Lincolnshire Community Health Services
NHS Trust

Annual Report and Accounts

2018-19

Great care, close to home

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Great care, close to home

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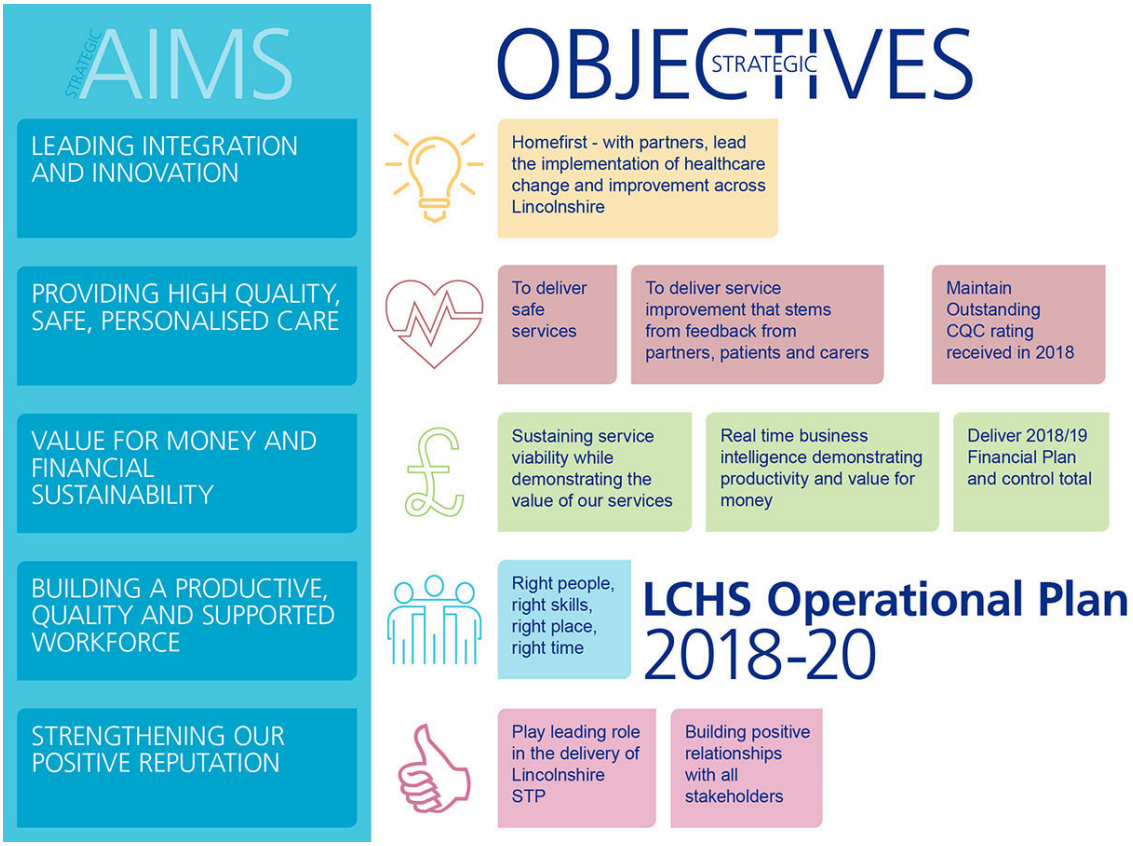


LCHS Way

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 2018/19 for Lincolnshire Community Health Services NHS Trust (LCHS).

On July 5 2018, the NHS marked its 70th birthday. To celebrate this anniversary, a ceremony was held at Westminster Abbey, where the Trust was represented by the Trust's chief executive, Andrew Morgan. Locally, LCHS joined with partners from the Lincolnshire NHS community to find 70 stars from across the seven provider and commissioning organisations.

As an NHS Trust, LCHS is an integral part of both the NHS family, one of the country's best loved institutions and also an integral part of the community in Lincolnshire. To borrow from the introduction of the NHS Constitution:

"The NHS belongs to the people.

"It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.

"The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it."

The NHS Constitution goes on to articulate the seven principles that guide the NHS:

1. The NHS provides a comprehensive service, available to all

2. Access to NHS services is based on clinical need, not an individual's ability to pay
3. The NHS aspires to the highest standards of excellence and professionalism
4. The patient will be at the heart of everything the NHS does
5. The NHS works across organisational boundaries
6. The NHS is committed to providing best value for taxpayers' money
7. The NHS is accountable to the public, communities and patients that it serves (information from www.gov.uk)

LCHS takes its role as a NHS organisation very seriously. It is both a moral and a statutory duty for the Trust to deliver quality services within its financial allocation. This is a duty that is accepted and understood by everyone who works within the Trust.

Notable achievements throughout the year

Without a doubt, the most notable achievement for the Trust this year was its overall rating of outstanding from the CQC; with a rating of good for the safe, effective and caring domains and outstanding in the responsive and well-led domains. This rating is something that everyone who works for LCHS is extremely proud of and reflects on the hard work and attitude of everyone within the Trust.

The Trust Board is particularly proud of the culture of the organisation that has enabled this to happen. LCHS has a strong ethic of valuing, encouraging and developing its staff and this is encapsulated within the foundations of the LCHS Way: we listen, we care, we act and we improve.

The Trust builds on these foundations by taking a proactive approach to engaging with its staff and developing its current and future leaders, with the firm belief that motivated and engaged staff directly improve the quality of the care it delivers to patients.

In June 2018, Trust Board chair, Elaine Baylis, signed the Armed Forces Covenant alongside Lieutenant Colonel Emma Read, commanding officer of 254 Medical Regiment, representing the Ministry of Defence. It is a matter of

great pride for the Trust to support the armed forces community that is such an integral part of life in Lincolnshire.

In October 2018, Scotter Ward at John Coupland Hospital in Gainsborough unveiled its refurbished palliative care rooms. The team on the ward has raised in excess of £56,000 over the last two-and-a-half years through various events. The team should be extremely proud of its efforts. It is not difficult to see why they are so loved and appreciated by the local community in Gainsborough.

In November 2018, Ellen Franklin was crowned the county's Healthcare Assistant of the Year at the Lincolnshire Media Health Awards. In the citation from the event, Ellen was said to have stood out because of her "extensive experience, her knowledge of mental health and her ability to impart knowledge to others and stand up for what she believes in." All in all, a great role model for LCHS.

In March 2019, LCHS was shortlisted in the Emergency, Urgent and Trauma Care Efficiency Initiative of the Year category of the 2019 HSJ Value Awards, after impressing judges with their innovative new ways of delivering care in Lincolnshire.

This highlights the success at introducing urgent care streaming in conjunction with the already nationally-recognised Clinical Assessment Service (CAS), which helps people to quickly access the most appropriate services for their needs either face-to-face or over the telephone. By supporting people at their first point of contact and working with other emergency organisations, the service is helping to reduce unnecessary ambulance call outs, hospital admissions and attendances to A&E departments.

Changes to the Trust Board

There have been a number of changes to the membership of the Trust Board during 2018/19.

The first change to the Trust Board was a change to medical director at the end of April 2019. Sue Elcock held the post on an interim basis whilst also

holding the same role on a substantive basis for Lincolnshire Partnership NHS Foundation Trust, the local mental health services provider. This role was taken by Dr Yvonne Owen, firstly on an interim basis and then appointed to the role substantively.

In May 2018, Dani Cecchini left her role as director of finance and strategy to take up a similar role with Leicestershire Partnership NHS Trust. Dani was succeeded by Sam Wilde; initially on an interim basis, Sam was successful in gaining the substantive role and subsequently changed his title to director of finance and business intelligence to better reflect the priorities of his directorate.

At the end of August 2018 the director of nursing and operations, Lisa Stalley Green left to take up a similar role with University Hospitals Birmingham NHS Foundation Trust, having been in post since January 2016. Since September 2018, the Trust's deputy director of nursing, Susan Ombler has held the role on an interim basis.

At the end of October 2018, Tom Dannatt resigned as a non-executive director/chair of the Audit Committee and in February 2019, Alan Kent became a substantive non-executive director of the Trust Board, having performed the function in an associate capacity. Alan has also taken over as chair of the Audit Committee.

Despite the changes to the Trust Board, the leadership of the organisation through its chief executive continues to be highly effective. This was the subject of positive comments in the CQC report and I would like to take this opportunity to thank the chief executive, Andrew Morgan, executive and non-executive colleagues and the wider leadership team for their dedication, motivation and commitment to providing high quality care to those who have needed our services over the course of the last year. It is a great privilege to be the chair of this organisation.

Performance report

Performance overview

A statement from the chief executive providing his perspective on the performance of the Trust during 2018/19

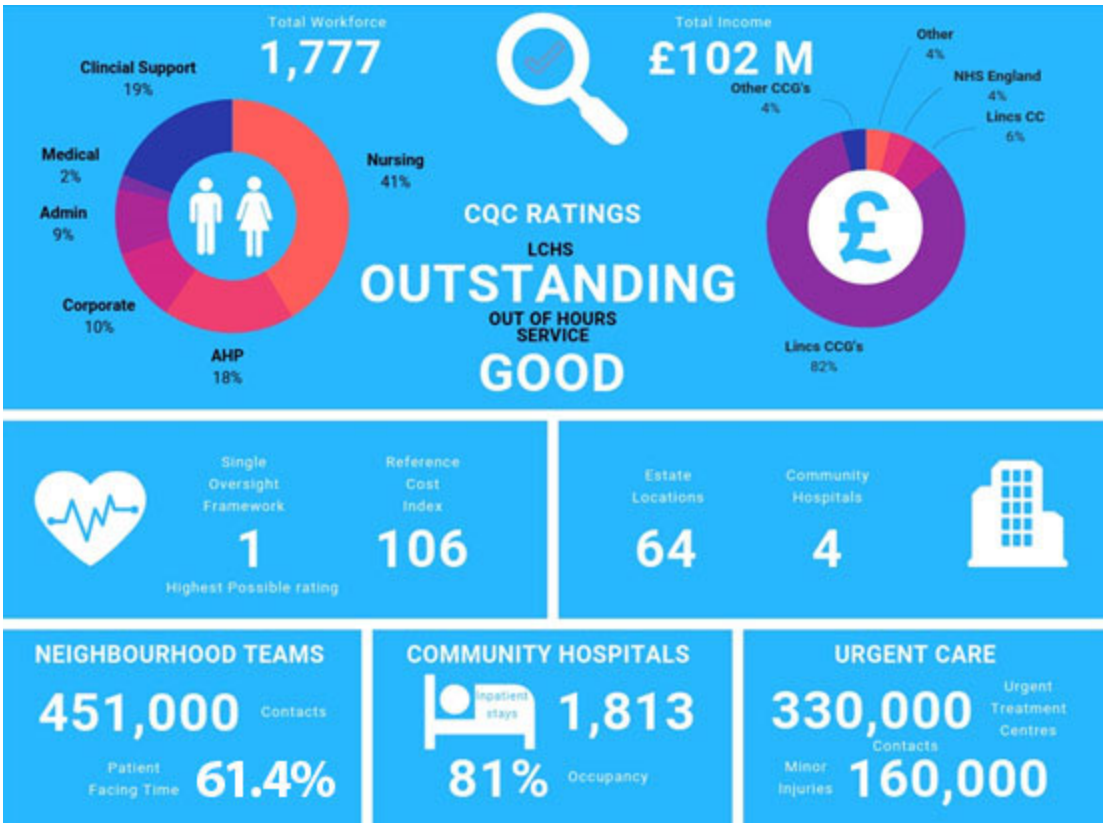
Andrew Morgan, Chief Executive
Lincolnshire Community Health Services NHS Trust

Lincolnshire Community Health Services NHS Trust (LCHS) provides community healthcare services for the population of Lincolnshire. The Trust has an annual turnover of c. £102m and employs c. 1,800 members of staff. The Trust was last inspected by the Care Quality Commission (CQC) in June 2018 and everyone who works here is incredibly proud to be rated 'Outstanding' overall. This is testament to the great work the staff do every day with the population of Lincolnshire.

Working in partnership with other health and social care bodies the Trust cares for thousands of patients every day, delivering care in community settings across a range of services including; community nursing, therapy, end of life care, urgent care, public health, children's health and social care services.

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 2018/19 the Trust has continued to develop its services in line with the needs of the Lincolnshire healthcare community.

Some of the Trust's key facts and figures are illustrated below:



While community care continues to be the Trust's main business, in September 2018 LCHS took over temporary responsibility for Pennygate Surgery in Spalding to maintain primary care services for its 3,000 patients following the departure of the lead GP. In March 2019 the Trust also began caretaking The Sidings Practice serving 18,000 patients in the Boston area again following the retirement of the GP partner. The Trust undertook this as part of its commitment to supporting the sustainability of healthcare services for patients and a desire to increase and diversify its portfolio of services.

The Trust is committed to engaging with patients, stakeholders and the public to understand what is important to them, to hear feedback on their experiences and how they would like to see the health service continue and improve. The Trust has taken an active role in the start of Healthy Conversation 2019, a discussion with the public and people who use its services about what, and how, to change to ensure that health services are fit for the future. The engagement started in February 2019 year and will continue throughout 2019.

LCHS continues to perform well and in addition to the positive CQC inspection result the Trust is one of only 40 Trusts in segment 1 of the Single Oversight Framework, out of the 226 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. Segment 1 is the top rating Trusts can receive.

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 2018/19, LCHS posted a year-end financial surplus of £4.821m, £1.988m higher than the planned surplus of £2.833m. Within the outturn position, the Trust has received Provider Sustainability Funding (PSF) income of £1.908m (planned allocation) and a further "bonus" allocation of £1.710m for achievement beyond NHS Improvement expectation.

Purpose and activities of the organisation

LCHS is the primary community healthcare provider in Lincolnshire, delivering care to thousands of patients every day. The Trust delivers a broad range of community nursing, therapy, urgent care, reablement, palliative care, public health, children's health, social care and primary 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. The Trust works 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
- urgent care services, including:
  - two Urgent Care Centres, one in Skegness and one in Louth
  - two Minor Injury Units, one in Gainsborough and one in Spalding
  - an Urgent Treatment Centre 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
- community surgery scheme including hernia repair
- primary care services in Boston and Spalding.

Service developments in 2018/19 include:

- a new step-up facility and frailty assessment service and treatment pathway at County Hospital Louth for patients who are too poorly to remain at home but who do not need to go into hospital
- a successful e-consultation pilot in urgent care that will be rolled out across urgent care and primary care services in 2019
- embedding of the Urgent Care Streaming Service provided at Lincoln County and Boston acute hospitals sites, supporting the A&E system in Lincolnshire.

Business environment

Key challenges for Lincolnshire's health and care system

Quality

- All four Clinical Commissioning Groups (CCGs) and the acute Trust are rated 'Requires Improvement' by NHS England and the CQC respectively.

Workforce

- Supporting the system during peak demand, for example; winter initiatives and mobilising to support primary care, leading to an increase in spend on agency/locum staff
- The shortage of GPs continues
- An ageing workforce may present challenges with many professionals eligible to retire within the next five years
- Ensuring the right staff are in the right place as services move from secondary care to primary care in line with the NHS Long Term Plan
- Sickness absence
- Alignment with national Advanced Clinical Practitioners (ACP) strategy.

Finance and contracting

- The cost of transformation – moving activity from secondary to primary care may necessitate 'double running' while the changes are made
- All CCGs are carrying significant financial risk.

Infrastructure

- Lack of shared patient management systems
- Lack of single system metrics
- Information sharing governance is needed to enable effectively working across organisations.

Leadership and culture

- Transformational change will not happen at scale and pace without the mind-set, behaviours and shared values needed to ensure real collaboration and genuine partnership working
- Willingness of staff to engage in transformational change.

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 NHS Long Term Plan published in January 2019 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 and self-care, choice and control, greater integration of services and providing care closer to peoples' homes.
- **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.

Planning has been reframed in line with the Sustainability and Transformation Partnership (STP) and the NHS Long Term Plan. The seven main NHS commissioning and provider organisations in Lincolnshire have committed to the following for the benefit of the Lincolnshire population:

- System working to address the challenges of improving quality, recruiting and retaining excellent people, and addressing the financial gap.
- Development and delivery of a single system plan for 2019/20 that will act as year one of the system's five year strategic plan aligned to the NHS Long Term Plan
- Agreement on what the Lincolnshire healthcare system will deliver for its population with its share of NHS resources for 2019/2020, applying all the collective resources to deliver better outcomes.

Lincolnshire's single system plan has four priorities:

System Priorities	2019/20 work programmes
System Working	• Workforce • IM&T • Quality • System estate • Contracting • Communications and engagement • Data analytics and technology
Integrated Community	• Urgent care and treatment • Increase community capacity

Care	• Mental health, learning disability and autism • Frailty • Diabetes • Community stroke rehabilitation • Primary care and general practice • Population health
Acute Services Delivery	• Outpatient services redesign • Planned care – bringing elective care back to Lincolnshire • Women's and Children's Services
Operational Efficiency	• IT • Corporate Services transformation • Corporate estate • Workforce • Procurement

LCHS Business Model

LCHS is the primary community healthcare provider in Lincolnshire, delivering services aimed at supporting people to manage their own health at home and reducing the need for people to go into hospital. In September 2018, the Trust was rated as 'Outstanding' by the Care Quality Commission.

In partnership with other health and social care services, the Trust delivers a broad range of community services, caring for thousands of patients every day. The Trust plays a part in supporting and delivering the Lincolnshire Sustainability and Transformation Partnership (STP), as well as ensuring its direction aligns to the recently published NHS Long Term Plan.

In 2018/19, the Trust's clinical services were configured into five service lines:

Summary of LCHS service lines and the services provided

Urgent Care

- Providing a highly responsive and effective network of community-based services for people with urgent but non-life threatening needs to avoid the need for hospital attendance and admission.
- Services include: Clinical Assessment Service (CAS); Urgent Treatment Centres; Home Visiting Service; Urgent Care Centres; Minor Illness and Injury Units; Home Visiting; and, Urgent Care Streaming Services to reduce the impact on A&E.
- The Urgent Care Team also provides specific services for Care Homes and has recently piloted the use of e-consultations

Community Nursing

- General and specialist integrated community nursing services for adults are organised into 12 Integrated Community Teams closely aligned to GP practices.
- They provide support to people with long term conditions, frail and the end of life.
- Nursing, physiotherapy, occupational therapy and speech and language services work as one team meaning patients only give their details once.
- Community nurses work closely with a range of professionals from other agencies as part of Neighbourhood Teams to provide integrated care for patients designed to meet local needs.

Community Hospitals and Transitional Care

- Health & Wellbeing hubs provide a range of ambulatory and inpatient services to prevent admission into/support timely discharge from acute hospital.
- Bridging the gap between hospital and home maximises recovery and promotes independence with an emphasis on 'Home First' through time-limited rehabilitation and support for older people and adults with long term conditions.
- The Operations Centre supports the system with referral handling and demand/capacity management to ensure the right care, first time.

Specialist Services

- Providing care closer to home, reducing hospital admissions and managing long term conditions through self-care.

• Specialist Nursing services are: Diabetes; Heart Failure; Respiratory; Pulmonary Rehab; Macmillan; TB; Tissue Viability; INR; Lymphoedema; Parkinson's; MSK Physiotherapy and Continence. • Other services include: countywide, integrated sexual health and contraceptive health services; and Electronic Assistive Technology Service supporting people with significant physical disabilities to regain or retain their independence.
Allied Health Professionals • Providing clinical interventions and support for adults and children in the community to improve functioning and increase independence. • Adult's Services include: Therapy services; Speech and Language Therapy; Podiatry; and Assisted Discharge Stroke Service. • Children's services include: Integrated Therapy Services; and Immunisation and Vaccination Services.

The deputy director of operations is accountable for service delivery. Heads of clinical services for each service line are responsible for the strategic and day-to-day operational management and integrated services clinical leads provide clinical and professional support.

The Trust is managed through five organisational directorates:

- Chief Executive's Office
- Nursing, AHPs and Operations
- Medical
- Workforce and Transformation
- Finance and Business Intelligence.

The corporate services directorates support the work of the Nursing, AHP and Operations Directorate to ensure delivery of high quality, effective and efficient services. All directorates work together in partnership to deliver this shared aim, reporting to the Trust Board through a dedicated executive director.

Key issues and risks to achieving the Trust's objectives

Providing high quality, safe, personalised care

- **Deliver safe services:** lack of relationship with partners; lack of identification of acquired harm incidents of admitted patients; continued

compliance with the Mental Capacity Act; lack of training around safeguarding and competency testing; HR processes: capacity for looked after children assessments; partnership working

- **To deliver services that are co-designed with partners, patients and carers:** lack of patient engagement; transformation skills
- **To maintain the Trust's CQC outstanding rating in 2019/20 and onwards:** culture; staff engagement; workforce; risk management; delivery objectives; evidence collation; collation of clinical audits; complaints; lack of staffing capacity; increasing levels of acuity of patients and demand; increasing complexity of patients co-morbidities; staff engagement; variation between providers.

Delivering value for money and financial sustainability

- **Sustaining service viability while demonstrating the value of our 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 Sustainability and Transformation Programme (STP) through the single plan; Clinical Commissioning Group (CCG) commissioning and contracting intentions; lack of engagement from stakeholders in reviewing and considering other contracting approaches
- **Real time business intelligence demonstrating productivity and value for money:** 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; 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
- **Deliver 2019/20 financial plan 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

- **Right people, right skills, right place, right time:** lack of candidates to fill difficult to recruit to posts; lack of operational capacity and capability in order to proactively manage attendance; lack of credible appraisal in capturing learning requirements in line with the training needs analysis reporting; lack of clinical and corporate buy in to vacate premises; lack of pace of achieving rationalisation plan by third parties; operational workforce does not fully engaged with the full system capabilities; risk of delivering at pace due to competing demands and resources

Strengthening the positive reputation of the Trust

- **Building positive relationships with all stakeholders:** 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
- **Play leading role in the establishment of an Integrated Care System (ICS) in Lincolnshire:** the lack of capacity to be able to participate in system deliver groups; commissioners want to lead the process rather than providers; lack of clarity around governance in the system; potential conflict of interests

Leading integration and innovation

- **Homefirst - with partners, shape and lead the implementation of healthcare change and improvement across Lincolnshire:** failure to maximise the opportunities to lead and participate in neighbourhood teams; commissioning re-tendering urgent care provision
- **Drive a digital revolution in integrated community care in Lincolnshire:** security risks and cyber-attacks

Transformation Team

The Transformation Team's role within Lincolnshire Community Health Services NHS Trust is to build the Trust's capacity and capability to achieve its goals through planned developments, improvements and alignment of strategies, structures, people, culture and processes that lead to organisational effectiveness.

Throughout 2018/2019, the Transformation Team has worked alongside both clinical and corporate teams to support and enable them to drive their services forward. The Trust's vision is at the heart of its transformation projects; leading innovation, high quality patient care, delivering high quality care through a quality workforce.

The team has worked with clinical teams, including; urgent care, community hospitals, community nursing teams, therapy services and specialist services, wider healthcare system partners and patients. Working across the health system supports the delivery of the Lincolnshire STP and Trust's strategic objectives.

Transformation Team achievements for 2018/19

- Successful refurbishment of Manby Ward, County Hospital Louth
- Successful delivery of improvements to inpatient services at County Hospital Louth – seeing a new range of integrated services designed to promote faster recovery from illness, prevent unnecessary hospital admissions and to support timely discharge from hospital
- Lincolnshire system leader for delivering efficiencies with estates management, ensuring fit for purpose buildings for our clinicians and patients
- Launched a new Estates Shared Service function across LCHS and LPFT to support cost efficiencies and better use of estate across Lincolnshire
- Successfully secured funding from NHS England to support the implementation of video consultations across LCHS and the Lincolnshire system. This significant investment will support in us driving our digital technology programme
- Shortlisted for a national HSJ award for Urgent Care Service with its Clinical Assessment Service and Urgent Care Streaming Service.

- Effective and timely implementation of the Trust E-Rostering solution to support right care at the right time through a delivery team that was shortlisted for non-clinical team of the year at the LCHS Celebrating Success awards
- Key role in the development of a single stroke service for Lincolnshire in partnership with other health and social care providers, and championing people being cared for at home
- Recognition from the CQC regarding key focus on integration and innovation and high quality levels of patient care – LCHS has been rated as 'Outstanding' from the CQC

Single Oversight Framework

The Single Oversight Framework was introduced from 1 October 2016 by NHS Improvement to help providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding'.

The framework is used to identify NHS providers' support needs and to segment Trusts according to the level of support required. Tailored support is offered or mandated as appropriate. Each Trust is segmented into one of four categories, see table below.

NHS Improvement Single Oversight Framework 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.

Segmentation is informed by data monitoring and judgement of providers' circumstances against five themes:

1. Leadership and improvement
2. Quality of care
3. Finance and use of resources
4. Operational performance
5. Strategic change.

Only the first three themes have indicators relating to LCHS. The Trust has consistently been assessed as being in segment 1, meaning there are no evident concerns and no support needs identified. As such, we have we have maximum autonomy and review meetings with NHS Improvement are held only quarterly.

NHS Improvement publishes segmentation data for the 226 Trusts operating under the framework on a monthly basis. The segmentation by type and most recently published performance is shown below. LCHS is one of only 40 Trusts in segment 1.

Single Oversight Framework segmentation by Trust type (as at February 2019)

	Segment 1	Segment 2	Segment 3	Segment 4
Acute	13	63	54	17
Ambulance	2	5	2	1
Care Trust	-	4	-	-
Community	9	8	-	-
Mental Health	16	28	3	1
Total	40	108	59	19

Performance summary

LCHS continues to deliver high quality, safe community healthcare services, which are rated as outstanding by the CQC, to the population of Lincolnshire and urgent care services to the people of Peterborough.

The Trust achieves this within its financial control total, whilst working within a challenged healthcare environment that has a substantial deficit.

System working continues to be a focus for the Trust, with an emphasis on out of hospital care. LCHS is working with partners in the development of shared estate, IT infrastructure and staff working across Trusts to support partners during times of need.

LCHS continues to have a robust approach to recruitment, to ensure its workforce has the right skills, in the right place at the right time, ensuring it is fit for future.

Performance analysis

Financial performance

Statement of Comprehensive Income

	2018/19 £000s	2017/18 £000s	Description
Operating income from patient care	86,099	91,839	Income received for provision of services from our commissioning and contractual partners.
Provider Sustainability Funding	3,618	2,804	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 and 2018/19.
Other operating income	12,500	9,814	Income received for providing services to other bodies, education and training income and other non-healthcare related income.
Gross Employee Benefits	(63,251)	(63,738)	The amount we spend on pay costs for our staff groups.
Other Operating expenses	(34,278)	(35,943)	Our non-pay costs for supplies, services and operational costs.
Operating surplus/(deficit) from continuing operations	4,688	4,776	
Finance income	133	47	Income generated from the interest on our cash balances.
Finance expenses	-	-	
Net finance costs	133	47	
Other gains / (losses)	-	-	
Surplus / (deficit) for the year from continuing operations	4,821	4,823	
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	-	-	
Surplus / (deficit) for the year	4,821	4,823	Our overall reported surplus/(deficit) for the year

Statement of Financial Position

	31 March 2019 £000s	31 March 2018 £000s	Description
Non-Current Assets			
Intangible assets	431	518	The value of software licences purchased by the Trust.
Property, plant and equipment	6,002	4,615	The value of our buildings, equipment and physical IT.
Total Non-Current assets	6,433	5,133	
Current Assets			
Receivables	7,255	8,485	Outstanding balances of money due to the Trust from its operating activities.
Cash and cash equivalents	24,968	21,260	The balance of cash held by the Trust
Total Current Assets	32,223	29,745	
Current Liabilities			
Trade and other payables	(11,140)	(12,890)	Outstanding balances of money owed by the Trust at the end of the period through its operating activities.
Provisions	(2,495)	(2,570)	Balance of estimates included for future settlements which the Trust may incur and expects to potentially settle within 12 months.
Other liabilities	(907)	(518)	
Total Current Liabilities	(14,542)	(15,978)	
Total Assets less Current Liabilities	24,114	18,900	
Non-Current liabilities			
Provisions	(451)	(396)	Balance of estimates included for future settlements which the Trust may incur and expects to potentially settle over a longer period than 12 months.
Other liabilities	-	-	
Total Non-Current liabilities	(451)	(396)	
Total assets employed	23,663	18,504	
Financed by			
Public dividend capital	520	381	The value of any additional funding the Trust has received from the

			Department of Health and Social Care to support its activities.
Revaluation reserve	1,095	910	Balances relating to increases in values of the asset the Trust owns.
Income and expenditure reserve	22,048	17,213	The accumulated surpluses/(deficit) balances which the Trust has generated over the period it has operated.
Total taxpayers' equity	23,663	18,504	

Statement of Cash Flows

	2018/19 £000s	**2017/18 £000s**
Cash flows from operating activities		
Operating surplus / (deficit)	4,688	4,776
Non-cash income and expense:		
Depreciation and amortisation	1,038	878
Net impairments	(27)	63
Income recognised in respect of capital donations	(239)	(24)
(Increase) / decrease in receivables and other assets	1,230	781
Increase / (decrease) in payables and other liabilities	(971)	1,035
Increase / (decrease) in provisions	(20)	604
Net cash generated from / (used in) operating activities	5,699	8,113
Cash flows from investing activities		
Interest received	133	47
Purchase of intangible assets	(97)	(369)
Sales of intangible assets	-	-
Purchase of property, plant, equipment and investment property	(2,362)	(742)
Receipt of cash donations to purchase capital assets	196	24
Net cash generated from / (used in) investing activities	(2,130)	(1,040)
Cash flows from financing activities		
Public dividend capital received	139	381
Public dividend capital repaid	-	-
Interest on loans	-	-
PDC dividend (paid) / refunded	-	-
Net cash generated from / (used in) financing activities	139	381
Increase / (decrease) in cash and cash equivalents	3,708	7,454
Cash and cash equivalents at 1 April - brought forward	21,260	13,806
Prior period adjustments	-	-
Cash and cash equivalents at 1 April - restated	21,260	13,806
Cash and cash equivalents transferred under absorption accounting	-	-
Unrealised gains / (losses) on foreign exchange	-	-
Cash and cash equivalents at 31 March	24,968	21,260

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

	Public dividend capital £000s	Revaluation reserve £000s	Income and expenditure reserve £000s	Total £000s
Taxpayers' equity at 1 April 2018 - brought forward	381	910	17,213	18,504
Surplus/(deficit) for the year	-	-	4,821	4,821
Other transfers between reserves	-	(14)	14	-
Impairments	-	(9)	-	(9)
Revaluations	-	208	-	208
Other recognised gains and losses	-	-	-	-
Public dividend capital received	139	-	-	139
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 2019	520	1,095	22,048	23,663

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.

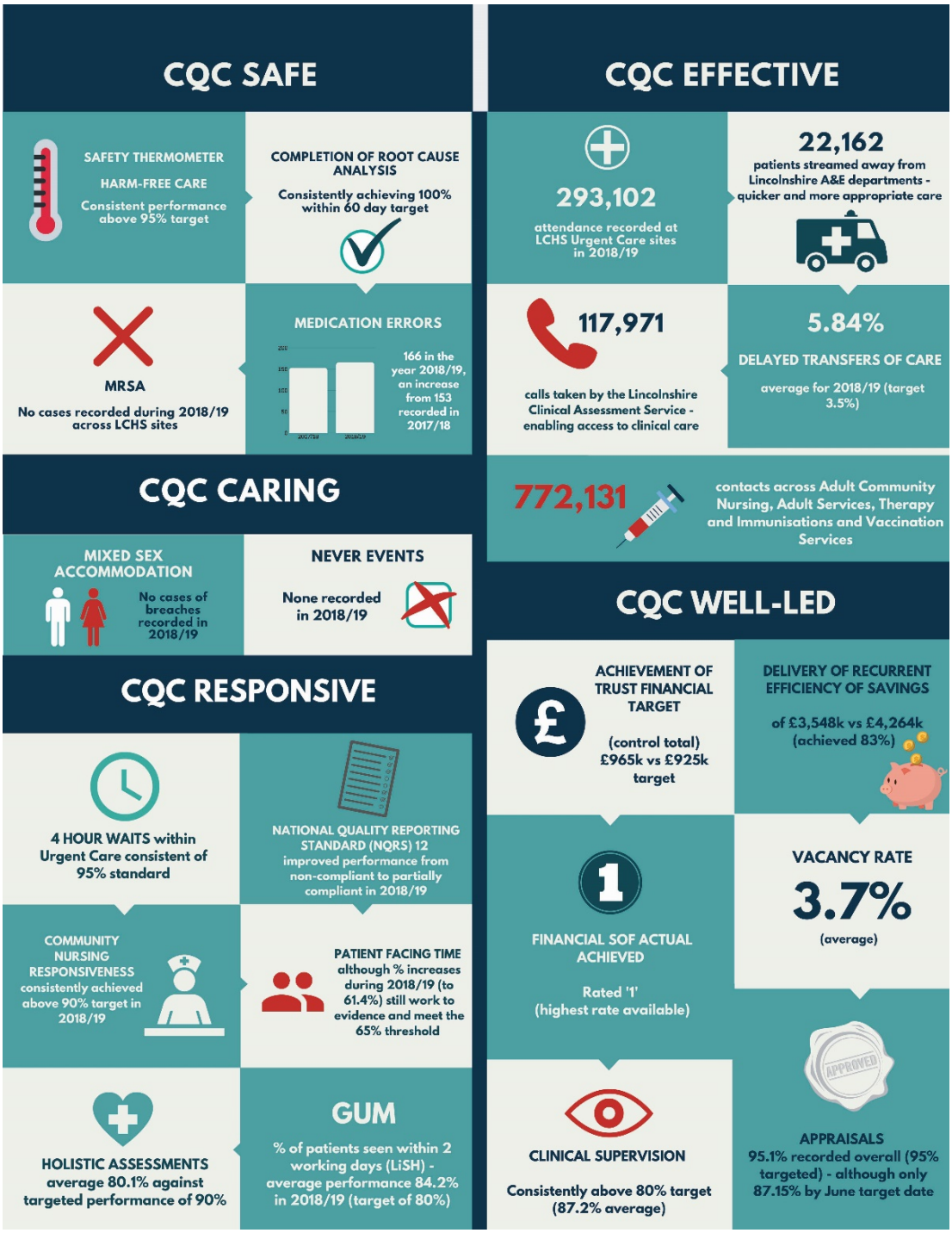
Going concern basis

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.

How the Trust measures performance

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.

Performance headlines 2018/19



Performance against Quality Account priorities

Priority 1: Leg ulcers
Improving outcomes for patients with leg ulcers

Senior Lead: head of clinical services south
Progress: Target Achieved

Why did the trust choose this priority?

Venous leg ulcers are estimated to affect around 1 in 500 people in the UK although they become much more common with age. It is estimated that around 1 in 50 people over the age of 80 has a leg ulcer. Management of leg ulcers represents a major component of the community nursing workload and has a major impact on patient's lifestyle both psychologically and socially.

How did the trust plan to address this priority?

The trust's aim was to ensure that at least 50% of patients were healed within a 12 week pathway. It planned to achieve this by improving the skills and knowledge of staff to undertake a review of treatment plans and their effectiveness. Self-care was also to be promoted wherever possible through individual management plans.

How has the trust measured progress?

Following successful outcomes demonstrated by a pilot scheme in the south of the county it was agreed that a new approach would be adopted across the remaining teams in the south during 2018/19. This included training leg ulcer specialist nurses and timely intervention whereby stockings were prescribed as the first line of compression treatment. This approach guaranteed compression, enabled self-management and improved the quality of life for patients with venous disease. As a result healing rates improved and reoccurrences decreased. At present, 82% of leg ulcer patients treated in this way self-manage and 90% heal in stockings.

Based on this learning LCHS leg ulcer clinics now offer:
A full holistic assessment: including Doppler assessment within the first 2 appointments to establish the cause of the ulcer as soon as possible, so that immediate treatment and/or referral can be instigated.
(*A Doppler assessment is a test that uses high-frequency sound waves to measure the amount of blood flow through the patients arteries and veins*)

Continuity of care: the same one or two nurses assess the leg ulcer 100% of the time; this improves healing rates and increases patient satisfaction.

Value for money: with the implementation of the two layer compression hosiery system at an early stage costs can be up to five times less than traditional use of bandages.

Self care: patients and families/carers have more control over the care of their leg. This has improved patient satisfaction, promoted self-care and reduced leg ulcer re-occurrence rates.

Although healing rates fell slightly in October, the patients who have care delivered through the new clinic model have demonstrated improved healing rates.

The trust's ongoing aims:

Implementation plans are now being activated to spread this model across teams in the north of the county to ensure the model is ultimately delivered countywide.

Teams will be trained and supported by the leg ulcer specialist nurses from the south.

The trust anticipates that it will take a further year to fully role out this new effective model of care in order to achieve a 50% increase in healing within 12 weeks across the whole county.

Priority 2: Falls prevention

To reduce falls with harm rates in our community hospitals

Senior Lead: Ward Manager - Skegness Community Hospital

Progress – Target Achieved

Why did the trust choose this priority?

Community hospitals form part of LCHS's transitional care pathway. This leads to challenges on hospital wards as the trust cares for people who are in need of rehabilitation relating to falls and are therefore at higher risk of falling upon the ward.

Falls in community hospitals are benchmarked nationally and measured per 1000 occupied bed days (OBD).

How did the trust plan to address this priority?

The trust's performance for its rate of falls remains positive with achievement being in line with or better than the national average of 7.5 falls per 1000 OBD.

Severity of falls are categorised as causing;

- no harm
- low harm
- moderate harm
- severe harm
- death

The focus of this priority was to reduce the rate of falls which result in harm within the trusts' community hospitals by 25%.

The trust planned a number of falls prevention initiatives which included establishing patient focus groups and undertaking a review of each hospital by ward. A falls pathway- to encompass environment assessment, prevention, rapid response and rehabilitation to ensure patients only stayed in hospital as long as they needed to. The trust uses patient experience intelligence and lessons learned to improve the ward environment and patient management.

How has the trust measured progress?

The rate of falls by number, severity and ward is monitored on a monthly basis at the Transitional Care and Community Hospital Quality Assurance Group.

Work to focus on overall reduction continues and numbers are lower than same time last year however the trust has not yet achieved the target 25% reduction. The impact of falls (harm rates) remains very low and specific actions to reduce the impact of falls remain the trust's priority.

The way in which staff report falls has been revised so that a greater depth of information is gathered to include the activity at the time of the fall and where the fall occurred. The additional information allows a further thematic

review of falls as a whole in order to identify any correlations or patterns. This reporting template also aims to introduce learning through the inclusion of prompts which encourage staff to think about medication reviews, falls care plan reviews, capacity assessments and appropriate patient footwear.

Learning from falls has been implemented in a variety of ways. One example of this is the "Slippers for Trippers" initiative which involves a stock of appropriate footwear being held in the wards for patients who are admitted without appropriate footwear.

A falls therapy activity programme for the patients has also been introduced. This was designed by the therapy team but involves all disciplines of staff on the ward. The weekly programme involves a slightly different element of care on each day that staff will focus on with patients. Each Monday the focus is around movement, Tuesday is cognition and dementia, Saturdays and Sundays are weight and nutrition and on Fridays the focus is specifically on falls prevention.

Another common sense initiative which the trust has implemented is the emergency stock of walking aids at all its community hospitals. Sometimes, due to lack of space on patient transport, patients are transferred from an acute hospital setting to an LCHS community hospital without their walking aid which arrives later. The absence of this aid, even for a short time period, can obviously lead to a higher likelihood of the patient falling. In order to address this staff now request the dimensions of the patient's issued walking aid at the time of referral into the community hospital. A small stock of walking aids is held at each site which enables ward staff to have an appropriately sized walking aid ready in case the patient arrives without their own.

The trust took part in the 2018 National Audit of Inpatient Falls https://www.hqip.org.uk/wp-content/uploads/2018/02/national-audit-of-inpatient-falls-audit-report-2017.pdf and the results have been implemented through an action plan that is monitored through the quality assurance group. Part of this includes an audit to evaluate effectiveness of the actions implemented. The trust is also participating in the 2019 National Audit which is taking place between January and June 2019.

The trust's ongoing aims:

Work continues to prevent patient falls within our community hospitals. Further initiatives are being undertaken:

- a programme of training on personalised care planning
- a review of the use, provision and training on falls sensors
- the introduction of an enhanced care policy to support review and falls care planning on admission and during the patient's stay on the ward
- the revision of the post falls assessment using the 'I-stumble tool' as adapted from West Midlands Ambulance Service University NHS Trust https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2018/06/I-STUMBLE.pdf
- the revision of the documentation to collect better falls information on referral to the ward
- the introduction of a patient leaflet into the acute trust to give patients and carers a better understanding of the care they will receive when they are transferred into a community hospital ward.

Priority 3: Pressure Ulcers – Further reducing harm from preventable pressure damage

Senior Lead: Head of Clinical Quality East

Progress – Behind target but improvements made

Why did the trust choose this priority?

LCHS continued to see an improvement in the management of pressure ulcers during 2017/18 both in terms of care delivered and accuracy and scrutiny of reporting. The incidence of all pressure ulcers grade 3 and 4 increased slightly from 203 in 2016/17 to 205 within 2017/18. This is within a context of teams needing to respond to the increasing complexity and high levels of frailty in patient groups.

The trust's focus for 2018/19 has been to take a more holistic approach, exploring all the determinants of frailty, to address the impact of these factors on skin damage both from an educational perspective but also enable individualised plans of care to be implemented to address unique patient need.

LCHS has been working with partners on the prevention on inherited damage. There was a slight reduction in the incidence of grade 3 pressure damage from 194 grade 3 pressure ulcers in 2016/17 to 187 in 2017/18. During the same time period grade 4 damage has risen from 9 in 2016/17 to 18 in 2017/18 however 50% of all damage remains unavoidable. Reductions in the incidence of pressure damage at all grades and specifically in relation to avoidable pressure damage, remains a priority.

How did the trust plan to address this priority?

LCHS has embedded into practice a thematic review process as part of the trust's investigation process. Teams spend an increasing amount of time supporting care of pressure damage patients inherited from other Lincolnshire providers and patients not known to any care services.

LCHS Neighbourhood Teams will continue to be an expert provider of pressure ulcer care within Lincolnshire and support other providers to improve their pressure ulcer management of patients impacting on improved patient outcomes.

The focus has been to further reduce harm from preventable pressure damage by 50%.

How has the trust measured progress?

In 2017/ 2018 there were 84 grade 3 and 4 avoidable incidences of pressure damage making the 2018 / 2019 50 % reduction target 42. Presently the trust is just falling short of achieving this target figure reporting 46 pressure incidences in Q3.

Pilot sites have seen positive outcomes both in terms of increased staff confidence and competence and a reduction in pressure damage incidence.

Positive practice includes evidence of increased professional curiosity and partnership working. The information and education APP developed as part of the 'stop the pressure' initiative http://nhs.stopthepressure.co.uk/ has now been downloaded onto staff work mobile phones.

Teams continue to see reductions in incidences of grade 3 and 4 pressure ulcers with a quarterly average number of 15. If LCHS continues to see this

rate in Q4 the overall potential reduction for the past year would be 25%. This is behind the target set but significantly lower rates than in prior years.

The trust's ongoing aims:
LCHS will continue to ensure that reductions in the incidence of pressure ulcers grade 3 and 4 are seen consistently across the county. Community teams will participate in county wide pressure thematic review meetings to enable further sharing of good practice and lessons learnt.

Priority 4: Medicines management – Improving medicines safety for our patients

Senior Lead: Medicines Management Officer & Head of Clinical Quality West
Progress – Behind target but improvements made

Why did the trust choose this priority?
Throughout the year 2017 / 2018 there was a reduction in total medicines errors to 204 when compared with the previous year 2016 / 2017 figure of 213.

In total there were 14 harm errors, 190 no harm errors and 156 medicines related incidents across all service areas.

In 2018 – 2019 LCHS' emphasis has been on delivering improved medicines management standards and addressing the medicines errors that could be eliminated as a result of better checking processes.

Throughout the year 2018 / 2019 there have been a total number of 167 medicines errors. Of these there were 28 low harm errors (requiring additional monitoring) and 139 no harm errors.

There has been a 18% reduction in errors when measured against 2017 / 2018 data in addition to a 16% increase in incidents reported (incidents reported in 2018 / 2019 totaled 525 whilst in 2017/2018 the total incidents reported were 442). This demonstrates an increased level of reporting and vigilance amongst all services.

How did the trust plan to address this priority?

The focus has been to improve medicines safety for our patients by 25% against the base line figure of 204.

Support has been offered through clinical practice, both face to face in the clinical setting and through mandatory training sessions. Peer to peer audit and a quality improvement plan has informed the improvement around standards and medicines safety.

Emphasis has been given to the safe and secure management of controlled drugs. A new process of supply for Out of Hours services has been introduced and monitored closely.

A more robust process for management of medication errors has been implemented with direct support provided to individuals and services. Action plans have been initiated in services and the development of a local link nurse framework has provided more local service level ownership of medicines management.

How has the trust measured its progress?

To date this quality priority target has only been partially met. Currently the reduction in medication errors is 12% against 2017/2018 figures. This is based on the data up to and including 29/01/19.

Specific actions have been put in place to achieve this quality priority target including local medicines training for specific teams and the reintroduction of medicines updates into the staff annual mandatory training programme with particular emphasis given to administration and checking processes.

Medicines management training is undertaken at induction, for new starters and for those returning to practice.

Clinical supervision is being delivered using real time local errors for scenario discussions and peer medicines supervisors have been adopted within one community hospital setting.

There is a continued focus on the promotion of self-care empowering and patients and carers to learn to safely and effectively administer their own medication where appropriate.

All medicines errors have been triangulated with the 'Eight rights of medicines administration' which will provide direct impact on support and provision for the next year.

Eight Rights of Medication Administration

1. Right patient

- Check the name on the order and the patient.
- Use 2 identifiers.
- Ask patient to identify himself/herself.
- When available, use technology (for example, bar-code system).

2. Right medication

- Check the medication label.
- Check the order.

3. Right dose

- Check the order.
- Confirm appropriateness of the dose using a current drug reference.
- If necessary, calculate the dose and have another nurse calculate the dose as well.

4. Right route

- Again, check the order and appropriateness of the route ordered.
- Confirm that the patient can take or receive the medication by the ordered route.

5. Right time

- Check the frequency of the ordered medication.
- Double-check that you are giving the ordered dose at the correct time.
- Confirm when the last dose was given.

6. Right documentation

- Document administration AFTER giving the ordered medication.
- Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.

7. Right reason

- Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication?
- Revisit the reasons for long-term medication use.

8. Right response

- Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant?
- Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.

Mandatory training continues to include a medicines management based on the trends through the year.

Competency packages are now in place with an expectation that these will be completed annually as toolkit for support and reinforcement of good practice.

The trust's ongoing aims:

This objective will continue to be an area of focus in 2019/20. Monthly thematic reviews have been introduced on order to provide greater understanding / ownership and share learning from errors more widely across the trust.

Medicines management is now a feature within staff mandatory training and training will be based on any trends identified from the previous year's errors using examples and scenarios as case studies.

'Champion' roles are being developed to support the flow of communication of information. LCHS enforces the message that medicines management is everybody's business however having a 'champion' will support the flow of communication and provide a 'go to' person within each service for support.

A staff engagement survey has been conducted to better understand the factors that can influence errors. This has resulted in a number of recommendations that will be implemented particularly around the provision of improved training and support. This engagement with staff will be undertaken regularly and evaluated against medication error data.

The use of the '8 rights of medicines administration' a basic aide memoire tool is being continually highlighted through all services. Benchmarking demonstrates that LCHS are a high reporter of incidents with a low rate of errors however it is clear that with increased vigilance that some further errors could be eradicated.

Social matters

Patient and Public Involvement

LCHS is committed to being responsive to the needs and wishes of the Lincolnshire population, all of whom will use its services at some point in their lives. Under the objective of providing high quality, safe personalised care the Trust's aim is to deliver service improvement that stems from feedback from partners, patients and carers.

2018/19 has seen a concerted effort to ensure that patient and public involvement (PPI) adds value and is meaningful. The establishment of a sub group that meets monthly to focus on patient experience has proved invaluable; allowing the opportunity to triangulate patient intelligence and design an approach to PPI that is consistent across LCHS and yet allows for the diversity of services the Trust provides.

Listening to and learning from patients has been reinforced as a priority at service line level and there is a renewed understanding of the value of PPI and this was reflected in the recent CQC feedback:

"The Trust had a structured and systematic approach to engaging with staff, patients, relatives, carers and stakeholders. Services were developed with full participation of those who use them, staff and external partners, as equal partners."

LCHS has developed a robust patient and public involvement programme that includes a range of proactive activity based on patient experience intelligence gathered to date and the space and flexibility to include additional reactive activities throughout the year.

Below is a list of some of the patient and public involvement achievements from 2018/19.

Urgent Care Services

Patient intelligence suggested that access to urgent care could be an issue for patients particularly within the Eastern European community. In response to this, the service worked in collaboration with the Equality and Diversity Team to develop and undertake language and communication access visits. These 'mystery shopper' style visits have been delivered across urgent care sites and have tested the service's ability to communicate with patients who do not use English as their first language. As a result of this work significant improvements have been made in regard to signage to assist patients in accessing translation services when booking in at reception and the education of front line staff on how to access translation services.

In addition, equality and diversity champions have been identified at a number of urgent care sites and much work has been done by the Equality and Diversity Team in engaging with Eastern European communities about appropriate use of urgent care services.

Integrated Community Teams, allied health professionals and specialist services including the Lincolnshire Integrated Sexual Health Service (LISH)

Although Friends and Family Test (FFT) returns have increased significantly this year in community services; this method of capturing feedback still only reaches a small percentage of patients. Therefore, the above services take a very proactive approach to gathering patient intelligence. 15 steps visits have

been an important PPI tool this year with eight visits taking place across a wide range of services. In addition, the services have gathered intelligence using a range of patient experience interviews and satisfaction surveys:

Whilst much of the feedback gathered was positive this activity enabled the services to share good practice across the organisation as a whole. Using an 'experience based co-design' (EBCD) approach to patient interviews, that allows patients to share their stories rather than answering prescriptive questions, meant that the quality team identified some small improvements that made a big difference to patient experience.

One example of this was that cardiac rehab patients would like relatives/carers to be more involved in their recovery programme. Patient feedback relating to this service is predominately positive and it is unlikely that this feedback would have been picked up through other methods of gathering patient experience. The service has since reviewed the new patient invitation and this now encourages a partner/relative/friend/carer to attend weekly with the patient.

Community Hospitals

As with the other community services community hospitals also take a proactive approach to gathering patient intelligence and testing out subsequent improvements.

A key achievement this year was the redesign of Scarbrough Ward at Skegness Hospital to ensure it was dementia friendly. This was done in partnership and co-produced with patient, carers, LCHS staff and other health professionals.

Scarbrough Ward had a patient led assessment of the care environment (PLACE) audit undertaken by a team including; volunteers, service users and members of the public. The audit findings reported that the environment failed to meet the needs of patients with dementia. This led to a service transformation and redesign.

A wide range of stakeholders including the carers and families of LCHS patients were interviewed. This provided data and insight from multiple areas

and involved those who deliver the service as well as those in receipt of care on the ward. Members of the multi-disciplinary team including a social worker, nurse, mental health nurse, administrator, physiotherapist, occupational therapist and student nurse were also asked to feed in their views and suggestions which added professional insight. Engagement with stakeholders continued whilst changes to the ward were being made. Families, carers, patients and staff were involved at every step of the project; allowing the service to continuously test whether the redesign was meeting needs and improving patient experience.

PPI remains a priority for the Trust and our on-going aims include:

- Encouraging and supporting greater use of the 'Experience Based Design' approach to involvement and introducing the concept of 'Always Events' to services.
- Analysis of patient FFT and staff FFT side by side to identify correlations

To ensure the patient voice is heard and considered at all levels of the Trust; LCHS has a Patient, Public, Staff and Stakeholder Engagement Group (PPSSEG). The group is appointed by the leadership team and chaired by the director of nursing, AHPs and operations in order to seek assurance on Trust activity in terms of patient, public, staff and stakeholder engagement.

PPSSEG has implemented and monitors this activity through the stakeholder engagement and involvement workplan. PPSSEG reports into the Quality and Risk Committee on a monthly basis to demonstrate effective internal control.

Stakeholder Engagement

In addition to the aforementioned activity to involve patients, much work has taken place during 2018 to further embed engagement/ consultation with wider stakeholders as part of service development and change. Some examples of this include:

- development of the Trust's 2018/19 quality priorities
- changes to location of service delivery due to the estates rationalisation programme

- stakeholder engagement to support growth of the wider neighbourhood working network
- involvement in system wide engagement to support Lincolnshire's Sustainability and Transformation Partnership (STP) Acute Services Review consultation
- support to the CCG led engagement around reconfiguration of inpatient services at County Hospital, Louth

The Trust has this year demonstrated consistent compliance with its statutory duty to engage/consult but also a commitment to the best practice approach of continuous engagement.

This was reflected in the CQC feedback:
"*There were consistently high levels of constructive engagement with staff, people who use services and external stakeholders. The chief executive and chair were proactively working to collaborate and build relationships with external partners."*

There is still work to do in this area and the year ahead will see a continued focus on the following:

- 'closing the loop' by revisiting patient experience once quality improvements have been made
- increased patient and public involvement and representation at all levels of the Trust
- identifying opportunities for co-production
- further embedding a business as usual approach to involving patients and carers in service delivery changes or new service models
- support of engagement/consultation requirements within STP work streams

In summer 2018, Lincolnshire's commissioner and provider organisations worked together as the Lincolnshire STP to undertake an engagement exercise designed to help inform the ongoing process of developing healthcare services in Lincolnshire.

The information gathered informed the emerging options contained in the county's Acute Service Review about the hospital services in Lincolnshire.

The full report can be found at https://www.lincolnshire.nhs.uk/together/july-2018-engagement-events .

March 2019 saw the launch of the 'Healthy Conversation 2019' campaign. The campaign focuses upon what change is needed and why; the importance of patients, public, and staff's views, and the services the health system expect to be discussing this year. These include:

- prevention and self-care
- integrated community care including general practice
- mental health and learning disabilities
- acute services

Further engagement and involvement activities are scheduled to continue the 'Healthy Conversation 2019' throughout the year for more information or to share your views visit https://www.lincolnshire.nhs.uk/healthy-conversation

Respect for human rights

LCHS has recently invested in an app called AccessAble that is designed to support people with disabilities and patients to access its services. The app supports people navigate around LCHS buildings by showing them where and how to access facilitates. The app will also be made available to LCHS staff so they can support patient and carers, promote access and facilitate a reporting mechanism from AccessAble to help shape the Trust's patient led assessment of the care environment (PLACE) scores.

Anti-corruption and anti-bribery statement

The NHS takes bribery very seriously. Bribery is a crime and Lincolnshire Community Health Services NHS Trust (LCHS) does not, and will not, pay bribes or offer improper inducements to anyone for any purpose. Nor do we accept bribes or improper inducements. This applies to everyone who works for us or with us, including third parties who carry out work on our behalf.

The Bribery Act 2010 came into force during 2011 and creates specific criminal offences which carry custodial sentences of up to 10 years and potentially unlimited fines.

LCHS, in conjunction with NHS Protect, will seek to obtain the strongest penalties, including criminal prosecution, as well as disciplinary and civil sanctions against anyone associated with LCHS who is found to be involved in any bribery.

We are committed to anti-bribery and, as an organisation, will expect everyone to play their part.

False or Misleading Information Offence

The Care Act 2014 put in place new legislation from April 1, 2015, which means that it is a criminal offence to publish, or otherwise make available, certain types of information that is either false or misleading. This includes outpatient and admitted patient care data, complaints information or information contained in reports such as the Quality Account. The legislation applies to all care providers, including Lincolnshire Community Health Services NHS Trust (LCHS).

LCHS takes false or misleading information very seriously and is committed to taking all reasonable measures to ensure that all information provided by, or on behalf of, the Trust is clear, accurate and factual.

False information is defined as that which can be demonstrably proved to be incorrect. There need not be any intent to supply or publish false information, only that the information is false or misleading in a material respect.

Misleading information is not necessarily false (although it can be) but is factually accurate, presented in such a way that the meaning of the information is distorted.

Failure to comply with these regulations is an offence under criminal law and if the organisation is convicted of the offence, it may result in a fine, together with a remedial or publicity order being imposed.

The Trust and its staff members must ensure that all information provided is accurate and is not presented in any way that could be considered to be misleading.

If you have any queries relating to these regulations please contact the head of corporate governance or any member of the Corporate Assurance Team on 01522 308857.

Emergency preparedness resilience and response compliance statement

Following an audit by the Care Quality Commission, Public Health England and NHS England in September 2018, LCHS received positive feedback and was rated as providing substantial assurance of good practice in accordance with the emergency preparedness, resilience and response (EPRR) core standards. The LCHS Trust Board continues to receive assurance on the further development and sustainability of resilience in relation to all aspects of EPRR supported by evolving and appropriate business continuity plans.

The Trust's emergency preparedness plans underpin the emergency preparedness portfolio and are aligned to the national and community risk registers. These plans, along with the emergency preparedness policy, are subjected to rigorous testing throughout the year as part of the overall work plan in relation to emergency preparedness. LCHS's emergency preparedness has been successfully tested with a serious risk of flooding along the east coast, cyberattacks and other incidents. On each occasion an incident room was established at the fire and rescue headquarters, with LCHS setting up its own incident room and evacuation plans created for vulnerable patients.

Britain's Exit from the European Union (Brexit)

As part of its business continuity and preparedness planning, the Trust has regularly reviewed and assessed risks in relation to Brexit throughout the course of 2018/19. Although, uncertainty remains around the timing the Trust has been able to assure itself on workforce and supply chain impacts through self-assessments and supplier engagement. The Trust has worked alongside nationally led central teams to ensure coverage of potential risk areas.

Sustainability

The Climate Change Act commits the UK Government by law to reducing greenhouse gas emissions by at least 80% of 1990 levels by 2050. The

voluntary target for the 'Emissions Reduction Pledge 2020' was set out in the governments 'Clean Growth Strategy'; the target aims to reduce greenhouse gas emissions by 30% by 20/21 compared to a 2009/10 baseline. LCHS has agreed to this pledge and is now working towards it. The Trust 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 that encourage partnership working and the provision of care closer to home. The Trust is increasing the efficiency of services through transformational change, estates alignment 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 that 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 and Lincolnshire Partnership NHS Foundation Trust (LPFT) to review these contracts and achieve further efficiencies.

The Trust is actively involved in the wider STP and One Public Estate programme, progressing partnership working initiatives whilst supporting the Greater Lincolnshire Local Enterprise Partnership's energy strategy for Greater Lincolnshire. 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. This new position will lead on environmental and energy management proposals, generating feasibility studies, performance specifications and instigating step change which will also align with the NHS agenda for sustainability and CO2 reduction targets. The role will also lead on managing internal energy data and provide support for the Trusts capital investment aspirations.

Performance on other matters

Health and safety

The accident figures this year were remarkably similar to the last; there were 129 staff health and safety related incidents reported (127 last year), and again, by far the majority resulted in no or low harm.

The number of reported “moving and handling” related incidents and “slips trips and falls” are low this year and this has led to “other causes” and “needlestick” injuries (a needlestick injury is the penetration of the skin by a needle or other sharp object, which has been in contact with blood, tissue or other body fluids before the exposure) having overtaken them as the highest categories. A special project team has been established to address the needlestick injuries. This will involve improved analysis of causes and benchmarking and sharing good practice with other Trusts.

There were 87 patient injuries reported that were almost all no or low harm. This was an improvement on the 96 last year. The majority of incidents are slips, trips and falls and work continues to assess patients and implement control measures as patients come into LCHS’s care.

As the year commenced, the landlord, NHS Property Services (NHSPS), was part way through improving the fire compartmentation in community hospitals. John Coupland Hospital in Gainsborough and Johnson Community Hospital in Spalding were complete and Skegness and County Hospital Louth were ongoing. These both presented challenges due to the construction/design of the properties. In Louth the project grew to include some considerable additions including bed head services, water pipework and fittings, electrical installations and fire alarm and emergency lighting. A new L1 standard fire alarm system is being installed across the whole of the Louth hospital site.

The “Water Safety Group” monitors the quality of water and management of the water systems. This is most important in the older community hospitals due to the ages of water systems and the design. This has resulted in considerable investment by the landlord NHSPS. This was particularly the case in Skegness where low water usage and large amounts of stored water were presenting challenges to maintaining water quality. This resulted in large capital investment by NHSPS. The pipework was improved with new, replacement, thermostatic fittings that protect from scalding throughout the wards. Stored water was reduced by removing and reducing tank sizes and taking cold directly from the mains. Temperatures and pressures of hot water were improved by installing new calorifiers (hot water cylinders) and pressurizing the system. The Water Safety Group is very happy with the results and the impact it will deliver for patients.

The Trust was randomly selected for a Health and Safety Executive (HSE) inspection of manual handling and management of violence, as part of the HSE national annual inspection programme. The inspectors visited the wards and emergency care at both Gainsborough and Louth hospitals. They interviewed staff at all levels across the Trust, from senior management to patient facing. The Trust obtained a favourable outcome, with no enforcement action and compliments on some outstanding practice. The inspectors were particularly impressed by the lone worker application on mobile phones and as a result the HSE is looking to implement it in their own organisation. The Trust still awaits the report from the visit. The inspectors commented on how committed and caring the staff were, and on the good practices that they had observed.

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 2018/19 the Trust received 191 formal complaints compared to 141 during 2017/18. The Trust also responded to a further 175 informal concerns, compared to 204 during 2017/18. LCHS also handled 22 professional to professional complaints.

Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) received a total of 198 contacts relating to LCHS services during 2018/19 compared to 172 during 2017/18. The PALS team also handles calls for commissioners, receiving 444 contacts during 2018/19 and signposted 424 contacts to other organisations.

Staff Survey

In September 2018, LCHS received an overall rating of outstanding from the CQC. The entire Trust Board is particularly proud of the culture that has contributed to this achievement; LCHS has a strong ethic of valuing, encouraging and developing its staff and this is encapsulated within the LCHS Way. The foundations of the LCHS Way are: we listen, we care, we act and we improve.

The Trust builds on these foundations by taking a proactive approach to engaging with its staff and developing its current and future leaders, in the belief that motivated and engaged staff directly improve the quality of the care they deliver to patients.

The results of the 2018 NHS staff survey were generally positive. There were improved results in eight of the ten themes. There was a new theme of morale which does not have a comparator from last year, and deterioration in one theme, namely experiencing bullying, harassment or abuse at work.

The Trust is particularly disappointed to see an increase in the number of staff experiencing bullying, harassment or abuse at work. LCHS is committed to an open and honest culture and takes its responsibility to ensure that the concerns of its staff are looked into and staff have access to the support they need.

To facilitate this responsibility, LCHS has appointed a Freedom to Speak Up Guardian. This role means that in addition to other identified ways to raise concerns, staff have access to an independent and impartial source of advice at any stage of raising a concern. Staff will be offered guidance and support and kept updated as to what is happening with their concern.

The Trust wants its staff to feel supported at work and ultimately ensure that it is providing excellent care to its patients and their families.

Accountable Officer:
Andrew Morgan, Chief Executive
Lincolnshire Community Health Services NHS Trust

Signature:  Date: 15 May 2019

Accountability report

Corporate Governance report

Corporate governance is the means by which Trust boards lead and direct their organisations so that decision-making is effective and the right outcomes are delivered. In the NHS this means delivering safe, effective services in a caring and compassionate environment in a way that is responsive to the changing needs of patients and service users.

Robust governance structures that encourage proper engagement with stakeholders and strong local accountability will help NHS organisations to maintain the Trust of the communities they service.

The LCHS Corporate Governance Team monitors the systems used by the Trust to ensure compliance and work with staff to ensure those systems are fit for purpose and effective.

Directors' report

Composition of the Board of Directors

Chair
Elaine Baylis QPM

Chief Executive
Andrew Morgan

Executive Directors

Director of Workforce and Transformation (Deputy Chief Executive)
Marie (Maz) Fosh

Director of Nursing and Operations
Lisa Stalley Green (to 31-08-2018)

Director of Nursing, Operations and Allied Health Professionals
Susan Ombler (Interim from 01-09-2018)

Director of Finance and Strategy:
Danielle Cecchini (to 31-05-2018)

Director of Finance and Business Intelligence:
Sam Wilde (Interim from 01-06-2018, substantive from 01-07-2018)

Medical Director:
Dr Sue Elcock (Interim to 31-04-2018)
Dr Yvonne Owen (Interim from 01-05-2018, substantive from 11-06-2018)

Non-Executive Directors

Tom Dannatt (to 31-10-2018)
Alan Kent (associate director until 31-01-2019)
Liz Libiszewski
Kevin Lockyer
Murray Macdonald

The Trust Board met on a monthly basis in 2018/19 and consists of a Chair, four non-executive directors (excluding the chair) and five voting executive directors (including the chief executive). The Head of Corporate Governance is also in attendance.

During the year the Trust Board has held 10 meetings with 80.3% attendance from non-executive directors.

Trust Board committees

Audit Committee	
Chair	Tom Dannatt, non-executive director (to 31/10/18) Alan Kent, non-executive director (from 01/02/19)
Membership	Liz Libiszewski, non-executive director Kevin Lockyer, non-executive director The following officers are in attendance at the Audit Committee: • Danielle Cecchini, Director of Finance and Strategy (to 31-05-2018) • Sam Wilde, Director of Finance and Business Intelligence (from 01-06-2018) • Head of Corporate governance

	• Client Manager (360 Internal Audit) • Partner (KPMG External Audit) • Senior Manager (PwC Counter Fraud)
Purpose	The Audit Committee is responsible for providing assurance to the Trust Board on the internal systems and controls in place across the Trust. The key roles of the Audit Committee are to: • monitor the integrity of the financial statements related to financial performance and review significant judgements contained in them • review all internal controls including risk management systems. • review the effectiveness of internal and external audit • make recommendations to the Trust Board • report to the Trust Board on how it has discharged its responsibilities
Frequency of meetings	Quarterly

Finance Performance and Investment Committee	
Chair	Mr Murray Macdonald, non-executive director
Membership	Tom Dannatt, non-executive director (to 31/10/18) Kevin Lockyer • Danielle Cecchini, Director of Finance and Strategy (to 31-05-2018) • Sam Wilde, Director of Finance and Business intelligence (from 01-06-2018) • Andrew Morgan, Chief Executive • Maz Fosh, 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
Membership	Alan Kent, non-executive director • Susan Ombler, Interim Director of Nursing, Allied Health Professionals and Operations (director of infection, prevention and control) • Deputy Director of Nursing • Head of Clinical service • Head of Clinical quality • Medical Director (Caldicott guardian and accountable officer for controlled drugs) • Head of Corporate Governance • Head of Safeguarding • Deputy Director of workforce and transformation • Quality Governance manager
Purpose	The role of the committee is to seek assurance on the Trust's delivery of its Strategic Objectives.

	The committee will: • provide assurance to the Trust Board to inform the clinical strategic direction of the refreshed annual plan. • hold Trust officers to account for delivery of actions articulated within the Board Assurance Framework relating to LCHS strategic objectives to include: • objective 1a - achieve harm free care about 95% through safety thermometer; • objective 1b - assure compliance with statutory duties for safeguarding; • objective 2a - developing a pro-active procedure and process for the co-design of pathways with staff, patients and carers; • objective 3a - continually improving standards so there is evidence to assure CQC enabling outstanding rating; • objective 3b - deliver quality priorities; • objective 10a - Neighbourhood Teams including ensuring the positive impact of and being at the cutting edge of rural healthcare provision; • objective 10b - Urgent Care is well commissioned and technology enabled supporting the Trust and system with the strategic direction; • objective 10c - Implementation of the identified changes developed in the self-care strategy. • agree the key priorities in terms of LCHS strategic objectives.
Frequency of meetings	Monthly

Register of interests

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
E Baylis	Chair	Owner of Baylishill, a performance development coaching and consultancy business, operated as a sole trading company from my home address.	Yes	13/04/11	13/04/11	
		Director & Trustee (Deputy Chair) Lincolnshire Action Trust. This is a registered charity & limited company that seeks to improve the skills and employability of offenders and prisoners	Yes	24/04/11	24/04/11	
		Interim Chair United Lincolnshire Hospitals NHS Trust	Yes	01/01/2018	09/02/2018	
		Chair of the Lincolnshire Co-ordinating Board	Yes	01/03/2018	14/04/18	
A Morgan	Chief executive	Board Governor – The Gainsborough Academy	No	26/03/15	27/03/15	30/06/18
		Board Member – East Midlands Leadership Academy	Yes	26/03/15	27/03/15	
M Fosh	Director of workforce & transformation	Nil	Yes	10/03/14	10/03/14	
M Macdonald	Non-executive director	Non-Executive Director Lincolnshire Community & Volunteer Service	No	02/07/13	19/07/13	16/04/18
		CEO - Boston Mayflower Ltd Boston Mayflower are a member of	No	02/07/13	19/07/13	10/04/18

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
		Lincolnshire Independent Living Partnership which is a consortium of Lincolnshire Charities working across the areas of Housing, Health and Social Care				
		Chair Manby Scout Association	Yes	14/04/15	14/04/15	
		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	
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	
L Stalley Green	Director of nursing and operations	Trustee, Lincolnshire HealthWatch	No	12/01/16	15/01/16	31/08/18
D Cecchini	Director of finance	Nil	Yes	12/01/16	15/01/16	31/05/18
E Libiszewski	Non-executive director	Elizabeth Libiszewski Consulting	Yes	09/05/17	11/05/17	
		Non-executive Director - United Lincolnshire Hospitals NHS Trust	Yes	13/03/18	13/03/18	
		Husband is a Non-executive Director at St Barnabas Hospice	Yes	13/03/18	13/03/18	
S Elcock	Interim medical director	Medical Director – Lincolnshire Partnership Foundation Trust	Yes	14/11/17	16/11/17	
A Kent	Associate non-executive director	Director and Shareholder of Litmus Health Limited	Yes	31/01/18	02/02/18	
		Lay member of South Norfolk CCG Governing Body	Yes	31/01/18	02/02/18	31/01/19

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
T Dannatt	Non-executive director	Executive director of Lincoln College and director of its subsidiary companies	Yes	10/4/18	14/4/18	31/10/18
		Director Great Grimsby Ice Factory Trust	Yes	10/4/18	14/4/18	31/10/18
		Tom Dannatt Consulting Limited (dormant)	Yes	10/4/18	14/4/18	31/10/18
S Wilde	Director of finance and business intelligence	Governor – Taplon School Sheffield	Yes	1/6/18	6/6/18	
Y Owen	Medical Director	LIVES Trustee	Yes	6/6/18	6/6/18	
S Ombler	Interim Director of nursing, AHPs and operations	Family member holds lead commissioner role for Urgent and Emergency Care with bordering CCG (North East Lincs CCG), which includes portfolio of Northern Lincolnshire and Goole Hospitals NHS Trust.	Yes	28/8/18	30/8/18	

Personal data related incidents where these have been formally reported to the information commissioner's office

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 senior information risk owner (SIRO) and membership includes other subject matter experts from information governance.

The IGMAG provides quarterly assurance reports and updates risks and work-plans to the Q&R committee including 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 strategy and where appropriate, recorded on the Corporate 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 information asset owner (IAO) with defined responsibilities; including risk management and responsibility for identifying IG risks. These are supported by 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 annual mandatory training and aligns to the Core Skills for Health Framework and the Data Security and Protection Toolkit (DSPT) requirements. IG is also delivered at the induction training for all new starters, including temporary staff. Dedicated data security awareness training for IAOs, IAAs and specialised functions is available as e-learning provided by NHS Digital (NHSD) and completed annually.

Training for board members, Caldicott Guardian, SIRO, data protection officer and subject access is provided by an external training company. Ad-hoc training is provided on request or individual need.

The annual IG self-assessment has taken place using the data security and protection toolkit (DSPT) provided by NHS Digital. The trust has achieved 29 of the 32 mandatory assertions with an improvement plan in place to complete the outstanding by July 2019.

During the last year there has been no reported serious incident requiring investigation (SIRI) through the DSPT incident reporting tool which will automatically trigger 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.

Accountable Officer:
Andrew Morgan, Chief Executive
Lincolnshire Community Health Services NHS Trust

Signature:  Date: 15 May 2019

Annual Governance Statement 2018-19

1. Scope of Responsibility

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

2. The purpose of the system of internal control

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

3. Capacity to handle risk

3.1 The Trust has a Risk Management Strategy which is endorsed by the Trust Board. The most recent refresh of the strategy was completed and approved in January 2019.

3.2 The strategy is available to the public and employees through its publication on the Trust website. The purpose of the strategy is to ensure that risks to the quality and delivery of patient services and care are managed, 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.

3.3 The risk management process is owned by Trust Board but with Executive Directors being directly accountable for each and every risk. All risks on the Corporate Risk Register and the Treatment Plan, which sits beneath it, reviewed at least monthly by Executive Directors. Feeding into this are operational risk registers which are similarly closely managed by Quality Assurance Managers. There are effective mechanisms in place to ensure the movement of risks between the various registers and to ensure provision of sufficient time within the appropriate forum is set aside for their consideration, review and management.

3.4 Through the risk identification process, staff at all levels are able to identify risks and, in consideration of the guidance given in the strategy, assess those risks. The Quality Assurance Managers play a key role, individually and collaboratively, in effecting consistency in the assessment of risks. Collectively, the Quality Assurance Managers and Head of Corporate Governance work to extend this consistency from the operational risk registers into the Treatment Plan and Corporate Risk Register.

4. The risk and control framework

4.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. The organisation's Risk Appetite Statement is published on the website and reviewed periodically, while the various risk registers are considered in its context.

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

- Corporate Risk Register
- Treatment Plan
- Board Assurance Framework

- financial risk management
- compliance with targets
- Single Oversight Framework
- Operational Delivery Plan
- Performance management reporting

4.3 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. The Board Assurance Framework is aligned to the organisation's Operational Plan. 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.

4.4 The Trust's approach to corporate governance is rooted within best practice and is regularly reviewed and assessed through internal processes. While the Strategy was most recently reviewed in January 2019, regular reports at every meeting of the Trust Board comment on the status quo and propose ongoing improvements and developments. The Corporate Risk Register including the Treatment Plan and Board Assurance Framework are reviewed and approved by the Trust Board as part of this process. In addition, processes have been involved to assist Executive Directors in assessing risks under their area of responsibility against those for which their peers are responsible. This harmonisation process not only promotes collective as well as individual responsibility at the highest level, but also promotes consistency in assessment.

4.5 Among the key high-scoring risks on the Corporate Risk Register during 2018/19 were:

- Risks to service sustainability and deliverability due to financial challenges and future changes to commissioning;
- Risks to urgent and emergency care services across Lincolnshire due to periods of seasonal high activity;
- Risks to community services due to staffing issues;

4.6 Of the three sample high-scoring risks from 2018/19 detailed above, one was successfully managed and closed during the year, one was

revised to reflect ongoing risks outside of seasonal changes, while one remains on the register but remains effectively managed and monitored.

4.7 Another ongoing high profile risk is the pursuit by the HMRC of an historic claim in relation to the employment status of GPs providing out of hours services. This has the potential for an adverse impact financially, reputationally and in terms of service delivery. A hearing is due to take place in January 2020.

4.8 The committees of the Trust Board – Quality and Risk Committee and Finance, Performance and Investment Committee – assess each and every business item against the Board Assurance Framework. This enables direct assessment against compliance on all fronts, including CQC requirements. The committees also review the risk registers monthly, immediately following their monthly review by Executive Directors and prior to the committees' findings/recommendations progressing to Trust Board.

4.9 Separately, the Workforce and Transformation Executive Group (WTEG), chaired by the Executive Director of Workforce and Transformation/ Deputy Chief Executive, has delegated responsibility for ensuring the Trust has developed and managed the short, medium and long-term workforce strategies and staffing systems to comply with the 'Developing Workforce Safeguards' recommendations. In addition, the WTEG provides quarterly People Strategy progress reports, WTEG assurance reports and updates risks and work-plans to FPIC. All policies approved by this forum are escalated to Board for endorsement and/or challenge. Any substantive changes to workforce follow the undertaking of a Quality Impact Assessment.

4.10 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 Group, Information Governance Management Assurance Group, Safeguarding and Patient Safety Group, Effective Practice

Assurance Group, Mortality Review Panel and Health and Safety Committee.

4.11 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

4.12 Another key area of learning for the Trust via engagement with employees is through the Freedom to Speak Up Guardian. This role supports the organisation in complying with the outcomes set up by the National Guardian Office and the outcomes include:

- A culture of speaking up being instilled throughout the organisation;
- Speaking up processes are effective and continuously improved;
- All staff have the capability to speak up effectively and managers have the capability to support those who are speaking up;
- All staff are supported appropriately when they speak up or support other people who are speaking up;
- The Board is fully sighted on, and engaged in, all Freedom to Speak Up matters and issues that are raised by people who are speaking up;
- Safety and quality are assured.

4.13 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.

4.14 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)
- STP Executive group
- Executive STP groups (including Finance Bridge Group)
- System Winter Team
- Groups to monitor impact and preparedness for Brexit

4.15 The Trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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

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

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

Reporting requirements are complied with.

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

5.1 The Trust Board approves the organisation's Annual Financial Plan. It is monitored and regularly reported upon to Board as well as Audit Committee (in terms of the arrangements that are in place) and the Finance, Performance and Investment Committee, from which the Board received monthly updates through 2018-19. As well as receiving endorsement from Trust Board, the Performance Dashboard and Integrated Performance Report was prepared by the Director of Finance and considered by the Finance, Performance and Investment Committee and by the Quality and Risk Committee throughout the year.

5.2 The Trust Leadership Team receives weekly updates on the organisation's financial position, including progress against setting and meeting savings targets and consideration of challenges and opportunities. Key progress is reported and discussed at every Board meeting, either in public or private session dependent on the content to ensure compliance against the Annual Financial Plan. Officers of the Trust manage resources in compliance with the Standing Financial Instructions, which are reviewed alongside other Standing Orders annually.

5.3 Both internal and external audit support these arrangements, with regular reporting, particularly to the Audit Committee. Following the conclusion of the 2018/19 year, the Trust changed its internal audit partner and the Trust Leadership Team met with the new auditors in April 2019 to ensure the programme for the forthcoming year would continue to support the Trust in meeting its objectives.

6. Information governance

6.1 There were no serious incidents relating to information governance, including data loss or confidentiality breaches, requiring disclosure to the Information Commissioner's Office during 2018/19.

6.2 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. The IGMAG is chaired by the SIRO, who is the Director of Workforce and Transformation/Deputy Chief Executive and membership includes the Caldicott Guardian and other subject matter experts from information governance.

6.3 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.

6.4 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.

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

6.6 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.

6.7 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.

6.8 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.

7. Annual Quality Account

7.1 The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

7.2 The Quality Account is developed through formal reporting to the Quality and Risk Committee. It considered the development of the account across four meetings during the year, receiving updates in August, November and February during the 2018/19 year prior to final approval in May 2019. This is reported to Board by the Chair of the committee through the monthly updates following each stage.

7.3 The Quality and Risk Committee considers a wealth of other relevant information through the year, including quarterly updates on safeguarding, Quality Impact Assessment post implementation reviews, Lessons Learned reports and National Quality Board data.

7.4 Quality and Risk Committee includes attendance of Quality Assurance Managers and a culture of health two-way challenge ensures the validity of data and the scrutiny of reporting. Internal Audit undertook a review of the Quality and Risk Committee during the year and was able to provide significant assurance on their systems and processes

8. Board and Trust Leadership

8.1 The Trust Board at the close of the 2018/19 year comprised the Chair (Elaine Baylis), four Non-Executive Directors (Alan Kent, Liz Libiszewski, Kevin Lockyer, Murray McDonald), the Chief Executive (Andrew Morgan) and four Executive Directors (Maz Fosh, Susan Ombler, Yvonne Owen, Sam Wilde).

8.2 Changes to the Board membership in-year were:

- Tom Dannatt departed as a Non-Executive Director;
- Alan Kent moved from being an Associate Director to a Non-Executive Director;
- Dani Cecchini was replaced as an Executive Director by Sam Wilde;
- Lisa Stalley-Green was replaced as an Executive Director by Susan Ombler (acting);
- Sue Elcock was replaced as an Executive Director (Acting) by Yvonne Owen.

8.3 The Trust Board met monthly throughout 2018/19, as did its main committees – the Quality and Risk Committee and the Finance, Performance and Investment Committee. The Remuneration and

Terms of Service Committee met as required

8.4 A CQC Well-Led Inspection of the Trust published its findings on 27 September 2018 and found it to be Outstanding.

8.5 A further well-led review was undertaken by Deloitte in January 2019 and reported back in March 2019, making recommendations to assist in moving the Trust Board forward as the organisation looks to build on its Outstanding rating.

9. Audit Committee

9.1 The Audit Committee meets quarterly and has a key role in providing assurance to the Trust Board on the control mechanisms that are in place across the Trust. 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 receives regular update reports from, among others, the Director of Finance, the Head of Corporate Governance, and both internal and external audit.

9.2 In addition to a number of issues being reviewed on a continuous basis, the Audit Committee undertook a specific review during 2018/19 on risk management.

9.3 The committee continues to develop and enhance mechanisms to gain assurance on all areas that come within its terms of reference. It approves 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.

10. Review of effectiveness

10.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and

other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Risk Committee, as well as sub committees and others within the group structure, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

10.2 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.

10.3 My review was also informed by:

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

10.4 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 2018/19.

10.5 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.

10.6 In conclusion, I am assured that no significant control issues existed within Lincolnshire Community Health Services NHS Trust during the 2018/19 year.

Accountable Officer:

Andrew Morgan, Chief Executive
Lincolnshire Community Health Services NHS Trust

Signature:  Date: 15 May 2019

Remuneration report

Board members and senior management remuneration (subject to audit)

Salaries and allowances for the year ending 31 March 2019 (subject to audit)

Name and Title	Period of Office	18/19 Salary	Expense Payments Taxable	Performance pay and bonuses	Long term performance pay and bonuses	18/19 Pension Benefits[1]	18/19 Total
		(Bands of 5k) £000s	*(Nearest hundred)* £00s	*(Bands of 5k)* £000s	*(Bands of 5k)* £000s	*(Bands of 2.5k)* £000s	*(Bands of 5k)* £000s
Mr AJ Morgan, Chief Executive	Full Year	145 - 150	150	0	0	0 - 2.5	160 - 165
Ms DD Cecchini, Director of Finance & Strategy	01/04/18 to 31/05/18	15 - 20	12	0	0	5 - 7.5	20 - 25
Mr S Wilde, Director of Finance & Business Intelligence	01/07/18 to 31/03/19	80 - 85	82	0	0	62.5 - 65	150 - 155
Mr S Wilde, Interim Director of Finance & Business Intelligence[2]	01/06/18 to 30/06/18	10 - 15	0	0	0	0	10 - 15
Mrs LM Stalley Green, Director of Nursing and Operations	01/04/18 to 31/08/18	40 - 45	57	0	0	35 - 37.5	85 - 90
Mrs S Ombler, Interim Director of Nursing, AHPs and Operations	01/09/18 to 31/03/19	50 - 55	79	0	0	155 - 155.5	215 - 220
Mrs ME Fosh, Director of Workforce & Transformation	Full Year	110 - 115	114	0	0	25 - 27.5	145 - 150
Dr S Elcock[3], Interim Medical Director	01/04/18 to 24/04/18	0 - 5	0	0	0	0	0 - 5
Dr Y Owen[4], Medical Director	11/06/18 to	45 - 50	3	0	0	0	45 - 50

Name and Title	Period of Office	18/19 Salary	Expense Payments Taxable	Performance pay and bonuses	Long term performance pay and bonuses	18/19 Pension Benefits[1]	18/19 Total
		(Bands of 5k) *£000s*	*(Nearest hundred)* *£00s*	*(Bands of 5k)* *£000s*	*(Bands of 5k)* *£000s*	*(Bands of 2.5k)* *£000s*	*(Bands of 5k)* *£000s*
	31/03/19						
Mrs E Baylis, Chair	Full Year	30 - 35	12	0	0	0	30 - 35
Mr M Macdonald, Non-Executive Director	Full Year	5 - 10	8	0	0	0	5 - 10
Mrs E Libiszewski, Non-Executive Director	Full Year	5 - 10	2	0	0	0	5 - 10
Mr K Lockyer, Non-Executive Director	Full Year	5 - 10	6	0	0	0	5 - 10
Mr T Dannatt, Non-Executive Director	01/04/18 - 31/10/18	0 - 5	1	0	0	0	0 - 5
Mr A Kent, Non-Executive Director	Full Year	5 - 10	34	0	0	0	5 - 10

1. Pensions related benefits are based on the NHS Manual of Accounts methodology and the pension data is provided by the Pensions Agency. The benefits calculated incorporate 20 times the annual real increase in pension and do not represent actual payments made. Non-Executive Board members do not receive pensions as part of their remuneration.

2. Mr S Wilde value includes recharge from Norfolk Community NHS Trust for the month of June when Mr Wilde was Interim Director of Finance and Business Intelligence prior to substantive appointment.

3. Dr S Elcock costs recharged from Lincolnshire Partnership Foundation Trust based on 4 PA's. Pension benefits are available in the LPFT Annual Report.

4. Dr Y Owen also provides Out of Hours practitioner services to the Trust as an independent contractor, disclosure of the value of these payments can be found in the related parties disclosure of the Trust Annual Accounts 2018/19.

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[1]	17/18 Total
		(Bands of 5k) £000s	*(Nearest hundred) £00s*	*(Bands of 5k) £000s*	*(Bands of 5k) £000s*	*(Bands of 2.5k) £000s*	*(Bands of 5k) £000s*
Mr AJ Morgan, Chief Executive	Full Year	145 - 150	74	0	0	20 - 22.5	175 - 180
Ms DD Cecchini, Director of Finance & Strategy	Full Year	105 - 110	55	0	0	15 - 17.5	130 - 135
Mrs LM Stalley-Green, Director of Nursing and Operations	Full Year	100 - 105	49	0	0	55 - 57.5	160 - 165
Mrs ME Fosh, Director of Workforce and Transformation	Full Year	105-110	79	0	0	25 - 27.5	140 - 145
Dr S Elcock, Interim Medical Director[2]	07/11/17 - 31/03/18	40 - 45	0	0	0	0	40 - 45
Mrs E Baylis, Chair	Full Year	25 - 30	16	0	0	0	30 - 35
Mr M Macdonald, Non-Executive Director	Full Year	5 - 10	11	0	0	0	5 - 10
Mrs E Libiszewski, Non-Executive Director	01/05/17 - 31/03/18	5 - 10	0	0	0	0	5 - 10
Mr K Lockyer, Non-Executive Director	Full Year	5 - 10	10	0	0	0	5 - 10
Mr A Kent , Non-Executive Director (Associate)	01/02/18 - 31/03/18	0 - 5	0	0	0	0	0 - 5

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[1]	17/18 Total
		(Bands of 5k) £000s	*(Nearest hundred) £00s*	*(Bands of 5k) £000s*	*(Bands of 5k) £000s*	*(Bands of 2.5k) £000s*	*(Bands of 5k) £000s*
Mr D Woodward, Non-Executive Director	01/04/17 - 30/09/17	0 - 5	12	0	0	0	0 - 5

1. Pensions related benefits are based on the NHS Manual of Accounts methodology and the pension data is provided by the Pensions Agency. The benefits calculated incorporate 20 times the annual real increase in pension and do not represent actual payments made. Non-Executive Board members do not receive pensions as part of their remuneration.
2. Dr S Elcock costs recharged from Lincolnshire Partnership Foundation Trust based on 4 PA's. Pension benefits are available in the LPFT Annual Report.

Pension benefits for the year ending 31 March 2019 (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 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	(bands of £2,500) £'000	**(bands of £2,500) £'000**	**(bands of £5,000) £'000**	**(bands of £5,000) £'000**	**£'000**	**£'000**	**£'000**	**£'000**
Ms DD Cecchini, Director of Finance & Strategy	0 - 2.5	0 - 2.5	35 - 40	105 - 110	792	690	11	0
Mrs ME Fosh, Director of Workforce & Transformation	0 - 2.5	0 - 2.5	15 - 20	0 - 5	215	161	34	0
Mr AJ Morgan, Chief Executive	0 - 2.5	2.5 - 5	65 - 70	205 - 210	1570	1369	139	0
Mrs LM Stalley Green,	0 - 2.5	0 - 2.5	25 - 30	20 - 25	406	325	24	0

Director of Nursing and Operations								
Mrs S Ombler, Interim Director of Nursing, AHPs and Operations	2.5 - 5	10 - 12.5	20 - 25	55 - 60	446	266	90	0
Mr S Wilde, Director of Finance & Business Intelligence	2.5 - 5	0 - 2.5	10 - 15	0 - 5	175	110	36	0

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) £'000	(bands of £2,500) £'000	(bands of £5,000) £'000	(bands of £5,000) £'000	£'000	£'000	£'000	£'000
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 & Strategy	0 - 2.5	2.5 - 5	30-35	100-105	626	64	690	0
Mrs LM Stalley Green, Director of Nursing and Operations	0 - 2.5	0 - 2.5	15-20	0-5	130	28	158	0
Mrs ME Fosh, Director of Workforce & Transformation	2.5 - 5	0 - 2.5	25-30	20-25	265	58	323	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 (2017/18: 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.

Relationship between the remuneration report and exit packages, severance payments and off-payroll engagements disclosures

In respect of the relationship between individuals in the remuneration report and links to exit packages, severance payments and off payroll engagement disclosures, the following information is applicable:

- Exit packages – no relationship
- Severance payments – no relationship
- Off Payroll Engagements – Dr Y. Owen has continued to provide Out of Hours practitioner services to the Trust as an independent contractor throughout 2018/19. The value of this can found in the related parties disclosure of the Trust Annual Accounts 2018/19.

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.

Compensation on early retirement or for loss of office

The Trust has not made any compensatory payments on early retirement for loss of office in 2018/19.

Payments to past directors

The Trust has not made any payments to past directors in 2018/19.

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 2018/19 was

£145-150k (2017/18: £140-145k). This was 5.45 (2017/18: 5.58) times the median remuneration of the workforce, which was £27,078 (2017/18: £25,551).

In 2018/19 and 2017/18 no employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £50 to £149,522 (2017/18: £1,150 to £144,515) 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.

	2018-19	**2017-18**
Highest paid director's remuneration £'000	145-150	140-145
Median total £	£27,078	£25,551
Ratio	**5.45**	**5.58**

Staff report

Senior managers by band

(correct as of 31/03/2019)

	Female		Male		Total Headcount
Seniority	***Headcount***	***Percentage***	***Headcount***	***Percentage***	***Headcount***
Executive Director	3	60.0%	2	40.0%	**5**
Senior Manager*	75	71.4%	30	28.6%	**105**
Other	1504	90.2%	163	9.8%	**1667**
Grand Total	**1582**	**89.0%**	**195**	**11.0%**	**1777**

** Senior Manager = Agenda for Change Band8+ and Medical Consultants*

Staff numbers and costs (subject to audit)

On a Whole Time Equivalent (WTE) basis, LCHS had average staff numbers across staffing groups as below in 2018/19:

	2018/19	2018/19	2018/19	2017/18
	Permanent	Other	Total	Total
	WTE	*WTE*	*WTE*	*WTE*
Medical and dental	12	14	26	10
Ambulance staff	-	-	-	-
Administration and estates	317	3	320	324
Healthcare assistants and other support staff	317	-	317	338
Nursing, midwifery and health visiting staff	626	32	658	670
Nursing, midwifery and health visiting learners	-	-	-	0
Scientific, therapeutic and technical staff	266	6	272	244
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	-	-	-	0
Total average numbers	1,539	55	1,594	1,586

Note: *1.00 Whole Time Equivalent (WTE) = 1 Full Time (37.5 contracted hours) employee.*
Headcount figures quoted in this report relate to actual numbers of staff.

Total cost for staff are illustrated in the table below.

	2018/19			2017/18
	Permanent	Other	Total	Total
	£000	*£000*	*£000*	*£000*
Salaries and wages	47,297	143	47,440	47,301
Social security costs (Employers National Insurance Costs)	4,516	-	4,516	4,411
Apprenticeship levy	226	-	226	224
Employer's contributions to NHS pensions	6,253	-	6,253	6,509
Pension cost – other pensions	23	-	23	10
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	286	-	286	216
Temporary staff	-	4,507	4,507	5,067
Total gross staff costs	58,601	4,650	63,251	63,738
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	58,601	4,650	63,251	63,738

Staff composition

(correct as of 31/03/2019)

	Female		**Male**		**Total Headcount**
Seniority	***Headcount***	***Percentage***	***Headcount***	***Percentage***	***Headcount***
Executive Director	3	60.0%	2	40.0%	**5**
Senior Manager	75	71.4%	30	28.6%	**105**
Other	1504	90.2%	163	9.8%	**1667**
Grand Total	**1582**	**89.0%**	**195**	**11.0%**	**1777**

Sickness absence data

The sickness absence figures are reported on a calendar year basis, rather than for the financial year. Figures for 2017 and 2018 calendar year are as below:

Calendar Year	Average FTE Calendar Year	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE - Days Available	FTE - Days Lost to Sickness Absence
2017	1,608	17,335	10.8	586,809	28,121
2018	1,525	14,663	9.6	556,828	23,786

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/EDS3) and the Workforce Disability Equality Standard, all LCHS workforce policies undergo an equality analysis to ensure they are fair. The equality analysis for all Trust policies states that it is a tool for helping the Trust's staff to consider the potential impact that their services, projects, strategies and policies might have on the community it serves from different equality perspectives.

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) that 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 31 March 2017 (The Equality Act 2010 Specific Duties and Public Authorities Regulations 2017) that requires 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 and 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 proportions of male and female employees in the four quartile pay bands (lower, lower middle, upper middle and upper)

The above measures are calculated using a 'snapshot date' and for public sector organisations this is the pay period which includes 31 March 2018. This statement therefore covers all LCHS employees including those on bank contracts as reported at 31 March 2018. The data is taken from the Electronic Staff Record (ESR).

The Trust is required to publish this information within one year of the snapshot date (i.e. by 30 March 2019) 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 governments 'Gender Pay Service' reporting site.

The Trust Board have approved for this gender pay gap statement to be published as required.

Workforce context

The gender split within the overall workforce is 89% female and 11% male at LCHS based on data reported at 31 March 2019. The table below breaks this down by the proportion of males and females in each pay band.

Gender	Female		Male		Total
Pay Band	Count	Percentage	Count	Percentage	Count
Band 1	17	89.5%	2	10.5%	19
Band 2	315	92.9%	24	7.1%	339
Band 3	261	92.2%	22	7.8%	283
Band 4	76	90.5%	8	9.5%	84
Band 5	328	95.1%	17	4.9%	345
Band 6	325	88.8%	41	11.2%	366
Band 7	173	82.0%	38	18.0%	211
Band 8a	47	71.2%	19	28.8%	66
Band 8b	20	74.1%	7	25.9%	27

Gender	Female		Male		Total
Pay Band	Count	Percentage	Count	Percentage	Count
Band 8c	3	75.0%	1	25.0%	4
Band 8d	2	50.0%	2	50.0%	4
Medical and Dental	4	26.7%	11	73.3%	15
Other	8	88.9%	1	11.1%	9
VSM	3	60.0%	2	40.0%	5
Total	1582	89.0%	195	11.0%	1777

*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. Pay progression is also linked to performance.

The table above outlines that women are represented across all pay bands within LCHS and there is a 4:1 ratio of females to males in very senior management (VSM). Despite the higher ratio of females to males within VSM, the chief executive within this staff group is male and therefore this affects the gender pay gap.

The highest proportion of females is concentrated within Band 2 and 5 posts and the highest proportion of males are concentrated within Band 6 and Band 7 posts. The occupancy of these different posts by gender therefore contributes to the gender pay gap.

Please note as part of the 2018 pay deal, band 1 will be closed to new entrants from 1 December 2018.

Mean and median hourly rate for males and females

Gender	Average (Mean) Hourly Rate	Median Hourly Rate
Male	£18.44	£16.60
Female	£14.47	£13.47
Difference	£3.97	£3.13
Pay gap	**21.5%**	**18.96%**

The mean gender pay gap for LCHS is 21.5%. This means that men are paid 21.5% 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 18.96%. 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 for men is 18.96% higher than the middle rate for all female staff.

The mean gender pay gap has remained the same when compared to 2017 snapshot, however the median gender pay gap has increased from 11.85% in 2017. The Trust has been recruiting to a new medical model and prior to March 2018 made the appointment of three male GPs and one female GP. This composition of male/female GPs will contribute to the Trust's gender pay gap as they sit within the higher bandings. The Trust's recruitment of GPs continues and equal opportunity recruitment practices are followed by the Trust.

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

The quartiles shown below 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	399	31	92.79%	7.21%
2	438	36	92.37%	7.73%
3	400	42	90.50%	9.50%
4	386	76	83.51%	16.49%

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.

Actions to reduce the gender pay gap

Whilst the Trust has excellent representation of females across all levels of the organisation and is predominantly female, this report shows that there are gender pay gaps which require the continued development of actions to close these gaps. The Trust has a dedicated equality and diversity lead that monitors the Trust's system to ensure legislative compliance, supporting staff around all equality areas.

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 with a formal and transparent appraisal process in place which links to performance related pay increases in accordance with Agenda for Change. 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.

Where staff are not employed on nationally agreed pay scales, the Trust has developed a structured pay scale for GP salaries which takes account of experience and skills.

The Trust is committed to ensuring an equitable workforce and will continue to work towards achieving the following actions in order to reduce the gender

pay gap. Please note a number of the actions are ongoing following the last gender pay gap statement with the addition of some newly identified areas:

- to continue employing and monitoring recruitment, performance and appraisal processes to ensure they are objective with structured and measured criteria that can be evidenced. The Trust undertakes annual appraisal audits to ensure a fair and equitable process is followed for all staff members
- continue to explore how we can attract more men into the organisation at the lower bands, to create a more even gender balance;
- the Trust will robustly evaluate starting salaries of all staff members to ensure they are commensurable with the individual's experience
- the continuation of promoting flexible working opportunities for both men and women (the Trust has made easily accessible on its Intranet site information for all employees in relation to applying for these opportunities)
- the Trust continues to offer leadership development programmes which are accessible to male and female employees equally and will continue to encourage engagement of staff members
- continue to monitor any shifts in the gender pay gap data each year to identify any trends and analyse underlying causes.

Trade union facility time

There is a requirement for relevant public sector organisations to publish information in relation to trade union facility time.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 ("the Facility Time Regulations") came into force on 1 April 2017 requiring relevant public sector employers to publish specified information on an annual basis covering the 12 month period beginning with 1 April.

The schedule of tables below shows the information the Trust is required to publish.

Facility time is the time off taken by a union official that is permitted by the Trust, in order to carry out trade union duties or activities (but not including partnership duties).

The schedule captures four tables of information:

- the number of employees who are union officials
- the percentage of their working hours spent on trade union facility time
- the percentage of the pay bill spent on facility time
- the percentage spent on paid trade union activities as a percentage of the total paid facility time hours.

To provide an insight into the information relevant to this LCHS, the tables have been populated with data received from union officials as at to 31 May 2018.

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
7	4.6

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Percentage of time	Number of employees
0%	2
1-10%	1
11-20%	1
21-30%	1
31-40%	0
41-50%	2
51-60%	0
61-70%	0
71-80%	0
81-90%	0
91-100%	0

Percentage of pay bill spent on facility time

Total cost of facility time (not including partnership working)	£13,193*
Total pay bill	£63,738,453*
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%*

*Based on 2017/18 pay bill

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	13.6%*

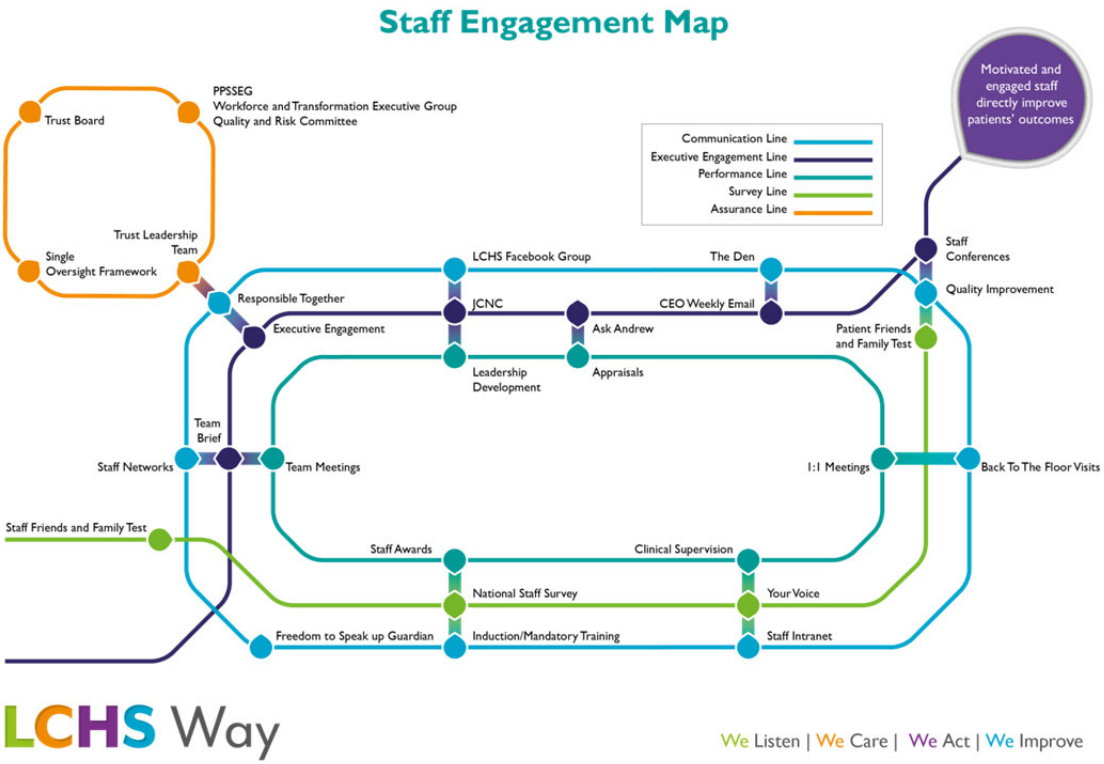
*Based on data as at 31st March 2018

Other employee matters

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 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.



What staff said about working in LCHS

Between October and November 2018, staff were asked to participate in the NHS National Staff Survey. The overall response rate was 55 per cent, higher than the 53% national average for community Trusts but 5% fewer than achieved in 2017.

LCHS performed extremely well in the NHS National Staff Survey results 2018. Of the 10 themes, LCHS's scores improved in eight areas, with significant improvement in three of those, and declined in one area (Safe Environment – Bullying/Harassment). The tenth theme of morale was new for 2018 and LCHS was above the average score.

The full results can be found on the NHS England website *http://www.nhsstaffsurveys.com* and some key findings are below:

Top six ranking scores in comparison to other community Trusts:

- the percentage of staff reporting satisfaction with level of pay is 47% (community average is 39%)

- the percentage of staff agreeing that senior managers act on staff feedback 45% (community average 35%)
- the percentage of staff agreeing that the organisation takes positive action on health and wellbeing 45% (community average 31%)
- the percentage of staff experiencing musculoskeletal problems as a result of work activities in the last 12 months is 22% (community average 27%)
- the percentage of staff appraised where the organisational values definitely discussed is 47% (community average 38%)
- the percentage of staff agreeing that they have had any non-mandatory training, learning or development in the last 12 months is 81% (community average 76%)

Bottom six ranking scores in comparison to other community Trusts:

- the percentage of staff agreeing that they are Trusted to do their job is 91% (community average 91%)
- the percentage of staff agreeing that their immediate manager can be counted on to help with difficult tasks is 69% (community average 72%)
- the percentage of staff agreeing that their immediate manager is supportive in a personal crisis 74% (community average 76%)
- the percentage of staff agreeing that they have not felt pressure from their manager to come to work when not feeling well enough is 75% (community average 78%)
- the percentage of staff who has felt pressure from colleagues to come to work is 19% (community average 18%)
- the percentage of staff agreeing that the organisation encourages reporting of errors, near-misses or incidents is 90% (community average 92%)

Where staff experience has improved the most in comparison to 2017

- Organisation has made adequate adjustments (Equality Act 2010) to enable staff to carry out work (74% compared to 64% in 2017)
- Senior managers try and involve staff in important decisions (45% compared to 36% in 2017)
- Senior managers act on feedback (45% compared to 35% 2016)
- The extent to which my organisation value my work (55% compared to 43% in 2017)

- Communication between senior management and staff is effective (50% compared to 40% in 2017)

Expenditure on consultancy

In 2018/19, the Trust spent £327k on consultancy expenditure. Key projects which engaged consultancy support included:

- Organisational development and leadership projects in conjunction with Lincolnshire Sustainability and Transformation Plan partners.
- Undertaking of the Trust tri-annual well-led review in line with NHS best practice

Off-payroll engagements

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

- In respect of off-payroll engagements, the Trust utilises independent medical contractors, generally General Practitioners in the delivery of its Out of Hours and Urgent Care Services.

	Number
Number of existing arrangements as of 31 March 2019	109
Of which, the number that have existed:	
For less than 1 year at the time of reporting	11
For between 1 and 2 years at the time of reporting	12
For between 2 and 3 years at the time of reporting	13
For between 3 and 4 years at the time of reporting	5
For 4 or more years at the time of reporting	68

Exit packages (subject to audit)

Reporting of compensation schemes - exit packages 2018/19

	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
	No.	*£000*	*No.*	*£000*	*No.*	*£000*	*No.*	*£000*
<£10,000	1	8	5	8	**6**	**16**	-	**0**
£10,000 - £25,000	1	11	1	10	**2**	**21**	-	**0**
£25,001 - £50,000	-	-	-	-	**0**	**0**	-	**0**
£50,001 - £100,000	-	-	-	-	**0**	**0**	-	**0**
£100,001 - £150,000	1	120	-	-	**1**	**120**	-	**0**
£150,001 - £200,000	-	-	-	-	**0**	**0**	-	**0**
>£200,000	-	-	-	-	**0**	**0**	-	**0**
TOTALS	**3**	**129**	**6**	**18**	**9**	**157**	**0**	**0**

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

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
	No.	*£000*	*No.*	*£000*	*No.*	*£000*	*No.*	*£000*
<£10,000	2	8	7	14	**9**	**22**	-	**0**
£10,000 - £25,000	2	30	-	-	**2**	**30**	-	**0**
£25,001 - £50,000	1	37	-	-	**1**	**37**	-	**0**
£50,001 - £100,000	-	-	-	-	**0**	**0**	-	**0**
£100,001 - £150,000	1	127	-	-	**1**	**127**	-	**0**
£150,001 - £200,000	-	-	-	-	**0**	**0**	-	**0**
>£200,000	-	-	-	-	**0**	**0**	-	**0**
TOTALS	**6**	**202**	**7**	**14**	**13**	**216**	**0**	**0**

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

Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed		Payments agreed	
	No.	£000	No.	£000
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	6	18	7	14
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**6**	**18**	**7**	**14**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Lincolnshire Community Health Services NHS Trust

Lincolnshire Community Health Services NHS Trust

Annual accounts for the year ended 31 March 2019

Further copies available on request from:
Director of Finance and Business Intelligence
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.....

Andrew Morgan, Chief Executive

Date: 15th May 2019

Statement of Directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

Signed:.....

Andrew Morgan, Chief Executive Officer

Date: 15th May 2019

Signed: .....

Sam Wilde, Director of Finance and Business Intelligence

Date: 15th May 2019

KPMG

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 Service NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers 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 2019 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 2018/19.

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

The Directors have prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

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 a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of Brexit, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

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 2018/19. 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 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 3, 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, on Page 2 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 set out on page 3, 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.

Andrew Cardoza
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Birmingham

24 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	89,717	94,643
Other operating income*	4	12,500	9,814
Operating expenses	7, 9	(97,529)	(99,681)
Operating surplus/(deficit) from continuing operations		**4,688**	**4,776**
Finance income	12	133	47
Finance expenses	13	-	-
PDC dividends payable		-	-
Net finance costs		**133**	**47**
Other gains / (losses)	14	-	-
Share of profit / (losses) of associates / joint arrangements		-	-
Surplus / (deficit) for the year from continuing operations		**4,821**	**4,823**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	**-**	**-**
Surplus / (deficit) for the year		**4,821**	**4,823**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(9)	-
Revaluations	19	208	101
Other recognised gains and losses		-	-
Other reserve movements		-	-
Total comprehensive income / (expense) for the period		**5,020**	**4,924**

* Other operating income for 2018/19 is inclusive of Provider Sustainability Fund (PSF) income of £3.618m. In 2017/18 the equivalent Sustainability and Transformation Fund (STF) income received was £2.804m.

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	16	431	518
Property, plant and equipment	17	6,002	4,615
Other assets	26	-	-
Total non-current assets		**6,433**	**5,133**
Current assets			
Inventories		-	-
Receivables	25	7,255	8,485
Other investments / financial assets		-	-
Other assets	26	-	-
Non-current assets held for sale / assets in disposal groups	27	-	-
Cash and cash equivalents	28	24,968	21,260
Total current assets		**32,223**	**29,745**
Current liabilities			
Trade and other payables	29	(11,140)	(12,890)
Borrowings	32	-	-
Other financial liabilities	30	-	-
Provisions	34	(2,496)	(2,570)
Other liabilities	31	(907)	(518)
Liabilities in disposal groups	27	-	-
Total current liabilities		**(14,543)**	**(15,978)**
Total assets less current liabilities		**24,113**	**18,900**
Non-current liabilities			
Trade and other payables	29	-	-
Borrowings	32	-	-
Other financial liabilities	30	-	-
Provisions	34	(450)	(396)
Other liabilities	31	-	-
Total non-current liabilities		**(450)**	**(396)**
Total assets employed		**23,663**	**18,504**
Financed by			
Public dividend capital		520	381
Revaluation reserve		1,095	910
Other reserves		-	-
Income and expenditure reserve		22,048	17,213
Total taxpayers' equity		**23,663**	**18,504**

The notes on pages 11 to 50 form part of these accounts.

Name .....

Position Chief Executive Officer, Lincolnshire Community Health Services NHS Trust

Date 15 May 2019

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**381**	**910**	**-**	**17,213**	**18,504**
Surplus/(deficit) for the year	-	-	-	4,821	**4,821**
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	-	(14)	-	14	**-**
Impairments	-	(9)	-	-	**(9)**
Revaluations	-	208	-	-	**208**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	**-**
Public dividend capital received	139	-	-	-	**139**
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 2019	**520**	**1,095**	**-**	**22,048**	**23,663**

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

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - bought 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	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	**-**
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**

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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,688	4,776
Non-cash income and expense:			
Depreciation and amortisation	7	1,038	878
Net impairments	8	(27)	63
Income recognised in respect of capital donations	4	(239)	(24)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		1,230	781
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilties		(971)	1,035
Increase / (decrease) in provisions		(20)	604
Tax (paid) / received		-	-
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**5,699**	**8,113**
Cash flows from investing activities			
Interest received		133	47
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(97)	(369)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(2,362)	(742)
Sales of property, plant, equipment and investment property		-	-
Receipt of cash donations to purchase capital assets		196	24
Cash movement from acquisitions / disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		**(2,130)**	**(1,040)**
Cash flows from financing activities			
Public dividend capital received		139	381
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		-	-
Movement on other loans		-	-
Other capital receipts		-	-
Interest on loans		-	-
Other interest paid		-	-
PDC dividend (paid) / refunded		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**139**	**381**
Increase / (decrease) in cash and cash equivalents		**3,708**	**7,454**
Cash and cash equivalents at 1 April - brought forward		**21,260**	**13,806**
Prior period adjustments		-	-
Cash and cash equivalents at 1 April - restated		**21,260**	**13,806**
Cash and cash equivalents transferred under absorption accounting	45	-	-
Cash and cash equivalents at 31 March	28	**24,968**	**21,260**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Secretary of State for Health, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS trusts 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 DHSC Group Accounting Manual 2018-19, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of Lincolnshire Community Health Services NHS Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 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 1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of Lincolnshire Community Health Services NHS Trust accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

Note 1.3.1 Critical accounting judgements and key sources of estimation uncertainty

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying 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 usage level.

Note 1.3.2 Sources of estimation uncertainty

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

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

Note 1.4 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income, and is disclosed separately from operating costs.

Note 1.5 Pooled Budgets

Lincolnshire Community Health Services NHS Trust is party to a 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 is detailed within note 2a to these accounts.

Note 1.6 Revenue from contracts with customers

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

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

· As per paragraph 121 of the Standard Trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

· The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

· The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

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

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer.

The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Payment terms are standard reflecting cross government principles. Significant terms include payment in line with the Better Payments Practice Code (BPPC).

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Revenue from NHS contracts

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

Revenue from research contracts

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

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.7 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 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 Other income

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

Note 1.9 Expenditure on employee benefits

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

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

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

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

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

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

Note 1.10 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.11 Value Added Tax (VAT)

Most of the activities of Lincolnshire Community Health Services NHS Trust are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.12 Property, plant and equipment

Note 1.12.1 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 will be supplied to the 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 a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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

Note 1.12.2 Measurement

Valuation

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

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

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

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

Note 1.13 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.

Lincolnshire Community Health Services NHS Trust does not currently hold any properties for the purpose of investment.

Note 1.13.1 Donated and grant funded assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Note 1.13.2 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and NHS LIFT transactions that 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.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

• payment for the fair value of services received
• repayment of the finance lease liability, including finance costs, and
• payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Lincolnshire Community Health Services NHS Trust has not entered into any arrangements involving PFI or LIFT transactions.

Note 1.13.3 Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	27
Dwellings	-	-
Plant & machinery	1	5
Transport equipment	-	-
Information technology	1	4
Furniture & fittings	1	4

Note 1.14 Intangible assets

Note 1.14.1 Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, Lincolnshire Community Health Services NHS Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000. Software that is integral to the operating 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 future economic benefits or service potential
● the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
● the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

Expenditure on research is not capitalised.

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

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

Note 1.14.2 Measurement
Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.
Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

Note 1.14.3 Useful economic life of intangible assets

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

Note 1.15 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 assets, less any residual value, on a straight-line basis over their estimated useful lives or expected consumption of economic benefits. The estimated useful life of an asset is the period over which Trust expects to obtain economic benefits or service potential from the asset. This is specific to Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

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

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

Note 1.15 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 1.15.1 Lincolnshire Community Health Services NHS Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

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

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

Note 1.16 Inventories

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

Note 1.17 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 1.18 Provisions

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2017-18: positive 0.24%) in real terms. All general provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

• A short term rate of [positive 0.54]% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years
• A medium term rate of [positive 1.13]% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years
• A long term rate of [positive 1.99]% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years.

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

Note 1.19 Clinical Negligence Costs

NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSR, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with Lincolnshire Community Health Services NHS Trust.

Note 1.20 Non Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the 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 1.21 Contingent liabilities and contingent assetss
A contingent liability is:

• a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust or
• a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

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

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Note 1.22 Financial assets
Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

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

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

Note 1.23 Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged – that is, the liability has been paid or has expired.

Loans from the Department of Health and Social Care are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Note 1.23.1 Financial liabilities at fair value through profit and loss

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

Note 1.23.2 Other Financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.24 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

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

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

• donated assets (including lottery funded assets)
• average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)
• any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

Currently, under this calculation methodology, Lincolnshire Community Health Services NHS Trust has negative net relevant assets and so does not incur PDC.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts. The PDC dividend calculation is based upon the trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

Note 1.25 Foreign Currencies
Lincolnshire Community Health Services NHS Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

Lincolnshire Community Health Services NHS Trust has not undertaken any transactions involving foreign currency in the financial year.

Note 1.26 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.

Lincolnshire Community Health Services NHS Trust does not hold money or assets on behalf of patients. .

Note 1.27 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 its own risks (with insurance premiums then being included as normal revenue expenditure).

Note 1.28 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 1.29 Early adoption of standards, amendments and interpretations

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

Note 1.30 Standards, amendments and interpretations in issue but not yet effective or adopted

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

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

No segmental analysis is shown as the sole activity of Lincolnshire Community Health Services NHS Trust in 2018/19 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 receives 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 is reviewed during the year by the Trust Board, dependent on the information required or requested by the Chief Operating Decision Maker.

The Trust has a grouping of customers, Lincolnshire Clinical Commissioning Groups from which more than 10% of its total revenue is derived for the provision of community health services.

Note 2a Pooled Budgets

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

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

	£000s **2018/19**	***£000s*** **2017/18**
Revenue	**1,907**	1,720
Expenditure	**1,907**	1,720

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Community services		
Community services income from CCGs and NHS England	82,645	83,614
Income from other sources (e.g. local authorities)	5,736	10,758
Other services		
Private patient income	5	3
Agenda for Change pay award central funding	1,089	-
Other clinical income	242	268
Total income from activities	**89,717**	**94,643**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	2,255	2,134
Clinical commissioning groups	80,390	81,480
Department of Health and Social Care*	1,089	-
Other NHS providers	188	30
NHS other	-	-
Local authorities	5,548	10,728
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	5	3
Injury cost recovery scheme	213	206
Non NHS: other	29	62
Total income from activities	**89,717**	**94,643**
Of which:		
Related to continuing operations	89,717	94,643
Related to discontinued operations	-	-

* Income from Department of Health and Social Care in 2018/19 relates to central funding for national pay award impact.

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

	2018/19	2017/18
	£000	£000
Income recognised this year	5	3
Cash payments received in-year	-	3
Amounts added to provision for impairment of receivables	5	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	212	411
Education and training (excluding notional apprenticeship levy income)	767	823
Non-patient care services to other bodies	7,096	5,245
Provider Sustainability Fund/ Sustainability and Transformation Fund income (2018/19: PSF, 2017/18:STF)	3,618	2,804
Income in respect of employee benefits accounted on a gross basis	406	403
Other contract income	4	25
Other non-contract operating income		
Research and development (non-contract)	-	-
Education and training - notional income from apprenticeship fund	123	38
Receipt of capital grants and donations	239	24
Charitable and other contributions to expenditure	35	41
Other non-contract income	-	-
Total other operating income	**12,500**	**9,814**
Of which:		
Related to continuing operations	12,500	9,814
Related to discontinued operations	-	-

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	210
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.1 Transaction price allocated to remaining performance obligations

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

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

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19	2017/18
	£000	£000
Income	-	-
Full cost	-	-
Surplus / (deficit)	**-**	**-**

Note 7 Operating expenses

	2018/19	2017/18
	£000	£000
Staff and executive directors costs	63,251	63,738
Remuneration of non-executive directors	61	55
Supplies and services - clinical (excluding drugs costs)	11,097	12,428
Supplies and services - general	3,014	2,567
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,527	2,744
Consultancy costs	327	243
Establishment	685	1,350
Premises	3,915	3,139
Transport (including patient travel)	2,005	1,824
Depreciation on property, plant and equipment	851	745
Amortisation on intangible assets	187	133
Net impairments	(27)	63
Movement in credit loss allowance: contract receivables / contract assets	(8)	
Movement in credit loss allowance: all other receivables and investments	-	13
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	43	52
other auditor remuneration (external auditor only)	-	2
Internal audit costs	61	50
Clinical negligence	162	187
Legal fees	444	548
Insurance	-	-
Research and development	77	314
Education and training	600	706
Rentals under operating leases	7,980	8,594
Early retirements	-	-
Redundancy	-	-
Car parking & security	-	-
Hospitality	-	-
Losses, ex gratia & special payments	-	-
Grossing up consortium arrangements	-	-
Other services, e.g. external payroll	-	-
Other	277	186
Total	**97,529**	**99,681**
Of which:		
Related to continuing operations	97,529	99,681
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 7.1 Other auditor remuneration

	2018/19	2017/18
	£000	£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 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5m (2017/18: £5m).

Note 8 Impairment of assets

	2018/19	2017/18
	£000	£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	(27)	63
Other	-	-
Total net impairments charged to operating surplus / deficit	**(27)**	**63**
Impairments charged to the revaluation reserve	9	-
Total net impairments	**(18)**	**63**

Impairments recognised above relate to valuation changes following formal independent asset revaluations being undertaken in the respective financial periods.

Note 9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	47,440	47,301
Social security costs	4,516	4,411
Apprenticeship levy	226	224
Employer's contributions to NHS pensions	6,253	6,509
Pension cost - other	23	10
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	286	216
Temporary staff (including agency)	4,507	5,067
Total gross staff costs	**63,251**	**63,738**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**63,251**	**63,738**
Of which		
Costs capitalised as part of assets	-	-

Note 9.1 Retirements due to ill-health

During 2018/19 there was 1 early retirement from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £52k (£99k in 2017/18).

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

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

The Trust also has a small number of employees who pay into the National Employment Savings Trust (NEST) pension scheme and this is not connected to the NHS Pensions Scheme.

Note 11 Operating leases

Note 11.1 Lincolnshire Community Health Services NHS Trust as a lessor

Lincolnshire Community Health Services NHS Trust has not acted as a lessor in any leasing arrangements in 2018/19 (2017/18: £0)

Note 11.2 Lincolnshire Community Health Services 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 and neighbouring counties. As a result, the Trust is party to a number of leasing arrangements for the 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 leasing arrangements between the Trust and private leasing providers.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	7,980	8,594
Contingent rents	-	-
Less sublease payments received	-	-
Total	**7,980**	**8,594**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	6,858	7,858
- later than one year and not later than five years;	2,150	1,910
- later than five years.	2,156	2,251
Total	**11,164**	**12,019**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	133	47
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total finance income	**133**	**47**

Bank interest represents interest on cash balances held within the Government Banking Service. LCHS is not permitted to hold balances with commercial banks.

Note 13 Finance expenditure

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

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	-	-
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	-	-
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**-**	**-**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**-**	**-**

Note 13.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

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

Note 14 Other gains / (losses)

	2018/19 £000	2017/18 £000
Gains on disposal of assets	-	-
Losses on disposal of assets	-	-
Total gains / (losses) on disposal of assets	**-**	**-**
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	-	-
Total other gains / (losses)	**-**	**-**

Note 15 Discontinued operations

	2018/19 £000	2017/18 £000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	**-**	**-**

Lincolnshire Community Health Services NHS Trust has none of its operations classified as discontinued in 2018/19 (2017/18; £nil)

Note 16.2 Intangible assets - 2018/19

	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**637**	**-**	**195**	**152**	**-**	**984**
Transfers by absorption	-	-	-	-	-	**-**
Additions	97	-	3	-	-	**100**
Impairments	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Reclassifications	152	-	-	(152)	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2019	**886**	**-**	**198**	**-**	**-**	**1,084**
Amortisation at 1 April 2018 - brought forward	**383**	**-**	**83**	**-**	**-**	**466**
Transfers by absorption	-	-	-	-	-	**-**
Provided during the year	185	-	2	-	-	**187**
Impairments	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Amortisation at 31 March 2019	**568**	**-**	**85**	**-**	**-**	**653**
Net book value at 31 March 2019	**318**	**-**	**113**	**-**	**-**	**431**
Net book value at 1 April 2018	**254**	**-**	**112**	**152**	**-**	**518**

Note 16.1 Intangible assets - 2017/18

	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017	**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	**-**	**-**	**-**	**-**	**-**	**-**
Valuation / gross cost at 31 March 2018	**637**	**-**	**195**	**152**	**-**	**984**
Amortisation at 1 April 2017	**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**	**0**	**83**	**0**	**0**	**466**
Net book value at 31 March 2018	**254**	**0**	**112**	**152**	**0**	**518**
Net book value at 1 April 2017	**129**	**0**	**81**	**85**	**0**	**295**

Note 17.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**681**	**2,832**	**564**	**1,907**	**2,175**	**417**	**8,576**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	66	360	425	1,086	75	**2,012**
Impairments	-	(32)	-	-	-	-	**(32)**
Reversals of impairments	-	(2)	-	-	-	-	**(2)**
Revaluations	-	139	-	-	-	-	**139**
Reclassifications	-	42	(562)	70	423	27	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2019	**681**	**3,045**	**362**	**2,402**	**3,684**	**519**	**10,693**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**704**	**-**	**1,392**	**1,542**	**323**	**3,961**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	191	-	170	419	71	**851**
Impairments	-	(22)	-	-	-	-	**(22)**
Reversals of impairments	-	(30)	-	-	-	-	**(30)**
Revaluations	-	(69)	-	-	-	-	**(69)**
Reclassifications	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2019	**-**	**774**	**-**	**1,562**	**1,961**	**394**	**4,691**
Net book value at 31 March 2019	**681**	**2,271**	**362**	**840**	**1,723**	**125**	**6,002**
Net book value at 1 April 2018	**681**	**2,128**	**564**	**515**	**633**	**94**	**4,615**

Note 17.2 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	**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	**-**	**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	**0**	**704**	**0**	**1392**	**1542**	**323**	**3961**
Net book value at 31 March 2018	**681**	**2128**	**564**	**515**	**633**	**94**	**4615**
Net book value at 1 April 2017	**681**	**1853**	**422**	**309**	**657**	**141**	**4063**

Note 17.3 Property, plant and equipment financing - 2018/19

	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 2019							
Owned - purchased	681	2,211	362	783	1,718	114	**5,869**
Finance leased	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	**-**
Owned - donated	-	60	-	57	5	11	**133**
NBV total at 31 March 2019	**681**	**2,271**	**362**	**840**	**1,723**	**125**	**6,002**

Note 17.4 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	-	-	-	-	-	-	**-**
Off-SoFP 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 18 Donations of property, plant and equipment

Lincolnshire Community Health Services NHS Trust received donated assets as detailed below:

£40k Physical Assets (Non-Cash) & £196k Cash Donations.

In total £236K donated additions were donated from the Lincolnshire Community Health Services NHS Trust linked Charitable Funds (£106k) and other charitable organisations (£130k).

Note 19 Revaluations of property, plant and equipment

A desktop revaluation exercise of the Trust owned property assets was undertaken during 2018/19 by DVS Property Specialist, an executive arm of the Valuation Office Agency, with an effective date of 31th March 2019.

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 and Social Care Group Accounting Manual (DHSC GAM).

Note 20.1 Investment Property
Lincolnshire Community Health Services NHS Trust does not hold any properties for the purposes of capital appreciation (investment)

Note 20.2 Investment property income and expenses
Lincolnshire Community Health Services NHS Trust does not hold any properties for the purposes of capital appreciation (investment) and thus incurred no income or expenditure in relation to this (2017/18: £nil)

Note 21 Investments in associates and joint ventures
Lincolnshire Community Health Services NHS Trust does not hold any Investment in associates and joint ventures and thus incurred no income or expenditure in relation to this (2017/18: £nil)

Note 22 Other investments / financial assets (non-current)
Lincolnshire Community Health Services NHS Trust does not hold any Other Investments and thus incurred no income or expenditure in relation to this for 2018/19 (2017/18: £nil)

Note 22.1 Other investments / financial assets (current)
Lincolnshire Community Health Services NHS Trust does not hold any Other Investments and thus incurred no income or expenditure in relation to this in 2018/19 (2017/18: £nil)

Note 23 Disclosure of interests in other entities
Lincolnshire Community Health Services NHS Trust holds no interests within other entities in 2018/19 (2017/18: nil)

Note 24 Inventories
Lincolnshire Community Health Services NHS Trust does not account separately for inventory on the basis of immateriality.

Note 25.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	6,458	
Contract assets*	-	
Trade receivables*		3,850
Capital receivables	-	-
Accrued income*		3,706
Allowance for impaired contract receivables / assets*	(34)	
Allowance for other impaired receivables	-	(42)
Deposits and advances	-	-
Prepayments (non-PFI)	798	916
Interest receivable	-	-
VAT receivable	-	21
Other receivables	33	34
Total current trade and other receivables	**7,255**	**8,485**
Non-current		
Contract receivables*	-	
Contract assets*	-	
Trade receivables*		-
Capital receivables	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	5,299	6,633
Non-current	-	-

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

Note 25.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**42**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	42	(42)
Transfers by absorption	-	-
New allowances arising	(8)	-
Changes in existing allowances	-	-
Reversals of allowances	-	-
Utilisation of allowances (write offs)	-	-
Changes arising following modification of contractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2019	**34**	**-**

Note 25.3 Allowances for credit losses - 2017/18

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

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**42**
Prior period adjustments	-
Allowances as at 1 Apr 2017 - restated	**42**
Transfers by absorption	-
Increase in provision	-
Amounts utilised	-
Unused amounts reversed	-
Allowances as at 31 Mar 2018	**42**

Note 26 Other assets

Lincolnshire Community Health Services NHS Trust does not hold any Other Assets and thus incurred no income or expenditure in relation to this (2017/18: £nil)

Note 27 Non-current assets held for sale and assets in disposal groups

Lincolnshire Community Health Services NHS Trust does not hold any Non-current assets held for sale and assets in disposal groups and thus incurred no income or expenditure in relation to this (2017/18: £nil)

Note 27.1 Liabilities in disposal groups

As at the end of 2018/19, the Trust held no liabilities classed in disposal groups (2017/18: £nil)

Note 28.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**21,260**	**13,806**
Prior period adjustments	-	-
At 1 April (restated)	**21,260**	**13,806**
Transfers by absorption	-	-
Net change in year	3,708	7,454
Transfer to FT upon authorisation	-	-
At 31 March	**24,968**	**21,260**
Broken down into:		
Cash at commercial banks and in hand	1	1
Cash with the Government Banking Service	24,967	21,259
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**24,968**	**21,260**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**24,968**	**21,260**

Note 28.2 Third party assets held by the trust

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

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

Note 29.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	3,229	4,243
Capital payables	270	660
Accruals	5,544	6,138
Receipts in advance (including payments on account)	-	-
Social security costs	681	640
VAT payables	121	-
Other taxes payable	434	414
PDC dividend payable	-	-
Accrued interest on loans*		-
Other payables	861	795
Total current trade and other payables	**11,140**	**12,890**
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	3,152	4,099
Non-current	-	-

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

Note 29.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2019 £000	31 March 2019 Number	31 March 2018 £000	31 March 2018 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 30 Other financial liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**

Note 31 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	907	518
Deferred grants	-	-
Other deferred income	-	
Total other current liabilities	**907**	**518**
Non-current		
Deferred income: contract liabilities	-	-
Deferred grants	-	-
Other deferred income	-	-
Total other non-current liabilities	**-**	**-**

Note 32 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Bank overdrafts	-	-
Loans from the Department of Health and Social Care	-	-
Other loans	-	-
Total current borrowings	**-**	**-**
Non-current		
Loans from the Department of Health and Social Care	-	-
Other loans	-	-
Total non-current borrowings	**-**	**-**

Note 32.1 Reconciliation of liabilities arising from financing activities

Lincolnshire Community Health Services NHS Trust does not hold any liabilities arising from financing activities and thus no reconciliation table is included within the Trust accounts (2017/18: also nil)

Note 33 Finance leases

Lincolnshire Community Health Services NHS Trust does not hold any finance leases and thus incurred no income or expenditure in relation to this (2017/18: £nil)

Note 34.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	**-**	**-**	**1,922**	**456**	**-**	**129**	**459**	**2,966**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	-	-	**-**
Arising during the year	150	-	440	-	-	-	1	**591**
Utilised during the year	-	-	(20)	(131)	-	-	(1)	**(152)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	(88)	(195)	-	(129)	(47)	**(459)**
Unwinding of discount	-	-	-	-	-	-	-	**-**
At 31 March 2019	**150**	**-**	**2,254**	**130**	**-**	**-**	**412**	**2,946**
Expected timing of cash flows:								
- not later than one year;	5	-	2,254	130	-	-	107	**2,496**
- later than one year and not later than five years;	20	-	-	-	-	-	91	**111**
- later than five years.	125	-	-	-	-	-	214	**339**
Total	**150**	**-**	**2,254**	**130**	**-**	**-**	**412**	**2,946**

Provisions included within the accounts of Lincolnshire Community Health Services NHS Trust as at 31 March 2019:
Pensions: these represent costs associated with departures where pension has been taken early as an alternative to ordinary termination. The Trust provides for the additional cost associated.
Legal: the Trust has provided against ongoing legal cases which may incur settlement costs at a future date. Further information can be found at Note 35.
Restructuring: are estimated costs relating to organisational restructuring and associated potential exit packages required.
Other: provisions categorised here relate to provisions estimated associated with leased buildings and dilapidations clauses within these leases.

Note 34.2 Clinical negligence liabilities

At 31 March 2019, £1,007k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lincolnshire Community Health Services NHS Trust (31 March 2018: £1,148k).

Note 35 Contingent assets and liabilities

During 2018/19, 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 2018/19 financial position as a provision (refer to note 34.1). The Trust continues to discuss with HMRC and legal advisors.

Note 36 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	10	35
Intangible assets	-	-
Total	**10**	**35**

Note 37 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 2019 £000	31 March 2018 £000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

Lincolnshire Community Health Services NHS Trust does not hold any On-SoFP PFI, LIFT or other service concessions and thus incurred no income or expenditure in relation to this (2017/18: £nil)

Note 39 Off-SoFP PFI, LIFT and other service concession arrangements

Lincolnshire Community Health Services NHS Trust does not hold any Off-SoFP PFI, LIFT or other service concessions and thus incurred no income or expenditure in relation to this (2017/18: £nil)

Note 40 Financial instruments

Note 40.1 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.

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 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups (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 40.2 Carrying values of financial assets

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

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	6,424	-	-	**6,424**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents at bank and in hand	24,968	-	-	**24,968**
Total at 31 March 2019	**31,392**	**-**	**-**	**31,392**

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

Note 40.3 Carrying value of financial liabilities

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

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	9,041	-	**9,041**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2019	**9,041**	**-**	**9,041**

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

Note 40.4 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 40.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	9,041	10,523
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	**9,041**	**10,523**

Note 41 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	-	-	-
Fruitless payments	1	11	2	-
Bad debts and claims abandoned	2	-	5	1
Stores losses and damage to property	-	-	-	-
Total losses	**6**	**11**	**7**	**1**
Special payments				
Compensation under court order or legally binding arbitration award	1	4	1	8
Extra-contractual payments	1	6	-	-
Ex-gratia payments	-	-	-	-
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**2**	**10**	**1**	**8**
Total losses and special payments	**8**	**21**	**8**	**9**
Compensation payments received		-		-

Note 42 Gifts

Lincolnshire Community Health Services NHS Trust did not expend on gifts during 2018/19 (2017/18: £nil)

Note 43.1 Initial application of IFRS 9

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

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

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0k, and trade payables correspondingly reduced.This had no effect for the Trust as it holds/held no borrowings.

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

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 43.2 Initial application of IFRS 15

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

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

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

Note 44 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, Lincolnshire Community Health Services NHS Trust				
1. Chair, United Lincolnshire Hospitals NHS Trust	1,916,806	2,484,615	307,121	523,296
E Libiszewski, Non- Executive Director, Lincolnshire Community Health Services NHS Trust				
1. Non Executive Director, United Lincolnshire Hospitals NHS Trust	1,916,806	2,484,615	307,121	523,296
A Morgan, Chief Executive, Lincolnshire Community Health Services NHS Trust				
1. Board Member - East Midlands Leadership Academy (hosted by Nottinghamshire Healthcare NHS Foundation Trust)	2,972	11,627	-	969
Dr S Elcock, Interim Medical Director (to April 2018), Lincolnshire Community Health Services NHS Trust				
1. Medical Director, Lincolnshire Partnership NHS Foundation Trust	583,464	203,304	34,656	43,604
Dr Y Owen, Medical Director, Lincolnshire Community Health Services NHS Trust				
1. Trustee - Lincolnshire Integrated Voluntary Emergency Service (LIVES)	161,861	-	0	-
2. Private Contractor providing OOH GP provision in Trust Services	43,281	-	2,705	-
S Ombler, Interim Director of Nursing and Operations, Lincolnshire Community Health Services NHS Trust				
1.Via Relation- North East Lincolnshire Clinical Commissioning Group	-	53,672	-	3,387

The Department of Health is regarded as a related party. During the year 2018/19, 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 (primarily with 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 (particularly North Lincolnshire and Goole NHS Foundation Trust and Lincolnshire Partnership NHS Foundation trust)
- NHS Trusts (particularly with United Lincolnshire Hospitals NHS Trusts)
- NHS Resolution (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 45 Transfers by absorption

Lincolnshire Community Health Services NHS Trust undertook no transactions which absorbed other entities during 2018/19 (2017/18: £nil)

Note 46 Events after the reporting date

At the time of preparation, the Trust had not been notified or become aware of any significant events which require disclosure.

Note 47 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	14,590	34,257	14,268	23,891
Total non-NHS trade invoices paid within target	11,502	28,278	10,563	17,418
Percentage of non-NHS trade invoices paid within target	78.83%	82.55%	74.03%	72.91%
NHS Payables				
Total NHS trade invoices paid in the year	1,450	15,456	1,490	15,933
Total NHS trade invoices paid within target	968	11,364	804	7,282
Percentage of NHS trade invoices paid within target	66.76%	73.52%	53.96%	45.70%

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 48 External financing

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

	£000	£000
Cash flow financing	(3,569)	(7,454)
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**(3,569)**	**(7,454)**
External financing limit (EFL)	3,115	304
Under / (over) spend against EFL	**6,684**	**7,758**

Note 49 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	2,112	1,615
Less: Disposals	-	-
Less: Donated and granted capital additions	(239)	(24)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**1,873**	**1,591**
Capital Resource Limit	2,033	1,731
Under / (over) spend against CRL	**160**	**140**

Note 50 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	4,607
Remove impairments scoring to Departmental Expenditure Limit	-
Breakeven duty financial performance surplus / (deficit)	**4,607**

Note 51 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	2018/19 £000
Breakeven duty in-year financial performance	1,081	1,473	1,825	1,274	569	3,940	4,903	4,607
Breakeven duty cumulative position	1,081	2,554	4,379	5,653	6,222	10,162	15,065	19,672
Operating income	108,738	108,773	109,612	110,487	105,943	109,336	104,457	102,217
Cumulative breakeven position as a percentage of operating income	0.99%	2.35%	4.00%	5.12%	5.87%	9.29%	14.42%	19.25%