gender breakdown

Gender	Headcount	Percentage
Female	1605	89.71%
Male	184	10.29%
Total	1789	100.00%

Ethnicity

	White		BME		Not stated		Total	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%
Clinical	1359	96.04%	40	2.83%	16	1.13%	1415	100.00%
Non-Clinical	348	95.87%	10	2.75%	5	1.38%	363	100.00%
Medical & Dental	5	45.45%	6	54.55%		0.00%	11	100.00%
Total	1712	95.70%	56	3.13%	21	1.17%	1789	100.00%

Policies applied during the year to give full and fair consideration to disabled staff members

The trust recognises and embraces its roles and responsibilities to give full and fair consideration to applications for employment by disabled persons. Following the principles of the Equality Delivery System (EDS2), all LCHS workforce policies undergo an equality analysis to ensure they are fair. The equality analysis for all trust policies states:

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the act.
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help LCHS staff members to comply with the general duty.

The trust has an ongoing commitment to the training needs of its staff to support both their personal and professional development. A training needs analysis is completed on an annual basis by the organisation, in order to identify its professional development needs. These organisational needs are further supported by individual annual performance reviews (appraisals) which identifies personal development plans. As indicated above all policies are subjected to the equality analysis including the education training and development policy.

Specific policies applied during the year to ensure full and fair consideration to disabled staff include:

- recruitment and selection policy
- promoting equality valuing diversity protecting human rights policy
- education training and development policy

Gender pay gap statement

New regulations took effect on March 31, 2017 (The Equality Act 2010 Specific Duties and Public Authorities Regulations 2017) requiring all public sector organisations in England employing 250 or more staff to publish gender pay gap information.

The gender pay gap shows the difference between the average (mean or median) earnings of all male and female employees. It is expressed as a percentage of earnings and it is a measure of disadvantage. The gender pay gap is not the same as equal pay. Equal pay is about ensuring men and women doing similar work or work that is different but of equal value (in terms of skills, responsibility, effort) are paid the same. A gender pay gap could reflect a failure to provide equal pay but it usually reflects a range of factors, including a concentration of women in lower paid roles and women being less likely to reach senior management levels.

LCHS is required to publish the below gender pay gap measures:

- the difference between the mean hourly rate of pay for male and female employees
- the difference between the median hourly rate of pay for male and female employees
- the difference between the mean bonus pay for male and female employees*
- the difference between the median bonus pay for male and female employees*
- proportions of male and female employees who were paid a bonus*
- the proportions of male and female employees in the four quartile pay bands (lower, lower middle, upper middle and upper)

**LCHS does not currently operate a bonus scheme and does not have a Clinical Excellence Awards scheme in operation*

The above measures are calculated using a 'snapshot date' and for public sector organisations this is the pay period which includes March 31, 2017. This statement therefore covers all LCHS employees including those on bank contracts as at March 31, 2017. The data is taken from ESR (electronic staff record).

The trust was required to publish this information within one year of the snapshot date (i.e. by March 30, 2018) and by the same date every subsequent year. It should be published on a website that is accessible to employees and the public. The data also has to be uploaded on the government's 'Gender Pay Service' reporting site.

Trust staffing data and analysis

The current gender split within the overall workforce is 91.1% female and 8.9% male at LCHS. The table below breaks this down by the proportion of males and females in each pay band.

Gender	**Female**		**Male**		**Total**	
Pay Band	Count	%	Count	%	Count	%
Band 1	19	1.0%	2	0.1%	21	1.1%
Band 2	366	18.5%	36	1.8%	402	20.3%
Band 3	249	12.6%	8	0.4%	257	13.0%
Band 4	81	4.1%	8	0.4%	89	4.5%
Band 5	383	19.3%	18	0.9%	401	20.2%

Gender	Female		Male		Total	
Band 6	414	20.9%	42	2.1%	456	23.0%
Band 7	199	10.0%	34	1.7%	233	11.8%
Band 8a	34	1.7%	7	0.4%	41	2.1%
Band 8b	14	0.7%	5	0.3%	19	1.0%
Band 8c	4	0.2%	2	0.1%	6	0.3%
Band 8d	-	-	1	0.1%	1	0.1%
Medical and Dental	4	0.2%	8	0.4%	12	0.6%
Other	34	1.7%	4	0.2%	38	1.9%
VSM	4	0.2%	1	0.1%	5	0.3%
Total	1,805	91.1%	176	8.9%	1,981	100.0%

**Please note the category entitled 'other' represents anyone who is not on agenda for change pay bands, for example apprentices and staff groups who have TUPE transferred into the organisation.*

The LCHS workforce is governed under the NHS Agenda for Change, excluding medical staff and very senior managers. It uses the NHS national job evaluation framework to determine appropriate pay bandings. This provides a clear process of paying employees equally for the same or equivalent work. Each grade has a set of pay points for annual progression; the longer period of time that someone has been in a grade the higher their salary is likely to be dependent on performance.

The table above outlines that women are represented across all pay bands within LCHS with a 4:1 ratio of females to males in very senior management (VSM). The highest proportion of both males and females are concentrated within Band 6 posts. A significantly higher proportion of females work within band 3 posts in comparison to males and further exploration is needed to understand any underlying reasons for this.

Mean and median hourly rate for males and females

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£18.23	£15.91
Female	£14.38	£14.09
Difference	£3.85	£1.82
Pay Gap %	21.1%	11.5%

The mean gender pay gap for LCHS is 21.1%. This means that men are paid 21.1% more than women on average. The average is calculated by adding up the hourly rates of all men and all women and dividing by the total number of men and women.

The median gender pay gap for LCHS is 11.5%. This means that when the hourly rates of all female and all male staff are put in order from smallest to largest, the middle rate is 11.5% higher than the middle rate for all female staff.

The proportions of male and female employees in each quartile of the pay distribution

The quartiles shown below in figure 3 are calculated by determining the hourly rate of pay and then ranking the relevant employees in order from the lowest to the highest. The calculation requires an employer to show the proportions of male and female full-pay in four quartile pay bands, which is done by dividing the workforce into four equal parts; lower middle, upper middle and upper quartile pay bands.

Quartile	Female	Male	Female %	Male %
1	464	31	93.8%	6.2%
2	455	40	91.9%	8.1%
3	455	35	92.9%	7.1%
4	431	70	86.1%	13.9%

The table above highlights that the trust employs more men in the higher banding categories than women which has an impact on the average hourly rate. LCHS has significantly less men employed when compared to women, however, of those employed a proportion are in either senior or specialist roles.
Within the medical workforce the male workforce is 2:1 to the female workforce with a high proportion of part time workers across the female population. This is an area our medical staffing team will be exploring further in order to make recommendations to the trust.

Actions to reduce the gender pay gap

Whilst the trust has excellent representation of females across all levels of the organisation, this report shows that there are gender pay gaps due to the level and type of roles undertaken by the trust's minority male workforce. We

will continue to monitor and promote equality and diversity in order to close these gaps.

LCHS can demonstrate that we are equal opportunity employer through policies and processes which support staff to make decisions, for example policies which support maternity, paternity and adoption leave, flexible working and disability leave. LCHS takes a proactive stance regarding progression and development of talent within the organisation. From the point of identifying a vacancy, there is a clear pathway for development through our talent pipeline, fully in line with our equal opportunities policy.

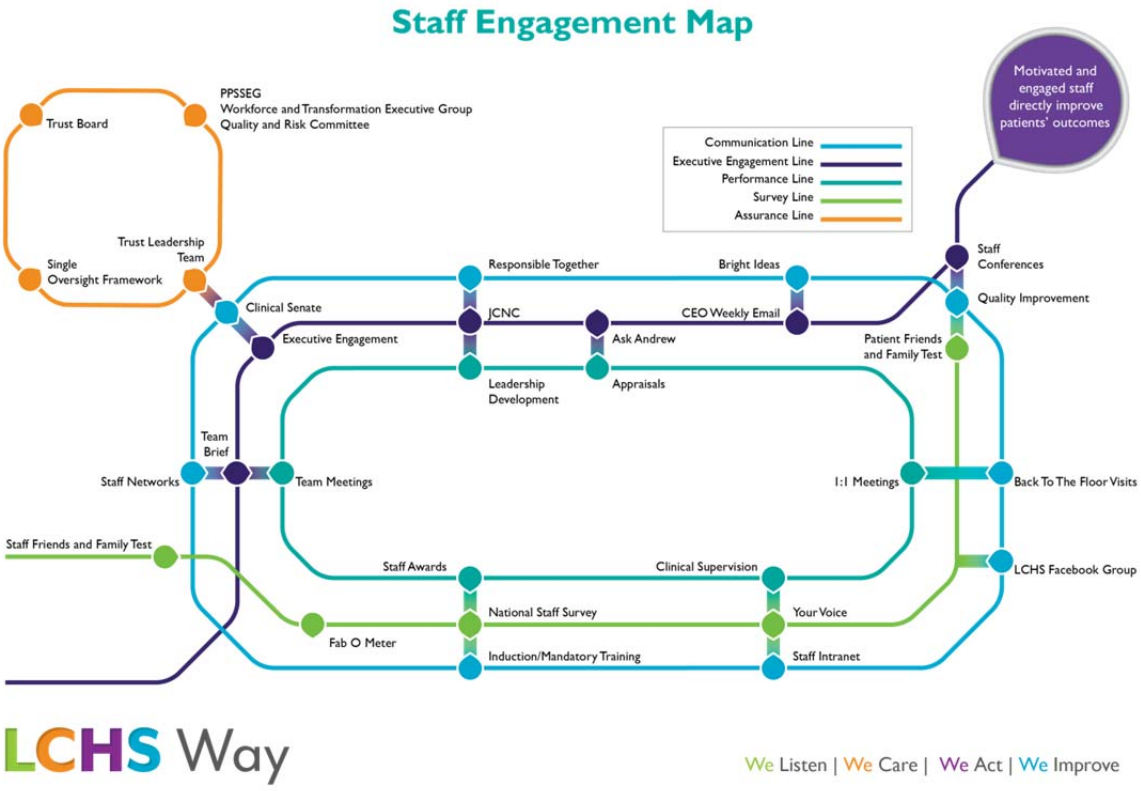
The trust is committed to ensuring an equitable workforce and we will continue to work towards achieving the following actions in order to reduce the gender pay gap:

- explore how we can attract more men into the organisation at the lower bands, to create a more even gender balance;
- medical staffing team to further investigate and advise on recommendations to the trust in relation to the medical workforce female/male composition;
- raise further awareness of shared parental leave entitlements and flexible working opportunities through our training and communications;
- take account of gender in the provision of leadership opportunities, including the recently launched Mary Seacole Leadership Programme;
- continue to monitor any shifts in the gender pay gap data each year to identify any trends and analyse underlying causes.

How LCHS has engaged with its staff

LCHS has long maintained that motivated and engaged staff directly improves patients' outcomes. The trust believes that staff engagement is not a one-off, not just an event – it is about creating an environment where engagement becomes business as usual, making success more likely. Engagement within LCHS focuses on three key combined areas, staff, patients and the system. The staff engagement map below is the trust's approach to developing a lifetime of engagement, ultimately leading to better patient outcomes.

The staff engagement map (see next page) is a reimagining of the iconic London tube map designed by Harry Beck, allowing the trust to develop new lines and stations to respond to the dynamic needs of the environment it lives in today, whilst retaining a clear staff engagement brand identity for LCHS.



What staff said about working in LCHS?

Between October and November 2017, staff were asked to participate in the NHS National Staff Survey. The response rate was 60 per cent – the highest ever recorded by LCHS and only 2 per cent below the highest amongst community trusts.

LCHS performed extremely well in the NHS National Staff Survey Results 2017, with 16 of the 32 key findings increasing and 16 not changing. The biggest shift was in job satisfaction, leadership and management and patient care and experience.

The full results can be found on the NHS England website *http://www.nhsstaffsurveys.com* and some key findings are below blending results as both percentages and scores out of five..

Top five ranking scores in comparison to other community trusts:

- The score given for staff confidence and security in reporting unsafe clinical practice is 3.87 (national average is 3.80)

- The percentage of staff appraised in the last 12 months is 94% (national average 91%)
- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months is 22% (national average is 23%)
- The percentage of staff reporting errors, near misses or incidents witnessed in the last month is 94% (national average 93%)
- The score given for staff satisfaction with resourcing and support is 3.39 (national average 3.30)

Bottom ranking scores in comparison to other community trusts:

- The percentage of staff experiencing discrimination at work in the last 12 months is 10% (national average 9%)
- The percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months is 10% (national average 8%)
- The percentage of staff agreeing that their role makes a difference to patients/service users is 89% (national average 90%)
- The score given for effective team working is 3.81 (national average 3.82)
- The score given for support from immediate managers is 3.85 (national average 3.86)

Where staff experience has improved the most in comparison to 2016

- Staff satisfaction with level of responsibility and involvement (3.88 compared to 3.72 in 2016)
- Effective use of patient/service user feedback (3.69 compared to 3.44 in 2016)
- Recognition and value of staff by managers and the organisation (3.53 compared to 3.30 in 2016)
- Staff satisfaction with resourcing and support (3.39 compared to 3.15 in 2016)
- Support from immediate managers (3.85 compared to 3.69 in 2016)

Health and Wellbeing

LCHS values the health of its staff and provides a range of support and initiatives to help staff maintain their own health and wellbeing.

The trust offers access to a full occupational health service which provides input in relation to pre-employment screening, health screening, fitness to work advice and team debriefs after traumatic incidents etc.
2017 saw the introduction of an Employee Assistance Programme (EAP) which is available to staff and their immediate family members to talk through any worries or concerns, for example; relationship problems, financial advice/support, work stress, health worries. Trained counselling and cognitive behavioural therapy (CBT) may be available if deemed appropriate.

The trust has a dedicated “Physio 4 You” service providing staff with access to a physiotherapist for advice and support regarding musculo-skeletal and other health related problems.

In addition, a number of initiatives have been implemented and are available to support both physical activity and mental health and wellbeing as follows:

- Cycle to Work Scheme
- health checks/body MOTs
- health and wellbeing days and roadshows across the county
- menopause workshops
- Mental Health First Aiders
- sports, holistic fully body and Indian head massages
- complimentary therapies including reflexology and hypnotherapy days
- yoga classes in different venues across the county
- mindfulness and mental health first aid courses
- qualified mental health first aiders
- step activity challenges such as pedometer and Global Corporate Challenge
- getting the most out of retirement workshops
- seasonal flu campaigns
- night worker health assessments
- managing stress in the workplace – e-learning packages and online stress tests
- headspace meditation app
- emotional wellbeing toolkit
- wellbeing workshops
- weight management support
- stop smoking support
- social activities in the community

Expenditure on consultancy

2017/18	2016/17
£000s	£000s
243	635

Lincolnshire Community Health Services NHS Trust

Annual accounts for the year ended 31st March 2018

Produced under the direction of National Health Service Act 2006 c. 41 Schedule 15

Further copies available upon request from:
Director of Finance
Lincolnshire Community Health Services NHS Trust
Beech House
Waterside South
Lincoln
LN5 7JH
www.lincolnshirecommunityhealthservices.nhs.uk

Statement of the Chief Executive's responsibilities as the accountable officer of the trust

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

Signed:  Chief Executive

Date: 24th May 2018

Statement of directors' responsibilities in respect of the accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

Chief Executive: ..... Date: 24th May 2018

Director of Finance and Strategy: Michelle Cecchi Date: 24 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Lincolnshire Community Health Services NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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. As explained more fully in the Statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the Statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by 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.

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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether 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. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- 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 issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Lincolnshire Community Health Services NHS 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 Board of the Trust, as a body, 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 Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Lincolnshire Community Health Services NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

John Cornett
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants

Nottingham Office
St Nicholas House
31 Park Row
Nottingham
NG1 6FQ

25 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	94,643	100,096
Other operating income*	4	9,814	9,240
Operating expenses	6, 8	(99,681)	(105,499)
Operating surplus/(deficit) from continuing operations		**4,776**	**3,837**
Finance income	11	47	25
Finance expenses	12	-	-
PDC dividends payable		-	-
Net finance costs		**47**	**25**
Other gains / (losses)	13	-	-
Share of profit / (losses) of associates / joint arrangements	20	-	-
Gains / (losses) arising from transfers by absorption		-	-
Surplus / (deficit) for the year from continuing operations		**4,823**	**3,862**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**-**	**-**
Surplus / (deficit) for the year		**4,823**	**3,862**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	-
Revaluations	18	101	(99)
Share of comprehensive income from associates and joint ventures	20	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability / asset		-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available-for-sale financial investments	13	-	-
Recycling gains / (losses) on available-for-sale financial investments	13	-	-
Foreign exchange gains / (losses) recognised directly in OCI	13	-	-
Total comprehensive income / (expense) for the period		**4,924**	**3,763**

* Other operating income for 2017/18 is inclusive of sustainability and transformation funding (STF) received. STF for 2017/18 totalled £2.804m (2016/17: £2.286m).

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	518	295
Property, plant and equipment	16	4,615	4,063
Total non-current assets		**5,133**	**4,358**
Current assets			
Trade and other receivables	24	8,485	9,266
Non-current assets held for sale / assets in disposal groups	26	-	-
Cash and cash equivalents	27	21,260	13,806
Total current assets		**29,745**	**23,072**
Current liabilities			
Trade and other payables	28	(12,890)	(11,508)
Borrowings	31	-	-
Other financial liabilities	29	-	-
Provisions	33	(2,570)	(2,362)
Other liabilities	30	(518)	(361)
Total current liabilities		**(15,978)**	**(14,231)**
Total assets less current liabilities		**18,900**	**13,199**
Non-current liabilities			
Trade and other payables	28	-	-
Borrowings	31	-	-
Other financial liabilities	29	-	-
Provisions	33	(396)	-
Other liabilities	30	-	-
Total non-current liabilities		**(396)**	**-**
Total assets employed		**18,504**	**13,199**
Financed by			
Public dividend capital		381	-
Revaluation reserve		910	824
Other reserves		-	-
Income and expenditure reserve		17,213	12,375
Total taxpayers' equity		**18,504**	**13,199**

The notes on pages 5 to 32 form part of these accounts.

Signed: .....

Name Andrew Morgan
Position Chief Executive Officer
Date **24 May 2018**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**-**	**824**	**-**	**12,375**	**13,199**
Surplus/(deficit) for the year	-	-	-	4,823	**4,823**
Transfers by absorption: transfers between reserves	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	**-**
Other transfers between reserves	-	(15)	-	15	**-**
Impairments	-	-	-	-	**-**
Revaluations	-	101	-	-	**101**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	**-**
Public dividend capital received*	381	-	-	-	**381**
Public dividend capital repaid	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	**-**
Other reserve movements	-	-	-	-	**-**
Taxpayers' equity at 31 March 2018	**381**	**910**	**-**	**17,213**	**18,504**

* In March 2018, Lincolnshire Community Health Services NHS Trust received an allocation of £381,000 of Public Dividend Capital (PDC). This was received to support investment in Cyber security infrastructure and resilience.

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**-**	**938**	**-**	**8,498**	**9,436**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**-**	**938**	**-**	**8,498**	**9,436**
Surplus/(deficit) for the year	-	-	-	3,862	**3,862**
Transfers by absorption: transfers between reserves	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	**-**
Other transfers between reserves	-	(15)	-	15	**-**
Impairments	-	-	-	-	**-**
Revaluations	-	(99)	-	-	**(99)**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	**-**
Other reserve movements	-	-	-	-	**-**
Taxpayers' equity at 31 March 2017	**-**	**824**	**-**	**12,375**	**13,199**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,776	3,837
Non-cash income and expense:			
Depreciation and amortisation	6.1	878	755
Net impairments	7	63	38
Income recognised in respect of capital donations	4	(24)	-
(Increase) / decrease in receivables and other assets		781	(3,346)
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilties		1,035	694
Increase / (decrease) in provisions		604	2,322
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**8,113**	**4,300**
Cash flows from investing activities			
Interest received		47	25
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(369)	(192)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(742)	(876)
Sales of property, plant, equipment and investment property		-	23
Receipt of cash donations to purchase capital assets		24	-
Net cash generated from / (used in) investing activities		**(1,040)**	**(1,020)**
Cash flows from financing activities			
Public dividend capital received		381	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		-	-
Movement on other loans		-	-
Other capital receipts		-	-
Other interest paid		-	-
PDC dividend (paid) / refunded		-	-
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**381**	**-**
Increase / (decrease) in cash and cash equivalents		**7,454**	**3,280**
Cash and cash equivalents at 1 April - brought forward		**13,806**	**10,526**
Prior period adjustments		**-**	**-**
Cash and cash equivalents at 1 April - restated		**13,806**	**10,526**
Cash and cash equivalents transferred under absorption accounting		**-**	**-**
Cash and cash equivalents at 31 March	27.1	**21,260**	**13,806**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
Lincolnshire Community Health Services NHS Trust annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Note 1.2 Acquisitions and discontinued operations
Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

Note 1.3 Movement of assets wihtin the DH Group
"Transfer as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

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

Note 1.4 Charitable Funds
Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated (if material) within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. Lincolnshire Community Health Services NHS Trust does not consolidate on the basis of materiality.

Note 1.5 Pooled Budgets
In 2016/17, Lincolnshire Community Health Services NHS Trust entered into S75 agreement with Lincolnshire County Council and Lincolnshire Clinical Commissioning Groups (CCGs) with regards to the provision of transitional care nursing beds to the Lincolnshire patient population. Lincolnshire County Council is the host organisation and Lincolnshire Community Health Services NHS Trust contribution for 2017/18 (and 2016/17) is detailed within note 2a to these accounts.

Note 1.6 Critical accounting judgements and key sources of estimation uncertainty
In the application of Lincolnshire Community Health Services NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about carrying amounts of assets and liabilities that are not readily apparent for other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.6.1 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Continence Products: as a result of varying levels of usage, accruals and prepayments are based upon the average level of usage

Note 1.6.2 Sources of estimation uncertainty
The following are assumptions about the future and other key sources of estimation uncertainty ,at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The key source of estimation uncertainty for the Trust relate to accruals included in the financial statements and the non-current asset lives and depreciation amounts.

Note 1.6.3 Interests in other entities

Associates
Material entities over which the NHS trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS trust's accounts using the equity method. No associates are included in these accounts.

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

Note 1.7 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for health care services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of the length of stay at the end of the reporting period compared to expected total length of stay

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

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

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.8 Employee Benefits

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

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pension Scheme. These schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Some employees are members of the NEST superannuation scheme, which is defined benefit pension scheme administered by the government. The Trust collects contributions from employees and pays them over on a monthly basis. The Trust incurs no costs or liabilities from the scheme.

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

Note 1.9 Other Expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Note 1.10 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the NHS trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably; and either
• the item 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, they had broadly simultaneous purchase dates, are anticipated to have simultaneous 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, the components are treated as separate assets and depreciated over their own useful economic lives.

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

Revaluation of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be deteremind at the end of the reporting period. Current values in exsiting use are determind as follows:
• Specialised buildings - depreciated replacement cost
• Land and non- specialised buildings - Market value for exsiting use.

The last revaluation exercise was undertaken as at 30th April 2017 by Robert Mapletoft Rob Mapletoft BSc (Hons) Urb Est Surv MRICS of the Valuation Office Agency (VOA) on the Trust owned land and buildings.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at deprecated historic cost as this is not considered to be martially different form fair value.

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

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

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

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

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 1.10.1 Derecognition

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

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

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

Note 1.10.2 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 1.10.3 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

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

Note 1.10.4 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	28
Dwellings	-	-
Plant & machinery	1	5
Transport equipment	-	-
Information technology	1	5
Furniture & fittings	1	4

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

Note 1.11 Intangible assets

Note 1.11.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

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

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

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.11.2 Measurement

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

Following initial recognition, intangible assets are carried at fair value in existing use by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant proce increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

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

Note 1.11.3 Useful economic lives of intangible assets

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

	Min life Years	**Max life Years**
Information technology	2	4
Development expenditure	-	-
Websites	-	-
Software licences	1	5
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.12 Depreciation, Amortisation and Impairments

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

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

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount if the asset is increased to the revised estimated of the reciverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Note 1.13 Donated Assets

Donated non-current assets are capitalised at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluation, impairments and sales are treated as the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recoginition of the gain.

Note 1.14 Government Grants

Government grant funded assets are capitalised at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Note 1.15 Non-current assets held for sale

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

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

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

Note 1.16 Leases

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

Note 1.16.1 The trust as lessee

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

Operating 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 and building components are separated and individually assessed as to whether they are operating or finance leases.

Note 1.16.2 The trust as lessor

Finance leases

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

Operating leases

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

Note 1.16.3 Private Finance Initiative (PFI) Transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust does not control the use of the infrastructure and the residual interest of any PFI schemes. Lincolnshire Community Health Services NHS Trust has not entered into any PFI arrangements.

Note 1.17 Inventories

The Trust does not hold a material level of inventories. No value of for interntories is included in the Statement of Financial Position.

Note 1.18 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.19 Cash and cash equivalents

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

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

Note 1.20 Provisions
Provisions are recognised when the NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016/17: positive 0.24%) in real terms. All other provisions are subject to three seperate discount rates according to the expected timing ofcashflows form the Statement of Financial Position date:
• A short term date of negative 2.42% (2016/17: negative 2.70%) for expected cash flows up to and including 5 years
• A medium term rate of negative 1.85% (2016/17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
• A long term rate of negative 1.56% (2016/17: negative 0.80%) for expected cash flows over 10 years

All percentages are in real terms.

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

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

Note 1.21 Clinical negligence costs

NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by NHSLA on behalf of the trust is disclosed at note 33.2.

Note 1.22 Non-clinical risk pooling
The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses as and when they become due.

Note 1.23 Carbon Reduction Commitment scheme (CRC)
CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS trust makes emissions, a provision is recognised with an an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. the asset, provision and deferred income amounts are valued at fair value at the end of the reporting period. Lincolnshire Community Health Services NHS Trust does not meet the thresholds for the Carbon Reduction Committment Scheme.

Note 1.24 Contingencies
A contingent liability is a possible obligation that arisies from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

Note 1.25 Financial assets
Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset have been transferred.

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

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

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

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

Note 1.26 Financial liabilities

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

Note 1.27 Financial instruments and financial liabilities
Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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

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

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

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

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

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

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

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

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

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

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

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

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

Note 1.28 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 1.29 Corporation tax
Lincolnshire Community Health Services NHS Trust does not undertake trading activities and as such is exempt from corporation taxation.

Note 1.30 Foreign exchange
The functional and presentational currency of the trust is sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.
Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.
Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.30.1 Foreign Currencies
The NHS Trust's functional and presentational currency is sterling.

Note 1.30.2 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in note 44 to the accounts.

Note 1.31 Public dividend capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the NHS trust. 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. As PDC is issued under legislation tather than contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. The Trusts currently Currently, under the calculation methodology, Lincolnshire Community Health Services NHS Trust has negative net relevant assets and so does not incur PDC dividend charges.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net asset occur as a result of the audit of the annual accounts.

Note 1.32 Losses and special payments

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

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

Note 1.33 Subsidiaries
Material entities over which the NHS trust has the power to exercise control are classifies as subsidairies and are consolidated. The NHS trus has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidairies are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

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

The Trust administers Lincolnshire Community Health Services NHS Trust Charitable Funds and has the power to exercise control in accordance with IAS27 requirements. As disclosed in note 1.4 the Charitable Funds are not material in relation to the Trust and are not consolidated within these accounts.

Note 1.34 Associates
Material entities over which Lincolnshire Community Health Services NHS Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and ar recognised in the NHS Trust's accounts using the equity method. No associates are included in these accounts.

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

Note 1.35 Joint Arrangements
Material entities over which Lincolnshire Community Health Services NHS Trust has joint control with one or more other entities ar classified as joint arrangements. No joint arrangements are contained within these accounts.

A joint operation exists where the parties thathave joint control have rights to the asset and obligations for the liabilities relating to the arrangement. Where the NHS trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

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

Note 1.36 Research and Development
Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenidture relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deffered is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. it should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

Note 1.37 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.38 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.
For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.
For functions that the trust has transferred to another [NHS / local government] body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net [assets/ liabilities] transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.39 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.40 Standards, amendments and interpretations in issue but not yet effective or adopted

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

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

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

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

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

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

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

For Lincolnshire Community Health Services NHS Trust, initial assessments have been undertaken with regards to the potential impact of the above standards. Given that the Trust currently leases the majority of its estate through lease agreements, it is envisaged that the implementation of IFRS16: Leases, will have a material presentational effect on the Trusts accounts. Whilst lease payments will remain as contractually agreed, classification of leases will be onto the Trust's Statement of Financial Position.

Note 2 Operating Segments

No segmental analysis is shown as the sole activity of Lincolnshire Community Health Services NHS Trust in 2017/18 was the provision of community health services for the people of Lincolnshire and surrounding areas.

The "Chief Operating Decision Maker" is deemed to be the Trust Board of Directors. The Board currently receives only high level financial reporting information and does not therefore review information or allocate resources in any way that could be perceived to represent operating Segments.This will be reviewed during the course of 2018/19 dependant upon the information received by the Chief Operating Decision Maker .

The Trust has a group of customers, Lincolnshire Clinical Commissioning Groups from which more than 10% of its total revenue is derived from from providing community health services

Note 2a Pooled Budgets

From 2016/17, Lincolnshire Community Health Services NHS Trust has participated within a pooled budget arrangement under Section 75 of the Health Act 2012 with Lincolnshire County Council and Lincolnshire Clinical Commissioning (CCGs) for the provision of Transitional Care nursing beds within Lincolnshire County Council are the host body.

Lincolnshire Community Health Services NHS Trust's share of the income and expenditure handled by the pooled budget in the financial year were;

	2017/18	**2016/17**
Revenue	**1720**	870
Expenditure	**1720**	870

2017/18 income and expenditure figures represent a full year of operation of the pooled budget arrangement.

2016/17 income and expenditure figures represent a part year operation (7 months from 1st September 2016)

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Community services		
Community services income from CCGs and NHS England	83,614	83,424
Income from other sources (e.g. local authorities)*	10,728	16,414
All services		
Private patient income	3	6
Other clinical income	298	252
Total income from activities	**94,643**	**100,096**

* From 1st October 2017, the responsibility for operation of 0-19 services (health visiting and school nursing) was taken back into Lincolnshire County Council operation. Prior to this date, Lincolnshire Community Health Services NHS Trust had been contracted to provide these services.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	2,134	3,251
Clinical commissioning groups	81,480	80,173
Department of Health and Social Care	-	-
Other NHS providers	30	7
NHS other	-	-
Local authorities	10,728	16,414
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	3	6
NHS injury scheme	206	206
Non NHS: other	62	39
Total income from activities	**94,643**	**100,096**
Of which:		
Related to continuing operations	94,643	100,096
Related to discontinued operations	-	-

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

	2017/18 £000	2016/17 £000
Income recognised this year	3	6
Cash payments received in-year	3	6
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2017/18 £000	2016/17 £000
Research and development	411	358
Education and training	861	1,035
Receipt of capital grants and donations	24	-
Charitable and other contributions to expenditure	41	50
Non-patient care services to other bodies	5,245	5,147
Sustainability and transformation fund income	2,804	2,236
Rental revenue from operating leases	-	-
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis	403	413
Other income	25	1
Total other operating income	**9,814**	**9,240**
Of which:		
Related to continuing operations	9,814	9,240
Related to discontinued operations	-	-

Note 5 Fees and charges

Lincolnshire Community Health Services NHS Trust has received no income from fees or charges in 2017/18 (2016/17: £nil)

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	-
Purchase of healthcare from non-NHS and non-DHSC bodies	-	-
Purchase of social care	-	-
Staff and executive directors costs	63,738	69,268
Remuneration of non-executive directors	55	64
Supplies and services - clinical (excluding drugs costs)	12,428	11,593
Supplies and services - general	2,567	2,568
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,744	2,723
Inventories written down	-	-
Consultancy costs	243	635
Establishment	1,350	1,393
Premises	3,139	2,783
Transport (including patient travel)	1,824	1,884
Depreciation on property, plant and equipment	745	663
Amortisation on intangible assets	133	92
Net impairments	63	38
Increase/(decrease) in provision for impairment of receivables	13	14
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor*		
audit services- statutory audit	52	46
other auditor remuneration (external auditor only)	2	-
Internal audit costs	50	53
Clinical negligence	187	202
Legal fees	548	1,635
Insurance	-	-
Research and development	314	217
Education and training	706	611
Rentals under operating leases	8,594	9,010
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	-	-
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-	-
Car parking & security	-	-
Hospitality	-	-
Losses, ex gratia & special payments	-	-
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	186	7
Total	**99,681**	**105,499**
Of which:		
Related to continuing operations	99,681	105,499
Related to discontinued operations	-	-

* Audit Fees included above are inclusive of irrecoverable value added tax (VAT) at 20%. It should also be noted that the 2017/18 figure is inclusive of charges of £6,090 (inc VAT) relating to additional assurance work undertaken on the 2016/17 statements resultant from the Cyber Attack in May 2017, during the audit period.

Note 6.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
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	2	-
Total	**2**	**-**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5m (2016/17: £5m)

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	63	38
Other	-	-
Total net impairments charged to operating surplus / deficit	**63**	**38**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**63**	**38**

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	47,301	51,959
Social security costs	4,411	4,808
Apprenticeship levy*	224	-
Employer's contributions to NHS pensions	6,509	6,926
Pension cost - other	10	7
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	216	975
Temporary staff (including agency)	5,067	4,593
Total gross staff costs	**63,738**	**69,268**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**63,738**	**69,268**
Of which		
Costs capitalised as part of assets	-	-

* The apprenticeship levy was introduced for the 2017/18 fiscal year by Government.

Note 8.1 Retirements due to ill-health

	2017-18	2016-17
	Number	Number
Number of person retired early on ill-health grounds	**3**	2
	£000s	£000s
Total additional pension liabilities accrued in the year	**99**	129

The cost of these ill-health retirements are borne by the NHS Business Services Authority - Pensions Division not the Trust. They are calculated by multiplying the average value of ill health pension by the number of years from payment to age sixty. Any pensions increase has been ignored.

Note 9 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

The Trust has employees who pay into the National Employment Savings Trust (NEST) pension scheme and this is not connected to the NHS Pension Scheme.

Note 10 Operating leases

NHS Trust as a lessor

Lincolnshire Community Health Services has not acted as a lessor in any leasing arrangements in 2017/18 (2016/17:£0)

NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Lincolnshire Community Health Services NHS Trust is the lessee.

Lincolnshire Community Health Services NHS Trust operates patient services in a variety of locations across the county of Lincolnshire.
As a result, the Trust is party to a number of leasing arrangements for occupation of properties. Many of these arrangements are with NHS Property Services Ltd.

The Trust also operates a lease car scheme to enable staff to deliver services in the community, these arrangements involve three-year agreements with private leasing providers.

	2017/18	**2016/17**
	£000	**£000**
Operating lease expense		
Minimum lease payments	8,594	9,010
Contingent rents	-	-
Less sublease payments received	-	-
Total	**8,594**	**9,010**

	31 March 2018	**31 March 2017**
	£000	**£000**
Future minimum lease payments due:		
- not later than one year;	7,858	8,343
- later than one year and not later than five years;	1,910	2,439
- later than five years.	2,251	2,410
Total	**12,019**	**13,192**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts*	47	25
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total	**47**	**25**

* Interest recognised by Lincolnshire Community Health Services NHS Trust for 2017/18 (and prior period) represents interest received on cash balances held within Government Banking Services accounts.

Note 12.1 Finance expenditure

Lincolnshire Community Health Services NHS Trust did not undertake any borrowing or financing arrangements during 2017/18. (2016/17: £nil)

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

Lincolnshire Community Health Services NHS Trust did not incur any fees under the late payment of commercial debts (interest) act during 2017/18 (2016/17: £nil)

Note 13 Other gains / (losses)

	2017/18	2016/17

Lincolnshire Community Health Services NHS Trust did not have any items classified as other gains or losses during 2017/18 (2016/17: £nil)

Note 14 Discontinued operations

Lincolnshire Community Health Services NHS Trust had none of its operations classified as discontinued during 2017/18 (2016/17: £nil)

Note 15.1 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**427**	**116**	**85**	**-**	**628**
Transfers by absorption	-	-	-	-	**-**
Additions	198	6	152	-	**356**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	12	73	(85)	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Gross cost at 31 March 2018	**637**	**195**	**152**	**-**	**984**
Amortisation at 1 April 2017 - brought forward	**298**	**35**	**-**	**-**	**333**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**
Provided during the year	85	48	-	-	**133**
Impairments	**-**	**-**	**-**	**-**	**-**
Reversals of impairments	**-**	**-**	**-**	**-**	**-**
Revaluations	**-**	**-**	**-**	**-**	**-**
Reclassifications	**-**	**-**	**-**	**-**	**-**
Transfers to / from assets held for sale	**-**	**-**	**-**	**-**	**-**
Disposals / derecognition	**-**	**-**	**-**	**-**	**-**
Amortisation at 31 March 2018	**383**	**83**	**-**	**-**	**466**
Net book value at 31 March 2018	**254**	**112**	**152**	**-**	**518**
Net book value at 1 April 2017	**129**	**81**	**85**	**-**	**295**

Note 15.2 Intangible assets - 2016/17

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**343**	**93**	**-**	**-**	**436**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**343**	**93**	**-**	**-**	**436**
Transfers by absorption	-	-	-	-	**-**
Additions	84	23	85	-	**192**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2017	**427**	**116**	**85**	**-**	**628**
Amortisation at 1 April 2016 - as previously stated	**233**	**8**	**-**	**-**	**241**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**
Amortisation at 1 April 2016 - restated	**233**	**8**	**-**	**-**	**241**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**
Provided during the year	**65**	**27**	**-**	**-**	**92**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Amortisation at 31 March 2017	**298**	**35**	**-**	**-**	**333**
Net book value at 31 March 2017	**129**	**81**	**85**	**-**	**295**
Net book value at 1 April 2016	**110**	**85**	**-**	**-**	**195**

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**681**	**2,400**	**422**	**1,601**	**1,811**	**385**	**7,300**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	185	564	306	172	32	**1,259**
Impairments	-	(68)	-	-	-	-	**(68)**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	85	-	-	-	-	**85**
Reclassifications	-	230	(422)	-	192	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2018	**681**	**2,832**	**564**	**1,907**	**2,175**	**417**	**8,576**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**547**	**-**	**1,292**	**1,154**	**244**	**3,237**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**178**	**-**	**100**	**388**	**79**	**745**
Impairments	-	(5)	-	-	-	-	**(5)**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	(16)	-	-	-	-	**(16)**
Reclassifications	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2018	**-**	**704**	**-**	**1,392**	**1,542**	**323**	**3,961**
Net book value at 31 March 2018	**681**	**2,128**	**564**	**515**	**633**	**94**	**4,615**
Net book value at 1 April 2017	**681**	**1,853**	**422**	**309**	**657**	**141**	**4,063**

Note 16.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**681**	**2,731**	**487**	**1,800**	**1,686**	**376**	**7,761**
Prior period adjustments	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**681**	**2,731**	**487**	**1,800**	**1,686**	**376**	**7,761**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	82	422	104	49	5	**662**
Impairments	-	(41)	-	-	-	-	**(41)**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	(727)	-	-	-	-	**(727)**
Reclassifications	-	355	(487)	-	128	4	**-**
Transfers to / from assets held for sale	-	-	-	(134)	(44)	-	**(178)**
Disposals / derecognition	-	-	-	(169)	(8)	-	**(177)**
Valuation/gross cost at 31 March 2017	**681**	**2,400**	**422**	**1,601**	**1,811**	**385**	**7,300**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**1,026**	**-**	**1,494**	**854**	**162**	**3,536**
Prior period adjustments	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**-**	**1,026**	**-**	**1,494**	**854**	**162**	**3,536**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**152**	**-**	**77**	**352**	**82**	**663**
Impairments	-	(3)	-	-	-	-	**(3)**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	(628)	-	-	-	-	**(628)**
Reclassifications	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	(110)	(44)	-	**(154)**
Disposals/ derecognition	-	-	-	(169)	(8)	-	**(177)**
Accumulated depreciation at 31 March 2017	**-**	**547**	**-**	**1,292**	**1,154**	**244**	**3,237**
Net book value at 31 March 2017	**681**	**1,853**	**422**	**309**	**657**	**141**	**4,063**
Net book value at 1 April 2016	**681**	**1,705**	**487**	**306**	**832**	**214**	**4,225**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018							
Owned - purchased	681	2,084	564	472	633	79	**4,513**
Finance leased	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	**-**
Owned - donated	-	44	-	43	-	15	**102**
NBV total at 31 March 2018	**681**	**2,128**	**564**	**515**	**633**	**94**	**4,615**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017							
Owned - purchased	681	1,788	422	251	657	134	**3,933**
Finance leased	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	**-**
Owned - donated	-	65	-	58	-	7	**130**
NBV total at 31 March 2017	**681**	**1,853**	**422**	**309**	**657**	**141**	**4,063**

Note 17 Donations of property, plant and equipment

Lincolnshire Community Health Services received donated assets as detailed below:

£24k donated additions made up of £6k Intangible and £18k Tangible. These assets were donated from the Lincolnshire Community Health Services NHS Trust linked charitable funds.

Note 18 Revaluations of property, plant and equipment

A full revaluation of the Trust owned property assets was undertaken during 2017/18 by DVS Property Specialist, an executive arm of the Valuation Office Agency, with an effective date of 30th of April 2017

The valuations have been undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HM Treasury FReM compliant Department of Health Group Accounting Manual (DoH GAM).

For each asset owned and used by the Trust in the delivery of services for which the Trust has a responsibility, the basis of valuation required from 1st April 2015 was the Current Value in use, as defined in DoH GAM and reflecting the adaptation approved by FRAB to IAS 16.

Note 19 Investment Property

Lincolnshire Community Health Services NHS Trust does not hold any properties for the purposes of capital appreciation (investment).

Note 20 Investments in associates and joint ventures

During 2017/18, Lincolnshire Community Health Services NHS Trust did not undertake any arrangements which involved investments in or with associates and/or joint ventures (2016/17: £nil)

Note 21 Other investments / financial assets (non-current)

During 2017/18, Lincolnshire Community Health Services NHS Trust did hold or have any non-current arrangements which involved other investments or financial assets (2016/17: £nil).

Note 21.1 Other investments / financial assets (current)

During 2017/18, Lincolnshire Community Health Services NHS Trust did hold or have any current arrangements which involved other investments or financial assets (2016/17: £nil).

Note 22 Disclosure of interests in other entities

Lincolnshire Community Health services does not hold any interest in other organisations

Note 23 Inventories

Lincolnshire Community Health Services NHS Trust does not account separately for inventory on the basis of immateriality.

Note 24.1 Trade receivables and other receivables

	Current		Non Current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Trade receivables	3,850	6,407	-	-
Capital receivables (including accrued capital related income)	-	-	-	-
Accrued income	3,706	1,735	-	-
Provision for impaired receivables	(42)	(29)	-	-
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	916	1,043	-	-
PFI prepayments - capital contributions	-	-	-	-
PFI lifecycle prepayments	-	-	-	-
Interest receivable	-	-	-	-
Finance lease receivables	-	-	-	-
VAT receivable	21	37	-	-
Corporation and other taxes receivable	-	-	-	-
Other receivables	34	73	-	-
Total trade and other receivables	**8,485**	**9,266**	**-**	**-**
Of which receivables from NHS and DHSC group bodies:				
Current	6,633	5,282	-	-
Non-current	-	-	-	-

The majority of trade is with NHS Clinical Commissioning Groups (CCGs) and other Government Funded bodies to fund patient care services and as such, no credit scoring of them is considered necessary.

Note 24.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**29**	**15**
Prior period adjustments	-	-
At 1 April - restated	**29**	**15**
Transfers by absorption	-	-
Increase in provision	13	14
Amounts utilised	-	-
Unused amounts reversed	-	-
At 31 March	**42**	**29**

Note 24.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	10	-	-	-
30-60 Days	-	-	-	-
60-90 days	23	-	-	-
90- 180 days	16	-	1	-
Over 180 days	33	-	28	-
Total	**82**	**-**	**29**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	796	-	1,792	-
30-60 Days	312	-	1,089	-
60-90 days	164	-	1,043	-
90- 180 days	393	-	340	-
Over 180 days	220	-	796	-
Total	**1,885**	**-**	**5,060**	**-**

Note 25 Other assets

Lincolnshire Community Health Services NHS Trust did not classify any other assets during to 2017/18 (2016/17: £nil)

Note 26 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**
Prior period adjustment		**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**-**	**-**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	**-**
Assets classified as available for sale in the year	-	**24**
Assets sold in year	-	**(24)**
Impairment of assets held for sale	-	**-**
Reversal of impairment of assets held for sale	-	**-**
Assets no longer classified as held for sale, for reasons other than disposal by sale	-	**-**
Transfer to FT upon authorisation	-	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 26.1 Liabilities in disposal groups

Lincolnshire Community Health Services NHS Trust did not have any liabilities classified as within disposal groups as at 31st March 2018 (2016/17: £nil)

Note 27.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**13,806**	**10,526**
Prior period adjustments	-	-
At 1 April (restated)	**13,806**	**10,526**
Transfers by absorption	-	-
Net change in year	7,454	3,280
At 31 March	**21,260**	**13,806**
Broken down into:		
Cash at commercial banks and in hand	1	1
Cash with the Government Banking Service	21,259	13,805
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**21,260**	**13,806**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**21,260**	**13,806**

Note 27.2 Third party assets held by the trust

Lincolnshire Community Health Services NHS Trust held no cash or cash equivalents on behalf of third parties or patients in 2017/18 (2016/17: £nil). This includes no bank balances or monies held on deposit.

Note 28.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	4,243	4,073
Capital payables	660	156
Accruals	6,138	5,259
Receipts in advance (including payments on account)	-	-
Social security costs	640	692
VAT payables	-	-
Other taxes payable	414	435
PDC dividend payable	-	-
Accrued interest on loans	-	-
Other payables	795	893
Total current trade and other payables	**12,890**	**11,508**
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	4,099	3,435
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

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

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	795		870	

Note 29 Other financial liabilities

Lincolnshire Community Health Services had no liabilities classifed as other financial liabilites in 2017/18 (2016/17: £nil)

Note 30 Other liabilities	31 March 2018	31 March 2017
Current	**£000**	**£000**
Deferred Income	518	361
Deferred Grants	-	-
PFI Deferred Income/Credits	-	-
Lease Incentives	-	-
	518	**361**

Lincolnshire Community Health Services NHS Trust does not have any non-current other liabilities (2016/17: £nil)

Note 31 Borrowings

Lincolnshire Community Health Services NHS Trust did not undertake any borrowing arrangements during 2017/18 (2016/17: £nil)

Note 32 Finance leases

Note 32.1 Lincolnshire Community Health Services NHS Trust as a lessor

Lincolnshire Community Health Services NHS Trust does not act as a lessor in any arrangements (2016/17: £nil)

Note 32.2 Lincolnshire Community Health Services NHS Trust as a lessee

Lincolnshire Community Health Services NHS Trust did not have any leasing arrangements meeting the classification as finance leases in 2017/18 (2016/17: £nil)

Note 33.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2017	**-**	**1,495**	**85**	**614**	**168**	**2,362**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	**-**
Arising during the year	-	447	456	255	-	**1,158**
Utilised during the year	-	-	-	(628)	459	**(169)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	-	(20)	(85)	(112)	(168)	**(385)**
Unwinding of discount	-	-	-	-	-	**-**
At 31 March 2018	**-**	**1,922**	**456**	**129**	**459**	**2,966**
Expected timing of cash flows:						
- not later than one year;	-	1,922	456	129	63	**2,570**
- later than one year and not later than five years;	-	-	-	-	136	**136**
- later than five years.	-	-	-	-	260	**260**
Total	**-**	**1,922**	**456**	**129**	**459**	**2,966**

Provisions categorised as "other" above include estimates made by the Trust with regards to required re-instatement and/or remedy clauses within leases which the Trust holds as a result of occupying properties from which it operates.

Restructuring and redundancy provisions contain balances where the Trust has estimated potential costs associated with reorganisation of Trust services and support services.

Please refer to note 34 for information regarding legal claims provisions.

Note 33.2 Clinical negligence liabilities

At 31 March 2018, £1,148k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lincolnshire Community Health Services NHS Trust (31 March 2017: £2,075k).

Note 34 Contingent assets and liabilities

During 2017/18, Lincolnshire Community Health Services NHS Trust has continued to engage in discussions with HM Revenue and Customs with regards to liabilities due in respect of pay-as-you-earn tax and national insurance. These liabilities relate to individuals engaged by the Trust in the delivery of its services (specifically the GP out-of-hours services), since the Trust's inception in 2011.

The arrangements were inherited from the Trust's predecessor organisation (Lincolnshire Primary Care Trust). Discussions with HMRC to date have included explanation of the detail of the arrangement involved and complying with requests for additional information.

Depending on the outcome of this issue, there is a potential for a liability to arise. The Trust has included an estimate within its 2017/18 financial position as a provision (refer to note 33.1). The Trust continues to discuss with HMRC and legal advisors.

Note 35 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	35	169
Intangible assets	-	-
Total	**35**	**169**

Note 36 Other financial commitments

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

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 37 On-SoFP PFI, LIFT or other service concession arrangements

Lincolnshire Community Health Services NHS Trust does not have any arrangements under Private Finance Initiative (PFI) or Local Improvement Finance Trusts (LIFT).

Note 38 Financial instruments

Note 38.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Lincolnshire Community Health Services NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Lincolnshire Community Health Services NHS Trust treasury activity is subject to review by the Trust's internal auditors.

Interest rate risk

NHS Trusts are eligible to borrow from government for capital expenditure purposes, subject to affordability assessments 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. Lincolnshire Community Health Services NHS Trust currently has no borrowings.

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 exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

The Trust therefore has low exposure to interest rate fluctuations.

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 exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups (CCGs), Local Authorities or NHS England, 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.

Note 38.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	7,515	-	-	-	**7,515**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	21,260	-	-	-	**21,260**
Total at 31 March 2018	**28,775**	**-**	**-**	**-**	**28,775**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	8,113	-	-	-	**8,113**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	13,806	-	-	-	**13,806**
Total at 31 March 2017	**21,919**	**-**	**-**	**-**	**21,919**

Note 38.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	10,523	-	**10,523**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2018	**10,523**	**-**	**10,523**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	10,742	-	**10,742**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2017	**10,742**	**-**	**10,742**

Note 38.4 Fair values of financial assets and liabilities

The majority of the Trust's financial assets relate either to cash or money due from other NHS organisations. Other NHS organisations are extremely unlikely to default on payments, and the Trust is only permitted to invest cash deposits within strict guidelines. Lincolnshire Community Health Services NHS Trust does not undertake any transactions involving hedging, foreign currency or other investments prone to market fluctuations. There is therefore, no material exposure to credit, market or liquidity risks.

The Trust's financial liabilities are generally of a short-term and uncomplicated nature which are not particularly influenced by external factors. The Trust updates a long term financial plan each year, which includes a detailed cash flow forecast, and has no reason to assume it will be unable to meet its obligations to suppliers, employees and financing costs. There are therefore not any material liquidity risks.

Note 38.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	10,523	10,742
In more than one year but not more than two years	-	-
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	**10,523**	**10,742**

Note 39 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	-	-
Fruitless payments	2	-	3	10
Bad debts and claims abandoned	5	1	-	-
Stores losses and damage to property	-	-	4	0
Total losses	**7**	**1**	**7**	**10**
Special payments				
Compensation under court order or legally binding arbitration award	1	8	3	30
Extra-contractual payments	-	-	-	-
Ex-gratia payments	-	-	7	5
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**1**	**8**	**10**	**35**
Total losses and special payments	**8**	**9**	**17**	**45**
Compensation payments received		-		-

Note 40 Gifts

Lincolnshire Community Health Services NHS Trust did not expend on gifts during 2017/18 (2016/17: £nil)

Note 41 Related parties

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
E Baylis, Chair				
1. Interim Chair, United Lincolnshire Hospitals NHS Trust	2,407,000	1,838,000	717,000	983,000
E Libiszewski, Non- Executive Director				
1. Non Executive Director, United Lincolnshire Hospitals NHS Trust	2,407,000	1,838,000	717,000	983,000
Mr A Morgan, Chief Executive.				
1. Board Member – East Midlands Leadership Academy (hosted by Nottinghamshire Healthcare NHS Foundation Trust)	21,000	23,000	6,000	3,000
Dr N Parkes, Medical Director (Honorary from January 2017)				
1. Partner in Newmarket Medical Practice	46,000	1,000	1,000	0
2. Director, Louth and District Medical Services (LADMS)	958,000	0	0	0
3. Director, Lincolnshire and District Medical Services (LADMS) - name change from above	394,000	0	47,000	0
S Elcock, Interim Medical Director (from 14 November 2017)				
1. Medical Director Lincolnshire Partnership NHS Foundation Trust	358,000	59,000	97,000	19,000
A Kent, Associate Non-Executive Director (from January 2018)				
1. Lay member of NHS South Norfolk CCG Governing Body	0	5,000	0	1,000

The Department of Health is regarded as a related party. During the year 2017/18, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

- Clinical Commissioning Groups (NHS Lincolnshire East CCG, NHS Lincolnshire West CCG, NHS South West Lincolnshire CCG and NHS South Lincolnshire CCG)
- NHS England (for the commissioning of specialised health services)
- NHS Foundation Trusts (particulary North Lincolnshire and Goole NHS Foundation Trust and Lincolnshire Partnership NHS Foundation trust)
- NHS Trusts (particularly with United Lincolnshire Hospitals NHS Trusts)
- NHS Litigation Authority (in respect of Clinical Negligence contributions)
- NHS Property Services (in respect of buildings, rentals and service charges)
- NHS Business Services Authority

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Lincolnshire County Council in respect of services commissioned by the local authority.

The Trust has also received revenue and capital payments from a number of charitable funds, Lincolnshire Community Health Services is the corporate trustee of the charitable fund.

Note 42 Events after the reporting date

At the time of preparation, the Trust has not been notified or become aware of any significant events which require disclosure.

Note 43 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	14,268	23,736	12,816	27,436
Total non-NHS trade invoices paid within target	10,563	17,418	10,534	22,344
target	**74.03%**	**73.38%**	82.19%	81.44%
NHS Payables				
Total NHS trade invoices paid in the year	1,490	15,933	1,587	18,505
Total NHS trade invoices paid within target	804	7,282	1,040	14,913
Percentage of NHS trade invoices paid within target	**53.96%**	**45.70%**	65.53%	80.59%

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 44 External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	**(7,454)**	**(3,280)**
Finance leases taken out in year	**0**	**0**
Other capital receipts	**0**	**0**
External financing requirement	**(7,454)**	**(3,280)**
External financing limit (EFL)	304	319
Under / (over) spend against EFL	7,758	3,599

Note 45 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	1,615	854
Less: Disposals	-	(23)
Less: Donated and granted capital additions	(24)	-
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	1,591	831
Capital Resource Limit	1,731	1,043
Under / (over) spend against CRL	140	212

Note 46 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	4,903
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	4,903

Note 47 Breakeven duty rolling assessment

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance	1,081	1,473	1,825	1,274	569	3,940	4,903
Breakeven duty cumulative position	1,081	2,554	4,379	5,653	6,222	10,162	15,065
Operating income	108,738	108,773	109,612	110,487	105,943	109,336	104,457
Cumulative breakeven position as a percentage of operating income	0.99%	2.35%	4.00%	5.12%	5.87%	9.29%	14.42%