NHS
Lewisham and Greenwich
NHS Trust

Annual report
2019/20

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


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

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Marvellous
Children's Cha

Chair's foreword

Welcome to the 2019/20 annual report – I hope you find it useful.

This has been a year like no other, with the early months of 2020 dominated by the coronavirus pandemic. I have worked for many years in the NHS, and never before have I seen anything like this.

The Trust went through a huge transformation in a short space of time as we responded to the crisis. Our emergency departments and wards were reconfigured, new protocols and clinical pathways were established, we started using video for outpatient appointments, and many staff were redeployed to other roles. Everyone worked together to support one another, and this co-operation and team spirit was very much evident in the many wards and departments I visited during this time.

I have been overwhelmed by the monumental efforts made by our staff as they responded to the pandemic. Their prime focus was to provide our patients with the very best care, despite the challenging circumstances we found ourselves in.

We expanded our critical care capacity across both University Hospital Lewisham and Queen Elizabeth Hospital to provide key treatment to all patients who needed it – moving from having 17 ventilated beds to over 85. We also worked very closely with neighbouring hospitals, ensuring that our critical care beds were filled at the same rate, so that no one hospital became overwhelmed at any point. Thanks to this work, we were able to meet the demand for intensive care treatment for patients with Covid-19.

The scale of the changes that have been made and continue to be made is nothing short of phenomenal. The resilience, commitment and unerring cheerfulness of our staff at such a stressful time is both inspirational and overwhelming.

On a personal note, I was very pleased to have my term as Chair extended until the end of July 2021. Back in April 2019 we were focussed on delivering our improvement plan, and we have made great progress over the year. Our emergency care improvement programme and developments in cancer treatment are truly impressive. As part of our respect and compassion programme, we rolled out specialist training for over 4,000 staff in supervisory roles to support our staff in displaying our values at all times and get the right culture across the whole Trust. This work has really paid off, and I see staff working together, treating everyone with respect and compassion, taking responsibility for their actions, learning and sharing knowledge and working as teams to improve quality every day.

On behalf of our communities who are relying on our services, I'd like to say a massive thank you to our staff – they really are amazing.

Val Davison, Chair
2020


My Doctor
My Nurse

About us

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

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

Vision, values and priorities

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

Our vision

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

Our values

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

Our priorities

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

Quality Continually improve safety and quality

Patients Put patients at the heart of everything we do

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

Partnership Work effectively with partner organisations

Money Ensure we spend every penny wisely.

What patients say about us

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

Friends and family test 2019/20

Patients	% who would recommend the Trust to friends and family
Inpatients	92%
ED patients	75%
Community	97%
Maternity	93%
Outpatients	87%

The Trust in numbers*

- 6,887 members of staff
- 584,216 outpatients appointments
- 300,661 A&E attendances
- 7,737 births
- 20,059 patients treated in our theatres
- 600,023 community contacts with patients
- 20 operating theatres
- 12 community sites in Lewisham
- 900 beds

*2019/20

The populations we serve

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

Affluence and life expectancy

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

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

Life expectancy has historically been lower in Lewisham than England. However, for females, Lewisham life expectancy is now 83.1, which exceeds the national average of 79.6. For male residents, life expectancy is 79, slightly lower than the national average of 79.6.

Life expectancy in Greenwich has been rising since 2000, but it is significantly shorter than the national average. Males are expected to live approximately 3.5 years less than females.

For Bexley, life expectancy for both men and women is in line with the national average.

Age profile

In Lewisham, Greenwich and Bexley, the 2011 census found around a quarter of the population was aged 19 or under. Bexley also has a higher percentage of people aged over 65.

According to the Office for National Statistics, 20 per cent of Bexley's population is expected to be over 65 by 2036, compared to 13 per cent in Lewisham and 14 per cent in Greenwich.

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

Ethnicity

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

How we are set up

We have around 6,887 staff, and our services are set up to ensure that patients are at the heart of what we do. Our clinical divisions are led by healthcare professionals, and supported by corporate dvisions All this work is then overseen by the Trust Board (see page 39).

Our services

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

The Trust is a centre for the education and training of medical students enrolled with King's College London's GKT School of Medical Education. We are a training centre for nurses, midwives and allied health professionals and are pioneering new roles that will support the changing needs of our patients.

In Lewisham, our health professionals also provide care to adults and children in a range of health centres, community clinics, and in patients' own homes. Our services for adults include community matrons and midwives, district nurses, the diabetes team, the home enteral nutrition team, the community head and neck team, podiatry and our sexual

and reproductive health team. Services for children and young people include health visiting, occupational therapy, physiotherapy and speech and language services.

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

Equality and human rights

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

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

Academic activities and research

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

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

Our structure

We have five patient facing divisions:

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

Each division is led by:

- A divisional director of operations
- A divisional medical director
- A divisional director of nursing/midwifery/professions.


Lewisham and Greenwich NHS Trust
hello my name is...
Lewisham and Greenwich NHS Trust
hello my name is...

Performance report

Chief Executive's statement on performance

This year has been overshadowed by the Covid-19 crisis, which has had a devastating impact on our Trust and on the NHS as a whole. Since January 2020, we have had to quickly change the way we deliver our services, and there isn't a single area of the Trust that hasn't been affected by the crisis.

Covid-19 hit the Trust at a time when we were already dealing with significant pressures. Fortunately, at the time of writing, we are starting to see fewer cases in our hospitals. Nevertheless, this crisis will have a long-lasting impact, and getting back to business as usual is likely to take some time.

The Care Quality Commission (CQC) inspected the Trust on 11 and 12 February 2020, which was an opportunity for us to showcase the improvements we've made to services over the last year. Developments across the Trust have been led by clinical leaders and frontline staff keen to adopt innovation, technology and different ways of working to provide the best care. At the time of writing, the CQC has not published its report from this inspection. We will update our website (www.lewishamandgreenwich.nhs.uk) to include a summary of the latest CQC report once it has been published.

Our performance on the emergency department four-hour target is holding up compared to other trusts in London. This year we introduced our same day emergency care (SDEC) programme, which enables clinicians to see and treat patients in our EDs without the need for hospital admission. And our Lewisham-based Community Acute Rapid Response Service (CARRS) has been visiting housebound patients who would otherwise need to attend the ED or be admitted to hospital, which reduces pressures on our emergency department. And I am really proud of the way we worked with our partners during the Covid-19 pandemic to speed up the discharge process and free up beds for more seriously ill patients.

I am so grateful for the flexibility and hard work of our staff in the face of considerable challenges this year. I am honoured to work with so many people who go the extra mile every day to keep our patients safe, support colleagues and make improvements.

Ben Travis, Chief Executive
2020

Performance overview

Our performance against NHS standards and targets

The Trust's performance is measured against national and local targets. This section provides and overview of our performance in these areas. You can see a table of where we met key targets on pages 16 and 17.

An overview of our performance against financial targets is included on page 36.

Emergency department four-hour wait

The national standard is for at least 95% of patients to wait no more than four hours to be treated when attending our emergency departments (EDs). As in previous years across England, it has been recognised that this standard has become increasingly difficult to achieve.

In line with the national picture, the Trust has not achieved the national standard for emergency department four-hour performance in 2019/20. We have continued to work closely with system partners to make further improvements to pathways to meet emergency demand. Since February 2020 the Trust has been responding to the Covid-19 pandemic, which required us to reconfigure our EDs and enhance infection prevention measures to protect patients and staff. As a result of these factors, we did not meet the four-hour wait target in 2019/20.

Due to the Covid-19 pandemic, we have not yet agreed performance trajectories (targets) for 2020/21 with our commissioners. However, we have laid excellent ground work for improving performance in 2020/21, trialling new models of services to reduce the need for a stay in hospital and improving the flow of patients through our hospitals. See page 20 for more details.

We have been building on our strong relationships with partners in the community and social services to speed up the discharge process for inpatients who are medically fit to leave hospital. This has freed up beds for more seriously ill patients who come through our EDs and need to be admitted. We hope to continue this good work over 2020/21, while ensuring we keep in place our enhanced arrangements to protect patients through infection control measures in our Emergency Departments and throughout our hospitals.

Cancer targets

The Trust has continued to consistently meet the cancer 31 day standard and the breast symptomatic two week wait standard. The Trust has not consistently achieved the two week wait standard and the 62 day treatment standard.

We continue to work closely with our local provider partners and with the SEL Accountable Cancer Network to maintain cancer services for urgent treatments during the pandemic, as well as strengthening pathways internally to improve performance in 2020/21 as services restart.

Two-week waiting standard

The national standard is that 93% of patients should wait no more than two weeks to be seen following an urgent referral for any type of cancer. This national standard is measured separately for patients with symptoms of breast cancer.

The Trust continued to meet the two-week wait standard up until August 2019, but since then we have not met the standard. In September 2019 the Trust made changes to our pathways, in line with best practice and in anticipation of a new standard being introduced in 2020/21: the 28 day faster diagnostic standard, which aims to reduce the time it takes for patients to be informed of a cancer diagnosis.

31-day standard

Following diagnosis, all patients who need cancer treatment should begin this within 31 days of the decision to treat. The Trust consistently met this target during 2019/20.

62-day standard

The NHS standard is that at least 85% of patients needing treatment for cancer should start their treatment within 62 days of referral.

Despite improvements, meeting the 62-day standard has remained challenging across south east London in 2019/20. As a Trust we have consistently met this standard for patients being treated in our hospitals. However, for more complex patients who require treatment at hospitals run by a different trust, the standard has not been met consistently. We will continue working with system partners to improve this as a key priority for 2020/21.

Referral to treatment targets

The NHS standard remains that 92% of patients referred to hospital should start their treatment within 18 weeks. The NHS 2019/20 national planning guidance included a focus on reducing the overall size of the waiting list compared to March the previous year.

The Trust did not meet the 92% standard in 2019/20. However, we did manage to keep our waiting list from growing, with only 24 additional patients on the waiting list in March 2020 (38,890) compared to March 2019 (38,866), narrowly missing the trajectory of 38,800.

During 2019/20, the Trust saw an increase in 52-week breaches (the number of patients waiting more than 52 weeks before starting treatment). We have put additional processes in place to help reduce the number of patients who have to wait a long time for treatment. However, maintaining these processes has become difficult because we had to stop planned surgery during the coronavirus pandemic.

Ensuring a fast recovery from the pandemic and re-starting elective (planned) care is a key priority for the Trust in 2020/21.

Infection control

The Trust ended the financial year with a total of 30 cases of Clostridium difficile (C. difficile), against a trajectory of no more than 27 cases. 22 cases were reported as Healthcare Onset Healthcare Associated and eight as the new definition of Community Onset Healthcare Associated.

This is an increase on last year's figures of 12 cases in total, but still a great achievement given the change in definition and the target having been reduced from 38 to 27 cases.

The Trust reported two Trust assigned MRSA bacteraemia over 2019/20. Although this breaches the zero trajectory and is a small increase for the Trust from last year's single case, it is still an improvement on 2017/18 when four cases were reported.

Safer staffing

The safer staffing target specifies the number of nursing and midwifery staff needed to deliver safe, high-quality patient care. We met the target consistently over 2019/20 and, following a staffing review, we have created several new nursing posts, which we plan to recruit to in 2020/21.

Nursing vacancies continue to be a challenge for the Trust and, while there has been improvement over the year – down from 18% in March 2019 to 11% in March 2020 – this remains a priority for us. In particular, we continue to recruit nurses from overseas and continue to work with staff to improve our retention rates and make the Trust a fantastic place to work for all.

VTE

The national standard is that 95% of patients are screened on admission for venous thromboembolism, more commonly known as VTE. This is the collective term for blood clots known as deep vein thrombosis (DVT) and pulmonary embolism (PE) – a significant cause of death, long-term disability and chronic health problems. We met this target consistently over 2019/20, apart from in May 2019, when we dipped to 94%.

Childhood obesity

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

The School Health Service in Lewisham aims to meet all the targets for measuring children so that early action can be taken to detect and treat obesity. The School health team have also developed a Healthy Lifestyle programme aimed at supporting children who have been identified as overweight or obese which is due to be piloted once schools reopen. In Greenwich, community services are provided by Oxleas NHS Foundation Trust.

Breastfeeding

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

In 2018/19, the Lewisham Health Visiting Service gained full "Baby Friendly" accreditation from UNICEF, showing that we are meeting the highest levels in supporting breastfeeding effectively. Over 2019/20, our focus has been on ensuring that this work is sustainable, and we are aiming to gain the UNICEF Baby Friendly Gold Award in recognition of this work. This was planned for summer 2020 but has been postponed until 2021/22 due to the Covid-19 pandemic.

Our community team in Lewisham has met all targets for ensuring that the majority of infants are fully or partially breastfed at six to eight weeks. For 2019/20 Quarter 3, 79.7% of babies in Lewisham were fully or partially breastfed, which far exceeds the national average. Lewisham is consistently the borough with one of the highest rates of breastfeeding at six to eight weeks in London.

Mortality data

We review mortality data about our patients so we can check that our services are safe and take action to improve where necessary. The Summary Hospital-level Mortality Indicator (SHMI) is a mortality measure that takes account of a number of factors. It includes patients who have died while having treatment in hospital or within 30 days of being discharged. The SHMI score is measured against the NHS average – which is 1. A score below 1 denotes a lower than average mortality rate and therefore indicates good, safe care.

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

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

Over 2019/20, the Trust's score was "as expected" (Band 2) in the SHMI, indicating that our care is safe.

Our SHMI score has gone down from 1.07 when the Trust was formed to 0.93, indicating lower than expected mortality rates.

This is due to a range of initiatives, including:

- Improving how we respond to inpatients showing early signs of deteriorating health (through use of the National Early Warning Score system – known as NEWS for short)
- Ensuring the intensive care teams provide outreach support on the wards when needed
- A wide range of improvements we've made through the national Sign up to Safety programme, and continue to make through our #ImprovingTogether programme.

The view from our regulators

The Trust's overall rating from the September 2018 Care Quality Commission (CQC) inspection is "requires improvement". The CQC commented on how caring they found our staff, with the Trust's rating in the caring domain improving to "good".

The Trust was inspected by the CQC in February 2020. At the time of writing, the CQC has not published its inspection report. We will update our website (www.lewishamandgreenwich.nhs.uk) to include details of the report once it has been published by the CQC, The full report will also be available on the CQC's website (www.cqc.org.uk).


NHS
Queen Elizabeth Hospital
SUBSTANCE MISUSE LIAISON TEAM

Performance table

National target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Emergency cases: 95% of all patients attending A&E should be treated, admitted or discharged within a maximum of four hours (performance against trajectory)	83.3%	80.6%	83.0%	78.4%	82.3%	85.3%	83.8%	80.9%	79.3%	79.7%	83.1%	81.2%
Infection control: the Trust should have no cases of MRSA bacteraemia	0	0	0	0	0	0	1	0	1	0	0	0
Infection control: the Trust should have no more than 27 cases of Clostridium difficile. The table lists the total number of cases in each month of the year to date (so there was a total of 30 cases over the year).	1	2	5	2	4	1	5	3	2	2	0	3
Infection control: Clostridium difficile ytd trajectory variance	-2	-3	-1	-1	1	0	3	4	4	4	2	3
Cancer: patients should wait no more than two weeks for an urgent referral. The standard is 93%	94.6%	95.7%	94.4%	94.1%	91.0%	91.9%	91.6%	90.2%	91.0%	89.8%	89.6%	86.6%
Cancer: patients with symptoms of breast cancer should wait no more than two weeks for treatment following an urgent referral. The standard is 93%	96.4%	96.2%	95.4%	96.6%	98.9%	96.2%	92.9%	93.8%	89.7%	91.7%	100.0%	100.0%
Cancer: patients should not wait more than 31 days from confirmed diagnosis to treatment. The standard is 96%	94.9%	97.9%	95.6%	99.2%	98.0%	97.9%	97.2%	98.0%	100.0%	96.2%	100.0%	99.1%
Cancer: patients should not wait more than 62 days for treatment from GP referral. The standard is 85%	77.6%	74.1%	72.5%	82.2%	82.5%	78.7%	73.0%	88.8%	81.2%	78.6%	79.8%	73.8%

National target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Cancer 62 day performance excluding shared pathway patients	85.3%	84.6%	86.5%	90.7%	93.4%	92.6%	87.5%	92.6%	88.9%	87.9%	87.0%	79.2%
18 weeks target: patients who have not been treated yet should not have waited longer than 18 weeks. The standard is 92%.	85.5%	86.4%	85.4%	83.0%	82.2%	82.1%	82.1%	80.9%	80.0%	80.3%	79.1%	77.8%
18 weeks target: number of open pathways	39186	39314	39508	41535	42287	41833	42155	41800	40383	41230	40172	38890
18 weeks target: patients waiting longer than 52 weeks	2	1	4	2	17	12	7	6	10	9	13	15
Safer staffing: we should be meeting 90% of staffing requirements	101%	104%	105%	104%	103%	101%	102%	105%	103%	103%	104%	n/r
95% of inpatients should receive a VTE assessment	97.3%	93.9%	96.1%	97.3%	96.8%	96.2%	97.3%	97.0%	96.7%	96.9%	97.0%	97.2%
Breastfeeding: ensure the feeding status of 95% of infants is checked within 6-8 weeks after birth	99.0%			100.0%			99.4%			100.0%		
Breastfeeding: ensure that 72.5% of infants are fully or partially breast fed at 6-8 week check	78.7%			79.5%			79.7%			76.9%		
Childhood obesity: ensure that 87% of children in Reception are measured as part of the Government's National Childhood Measurement Programme - Academic year 2018-19	93.3%											
Childhood obesity: ensure that 87% of children in Year 6 are measured - academic year 2018-19	93.1%											
Standardised Hospital Mortality Indicator (SHMI)	0.9713			0.9701	0.958	0.946	0.9303	0.9225	0.9467	0.9357	0.9393	0.9443

Cancer improvements

"We have made many improvements during the past year in the diagnosis and treatment of cancer. As members of the South East London Accountable Cancer Network, we are working with our partners to ensure that we work as efficiently as possible for our patients."

Dr Elizabeth Aitken, Medical Director

Two respiratory doctors with the new EBUS machine

Improving lung cancer diagnosis

Queen Elizabeth Hospital now has a specialist lung cancer diagnosis machine, which means our patients no longer have to travel to Guy's and St Thomas' NHS Trust for the procedure.

The new piece of equipment, an Endobronchial ultrasound (EBUS), is a minimally invasive but highly effective procedure used to diagnose lung cancer and other diseases. The procedure can both diagnose the type of lung cancer and accurately stage the disease.

The EBUS is a small camera with a specialised ultrasound tip, which allows doctors to see the lymph nodes (glands) in the centre of the chest. The physicians are then able to take samples from the lymph nodes and send them to the laboratory to look for any abnormalities.

The Respiratory Team at QEH said: "Having the EBUS ultrasound machine at QEH will greatly improve patient care as well as helping us meet our cancer targets.

"Not only will we be able to diagnose patients in a more timely manner, but our patients will no longer have to travel all the way to Guy's and St Thomas' NHS Trust to undergo the procedure."

The machine cost £250,000 and was funded by the South East London Accountable Cancer Network.

Straight to test

The current national standard is that patients with suspected cancer are seen within 14 days of referral. However, although patients may have an appointment within 14 days, they often wait longer than this for a diagnostic test.

The Trust has been trialling a new process in which patients are given an appointment and test on the same day. Currently this is being piloted for patients with suspected bowel cancer, who receive a call from one of our clinical nurse specialists within 24 hours of referral from a GP. The nurse carries out a phone assessment and, if required, books the patient in for a colonoscopy (a test to check inside the bowels) within two weeks. Currently, half of all patients with suspected bowel cancer have a test within 14 days, which means they receive a diagnosis or reassurance much faster.

A similar process is being piloted with suspected breast cancer and gynaecological cancer patients, who see a consultant and have a test the same day.

Gold standard in cancer biopsies

Last year, we became the first district general hospital in the UK to phase out standard biopsies for prostate cancer (TRUS biopsies) and roll out the gold standard in cancer biopsies – template prostate biopsies.

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

Brook Hospital Cancer Care Fund raised money for a new breast biopsy machine at QEH

New breast biopsy machine

In June 2019, the breast unit at Queen Elizabeth Hospital (QEH) received a donation of £84,710 to fund a breast biopsy machine called the Brevera System.

The money was donated by Brook Hospital Cancer Care Fund, which has been raising money for QEH for 31 years. As well as funding the machine, the money will cover maintenance and running costs over the next five years.

The state-of-the-art Brevera System allows clinicians to perform breast biopsies in just three steps as opposed to the usual eight steps. The machine takes a sample of tissue and creates an x-ray image at the same time – all while the patient is awake. This speeds up the diagnostic process and means that patients don't have to wait so long to find out whether they have cancer.

Surinder Matharu, consultant mammographer at QEH, said: "We cannot thank Betty, Jean and Mary from the Brook Hospital Cancer Care Fund enough for this donation. Breast referrals have increased over the years, which means that the biopsy rate has too. This new machine will help us work more efficiently and patients won't have to wait so long for their results."

Members of the Brook Hospital Cancer Care fund charity have been doing voluntary work at QEH for many years, and the charity has donated money to many important causes. In January 2014 it donated £77,500 towards a specialist X-ray machine for the breast unit, known as a Faxitron.

Betty Rabbit from Brook Hospital Cancer Care fund said: "This is an important cause to us as QEH is our local hospital and we want to help. These kinds of donations would not be possible without the generous contributions we receive from the local community, friends and staff who work at the hospital."

Emergency care improvement programme

"The Trust has made many improvements to emergency care over 2019/20 to ensure that we provide the right care, in the right place, at the right time for patients."

Dr Jim Milton, Divisional Medical Director, QEH Medicine

Same day emergency care (SDEC)

Many patients who present at our Trust's Emergency Departments are now able to access same-day, emergency care without the need for admission.

Dr Jim Milton, Divisional Medical Director, QEH Medicine, said: "We set up a clinical cabinet at QEH to bring together clinical colleagues from different disciplines and services and to lead on improvement plans.

"One the big areas of focus has been introducing Same Day Emergency Care (or SDEC for short) – so, when clinically appropriate, more patients who come to our Emergency Departments (EDs) can be cared for on the same day without the need for admission."

To enable this, we have set up Acute Assessment Units at both our hospitals so that patients with urgent medical and surgical conditions can be seen by a consultant-led team.

This reduces the pressures on our EDs, as a large number of these patients can go home after they've been seen and treated; those that can't will benefit from better continuity of care and stronger specialty based care.

We also have Surgical Assessment Units at both our hospitals where patients with confirmed or suspected surgical conditions can be assessed by a specialist.

HIV testing in ED

For the last year, anyone who has had a blood test as part of their care in the Emergency Department (ED) at University Hospital Lewisham has been screened for HIV as a matter of routine, unless they opt out.

Dr Melanie Rosenvinge, Consultant HIV Specialist, explained: "We have worked with the Elton John AIDS Foundation to trial offering opt-out HIV testing in the Emergency Department at University Hospital Lewisham. We are one of the few Trusts in the country to do this, and we've already been able to diagnose new cases of the virus as a result, so early treatment can be given.

"We're thrilled that this pilot scheme is progressing so well, allowing us to provide our exemplary care to HIV positive patients who were previously unaware of their status at a much earlier, safer stage."

Extended Length of Stay (ELoS)

ELoS is defined as a hospital stay of 21 days or longer. Remaining in hospital longer than necessary is not good for patients and can lead to poor outcomes; it can lead to loss of muscle strength (deconditioning) and increase the risk of falls, fractures and healthcare-associated infections. Long stays can also mean that we don't have enough beds to move patients from the Emergency Department. Many elderly and frail patients become stranded in hospital because they are waiting for suitable care home placements, or because they need specialist care at home. The demand for out of hospital care is significant and this can often cause very long delays.

Every week both our hospitals review patients who have stayed for more than 14 days.

At University Hospital Lewisham, this is led by the flow centre. Darren Foskett, General Manager for the Emergency Department, explains: "Once a review has taken place, I can set clear actions for clinical staff and liaise with social care, local authority and mental health teams to help move on the stranded patients to a more suitable setting. I check the progress daily and run conference calls twice weekly along with an escalation call on Friday." The reviews are already having a dramatic effect. In July 2019, we had 60 patients stranded for more than 100 days, and by December 2019 this had reduced to 17 patients. Darren says: "This has been a team effort and requires considerable support from clinicians, therapists, social care and system partners. It remains one of the top priorities for the Trust."

At Queen Elizabeth Hospital we carry out the ELoS review with system partners and they walk around each ward to make sure that all clinical staff are clear about the next steps. The discharge team is expanding which will help us to reduce the number of patients staying longer than 21 days.

Specialist help for mental health patients

We have seen an increase in the number of patients who present to our emergency departments with mental health problems. To help address this, in January 2019 we opened The Harbour, a brand new mental health crisis café, at University Hospital Lewisham.

The Harbour is a joint venture between our Trust, South London and Maudsley NHS Trust (SLaM) and Certitude, a mental health charity. It provides peer support to people experiencing a mental health crisis, and offers people feeling distressed someone to talk to in a relaxed and calm non-clinical setting. This helps them avoid spending extended time in ED or as an inpatient. It is not a walk-in service but takes hospital and community referrals for those aged 18 and over. The café is open from 2pm to 6am, seven days a week.

At Queen Elizabeth Hospital, the Trust has worked with Oxleas NHS Foundation Trust to set up a mental health suite next to the Urgent Care Centre, so that the high number of mental health patients requiring emergency care can be treated in the right environment. Specialist nurses and therapists from Oxleas staff the area, overseen by consultants from the Emergency Department.

CARRS service takes pressure off ED

Our Health Service Journal Award-nominated Community Acute Rapid Response Service (CARRS) offers home visits to housebound patients who would otherwise need to come to the Emergency Department or be admitted to hospital. It is a collaboration with primary care to identify patients who require multidisciplinary secondary care input whilst remaining in their own home.

The service was piloted during winter 2019 with three partner GP practices and enables housebound patients to be assessed by a specialist nurse from the CARRS team in their own homes, with the support of consultant physicians and geriatricians. Based on the patient's needs, the team would then arrange to either visit the patient again, telephone them or discharge them.

This has resulted in a 7.5% reduction in emergency department attendances for elderly people in our community, whose access to appropriate care is so important. Following the successful pilot, CARRS is now live across the whole of Lewisham.

Sapphire Ward reopening

The Trust secured £600,000 funding from NHSI to reopen Sapphire Ward at University Hospital Lewisham as an elderly care ward to cope with the high demand for these services.

Belinda McCall, Interim Director for Lewisham Medicine and Community, said: "We know that early support for older patients can be a key factor in promoting health and independence, and Sapphire Ward provides high-quality specialist care over the busy winter period."


hello my name is
Chioma

Quality: continually improve safety and quality

"Our Quality Improvement programme encourages and supports front-line staff to make improvements in their own areas. Through this, we aim to embed a culture of continuous improvement to help us meet our vision of providing high-quality care for every patient, every day."

Dr Elizabeth Aitken, Medical Director

Improving Together

In 2018 we launched our "Improving Together" campaign to focus on safety and quality throughout the organisation. Our Quality Improvement and Ward Accreditation programmes are two new projects we launched this year as part of this campaign.

Quality Improvement programme

The Trust's Quality Improvement (Qi) programme, launched in November 2019, is a systematic approach to improvement using a recognised model. It is a "bottom up" approach and recognises that front line staff are best at identifying where things could be done differently and finding the solutions. Qi involves scoping the problem, understanding the current processes and systems, listening to and involving staff and patients in changes, and measuring the impact of the change over time. Our central Qi team helps give staff the tools and skills to make changes needed for patients and colleague.

We want to embed a culture of continuous quality improvement across the organisation, to help us meet our vision of delivering high quality care for every patient, every day. This means empowering all colleagues to make improvements, using an approach that is consistent across the organisation.

Angela Helleur, Chief Nurse, says: "We've seen a huge range of improvements over the last year. Our focus now is on building on this work to meet our vision of getting it right for every patient, every time.

"QI is about supporting continuous improvement, so whatever changes are made are not forgotten about, but become new and improved ways of working.

"This is about empowering our staff, giving them the tools they need to deliver improvements, so we can build on the progress we have made over the last year. Other NHS trusts have been able to deliver significant improvements by training staff in quality improvement methodology, and we are really excited about launching our own programme."

Accreditation programme

In 2019 we introduced a ward accreditation programme, with colleagues visiting our clinical services to look at what we are doing well, and identify where more support is needed to make improvements. The inspections are carried out by senior nursing staff and patient groups using an app, called "Perfect Ward", to rate in a systematic way whether our services are safe, effective, caring, responsive to people's needs, and well led. These aspects are the things that matter most to patients and their families, and are also at the heart of how the Care Quality Commission (CQC) regulates NHS services.

After the inspection, staff go through the findings and create a plan to address any shortcomings in their area, with the aim of receiving accreditation – recognition for providing outstanding patient care.

Technology

Innovation and technology

We have been recognised by the Health Foundation and NHS England and Improvement (NHSE/I) as one of the leading Trusts in the country for introducing new technology to improve patient care. It is particularly impressive for a district general hospital to be named in NHSE/I's forthcoming report on best practice along with much larger specialist and/or teaching hospitals. NHSE/I and the Health Foundation are

particularly impressed with the way our clinical teams have adopted technology including:

- Endocuff – a device that attaches to a colonoscope to maximise viewable mucosa during endoscopic therapy
- HeartFlow – a non-invasive coronary artery test that uses data from a standard CT scan to create personalised 3D models of coronary arteries
- Transfer of Care Around Medicines (TCAM) – a programme that sets up a secure digital platform for discharged patients to access their local community pharmacy
- PReCePT – antenatal administration of magnesium sulphate (MgSO4) to mothers during preterm labour, to reduce the risk of cerebral palsy in neonates.
- Urolift – an innovative and minimally invasive way of treating enlarged prostrate.

Safer prescribing and documentation through iCare

Last year, we introduced electronic prescribing and medicines administration (EPMA) and clinical documentation (clindocs) for adults' inpatients services at both QEH and UHL.

Dr John O'Donohue, Clinical Lead for IT and Associate Medical Director, said: "This was a massive step towards being a paper-light hospital. Electronic prescribing and clindocs make medicine and fluid administration more accurate and safer. Doctors, nurses and other clinical staff can now document their findings and prescriptions on our electronic iCare system so our records are legible, easy to find and available in one place."

Remote speech and language therapy

The children's speech and language therapy team, based at Kaleidoscope, launched a pilot study last summer using teletherapy in primary schools. This means that, rather than the therapist seeing children face to face, he or she can offer assessments and interventions remotely via a computer attached to a TV screen fitted with a 180 degree webcam and speaker.

Dorett Davis, Head of Children's and Young People's Therapies and Allied Health Professional digital Lead, says: "We've found that this is a very efficient way of delivering speech and language therapy. Therapist Angela Whiteley spends one day a week using teletherapy, seeing 10 students during the day, usually in twos and threes. The children, aged between 8 and 11, love the sessions and call them 'Angi on the telly'".

Transforming outpatient services

Our outpatient transformation programme brings together different services and staff from across the Trust to drive through changes and introduce different ways of working, in line with the national NHS long term plan.

We have recently had success in reducing the number of patients not turning up for appointments by introducing a text reminder service. We are also starting to offer more video consultations for services, building on the success of the virtual clinics for cardiology started last year. And we've expanded the use of kiosks in our outpatient clinics, so that patients can sign in when they arrive and don't have to queue.

During the coronavirus pandemic we were able to roll out a video consultation programme called Attend Anywhere. So far, over 30 services and 100 clinicians across the Trust are using the platform, with over 232 consultations being completed on Attend Anywhere in March 2020.

The software allows people to attend their appointment from home on a smartphone or PC via video link. The roll-out of the software has been accelerated by the Trust due to COVID-19, and has enabled clinicians to continue clinics that may have been cancelled otherwise.

Respiratory Physiotherapist, Inge Vermeulen, has been using the platform to continue providing clinics to patients. She said: "Patients have been so pleased that they can still interact with me through video appointments. Correcting a patient's technique is so important in physiotherapy, and using Attend Anywhere has meant I can still do this."

Ensuring treatment in the right place, right person, first time

We've introduced Referral Assessment Services (RAS) in nine specialties – with consultants reviewing referrals made by GPs to ensure patients are seen by the right service – including community and diagnostic services – first time. This can reduce the number of appointments patients need to attend and improves the patient experience.

The participating specialties are cardiology, gynaecology, respiratory, paediatrics, ENT (ear, nose and throat), endocrinology, urology, gastroenterology and haematology.

Surgery improvements

Emergency bowel surgery

Last year the Trust achieved top results for key patient safety measures in the National Emergency Laparotomy Audit (NELA).

Due to the high risk nature of emergency bowel surgery, the target is for 80% of these procedures to be carried out by a consultant surgeon and a consultant anaesthetist, with patients then admitted to intensive care. We managed to perform significantly better in the recent NELA audit, with 96% of all high-risk laparotomies carried out by a consultant surgeon, 93% of these patients looked after by a consultant anaesthetist – and every patient then admitted to intensive care.

Dr Ben Eden-Green, Consultant Anaesthetist, said: "This is a huge improvement on previous years. All involved in the clinical turnaround should be especially proud, as the improvement doesn't stem from extra financial investment, just the application of hard work and co-operation across lots of departments – a real team effort, motivated by improving the quality of patient care."

Planned orthopaedic procedures

The Trust has made major improvements for people having planned orthopaedic procedures such as hip replacements at University Hospital Lewisham. We use our operating theatres more efficiently for planned procedures than any other NHS hospital in south east London. We also provide early rehabilitation support, as well as preparation classes for patients on what to expect – including important advice on recovery from occupational therapists and physiotherapists.

Mr Laurence James, Orthopaedic Consultant and Clinical Lead, said: "All this has reduced the length of stay for hip replacement patients down from five to three days – freeing up beds and improving the patient experience. We are now developing similar plans for elective orthopaedics at QEH."

Stroke rehabilitation

Since we consolidated our inpatient stroke services at University Hospital Lewisham we have seen continuous and steady improvement in the quality of care for both stroke inpatients and the neurovascular (TIA) service over the last five years. We now have the largest acute stroke and rehabilitation unit (50 bedded) in the capital, serving a wide catchment area covering Lewisham, Greenwich, Bexley and some parts of Southwark.

As well as consistently meeting all NHS England (London) quality standards for multi-disciplinary stroke care, we now provide a same-day service for investigations – including brain scans – for patients with definite or probable TIAs.

QEH Critical Care Unit meeting gold standard

Dr Waqas (Vic) Khaliq, Clinical Director of Critical Care: "We've introduced new ways of working at Queen Elizabeth Hospital, which have resulted in us being one of the few Critical Care Units in the country to meet the gold standard for consultant and junior doctor staffing – with similar plans being developed for the University Hospital Lewisham site. We have also been focusing on staff engagement across both sites – including producing a newsletter to share learning, highlight risks and celebrate best practice."

Transforming X-Ray services at UHL

Last year, the Trust invested in three new digital radiography machines at UHL and at the same time re-modelled the whole general X-Ray department, including introducing new changing rooms, separate inpatient and outpatient waiting rooms, facilities for disabled patients, and a dedicated imaging review area for staff.

Aminah Ayinde-Usman, General Radiography Lead in Radiology, said: "It's much better for patients and also for staff. We used to have a five to six week waiting list for GP referrals but this is no longer the case because we have moved to a walk-in service, which allows patients immediate access to the service after a GP has referred them for an X-ray. We've also hugely improved staff retention and it's great to be part of such a motivated team."

Maternity

Better Births

The Trust continues to report a lower than national average rate of brain injury (due to lack of oxygen in labour). This is a one of the outcomes of the National Maternity Review, which is around improving both maternal and neonatal outcomes.

Helen Knower, Director of Midwifery, said: "The improvements have been made possible through joint working between our midwives, obstetricians, consultants and support staff. I'd like to thank everyone, with special praise going to our fetal wellbeing teams.

"We've improved how we share learning across the department, circulating a "tip of the week" and running study days and masterclasses, which includes competency testing everyone who cares for women in labour. We've also introduced safety huddles that can be triggered by midwives as well as consultants when there are causes of concern. The Trust has also installed central monitoring to ensure that the fetal heart traces can be seen by all outside of the room."

Continuity of care

The maternity service has established six continuity teams across Lewisham, Greenwich and Bexley, which enables women to be cared for by a small team of named midwives throughout their pregnancy and birth. Research shows that continuity of carer means that women are more likely to give birth naturally and less likely to experience a pre-term birth.

Upgrading neonatal equipment

In January 2020, the Trust secured funding for four additional Vapotherm machines, which provide respiratory support for newborn babies. This means we will now have eight machines at each hospital, allowing us to provide the best high dependency care.

We also now have reusable umbilical transfusion sets, which are used for blood transfusions when the baby is still in the womb. This ensures we have the best sterile equipment and is far better for the environment than the disposable sets we used to use. In addition, we have invested in reusable breast pump sets with sterilising tanks. This has saved the Trust £12,000 a year and is also better for the environment.

Medical examiners

The new medical examiner system was rolled out to acute trusts in 2019 to provide greater scrutiny of deaths. The Trust has recruited eight medical examiners, senior doctors who verify clinical information on death certificates to ensure appropriate referrals are made to the Coroner and that death certificate content is accurate and consistent.

Medical examiners across England and Wales are responsible for the scrutiny of the documentation and circumstances arising from the majority of deaths.

Understanding why people die is beneficial as it:

- Provides valuable statistics about the health of the nation
- Helps families understand what happened to their loved ones and
- Enables health professionals to improve care for the living.

Medical examiners work closely with families and health professionals to answer questions, address concerns and identify problems with care at an early stage, so that action can be taken to safeguard patients in the future.

Dr Charles Mazhude, the Trust's lead medical examiner, says: "The Trust is one of only three trusts in London to have implemented this system, and the only one achieving 100% scrutiny of adult deaths (before Covid-19)."

Getting it right First Time (GIRFT)

Getting It Right First Time (GIRFT) is a national NHS programme established in 2016 to help improve the quality of medical and clinical care by identifying and reducing unnecessary variations in service and practice. Led by frontline clinicians, it is a partnership between the Royal National Orthopaedic Hospital NHS Trust (RNOH) and NHS Improvement/NHS England (NHSI/E).

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

The Trust is involved in 36 GIRFT workstreams covering various medical and surgical specialties across the Trust. In 2019/20 the Trust received several in depth visits from the national GIRFT team, all of which have resulted in detailed action plans.

During 2019/20, a new monitoring process was established to support the implementation of the GIRFT programme across the Trust. This involved the establishment of the Trust GIRFT steering board, chaired by the Trust Medical Director, to allow clinical and financial releasing benefit opportunities to be identified and achieved from the actions agreed at the deep dive meetings. As part of the new process, quarterly GIRFT reports are provided by the Trust GIRFT Project Manager to the divisions to allow them to monitor and track progress against the action plans. The expectation is for the process to continue until all outstanding actions are completed, so that implementation plans become business as usual with a final sign off from the Trust Board.

Seven day hospital services

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

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

In December 2018, NHSE announced a revised process for assessing compliance with these standards through implementing a self-assessment process that should be signed off at Board level.

The results of the local audit in 2019/20 show that performance has improved at the weekend and that the Trust is now compliant with the standard for 14 hour review (standard 2) at 96% overall.

Standard 8 (ongoing review) demonstrates further improvement when compared to the previous audit of this standard. However, at 87%, compliance is still slightly below the required 90% when reviewed through this audit.

We will continue to work to improve compliance.

Patients: put patients at the heart of everything we do

"This year, we have continued to work in partnership with patients, relatives and carers and used their feedback to make improvements to our services."

Sophie Gayle, Associate Director of Governance and Patient Experience

Listening to patients

As well as receiving feedback through formal routes such as our Patient Advice and Liaison (PALS) and complaints services, the NHS Friends and Family test and informal email and social media, we also introduced a new electronic feedback system in 2019/20. This has enabled us to interact with patients in a more timely way, and be more responsive to the feedback provided. We have held a number of engagement workshops which have covered a range of issues, including our catering, portering, cleaning service and development of our Clinical Strategy.

A number of engagement events were held with former Intensive Care Unit (ICU) patients and carers to support them through the long road to recovery from critical illness. These events are an opportunity for clinicians to gain insight into patients' experiences of critical illness to improve our service for future patients and for patients to share and learn from each other. These events are supported by the ICU Steps charity, which provides helpful educational booklets.

We have implemented our patient stories programme – short videos of patients talking about their experiences (good and bad) – and these are now featured at Trust Board meetings for background information and to inform future decisions.

Improving patient experience

The wealth of feedback we have received has been used to inform a range of improvements including:

- Reorganisation of the antenatal diabetes clinic so that women can be reviewed by an obstetrician and diabetes specialist in one consultation, without the need to come back for a separate appointment.
- Reconfiguration and refurbishment of the radiology department at University Hospital Lewisham, including three new digital radiography machines, and new changing and waiting rooms.
- Implementation of virtual clinics in cardiology, which means patients get the specialist advice they need without the hassle of travelling to hospital
- Continuity of care teams in maternity, enabling women to be cared for by a small team of named midwives throughout pregnancy and birth
- Centralisation of outpatient calls through a single call centre, improving response times.

Working with patient groups

Patient Welfare Forum, University Hospital Lewisham

"The Patient Welfare Forum (PWF) works closely with the Trust's Patient Experience team to introduce improvements across the hospital. Before the Covid-19 outbreak, PWF had completed visits to all wards and outpatient clinics at University Hospital Lewisham to find out what improvements were needed. For example, we raised concerns about waiting times in gastro and ophthalmology clinics and the Trust is now looking at ways to improve this. And we asked the Trust to supply a vacuum cleaner for the Dermatology department to make it easier to clean clinical areas between patients – a small item but one that was much needed.

"Additionally, our members have continued to represent the patient voice at Trust-wide committees, such as patient experience, complaints and catering, and this year PWF members took part in the tender process for new facilities management contracts, as well as the recruitment of senior staff.

"Our PWF ward and clinic visits were suspended during the Covid-19 crisis. We would like to express our complete support for the way the Trust has dealt with this immensely difficult situation – we know that staff are rising to the challenge and will continue to do so."

Patient User Group, Queen Elizabeth Hospital

"The Patient User Group (PUG) appointed a new chair and recruited new members over 2019/20.

"This year PUG members took part in the patient-led assessments of the care environment (PLACE), working with other volunteers and clinicians. The Group also contributed to the consultation on the Trust Clinical Strategy. Members of the Group also attended the Trust Patient Experience Committee.

"The Group carried out a number of structured visits to wards and outpatient services, facilitated by the Patient Experience team, to help the new members gain a better understanding of the role. In 2020/21 the Group will undertake a full programme of visits to all parts of the hospital, including outpatient clinics, emergency department and ambulatory care. We remain committed to working as a 'critical friend' of the Trust."

PALS and complaints

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

During 2019/20 we received 5,607 PALS contacts and 951 formal complaints compared with 6,577 contacts through PALS and 742 formal complaints in 2018/19.

Complaint themes over 2019/20

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

We expect the highest standards of care from all our staff and work hard to listen to patients and put things right at the earliest opportunity. Learning from complaints is shared with teams involved locally and discussed monthly at a divisional level. Any actions identified are shared between different teams to ensure that we are sharing good practice. We also work with complainants to produce patient story videos for sharing with our Trust Board and staff.

We also use the learning from complaints, along with all the other feedback we receive from patients, to implement changes in practice or process throughout our services.

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

"Our staff have spent months on the front line of one of the greatest threats ever faced by the world and by the NHS – coronavirus. The way they have dealt with this devastating pandemic has been truly inspiring and humbling."

Meera Nair, Chief People Officer

Coronavirus

The pandemic has affected ways of working for staff in all areas of the Trust, requiring all of us to be flexible, calm, resourceful and brave in what has been an evolving and unnerving situation. Sadly, at the time of writing, two members of staff had died after being diagnosed with Covid-19. This is an absolute tragedy for all of us and our thoughts are with their friends, families and colleagues. We have set up a fundraising page to support the families of colleagues who have died and a memorial event is scheduled for October 2020.

Celebrating our staff

Broadcaster Richard Bacon joined hundreds of Lewisham and Greenwich NHS Trust staff on Tuesday 3 March to host the Trust's annual Staff Awards ceremony at the InterContinental London at the O2.

In a powerful moment, the final trophy for Inspirational Leader was awarded to Waqas 'Vic' Khaliq, the Intensive Care Consultant who had provided life-saving treatment to Richard in summer 2018, when Richard fell ill with a double chest infection. Vic was unable to attend the awards ceremony because he was so busy at work – so Richard went straight to Queen Elizabeth Hospital (QEH) after the ceremony to hand him his Inspirational Leader of the Year award in person.

Richard said: "These awards were inspiring, and I was so touched to thank all the healthcare heroes at Lewisham and Greenwich NHS Trust who go the extra mile for patients every day. Of course, I have a personal connection to the Trust, and it was wonderful to announce Vic as the winner of the Inspirational Leader Award, the big award at the end of the night. He's also the consultant who saved my life.

"He is such a modest man, and when I thanked him previously he just said "that's what we do". It was great to thank him in person for all his amazing work. People like Vic show why we should be proud of the NHS."

As well as working as a busy medical consultant, Vic has been promoted to Head of Critical Care and was nominated for the Inspirational Leader Award by members of his team at University Hospital Lewisham and Queen Elizabeth Hospital – for his role in supporting colleagues to provide the best care for critically ill patients.

The awards saw nurses, doctors, porters, security officers and more crowned winners in 13 different categories.

The awards ceremony was generously sponsored by our partners: Abbey Travel, Meridian Hospital Company, ISS, G4S, Capsticks, CIS Security, Omni, Tusker, Ravensbourne Health Services, ResourceBank and Vinci.

Recruitment

We have continued our recruitment drive over 2019/20 and succeeded in reducing the vacancy rate from nearly 15% in April 2019 to 9.98% in March 2020, which means we've already met our target of achieving 10% by March 2021. This has been possible through sustained engagement from leaders across the trust, and successful recruitment campaigns in the UK and overseas.

We have also made steady improvements in processes, resulting in a marked increase in satisfaction from recruiting managers and candidates as well as improved timescales to complete recruitment and employment checks.

Clinical leadership

In 2018/19, we carried out a divisional restructure and invested in more leadership posts to make sure that we are clinically led as an organisation, and fully able to focus on the challenges that we face.

Dr Elizabeth Aitken, Medical Director, said: "I host regular drop-in sessions for junior doctors, and we have also developed programmes to support staff in leadership roles. As part of the programme, we've provided additional training and development opportunities, such as a regular development day for all new consultants, and a new Clinical Directors' induction programme. We were pleased to see that, in our recent medical engagement survey, 72% of consultants said that they feel engaged with the Trust, compared with 52% the previous year.

"We've introduced a number of initiatives to support nursing staff across the Trust, such as our career clinics to make it easier for nursing staff to move within the organisation without having to go through the recruitment process. Last year, we were awarded the CapitalNurse Preceptorship Quality Mark, which means that our newly qualified nurses and midwives are well supported to develop their skills and feel valued during their first year of work."

New roles at the Trust

Physician associates

The Trust has been quick to adopt new roles in the NHS, and we are one of the largest employers in the country of physician associates – one of the fastest growing healthcare professions in the UK.

Physician associates are graduates who have undergone intense training to gain key medical skills. They work alongside our medical and surgical teams to support patient care. They play a key role in engaging with families and patients and helping smooth the patient's journey from admission to discharge. Their roles are constantly evolving and they allow consistency and continuity of care.

Nursing associates

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

In December 2018 our first group of apprentice nursing associates started work on the wards, having begun their university studies in November.

On Wednesday 4 December 2019, the Trust held a graduation ceremony to celebrate our apprentices who have completed their first apprenticeship programmes – 24 staff spanning business administration, healthcare support work, pharmacy services and health visiting achieved qualifications.

Apprentice Nursing Associate Rosemary Doughan said: "I am loving being an apprentice nursing associate. It has been a real journey already, and it's improving all the time as people learn more about our role. I have been on some amazing placements, both ward based and in the community, and I've learnt so much. I am now at QEH on Ward 2. It's busy, so you need to be really focussed, but the staff are so supportive, they really listen and I can go to them with anything I need to ask."

Fay Blackwood, Associate Director of Education and Development, said: "It's important to remember that an apprentice is not necessarily young, or doing a 'little' job – they are skilled people making a really significant contribution to our Trust."

Flexible working

The Trust is committed to supporting flexible working and making Lewisham and Greenwich NHS Trust a great place to work for everyone. Our Flexible Working Group has around 30 members of staff from across the Trust, who have acted as champions of flexible working. After a focused programme of work in collaboration with Timewise, a social enterprise company that works with government and other public service organisations to promote flexible working, we have become Timewise Accredited – only the second NHS Trust to do so.

The programme supported the roll-out of a range of initiatives, including:

- self-rostering to help frontline staff achieve a better work life balance
- encouraging managers to consider flexible working to improve the chances of recruiting to hard-to-fill posts
- a guide to support managers and employees in improving flexible working while managing service demands.

The results of the 2019 staff survey show improvements in perception of how well the Trust supports flexible working.

NHS staff survey

All NHS organisations take part in the national NHS staff survey. The 2019 survey was carried out between September and November 2019 and the results were published in February 2020. Our response rate to the survey increased markedly from 36% last year to 46%, a sign of increased levels of engagement within the trust.

The survey analysed responses across 11 themes and showed a number of improvements when compared to results from our 2018 survey:

The key highlights were:

- Improved response rates amongst nurses and doctors compared to the national average, and when compared to 2018
- Improvements in perceptions regarding quality of appraisals, and most particularly that values were discussed as part of the process
- Improvement in staff perception of being able to deliver the care they aspire to provide, as well as being able to recommend the trust as a place to work
- Improvements in perceptions of bullying/harassment from managers and colleagues, but worsening in experience of bullying/harassment towards staff from patients. This is particularly so for BAME staff
- Small improvements in perceptions of violence/aggression from managers and colleagues, but significant worsening in experience from patients
- Improvement in levels of confidence with the incident reporting processes

Meera Nair, Chief People Officer, said: "These survey results give us really important feedback to help us make the Trust a great place to work for all staff. For example, we launched our Respect and Compassion programme in response to feedback in previous staff surveys. The latest survey shows that the work we are doing is having an impact. It is important that we sustain this work and respond to the feedback that we receive from our staff."

There is a detailed programme of work that will be taken forward in 2020/21 to address areas of concern as well as cement improvements that have been made.

Respect and Compassion programme

Previous staff surveys showed a higher than average number of staff reporting bullying and harassment, and we commissioned and published an independent report into this issue in December 2018. The report gave us clear recommendations on what we need to do to ensure that all members of staff are treated in the right way. Since it was published, we've been working with colleagues to put our action plan in place.

We set up our Respect and Compassion Programme in 2019 to create a compassionate and respectful culture for all our colleagues and patients.

We set up a monthly programme board, chaired by the Chief Executive, to oversee our action plan on making sure that colleagues are treated fairly and with respect. We also set up an oversight panel to hold us to account on this work. Following engagement with staff-side (trade union) colleagues and with the Trust's equality, diversity and inclusion (EDI) network, we appointed Roger Kline and Sir Steve Bullock to act as joint chair to this group.

Roger Kline is a research fellow from Middlesex University who specialises in diversity, inclusion and tackling bullying. Sir Steve Bullock has played a major role in the local community over the last four decades, and served as Mayor of the Borough of Lewisham for 16 years.

Through this programme, we have reviewed our arrangements to support staff in speaking up on issues of concern, and improved our approach to the health and wellbeing of our workforce. We have reviewed cases where staff reported bullying and harassment and published details to provide assurance that the trust addresses instances of misconduct. We have also reviewed employee relations processes to improve timeliness and quality.

Improving diversity and inclusion

The equality, diversity and inclusion (EDI) network was set up in 2017 to support the Trust in promoting, delivering and embedding EDI in the everyday work of the Trust.

In 2019 we launched the NHS Rainbow Badge Campaign across the Trust. Wearing the badge shows patients that we offer open, non-judgemental and inclusive care for all who identify as LGBT+ (lesbian, gay, bisexual, transgender, the + simply means inclusive of all identities, regardless of how people define themselves).

The campaign won in the Respect and Compassion category at the 2019/20 Staff Awards and to date over 1,000 staff have signed their pledges and are wearing their badge. In February 2020 we also launched our new LGBT+ network.

Our Black, Asian and Minority Ethnic (BAME) network also launched in 2019 with a focus on Black History Month.

We have improved our representation of BAME staff in senior roles, and were ahead of the NHSI Workforce Race Equality Standard (WRES) Aspirational Goals for 2019/20. We also reduced the likelihood of BAME staff entering formal disciplinary processes from 3.09 to 1.24, where the ideal score is 1.

However, we recognise the challenges that remain in relation to equality, diversity and inclusion, and creating inclusive workplaces is a key pillar of our workforce strategy. We will be working with the various networks to make improvements in the year ahead, including in our recruitment processes and in developing coaching programmes to support under-represented groups.

Embedding our values

In June 2019, after a Trust-wide engagement programme to agree our values, we launched a training programme to embed those values within the organisation and support our staff in displaying the Trust's values at all times. Over 4,000 staff in leadership roles across the Trust have completed the programme since its launch, with overwhelmingly positive feedback. Our staff also increasingly felt that values were discussed as part of the appraisal and development review process, a sign that our values are becoming embedded within the Trust.

In summer 2019, we also launched our Employee of the Month awards to help us celebrate great work. We have been receiving around 30 nominations a month and have heard many examples of staff going the extra mile.

Freedom to Speak up Guardians

We are fully committed to supporting anyone who speaks up and raises concerns. In 2017 we appointed seven Freedom to Speak up Guardians, who were independent of the Trust but had worked here in the past. Over the course of the year, the guardians supported 62 members of staff with the concerns that they wished to raise.

Based on feedback from staff, we have reviewed the service and in June 2020 began working with The Guardian Service, an independent service offering confidential support to staff who wish to raise concerns.

Partnership: work effectively with partners

"Being part of the South East London Integrated Care System (ICS) means that we can share expertise, make best use of resources and provide more coordinated care for our patients."

Jim Lusby, Director of Integrated Care

The Trust is now part of the South East London Integrated Care System (ICS), the first ICS to be created in London. It includes six clinical commissioning groups (CCGs), six local authorities and five provider trusts, serving a diverse population of around two million. Their ambition is to "to deliver a clinically and financially sustainable system for the future and address health inequalities in south east London".

The priorities of the ICS are:

- Integrated community based care
- Reduce pressure on urgent and emergency care
- Improve planned care outcomes and performance
- Deliver better outcomes for major health conditions
- Deliver financial savings and achieve agreed financial targets

These shared priorities are reflected in our clinical strategy.

We work closely with our system partners across the ICS in a number of different ways. We are members of local health and care partnership boards in Bexley, Greenwich and Lewisham, where we work together to identify local priorities and jointly plan how to address them. We collaborate with other providers across south east London to align strategy, share good practice, and build resilience in fragile services by making the best use of scarce resources.

We are building alliances with other healthcare providers to integrate services around patients and address any gaps in provision. For example, south east London community providers have been collaborating to agree a shared strategy for south east London adult community services. We increasingly try to address workforce shortages across wider geographical areas by using joint appointments and staff rotations to make roles more attractive.

Clinical networks

The Trust is involved in several clinical networks in south east London alongside Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. The aim is to develop common pathways, share knowledge, improve quality and ensure consistency of care. This involves some joint appointments – ie specialist clinicians who work across the three providers. Each network meets regularly to discuss progress and future plans.

The clinical networks include:

- SEL Elective Orthopaedic Network (SELEON)
- SEL Urology Network (SELUN)
- SEL Dermatology Network (SELDN)
- SEL Plastics Network (SELPN)
- SEL Bariatric Network (SELBN)
- SEL Endoscopy Network (SELEN)
- Accountable Cancer Network (ACN)
- SEL Diagnostic and Imaging
- Vascular Network
- Trauma Network
- Paediatrics

Developing an NHS pathology partnership in London

The Trust has been working with Barts Health NHS Trust and Homerton University NHS Foundation Trust to develop a pathology network across south east and east London.

All NHS Trusts are required to form pathology partnerships to improve the quality of services, speed up response times and achieve efficiencies.

Our partnership with Barts and Homerton will keep local pathology services in the NHS, whereas it would have been necessary to work with the private sector if we had chosen to join a partnership with neighbouring trusts in south east London.

The outline business case to form a partnership has now been approved by our board and by the boards of Barts and Homerton. The next step is developing a full business case. After this has been approved, the services will start to transition to a partnership.

Our clinical teams are involved in developing the operating model for the partnership, and all three organisations have agreed in principle to be equal partners in developing the network, working together to share information.

Once it has been developed, the partnership will give staff more development opportunities and access to the latest technology. It is expected that the transition to the final model will take around four years. Amongst other things, work is required to integrate the IT systems, assess equipment and staffing capacity, and increase the frequency of transport between the sites.

Soft facilities management

In early 2019 we began a tendering process for our non clinical 'soft facilities management' (soft FM) services– ie portering, cleaning, catering, pest control, helpdesk and switchboard, post room, waste and linen services.

For many years we'd had two different contracts for these services at each of our hospitals but decided to consolidate this into one contract in order to standardise services and introduce improvements. A number of staff with expertise in particular areas – including matrons, clinical leads and ward managers – were involved in the tendering process, as well as members of the public.

As part of the tendering process, we asked companies bidding for the contract to look at moving staff to a minimum of £10.55 an hour. This figure was chosen as it is equivalent to the current London Living Wage. Going forward, we have made a commitment that the salaries of soft FM staff will go up in line with the annual NHS pay increase. If there are additional increases to the London Living Wage on top of that, a decision on whether we can continue to meet the London Living Wage will be made by Board of Lewisham and Greenwich NHS Trust.

In November 2019, the contract was awarded to ISS, which was already providing services at Queen Elizabeth Hospital. The new contract began in February 2020. Staff who worked at our previous provide for UHL, Interserve, were transferred over to ISS.

ISS will be setting up a training academy for their staff at Lewisham and Greenwich NHS Trust. Staff will be offered enhanced training and development opportunities through the academy.

ISS will be investing £4 million to make the following improvements:

- New catering and housekeeping equipment
- More wheelchairs for patients
- Refurbishing the restaurant at QEH – in response to staff and patient feedback
- Better technology such as touchscreens on our wards to make it easier for staff to call for porters and cleaners when needed
- Consistent levels of services across all our sites
- Improved waste management including more recycling
- Improved out-of-hours food services for staff
- Specialist equipment (HPV and UV machines) to support infection control.

Renal dialysis unit

In 2019, the Trust opened a state-of-the-art renal dialysis unit at University Hospital Lewisham, working in partnership with Guy's and St Thomas' Hospital (GSTT). Previously, GSTT, which runs the renal dialysis service along with specialist providers Diaverum, provided dialysis at a satellite unit in Forest Hill.

The new unit has 20 dialysis stations, five more than its predecessor, and includes two rooms dedicated to inpatient haemodialysis. This means that inpatients at University Hospital Lewisham who need dialysis no longer have to be transferred to Guy's Hospital, a round trip that could take up to eight hours.

The new unit is modern, spacious and more comfortable for patients. It is staffed by the same team and operates the same opening hours as the Forest Hill centre. It can treat a maximum of 120 patients on three shifts – mornings, afternoons and evenings.

Dr Elizabeth Aitken, Medical Director for Lewisham and Greenwich NHS Trust, said: "This is partnership working at its very best. This new renal dialysis centre will bring huge benefits to local residents who need regular dialysis.

"The new centre will also improve the experience of our hospital patients who require dialysis as they will no longer need to be transferred offsite. This will mean rehabilitation treatment will not be interrupted, enabling them to recover faster."

Research

The Trust has continued its research activities in 2019/20 and has seen a remarkable increase in its research portfolio. Several multidisciplinary health care professionals working at the Trust have been active participants in research activities, and the Trust attracted £818,000 in research funding this year.

The Trust is a member of the South London Clinical Research Network and has successfully recruited 1,352 subjects to a wide range of National Institute of Health Research (NIHR) registered research trials. There are currently 92 research studies to which recruitment is open and a further 53 studies where follow up data is being collected.

The Trust was also successful this year in securing three Greenshoots grants to enable our staff to develop their skills as principal investigators.

Money: Ensure we spend every penny wisely

"We worked hard to reduce our deficit in 2019/20, and I'm pleased to report that we achieved our target, continuing our recent positive trend. For 2020/21 we plan to break even; this marks the start of a sustainable financial position, which we will work hard to maintain."

Spencer Prosser, Chief Finance Officer

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

In 2019/20, we effectively achieved our key financial targets in terms of our control total, external financing limit and capital resource limit. The year-end adjusted deficit position of £15m is £1.1m away from the control total plan of £13.9m. This is due to the cost of staff delaying annual leave into the new financial year because of Covid-19, which will incur extra costs due to reduced output and having to backfill shifts. This adjustment has been recognised by NHSE/I and, as such, the Trust still receives the Provider Support Funding and Financial Recovery Funding payable for achievement on financial targets. Most importantly, the adjusted deficit of £15m is an improvement of £15.6m on the £30.6m achieved last year.

The improvement was due, in large part, to additional provider sustainability funding from the Department of Health and Social Care (DHSC) for improved performance.

Together with the initiatives introduced to improve our productivity, £19m of savings were delivered in the financial year.

Next year we have agreed a breakeven plan. Building on our performance last year, we will not only continue to deliver improvements in our finances, but also invest in our services to support our long term recovery. This includes investing in diagnostics, the imaging IT system, quality improvement processes and our pathology network in order to transform our services and ensure they are fit for the future.

Going concern

Under accounting rules, organisations are required to report that they are able to continue for the foreseeable future in broadly the same form as at present. Doing so means that, in accounting terms, the organisation is a "going concern". The Board has reported that the Trust is a going concern (with no plans for any substantial changes to services). The auditors will also be reporting to the Secretary of State that the Trust met its financial targets in 2019/20.

Sustainability report

Reducing our carbon footprint

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

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

The NHS has restated its commitment to the carbon targets in the UK government Climate Change Act (2008), reducing carbon emissions (on a 1990 baseline), by:

- 34% by 2020
- 51% by 2025

Sustainable development management plan

One way that an organisation can embed sustainability is to use a sustainable development management plan (SDMP). The Trust is currently working with the London boroughs of Lewisham and Greenwich, as well as external consultancies, to develop an SDMP. This plan will set out the Trust's approach to becoming net carbon zero by 2030 in line with the goals of the London boroughs of Lewisham and Greenwich.

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

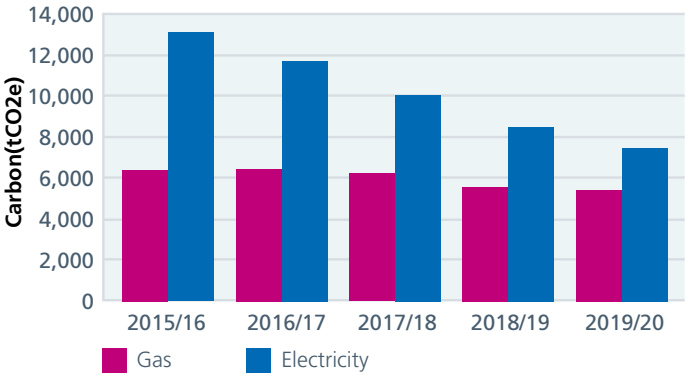
Climate change brings new challenges to our business both in direct effects to our buildings, facilities and land, but also to patient health. Examples in recent years include the effects of heatwaves, extreme temperatures and prolonged periods of cold, floods, droughts etc. As an organisation we have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

Energy use over 2019/20

Lewisham and Greenwich NHS Trust spent £4,572,091 on energy in 2019/20, which is 14% higher than we spent on energy last year. However, at the same time we reduced carbon emissions by 7% from 2018/19. This is because the proportion of coal-powered generation has decreased significantly while the proportion of nuclear and renewable generation has increased.

Carbon(tCO2e)	Gas	Electricity
2015/16	6,443	13,143
2016/17	6,457	11,766
2017/18	6,250	10,078
2018/19	5,607	8,514
2019/20	5,569	7,559

Carbon emissions



Travel

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

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

Planning for the future

Caring for our communities

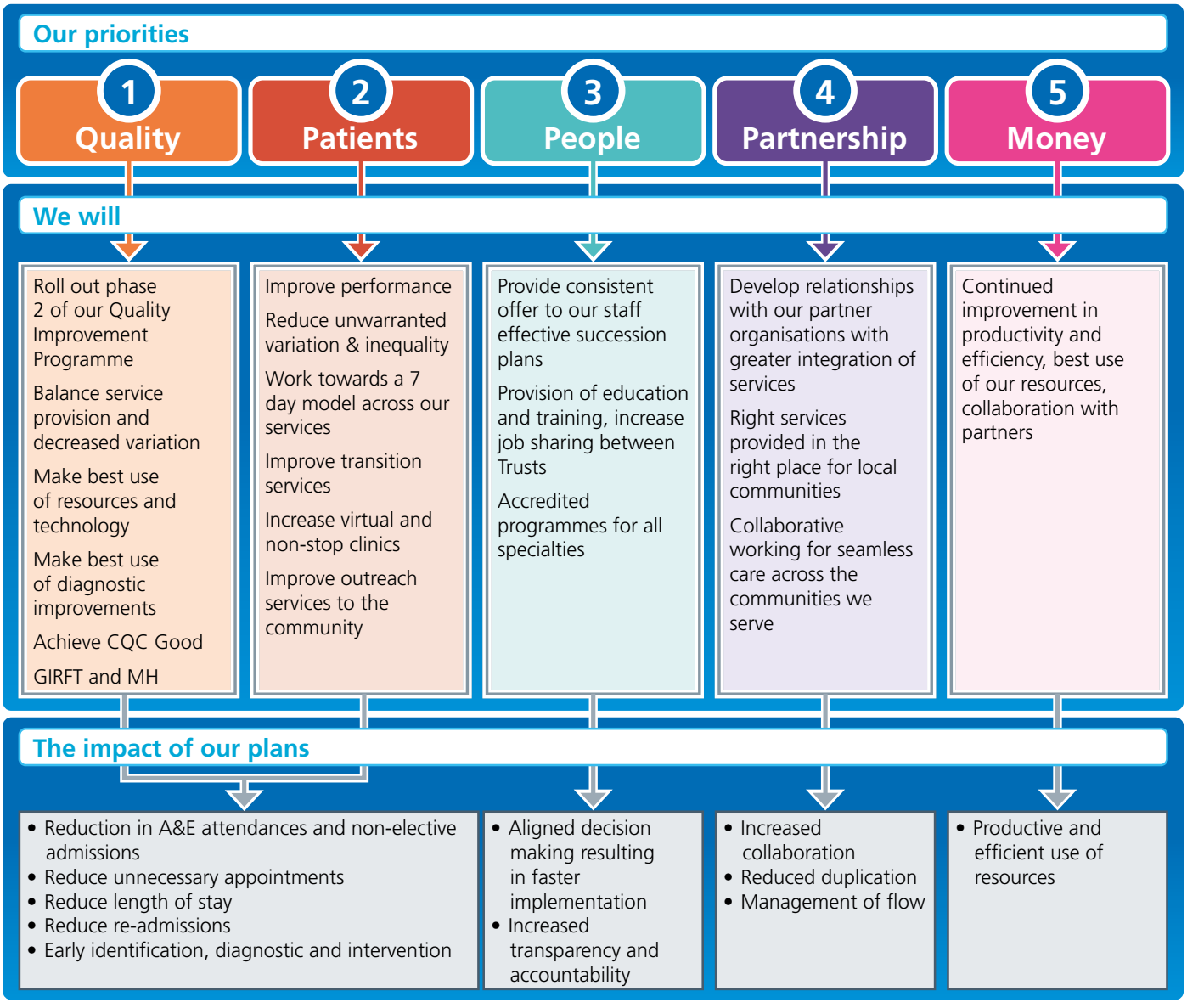
In February 2020, we published "Caring for our Communities", a five-year strategy for providing high-quality, best value care. The document, which you can read on our website (www.lewishamandgreenwich.nhs.uk), sets out our vision of where we see ourselves in 2025 and our ambitions for continuous improvement.

We are clear that we want to provide the best quality local care to the people of Bexley, Greenwich and Lewisham. We will continue to develop strong partnerships and alliances with our system partners and provide increasingly personalised models of care to meet the health and care needs of our local population. The ongoing dedication and commitment of our staff will be crucial to our success.

We take pride in all our services, whether provided in hospital or in the community, and are committed to working with our partners in primary care, mental health, social care and the voluntary sector. Similarly we will forge ever stronger partnerships with our neighbouring acute providers, particularly where it makes sense for patients that we develop strong clinical networks.

We have engaged extensively with our teams, partners and local people during the development of this strategy and will continue to do so. We will use the strategy as a launchpad to explore new ways of engaging with our communities and welcome all views and contributions. This is a strategy for the people of Bexley, Greenwich and Lewisham and we are proud to serve them.

Overview of our strategy



Accountability report

Directors' report

Role of the Trust Board

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

Trust Board members

Members of the Trust Board during 2019/20 are listed below.

Voting

Ms Val Davison, Trust Chair
Mr John Ballard, non-executive director (up to September 2019)
Mr Harry Bright, non-executive director
Ms Sarah Higgins, associate non-executive director
Ms Sukhvinder Kaur-Stubbs, non-executive director
Ms Binka Layton, non-executive director
Dr Julia Mundy, non-executive director
Prof I Norman, non-executive director (from June 2019)
Ms Katherine Yeung, non-executive director
Dr Elizabeth Aitken, Medical Director
Mr Ben Travis, Chief Executive
Ms Angela Helleur, Chief Nurse
Ms Meera Nair, Chief People Officer (from August 2019)
Mr Seb Nai, Interim Chief Financial Officer (up to July 2019)
Mr Spencer Prosser, Chief Financial Officer (from August 2019)

Non-voting

Ms Kate Anderson, Director of Corporate Affairs
Ms Rachael Backler, Director of Performance (from December 2019)
Mr Keith Howard, Director of Estates, Facilities and Redevelopment
Mr Nigel Kee, Interim Chief Operating Officer (to July 2019)
Mr Jim Lusby, Director of Strategy and Integrated Care
Ms Lynn Saunders, Director of Strategy, Business and Communications (to August 2019)
Ms Suzanne Wills, Chief Operating Officer (from January 2020)

How the Board is appraised

The Chief Executive is appraised by the Chair who also appraises the non-executive directors. An independent director reviews the Chair's personal appraisal and the Chair is appraised by NHS Improvement. The Chief Executive appraises the executive members of the Board.

Audit committees

A range of committees report directly to the Board and are chaired by non-executive directors. These include the audit and risk committee, which meets five times a year and approves the annual accounts and annual report. Over 2019/20, membership of the audit committee included:

- Binka Layton, Committee Chair
- John Ballard (up to September 2019)
- Katherine Yeung

The other Board committees are the Finance and Performance Committee, Remuneration Committee, Workforce and Education committee, Strategic Projects Committee and Quality Governance Committee.

Details of company directorships and other significant interests

The register of interests for Board members is in the table below, as of April 2020:

Name	Declaration
Dr Elizabeth Aitken	Nil
Ms Kate Anderson	Nil
Ms Rachael Backler	Nil
Mr Harry Bright	Director, Dartford Cricket Club Ltd Director, Hesketh Park Sports Club Ltd
Ms Val Davison	Director of Dulwich Consulting Ltd Undertakes consultancy for NHS organisations and organisations doing business with the NHS. Chair Youth First, a community interest company providing youth services primarily in Lewisham. NHS Providers – provision of occasional facilitation support for events
Ms Angela Helleur	Various clinical negligence and litigation teams Expert witness midwifery No formal connection but undertakes services as an independent expert witness in an advisory role. Member, Kings Fund Council Associate Governor, Torridon Primary School
Ms Sarah Higgins	Nil
Mr Keith Howard	Nil
Ms Sukhvinder Kaur-Stubbs	MD of Engage – Us Ltd NED, Chair of Quality Governance, GP Care Group Tower Hamlets NED, Chair of Regeneration, London Legacy Development Corporation CEO of Advice Lewisham Partnership & Citizens Advice Lewisham
Ms Binka Layton	Nil
Mr Jim Lusby	Nil
Dr Julia Mundy	Employee, University of Greenwich Independent member, Audit & Risk Committee, UK Statistics Authority. Member, Financial Services Consumer Panel (from 1 November)
Ms Meera Nair	Trustee, The Maya Centre
Prof. Ian Norman	Trustee, Florence Nightingale Museum
Mr Spencer Prosser	Nil
Mr Ben Travis	Nil
Ms Suzanne Wills	Nil
Ms Katherine Yeung	Nil

Information governance and data security

Information governance (IG) refers to the way in which the NHS handles all data in a secure and confidential manner – in particular the personal and sensitive data of patients and employees.

Effective information governance is about ensuring that personal confidential data is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

Every year the Trust is required to submit an annual data security and protection toolkit assessment (DSPT). This is an online self-assessment which allows NHS and other related organisations to demonstrate whether they are compliant in data security and data protection standards. The new Data Security and Protection Toolkit came into force in July 2018 and the Trust is required to upload evidence to support this assessment. The new toolkit gives the auditors, who review the toolkit, extra powers to ensure the Trust is compliant with the standards.

Like all NHS Organisations in England and Wales, the Trust is required to submit the mandatory Data Protection Toolkit self-assessment to the Department of Health, the Information Commissioner's Office and the Care Quality Commission. This Data Security and Protection Toolkit (DSPT) is in its second year and the standards have been almost the same, except for Data Security Standard 1, which has been changed.

The 10 standards are:

Data Security Standard 1	All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.
Data Security Standard 2	All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.
Data Security Standard 3	All staff complete appropriate annual data security training and pass a mandatory test, linked to the revised Information Governance Toolkit.
Data Security Standard 4	Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals.
Data Security Standard 5	Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.
Data Security Standard 6	Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.
Data Security Standard 7	A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.
Data Security Standard 8	No unsupported operating systems, software or internet browsers are used within the IT estate.
Data Security Standard 9	A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.
Data Security Standard 10	IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

Information governance incidents for 2019/20

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

Also for 2019/20, IG training at the Trust will focus on incidents as well as the legalities of information governance. The number of incidents for the period is 137, an increase of 26 from the previous year. The breakdown of the incidents is as follows:

Corruption or inability to recover electronic data	1
Disclosed in error	40
Other information governance	48
Unauthorised access/disclosure	10
Lost or stolen hardware	4
Lost or stolen paperwork	3
Non-secure disposal of paperwork	1
Non-secure disposal of hardware	5
Lost or stolen paperwork	5
Technical security failings (including hacking)	1
Fax/email transmitted to incorrect destination	10
Disclosure via social media	10
Cyber incident	1
Total	**137**

Statement of Chief Executive's and Directors' responsibilities

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

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

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

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

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

Ben Travis, Chief Executive
June 2020

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, other items of comprehensive income 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; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 Trust's performance, business model and strategy

By order of the Board

Ben Travis, Chief Executive
June 2020

Spencer Prosser, Chief Financial Officer
June 2020

Governance statement signed by accountable officer

1. Scope of responsibility

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

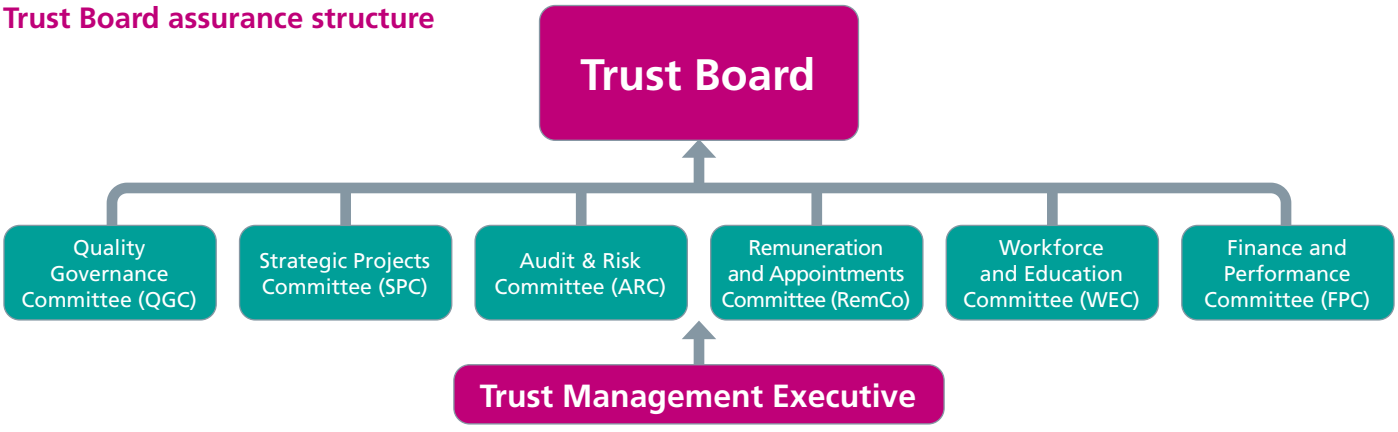
I report to the Chair of the Trust and ensure appropriate systems exist to support the work of the Trust and the Board. I manage the executive team who have clear accountabilities and annual objectives, drawn from the annual operating plan for the Trust which sets out our approach to planning and the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

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Trust Board assurance structure



Key | Trust Board sub-committees

3. The governance framework of the organisation

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

4. The Trust Board

The Trust Board consists of five voting executive directors, eight voting non-executive directors (including the Chair), one non-voting associated non-executive director and three non-voting executive directors. The Trust Board meets ten times a year in public, with minutes and papers available on the Trust's website. The Board also meets four times a year for 'Board Seminars', and twice a year for "Board Away Days". During the 2019/20 period there were a number of changes to the Executive team. These changes included the appointment of a new Chief People Officer, Chief Financial Officer, Chief Operating Officer and Director of Performance. In addition, there is currently a NED vacancy on the Board which was advertised in February 2020 with an appointment made in April 2020. In December 2020 the Trust appointed two of its existing Non-Executive Directors to be the Trust Vice Chair, and the Trust's Senior Independent Director.

Noting a significant level of recruitment to Executive Director roles during 2019/20, attendance at Trust Board meetings by Board members remained consistently high. I am confident that the Executive Team and Board members were suitably engaged and informed in both Board and Trust management throughout the period.

In 2018 the effectiveness of the Board was considered as part of the CQC's 'Well Led' assessment. A further CQC well led assessment was undertaken in March 2020. The results of this latest inspection are yet to be published.

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

Summary of Public Board Activity and points of note

During the 2019/20 period, the Board met ten times in public as set out within the Trust's Corporate Governance Manual. Standing items include a report from the Chair, summaries from the monthly board committee meetings, workforce, financial and performance reports, the Board assurance framework, Corporate Risk Registers, Board visit reports, a report from the Trust Chair and my report as Chief Executive Officer. Throughout 2019/20, the Board routinely received reports from its Committees, as well as those reports that it is required to review by legislation or national guidance. The Board agenda also regularly included a patient or staff story, presentations or reports about clinical work in the Trust, and reports relating to patient safety and quality including the CQC Inspection Report and resulting action plan.

The Board regularly discussed the changing local operational picture noting developments in the South East London Sustainability and Transformation Partnership and Integrated Care System, current capacity issues and planning for winter pressures. The Board's programme of visibility visits – which has involved Board Members visiting and observing clinical areas – was also revised to ensure board members visit a different area each financial year. Working in pairs, Non-Executive and Executive Directors have adopted divisions for a twelve-month period, spending time visiting different areas of the hospital, to understand the challenges faced by each area, and taking part in quality assessments and environmental audits.

During 2019/20, the Board has considered input from a range of stakeholders including:

- **Patients:** via the Trust's Annual General Meeting and Question and Answer sessions before each Board meeting. The Trust also engages with patient groups – including Healthwatch, the Patient Welfare Forum and the Patient User Group – through the Patient Experience Committee. Public engagement activities have been undertaken with patients, the public and Trust membership on key topics such as the development of the Trust's clinical strategy.
- **Public/voluntary sector:** Several of the Board Committees (The Workforce and Education, Strategic Projects and Quality Governance Committees) include lay members within their membership. A further campaign to identify lay members for the Finance and Performance and Audit and Risk Committees will be undertake in 2020/21. In addition, the Trust has hosted information stalls at community events across the boroughs of Lewisham and Greenwich, and organised membership events, including patient workshops (on topics such as developing the Trust's values and improving facilities management). The Trust has also undertaken wider public surveys to influence key workstreams, including the development of the organisation's values.

- **Staff:** The Board is informed of staff views through reporting from Staff Surveys, the Staff Friends and Family test, by members of the Trust management teams, Board walkabouts and visibility visits and by the discussions held during the monthly Trust Joint Partnership Board. The Trust also holds regular staff feedback and engagement events with members of the Executive Team.
- **GPs and clinical commissioners:** The views of provider and commissioner GPs are of key importance to the Board. The Trust engages with GP commissioning, provider and educational leads in a number of ways to ensure it responds to the needs of our local population and to the views and expectations of those responsible for commissioning services for them. In practice these relationships are maintained through daily dialogue, as well as more formal interaction with the CCG Governing Body. The Trust is engaged in the development of place-based governance at borough level as part of the ongoing development of an Integrated Care System across South East London – the first to be authorized in the capital. Increasingly this will provide the framework through which partnerships will evolve and be strengthened between the Trust and local GPs as well as with other providers.

In 2019/20 the membership for Board committees was reviewed and updated.

The remit, membership and Terms of Reference for all Board Committees will be included in the annual Board Committee reports to Trust Board which are due in Spring 2020.

The Board receives a written summary report from each Committee Chair at the following public board meeting.

5. Risk assessment

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

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

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

- The Audit and Risk Committee and Trust Board receive details of significant risks through regular presentation of the Corporate Risk Register and Board Assurance Framework.
- All Board Committees review the corporate risks related to their Committees on a monthly basis. The risk registers for Board Committees have recently been reviewed to ensure consistent reporting and provide more narrative on the risks and mitigations.

The Board will also identify risk through its review of the reports received from the Board Committees and any self-assessment exercise required for regulators or commissioners of service.

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

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

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

The Trust's Raising Concerns (Whistle-blowing) Policy was reviewed and updated in February 2020. The Trust has reviewed local processes and arrangements in response to the CQC feedback on the Trust's Freedom to Speak Up framework and has an action plan in place to implement recommendations. The Trust has designated 'Freedom to Speak Up' Guardians to facilitate any concerns raised by staff and also has in place a Guardian of Safe Working Hours for junior doctors.

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

Other methods of identifying risks include:

- Complaints and Parliamentary Health Service Ombudsman Reports and recommendations;
- Care Quality Commission inspections;
- Inquest findings and HM Coroners' recommendations;
- External reports such as the Francis Inquiry and National Confidential Inquiries
- Medico-legal claims and litigation;
- Learning from Serious Case Reviews;
- Incident reports and trend analysis;
- Internal reports that contribute towards revalidation of doctors;
- Internally generated reports from the Performance/ Information Team;
- Internal and external audit reports;
- Performance Reviews;
- Feedback from patient/public groups;
- Feedback from Health Overview and Scrutiny Committees;
- Patient satisfaction surveys including 'Friends and Family' test;
- Chats, Queries and Concerns sessions;
- Focus Groups;
- Environmental Audits;
- Quality and Safety / Visibility visits by Executive and Non-Executive Directors;
- Patient-Led Assessment of the Care Environment inspections; and
- Public attendance and questions at Trust Board meetings.

6. Capacity to handle risk

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

The Chief Nurse is the lead executive for the risk management structure and processes.

The Medical Director is the Executive Lead for patient safety, supported by the Chief Nurse. The Deputy Medical Director (Quality and Safety) is the responsible officer for the revalidation of doctors.

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

Trust Audit and Risk Committee

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

Trust Management Executive (TME)

The TME is chaired by the Chief Executive and membership consists of Executive Directors, Divisional Medical Directors, Divisional Directors of Operations and Divisional Directors of Nursing and Governance. The TME is responsible for ensuring that there are clear and robust accountability arrangements at all levels of the organisation for risk management, including within the Divisional structure, which are explicit and understood.

The TME also has the responsibility for regular review and challenge of the Corporate Risk Register / Board Assurance Framework.

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

The main purpose of the audit reports is to provide Management, the Audit and Risk Committee and the Trust Board with:

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

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

Serious Incidents (SIs) are investigated through the Divisions involved, with reports generated by managers and signed-off by the Chief Executive. The Outcomes with Learning Group reviews all incidents after completion and monitors implementation of learning derived from each SI as well as delivery of action plans arising. In 2019/20 the Trust has developed a quarterly thematic SI report for the part one Board meeting.

All Divisions have a Medical Quality and Safety lead as well as a substantive governance and risk lead, with responsibility for ensuring that risk management and clinical governance processes are applied consistently within their Division.

7. Risk and control framework

The Trust Management Executive reviews the Corporate Risk Register on a bi-monthly basis. The recommendations of national and other high-level reports are reviewed at appropriate Trust level committees and where gaps are identified, these are also submitted for consideration in the Corporate Risk Register.

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

The Trust's system of internal control is designed to manage the risks associated with achieving aims, objectives and policies to a reasonable level. During 2019/20 the Trust Management Executive sought to identify those key strategic risks which were most significant to delivery of the Trust's priorities. This process identified the following 'top three' significant strategic risks:

- Inconsistent delivery of high-quality standards/ services
- Inability to respond to demand on services – If demand exceeds capacity then service quality, safety and performance could deteriorate; and
- Financial unsustainability in the medium to long term.

Alongside regular review of the Corporate Risk Register, the Trust Board requires ongoing assurance in relation to each of the above key strategic risks to confirm that appropriate risk management and mitigation strategies are in place.

8. Care Quality Commission

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

In February and March 2020, the CQC undertook a planned focused inspection, as well as 'use of resources' and 'well led' assessments. The results of this inspection are yet to be published.

The previous CQC inspection was undertaken in September 2018, this was also a planned focused inspection, following the Trust wide inspection undertaken in March 2017. The current CQC overall rating for the Trust has remained 'Requires Improvement' since March 2017.

The Trust's response to CQC reports is monitored by the Quality and Safety Improvement Group, chaired by the Chief Executive, which in turn reports through to both TME and the Quality Governance Committee.

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

As noted above, the CQC undertook an assessment of the Trust's Use of Resources in March 2020. In this report the CQC rated the Trust as 'requires improvement' in the use of resources. To address this the Trust has established an Improving Use of Resources Programme, aimed at delivering £24m of efficiencies. Alongside this there are a number of processes used by the Trust to deliver economy, efficiency and effectiveness of the use of resources. These include:

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

10. Annual quality account

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

The Deputy Director of Governance co-ordinates the production of the Trust's Quality Account, with the Medical Director, as Chair of the Quality and Safety Committee, leading on the Patient Safety and Clinical Quality Sections and the Chief Nurse leading on Patient Experience and Infection Control areas.

11. The management of incidents and identification of clinical risk

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

12. Clinical audit

The Trust has an established Clinical Audit programme as detailed in the Trust's Quality Account. The program aims to drive continuous improvement of services and quality of care. The Clinical Audit Programme priorities in 2019/2020 were the National Clinical Audit and Confidential Enquiries Programme, Mandatory Audits, NICE Guidance and Quality Standards, Trust Wide Governance and Risk Audits and local Clinical Specialty level Audits. The internal monitoring and reporting of Clinical Audit activity within the Trust is established through a range of structures, systems and processes. The overall monitoring and reporting of all Clinical Audit activity is led by the Clinical Effectiveness Department supported by Directorate Level Governance and Audit Meetings, Divisional Level Governance and Risk Meetings and is overseen by the both the Quality & Safety and Quality Governance Committees.

13. Information governance/data security

Information governance is a framework for managing information, particularly personal information of patients and employees. The framework is responsible for ensuring that all personal information is handled and processed fairly and securely by the Trust to support its future regulatory, legal, risk and operational requirements. As part of this remit, and on 25th May 2018, the new legislation for GDPR Regulations came into force and introduced a new set of performance standards/regulations. This has now been incorporated with the UK Data Protection Act 2018.

The new regulations have been implemented across the Trust and are subject to a new self-assessment toolkit (known as the Data Security Protection Toolkit) which all Health and Social Care Organisations must comply with. The Trust's compliance is reviewed on an annual basis through our internal audit programme and is reviewed by the CQC as part of Well Led Inspection.

Our aim is to continually improve our compliance year on year with improved standards. A key element in achieving this is ensure that all staff undertakes an annual Information Governance and Data Protection training and receive regular updates relating to Information Governance and Data Security.

The Trust has an established Information Governance Steering Committee (IGSC) which meets monthly that is chaired by the Head of Information Governance and Assurance. The Trust's Caldicott Guardian is a member of this Committee as well as the Senior Information Risk Owner (SIRO). The Steering Committee reports into the Trust's Digital Committee, both through the minutes of its meetings and also on an exception-reporting basis, so that the Committee is kept informed of any risks relating to information assurance within the Trust and to ensure that mitigating action plans are in place to address such risks.

The number of Data/ Information Governance Incidents for the period is 137, an increase of 26 from the previous year. The breakdowns of the incidents are as follows:

Corruption or Inability to recover electronic data	1
Disclosed in error	40
Other Information Governance	48
Unauthorised access/disclosure	10
Lost or stolen hardware	4
Lost or stolen paperwork	3
Non-secure disposal of paperwork	1
Non-secure disposal of hardware	5
Lost or stolen paperwork	5
Technical Security failings (including hacking)	1
Fax/email transmitted to incorrect destination	10
Disclosure via Social Media	10
Cyber Incident	1
Total	**137**

There also have been five incidents that were reported to the Information Commissioner's Office during the period 1st April 2019 to 31st March 2020. These were as follows:

1	Data disclosed in error by 3rd party
2	Training package had real patient data rather than dummy data
3	Lapse in procedure in the use of Body Worn Video
4	Trust has been sharing personal information with third party without the knowledge of the data subject that their personal information being shared
5	Patient list containing Name, D.O.B, Hospital number, age and abbreviated acronyms for clinical information

Four of five incidents identified above have been dealt with by the ICO as "Not required to report". One is still being investigated by the ICO.

Due to the Covid 19 the Data Security and Protection Toolkit have been extended until 30th September 2020. Therefore, the Trust has a breathing period to ensure the Toolkit is completed and intends to publish "Standards Met" by 30th September 2020.

14. Data quality

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

Data quality audits looking at data recording and quality issues across Wards, Emergency Departments (ED) and Outpatient areas (OPDs) are carried out on a weekly basis with the reports being shared with Divisions for them to identify and implement improvement actions, with areas revisited to monitor the impact of improvements introduced from their previous audit.

Daily reviews of demographic details for current activity and future patients on the Trust waiting lists are being carried out to confirm that the details are correct and up-to-date and iCare is synchronised with the Spine. Investigations and updates are performed when errors and inconsistencies are found.

Routine daily reports identifying data quality issues that require action are being sent out automatically to service staff for corrective action. Live reports have been introduced to highlight where data on iCare is not being updated in a timely manner in (ED arrivals, Inpatient admissions and discharges). The number of live data quality reports will be increased throughout 2020/21.

The Trust has established processes to assure the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of this data.

Data Assurance meetings, led by the Data Quality Team, are held quarterly with membership drawn from clinical divisions and corporate areas. These meeting are a forum for data quality issues and risks to be raised and solutions to be identified and their implementation monitored. They have been relatively successful and the action notes from these meetings are reported into the Information Governance Steering Committee along with the Data Quality scorecard. The attendance of the Data Assurance meeting will need improvement throughout 2020/21 if this is to become a truly effective forum for improving data quality across the Trust.

15. Counter fraud

The anti-fraud, bribery and corruption work carried out during the financial year 2019/20 has been assessed by the Trust against the NHS Counter Fraud Authority Standards for Providers 2019/20 - Fraud, Bribery and Corruption/NHS Standard Contract. Following the annual Self-Review Toolkit return on 31st March 2020, changes to the standards were incorporated into the 2020/2021 annual Counter Fraud plan to improve ratings not assessed as green.

16. Register of interests

The Trust published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

17. Workforce

The Workforce Committee endorsed the Trust's two-year Workforce Strategy to 2021 which focuses on 4 main themes, staff satisfaction and retention, recruitment, leadership and improving our collective workforce processes with 11 key goals. As part of the wider development the strategy the key challenges and risks the Trust faces have been acknowledged with clear goals identified. The Committee agreed a new reporting format to update the committee monthly on key progress.

Workforce planning is undertaken with active engagement and in collaboration with services, professional leads, Finance and Workforce. Workforce plans are reviewed and risk-adjusted to ensure that they are able to meet the Trust's key workforce targets, including reductions in vacancies and temporary staffing spend. Reviews of the workforce and establishments take place throughout the year with services with key stakeholders for the process in attendance, including divisional performance review meetings and quarterly Operating Plan Review meetings where divisional performance against these trajectories is monitored and any associated risks for delivery are identified. Plans are submitted to the Board annually, and presented by divisions tot our Workforce and Education Committee on a six-monthly basis.

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

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

18. Sustainable development

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

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

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

One way that an organisation can embed sustainability is to use a sustainable development management plan (SDMP). We will be putting together an SDMP in the near future for consideration by the board. This plan will seek to set out the Trust's approach to becoming net carbon zero by 2030 in line with the goals of the London Borough of Lewisham and Greenwich.

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

Climate change brings new challenges to our business both in direct effects to our buildings, facilities and land, but also to patient health. Examples in recent years include the effects of heatwaves, extreme temperatures and prolonged

periods of cold, floods, droughts etc. As an organisation we have identified the need to develop a board approved plan for future climate change risks affecting our area.

Travel

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

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

19. Other aspects

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

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

20. Review of effectiveness

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

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The 2019/20 Head of Internal Audit opinion is one of: "Partial assurance with improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.' During the period KPMG completed eight reviews. Of these, seven reviews received 'partial assurance with improvement required', improvement work is underway to address the recommendations that have been raised and this is regularly tracked through the Audit and Risk Committee.
- The findings and recommendations detailed within reports of the CQC. As noted above, in February and March 2020 the CQC undertook a planned focused inspection, as well as 'use of resources' and 'well led' assessments. The results of this latest inspection are yet to be published.
- Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.
- The regular reviews of the Corporate Risk Register and Board Assurance Framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation in achieving its strategic priorities have been regularly reviewed.
- The Trust's committee structures ensure sound monitoring and review mechanisms to make certain that the systems of internal control are working effectively.
- External auditor assurances provided through the annual opinion on the financial statements and value for money conclusion.
- Clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.
- Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports and mortality monitoring; reports from external assessments.

21. Concluding statement

This report sets out an open and balanced reflection of the Trust's progress over the past year. The Board and Executive have a clear understanding of the significant issues facing the Trust to address its workforce, financial and performance challenges and the work it must focus on during the 2020/21 period and beyond to address these. Recognising this, I am satisfied that Lewisham and Greenwich NHS Trust has a sound system of internal controls that supports the achievement of its policies, aims and objectives and that no significant internal control issues have been identified.

Ben Travis, Chief Executive
June 2020


Shuttle bus
Eric

Remuneration report

Pay for executive directors is set and agreed by the Trust's remuneration Committee. Other senior managers' pay is in line with Agenda for Change pay scales. All executive directors report to the chief executive and, like other staff, have regular appraisals to set and assess performance against objectives. There is no performance related pay within the Trust.

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

2019/20 – Salary and pension entitlements of senior managers - remuneration - audited

Name		Title	Salary (bands of £5,000)	Expense payments (Taxable) Nearest £100	Performance pay and related bonuses (bands of £5,000)	Long term performance related pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	2019/20 Total (a-e) (bands of £5,000)
1. Executive Directors								
Ben Travis	1	Chief Executive	200-205	-	-	-	-	200-205
Elizabeth Aitken	2	Medical Director	210-215	-	-	-	37.5-40	250-255
Angela Helleur	1	Chief Nurse	145-150	-	-	-	82.5-85	225-230
Sebastian Nai	3	Chief Financial Officer to 26-Jul-19	70-75	-	-	-	-	70-75
Spencer Prosser		Chief Financial Officer from 01-Aug-19	115-120	-	-	-	-	115-120
Meera Nair		Chief People Officer from 15-Sep-19	75-80	-	-	-	25-27.5	100-105
2. Other Members of the Board - Non Voting								
Rachael Backler		Director of Performance from 09-Dec-19	40-45	-	-	-	37.5-40	75-80
Keith Howard	1	Director of Estates, Facilities and redevelopment	135-140	-	-	-	12.5-15	145-150
Kate Anderson		Director of Corporate Affairs	100-105	-	-	-	25-27.5	125-130
Nigel Kee		Interim Director of Service Delivery to 10-Aug-19	50-55	-	-	-	257.5-260	310-315
Jim Lusby	1	Director of Strategy and Integrated Care	145-150	-	-	-	-	145-150
Suzanne Wills		Chief Operating Officer from 01-Jan-20	30-35	-	-	-	60-62.5	90-95
Lynn Saunders	4	Director of Strategy, Business and Communications to 31-Aug-19	65-70	-	-	-	-	65-70
3. Chairman & Non Executive Directors (5)								
Val Davison		Chair	35-40	-	-	-	-	35-40
John Ballard		Non-Executive Director to 30-Sep-19	0-5	-	-	-	-	0-5
Sukhvinder Kaur-Stubbs		Non-Executive Director	5-10	-	-	-	-	5-10
Harry Bright		Non-Executive Director	5-10	-	-	-	-	5-10
Binka Layton		Non-Executive Director	5-10	-	-	-	-	5-10
Julia Mundy		Non-Executive Director	5-10	-	-	-	-	5-10
Katherine Yeung		Non-Executive Director	5-10	-	-	-	-	5-10
Ian Norman		Non-Executive Director from 24-Jun-19	5-10	-	-	-	-	5-10
Sarah Higgins		Associate Non-Executive Director (non-voting)	5-10	-	-	-	-	5-10
4. Payments to Past Directors and Senior Managers								
Janet Lynch		Ex Director of Workforce and Education - Pay in Lieu of Notice	65-70	-	-	-	57.5-60	120-125

(1) Included within the salaries disclosed is a payment of £0-5K relating to 2018/19
(2) Elizabeth Aitken's salary includes both Clinical and Medical Director earnings
(3) Sebastian Nai was seconded from NHSI and the costs disclosed are gross
(4) Part time
(5) Chair and Non Executive Director salaries are in line with revised guidance published by NHSI/E on the 26th September 2019.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual

2018/19 – Salary and pension entitlements of senior managers - remuneration - audited

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

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

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

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

(4) Part time

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

(6) During the noted periods both directors were seconded to other NHS organisations and subsequently took up substantive board level positions within these NHS organisations.

2019/20 – Salary and pension entitlements of senior managers - pension benefits - audited

Name		Title	Real increase/ (decrease) in pension at age (bands of £2,500)	Real increase/ (decrease) in pension lump sum at age (bands of £5,00)	'Total accrued pension at age 31 March 2020 (bands of £5,000)	'Lump sum at pension age related to accrued pension at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019 £000s	Real Increase in Cash Equivalent Transfer Value £000s	Cash Equivalent Transfer Value at 31 March 2020 £000s	Employers Contribution to Stakeholder Pension £000s
Elizabeth Aitken		Medical Director	2.5-5	0-2.5	65-70	95-100	1,012	59	1,095	-
Angela Helleur		Chief Nurse	2.5-5	12.5-15	60-65	180-185	1,243	139	1,411	-
Meera Nair		Chief People Officer from 15-Sep-19	0-2.5	(2.5)-0	20-25	45-50	384	17	424	-
Rachael Backler		Director of Performance from 09-Dec-19	0-2.5	0-2.5	5-10	-	43	6	65	-
Keith Howard		Director of Estates, Facilities and Redevelopment	0-2.5	2.5-5	30-35	100-105	-	-	-	-
Kate Anderson		Director of Corporate Affairs	0-2.5	0-2.5	5-10	-	59	20	81	-
Nigel Kee		Interim Director of Service Delivery to 10-Aug-19	10-12.5	27.5-30	45-50	140-145	831	98	1,125	-
Suzanne Wills		Chief Operating Officer from 01-Jan-20	2.5-5	2.5-5	30-35	70-75	569	15	644	-

The Chief Executive is no longer contributing to the scheme so is not included above and the Ex Director of Workforce and Education is not included as they have taken retirement.

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

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement. During the year, the Government announced that public sector pension schemes will be required to provide indexation on the Guaranteed Minimum Pension element of the pension. NHS Pensions has updated the methodology used to calculate CETV values as at 31 March 2020. The impact of the change in methodology is included within the reported real increase in CETV for the year.

2018/19 – Salary and pension entitlements of senior managers - pension benefits - audited

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

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

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

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

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

Exit packages 2019/20 - audited

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £	Number of other departures agreed Number	Cost of other departures agreed £	Total number of exit packages Number	Total cost of exit packages £	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £000s
<£10,000	-	-	8	32,966	8	32,966	-	-
£10,000 - £25,000	-	-	-	-	-	-	-	-
£25,001 - £50,000	-	-	-	-	-	-	-	-
£50,001 - £100,000	-	-	1	53,822	1	53,822	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Total	-	-	9	86,788	9	86,788	-	-

Analysis of other departures - audited

	Agreements Number	Total value of agreements £000s
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	9	87
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
Total	9	87

Exit packages 2018/19 - audited								
Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £	Number of other departures agreed Number	Cost of other departures agreed £	Total number of exit packages Number	Total cost of exit packages £	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £000s
<£10,000	1	3,742	11	60,244	12	63,986	0	0
£10,000 - £25,000	0	0	5	63,352	5	63,352	0	0
£25,001 - £50,000	1	32,718	1	27,283	2	60,001	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	2	36,460	17	150,879	19	187,339	0	0

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

Highest paid director and median pay of workforce

Audited

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

The banded, full time equivalent, annualised total remuneration of the highest paid director in Lewisham and Greenwich NHS Trust in the financial year 2019/20 was £210K-£215K (2018/19 £365K-370K). This was 5.67 times (2018/19 10.07 times*) the median remuneration of the workforce, which was £37,488 (2018/19 £36,511*). The change arises from the highest paid director in 2018/19 being the Interim Director of Finance from 01-Aug-18 to 07-Feb-19, in 2019/20 the Medical Director is the highest paid.

In 2019/20 two employees received remuneration in excess of the highest-paid director (none in 2018/19). Remuneration ranged from £15K-£20K to £240K-£245K (2018/19 £15K-£20K* to £365K-£370K).

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

Median pay and highest paid director	2019-20	2018/19
Pay of highest paid director (bands of £5,000)	210-215	365-370
Median pay	£37,488	£36,536
Median as multiple of highest paid director	5.67	10.06

*Restated for 2018/19 to include temporary staff.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:

Off-payroll engagements longer than six months	
	Number
Number of existing engagements as of 31 March 2020	-
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

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

New off-payroll engagements	
	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	1
Of which	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	-
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	-
No. of engagements reassessed for consistency / assurance purposes during the year.	-
No. of engagements that saw a change to IR35 status following the consistency review	-

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

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


hello my name is..
Lewisham and Greenwich
hello my name is...
Lewisham and Gree

Staffing report

Our staffing profile

At the time of writing (March 2020), we have 5,114 full time members of staff. In addition a total of 1,773 employees work part-time, making up 26% of the Trust's permanent workforce. We have recruited 1,604 new members of staff in the last year and our vacancy rate has reduced to below 10% and recruitment continues to be a key priority for the Trust.

The Trust's most recent workforce equalities report is available on our website https://www.lewishamandgreenwich.nhs.uk/equality or on request (tel: 020 8333 3297). We regularly analyse our staffing to help us better understand workforce representation and staff experience. This enables us to take appropriate action to improve outcomes where necessary.

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

- 79% of the Trust's overall permanent workforce is female
- 73% of staff above band 8a are female. This represents a 1% decrease since the last report
- 56% of directors in the organisation are female. This represents a 2% decrease since the last report.

The Trust has an ethnically diverse workforce. Black and minority ethnic (BAME) employees make up 51% of the Trust's permanent workforce. In general though, there is under representation of BAME staff amongst the higher pay bands. This is an ongoing issue that the Trust is committed to addressing, and continues to feature as a focus for action within our equality objectives.

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

- 3.4% of permanent staff have stated they have a disability
- 83.1% have stated they do not have a disability
- 13.5% of staff have chosen not to disclose information with regards to disability

Equality, diversity and inclusion

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

The WRES and WDES seek to ensure that black and minority ethnic (BAME) and disabled staff are treated fairly within NHS organisations. The WRES has nine workforce indicators and each indicator compares the metrics for white and BAME staff with the aim of closing any gaps. Similarly, the WDES has 10 workforce indicators, and each indicator compares the metrics for non-disabled and disabled staff with the aim of closing any gap.

The EDS is a tool designed to support NHS commissioners and providers to deliver better outcomes for patients and communities, and better working environments for staff. It provides a framework for assessing performance and setting equality objectives. The Trust carried out an engagement and grading exercise in partnership with staff and service users to review its overall performance on equality matters, using the EDS framework. This piece of work was completed and the output informed the trust's equalities objectives for the next four years (2019-2023).

NHS pensions scheme

Past and present employees are covered by the provisions of the NHS pensions scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. For further detail, please refer to note 9 on page 85 of the annual accounts.

Staff sickness absence

Sickness Absence rates are available on the NHS Digital website;

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/october-2019-to-december-2019-provisional-statistics

Staff costs - audited				
	Permanent	Other	2019/20 Total	2018/19 Total
	£000	£000	£000	£000
Salaries and wages	260,941	44,755	305,696	284,518
Social security costs	28,530	3,469	31,999	29,952
Apprenticeship levy	1,419	-	1,419	1,397
Employer's contributions to NHS pensions	30,527	1,885	32,412	31,004
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	13,369	825	14,194	-
Pension cost - other	18	5	23	13
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	87	-	87	151
Temporary staff	-	25,721	25,721	23,887
Total gross staff costs	**334,891**	**76,660**	**411,551**	**370,922**
Recoveries in respect of seconded staff	(5,341)	-	(5,341)	(3,580)
Total staff costs	**329,550**	**76,660**	**406,210**	**367,342**
Of which				
Costs capitalised as part of assets	1,503	514	2,017	1,735

Average number of employees (WTE basis) - audited				
	Permanent	Other	2019/20 Total	2018/19 Total
	Number	Number	Number	Number
Medical and dental	904	85	989	1,036
Ambulance staff	-	-	-	-
Administration and estates	1,281	184	1,465	1,401
Healthcare assistants and other support staff	753	243	996	1,034
Nursing, midwifery and health visiting staff	2,179	498	2,677	2,579
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	1,066	92	1,158	1,120
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	5	-	5	5
Total staff costs	**6,188**	**1,102**	**7,290**	**7,175**
Of which				
Costs capitalised as part of assets	24	8	32	35

Ben Travis, Chief Executive
June 2020

Parliamentary accountability and audit report

Parliamentary accountability

Lewisham and Greenwich NHS Trust does not produce a separate parliamentary accountability report but has opted to include disclosures on contingent liabilities, losses and special payments on page 97.

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

Report on the audit of the financial statements

Opinion

We have audited the financial statements of Lewisham and Greenwich NHS Trust (the 'Trust') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Directors and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the Trust's financial statements shall be prepared on a going concern basis, we considered the risks associated with the Trust's operating activities, including effects arising from macro-economic uncertainties such as Covid-19 and Brexit. We analysed how those risks might affect the Trust's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, 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.

Emphasis of matter – effects of Covid-19 on the valuation of land and buildings

We draw attention to Note 17 of the financial statements, which describes the effects of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. As, disclosed in Note 17 to the financial statements, The valuation from ME is on an Modern Equivalent Asset (MEA) basis as at 28 February 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by Covid-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. Our opinion is not modified in respect of this matter.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

We have nothing to report in respect of the above matters.

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Matter on which we are required to report by exception – 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, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

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

Use of our report

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

Iain Murray, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London
25 June 2020

Accounts

Statement of comprehensive income	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	545,526	501,042
Other operating income	4	80,897	73,499
Operating expenses	6, 8	(614,554)	(588,528)
Operating surplus/(deficit) from continuing operations		**11,869**	**(13,987)**
Finance income	11	139	114
Finance expenses	12	(22,765)	(21,532)
PDC dividends payable		(2,599)	(3,075)
Net finance costs		**(25,225)**	**(24,493)**
Other gains / (losses)	13	(44)	-
Surplus/(deficit) for the year from continuing operations		**(13,400)**	**(38,480)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	-	-	-
Surplus/(deficit) for the year		**(13,400)**	**(38,480)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(644)	(17,207)
Revaluations	17	26,492	6,270
Other recognised gains and losses		-	-
Total comprehensive income / (expense) for the period		**12,448**	**(49,417)**
Adjusted financial performance (control total basis)			
Surplus / (deficit) for the period		(13,400)	(38,480)
Remove net impairments not scoring to the Departmental expenditure limit		(1,660)	7,808
Remove (gains) / losses on transfers by absorption		-	-
Remove I&E impact of capital grants and donations		49	71
Prior period adjustments		-	-
Remove non-cash element of on-SoFP pension costs		-	-
Adjusted financial performance surplus / (deficit) Excl 18/29 PSF		**(15,011)**	**(30,601)**
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(807)	-
Adjusted financial performance surplus / (deficit)		**(15,818)**	**(30,601)**

The notes on pages 73 to 105 form part of these accounts.

Statement of financial position	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	14	28,456	29,250
Property, plant and equipment	15	377,597	344,526
Investment property		-	-
Investments in associates and joint ventures		-	-
Other investments / financial assets		-	-
Receivables	19	3,132	2,943
Other assets		-	-
Total non-current assets		**409,185**	**376,719**
Current assets			
Inventories	18	4,870	4,412
Receivables	19	68,622	49,997
Other investments / financial assets	17	-	-
Other assets		-	-
Non-current assets for sale and assets in disposal groups		-	-
Cash and cash equivalents	20	2,064	2,064
Total current assets		**75,556**	**56,473**
Current liabilities			
Trade and other payables	21	(49,542)	(47,177)
Borrowings	23	(199,167)	(51,135)
Other financial liabilities		-	-
Provisions	25	(4,302)	(3,277)
Other liabilities	22	(10,125)	(10,507)
Liabilities in disposal groups		-	-
Total current liabilities		**(263,136)**	**(112,096)**
Total assets less current liabilities		**221,605**	**321,096**

Statement of financial position	Note	31 March 2020 £000	31 March 2019 £000
Non-current liabilities			
Trade and other payables		-	-
Borrowings	23	(103,057)	(222,313)
Other financial liabilities		-	-
Provisions	25	(5,380)	(5,457)
Other liabilities	22	(507)	(557)
Total non-current liabilities		**(108,944)**	**(228,327)**
Total assets employed		**112,661**	**92,769**
Financed by			
Public dividend capital		208,279	200,835
Revaluation reserve		174,277	148,429
Financial assets reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(269,895)	(256,495)
Total taxpayers' equity		**112,661**	**92,769**

The notes on pages 73 to 105 form part of these accounts.

Ben Travis
Chief executive
June 2020

Statement of changes in equity for the year ended 31 March 2020	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**200,835**	**148,429**	**-**	**-**	**-**	**(256,495)**	**92,769**
Surplus/(deficit) for the year	-	-	-	-	-	(13,400)	(13,400)
Impairments	-	(644)	-	-	-	-	(644)
Revaluations	-	26,492	-	-	-	-	26,492
Public dividend capital received	7,444	-	-	-	-	-	7,444
Taxpayers' and others' equity at 31 March 2020	**208,279**	**174,277**	**-**	**-**	**-**	**(269,895)**	**112,661**

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

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 flow	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		11,869	(13,987)
Non-cash income and expense			
Depreciation and amortisation	6	28,559	26,840
Net impairments	7	(1,660)	7,808
(Increase) / decrease in receivables and other assets		(19,479)	(10,367)
(Increase) / decrease in inventories		(458)	651
Increase / (decrease) in payables and other liabilties		(2,178)	1,768
Increase / (decrease) in provisions		697	1,450
Net cash generated from / (used in) operating activities		**17,350**	**14,163**
Cash flows from investing activities			
Interest received		139	114
Purchase of intangible assets		(4,396)	(5,670)
Purchase of PPE and investment property		(24,872)	(24,400)
Sales of PPE and investment property		7	-
Net cash generated from / (used in) investing activities		**(29,122)**	**(29,956)**
Cash flows from financing activities			
Interest received		7,444	2,123
Purchase of intangible assets		31,939	34,683
Purchase of PPE and investment property		1,500	1,000
Sales of PPE and investment property		(183)	(182)
Capital element of PFI, LIFT and other service concession payments		(4,596)	(3,974)
Interest on loans		(3,494)	(2,954)
Other interest		(2)	-
Interest paid on finance lease liabilities		(50)	(50)
Interest paid on PFI, LIFT and other service concession obligations		(18,852)	(18,394)
PDC dividend (paid) / refunded		(1,934)	(2,927)
Net cash generated from / (used in) financing activities		**11,772**	**9,325**
Increase / (decrease) in cash and cash equivalents		**-**	**(6,468)**
Cash and cash equivalents at 1 April - brought forward		**2,064**	**8,532**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**2,064**	**8,532**
Cash and cash equivalents transferred under absorption accounting		-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	20.1	**2,064**	**2,064**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Notes to the accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care (DHSC). The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

International Accounting Standard 1 (IAS1) requires management to assess the Trust's ability to continue as a going concern.

In keeping with DHSC Group Accounting Manual (GAM), it is the view of the Directors that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents; such as the 2020/21 operating plan submission to NHS England and NHS Improvement (NHSE/I) and together with the absence of a notification from DHSC or any other relevant national body of the intention for the dissolution of the Trust, is sufficient evidence of going concern.

The current situation is that:

- The Trust has been able to agree with NHSE/I a breakeven Control Total target
- No interim cash funding will be required to deliver this plan
- On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £194,139K are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust
- The operating plan assumes delivery of a £24,400K cost improvement program which is considered an ambitious, yet achievable, target.

Whilst these factors reflect some uncertainty the Director's expectation is that:

- The contracts agreed with commissioners will provide the Trust with a sound level of income
- The operating plan will produce a significant improvement in the Trust's underlying run rate
- DHSC will, as in previous years, provide revenue cash support should an requirement arise, although this is not anticipated
- Neither DHSC or any other relevant national body will seek to dissolve the Trust in the foreseeable future.

Taking account of the GAM and the factors outlined above, the Directors believe that it is a realistic expectation that the Trust will have sufficient resources to continue as a going concern for the foreseeable future through to the 31st March 2021 and beyond.

Note 1.3 Revenue from contracts with customers

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

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

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

Revenue from NHS contracts:

Commissioners

The main source of income for the Trust is contracts with commissioners for 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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Private Finance Initiative Funding

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

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

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

Note 1.5 Expenditure on other goods and services

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

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

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

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

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

Subsequent expenditure

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

Note 1.6.2 Measurement

Valuation

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

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

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

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

Current values in existing use are determined as follows:

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

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

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

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

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

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

Note 1.6.3 De-recognition

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

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

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

Note 1.6.4 Donated and grant funded assets

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

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

Note 1.6.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

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

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

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

Lifecycle replacement

The Trust has not capitalised lifecycle replacement costs for the PFI building (Riverside and QEH) on the basis that the costs identified in the PFI provider financial model cannot be analysed over the following headings with adequate certainty:

1. Property, plant and equipment
2. Improvement or day-to-day maintenance

Assets contributed by the Trust to the operator for use in the scheme

The Trust has no assets contributed to the operator for use in the scheme.

Note 1.6.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	59
Dwellings	-	-
Plant & machinery	1	18
Transport equipment	-	1
Information technology	1	9
Furniture & fittings	1	7

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

Note 1.7 Intangible assets

Note 1.7.1 Recognition

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

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

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

Note 1.7.2 Measurement

Valuation

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

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

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

Amortisation

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

Note 1.7.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Information technology	1	10

Note 1.8 Inventories

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

Note 1.9 Cash and cash equivalents

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

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

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 Recognition

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

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

Note 1.10.2 Classification and measurement

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

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

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

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

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

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

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

Outstanding Injury cost recovery balances have been impaired at 21.79% of total notified oustanding debt line with DHSC guidance (2018/19 21.89%).

Note 1.10.3 Derecognition

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

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

Note 1.11 Leases

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

Note 1.11.1 The trust as lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

Note 1.11.2 The trust as lessor

Finance leases

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

Operating leases

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

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

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

Early retirement costs

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

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

Contingent liabilities are defined as:

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

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,
(iii) any PDC dividend balance receivable or payable, and
(iv) PSF Incentive receivables

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

Note 1.15 Value added tax

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

Note 1.16 Third party assets

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

Note 1.17 Losses and special payments

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

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

Note 1.18 Critical judgements in applying accounting policies

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

Note 1.19 Sources of estimation uncertainty

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

1. Property, Plant and Equipment (PPE) - PFI buildings are on the Statement of Financial Position at current value as determined by an independent professional valuer on the basis of depreciated replacement cost (DRC). The associated liability has been included using the Department of Health and Social Care (DHSC) Universal Model.
2. The useful economic life of plant and machinery and IT equipment has been estimated on a probable life basis; consistent with actual experience inside the Trust and across similar NHS provider organisations.
3. The valuation exercise was carried out in Febuary 2020 with a valuation date of 28 Febuary 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

   Of the £340,595K net book value of land and buildings subject to valuation, £308,883K relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service.

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

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 14 Regulatory Deferral Accounts

Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 16 Leases

Standard is effective at 1 April 2021 per the FReM.

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities

in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have an impact on non-current assets, liabilities and depreciation.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 2 Operating segments

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

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)

	2019/20 £000	2018/19 £000
Acute services		
Elective income	45,718	50,234
Non elective income	162,516	142,632
First outpatient income	37,746	32,199
Follow up outpatient income	31,554	34,151
A & E income	40,476	35,529
High cost drugs income from commissioners (excluding pass-through costs)	23,451	25,611
Other NHS clinical income	138,377	123,781
Community services		
Community services income from CCGs and NHS England	29,192	26,726
Income from other sources (e.g. local authorities)	7,660	8,028
All services		
Private patient income	-	-
Agenda for Change pay award central funding*		4,715
Additional pension contribution central funding**	14,194	
Other clinical income	14,642	17,436
Total income from activities	**545,526**	**501,042**

* Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

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

Note 3.2 Income from patient care activities (by source)

	2019/20 £000	2018/19 £000
Income from patient care activities received from:		
NHS England	69,689	52,434
Clinical commissioning groups	444,420	413,376
Department of Health and Social Care	41	4,727
Other NHS providers	2,750	5,144
NHS other	-	-
Local authorities	11,604	11,707
Non-NHS: private patients	190	171
Non-NHS: overseas patients (chargeable to patient)	3,048	4,148
Injury cost recovery scheme	1,589	1,517
Non NHS: other	12,195	7,818
Total income from activities	**545,526**	**501,042**
Of which		
Related to continuing operations	545,526	501,042
Related to discontinued operations	-	-

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

	2019/20 £000	2018/19 £000
Income recognised this year	3,048	4,148
Cash payments received in-year	720	528
Amounts added to provision for impairment of receivables	2,052	3,267
Amounts written off in-year	1,346	994

Note 4 Other operating income

		2019/20 £000	2018/19 £000
Other operating income from contracts with customers:			
Research and development		967	1,096
Education and training		21,376	20,162
Non-patient care services to other bodies		8,202	8,870
Provider sustainability fund (PSF)		13,653	23,311
Financial recovery fund (FRF)		14,807	
Marginal rate emergency tariff funding (MRET)		1,191	
Income in respect of employee benefits accounted on a gross basis		-	-
Receipt of capital grants and donations		-	-
Charitable and other contributions to expenditure		-	-
Support from the Department of Health and Social Care for mergers		-	-
Rental revenue from finance leases		-	-
Rental revenue from operating leases		1,530	1,530
Amortisation of PFI deferred income / credits		-	-
Other income	*	19,171	18,530
Total other operating income		**80,897**	**73,499**
Of which			
Related to continuing operations		80,897	73,499
Related to discontinued operations		-	-

* Other Income Includes £16,440K (£16,440K in 2018/19) of financial support received under the SLHT dissolution agreement to off-set the additional cost imposed by the QEH PFI building - Reference the TSA 2013 report "Securing sustainable healthcare for the people of South East London".

Note 5 Additional information on revenue

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

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	10,507	8,106
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2020 £000	31 March 2019 £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 Operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from non-NHS and non-DHSC bodies	481	530
Staff and executive directors costs	402,940	364,384
Remuneration of non-executive directors	105	94
Supplies and services - clinical (excluding drugs costs)	44,790	46,822
Supplies and services - general	6,330	2,965
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	35,695	36,151
Inventories written down	186	70
Consultancy costs	854	729
Establishment	3,686	6,410
Premises	27,765	28,764
Transport (including patient travel)	4,581	4,605
Depreciation on property, plant and equipment	23,369	22,492
Amortisation on intangible assets	5,190	4,348
Net impairments	(1,660)	7,808
Movement in credit loss allowance: contract receivables / contract assets	2,073	2,068
Change in provisions discount rate(s)	(27)	(64)
Audit fees payable to the external auditor		
audit services- statutory audit	108	97
other auditor remuneration (external auditor only)	-	10
Internal audit costs	238	222
Clinical negligence	24,383	28,523
Legal fees	539	864
Insurance	20	12
Education and training	3,443	2,249
Rentals under operating leases	1,826	1,414
Early retirements	271	214
Redundancy	-	36
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	25,990	25,062
Hospitality	51	51
Losses, ex gratia & special payments	15	16
Other services, eg external payroll	968	1,128
Other	344	454
Total	**614,554**	**588,528**
Of which		
Related to continuing operations	614,554	588,528
Related to discontinued operations	-	-

Note 6.1 Other auditor remuneration

Other auditor remuneration paid to the external auditor	2019/20 £000	2018/19 £000
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services	-	10
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**10**

No other audit remunation was paid in 2019/20 due to removal of the need to obtain assurance from the external auditor on their quality accounts for 2019/20.

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 7 Impairment of assets

Net impairments charged to operating surplus / deficit resulting from	2019/20 £000	2018/19 £000
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	(1,660)	7,808
Other	-	-
Total net impairments charged to operating surplus / deficit	**(1,660)**	**7,808**
Impairments charged to the revaluation reserve	644	17,207
Total net impairments	**(1,016)**	**25,015**

Note 8 Employee benefits

	2019/20 £000	2018/19 £000
Salaries and wages	305,696	284,518
Social security costs	31,999	29,952
Apprenticeship levy	1,419	1,397
Employer's contributions to NHS pensions	46,606	31,004
Pension cost - other	23	13
Termination benefits	87	151
Temporary staff (including agency)	25,721	23,887
Total gross staff costs	**411,551**	**370,922**
Recoveries in respect of seconded staff	(5,341)	(3,580)
Total staff costs	**406,210**	**367,342**
Of which		
Costs capitalised as part of assets	2,017	1,735

Reconcilation to employee benefits in Note 6 Operating expenses	2019/20 £000	2018/19 £000
Total staff costs	**406,210**	**367,342**
Costs capitalised as part of assets	(2,017)	(1,735)
Education and training	(982)	(973)
Redundancy	-	(36)
Early retirements	(271)	(214)
Total staff and executive directors costs as per Note 6 Operating expenses	**402,940**	**364,384**

Note 8.1 Retirements due to ill-health

During 2019/20 there were no early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is 0K (£157K in 2018/19).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting 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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 to 20.6%, and the Scheme Regulations were amended accordingly.

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

Alternative pension Scheme "NEST"

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

The specific characteristics of NEST are as follows:

- Contributions to NEST are based on 8% for employees and 3% for employers.
- Retirement age within this scheme is set at 65.
- Pensions are based on investment and growth funds.
- Employees can pay into these funds directly to top up their pension.
- Pensions can be drawn from age 55.
- At retirement employees can choose how they receive their funds – based on pension pot value.
- Cash only – cash payment up to 25% value will be tax free.
- Retirement income.
- Cash and retirement income – cash payment up to 25% will be tax free.
- Transfer pension – open market.
- Survivor's pensions are included as well as death benefits.
- Employees can choose to opt out of the scheme.
- From April 2020 employees will contribute 8%.
- From April 2020 employers will contribute 3%.

Contributions will be reviewed in 2020.

Note 10 Operating leases

Note 10.1 Lewisham and Greenwich NHS Trust as a lessor

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

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

Operating lease revenue	2019/20 £000	2018/19 £000
Minimum lease receipts	1,530	1,530
Contingent rent	-	-
Other	-	-
Total	**1,530**	**1,530**

Future minimum lease receipts due	31 March 2020 £000	31 March 2019 £000
- not later than one year;	1,530	1,530
- later than one year and not later than five years;	6,120	6,120
- later than five years.	6,120	7,650
Total	**13,770**	**15,300**

Note 10.2 Lewisham and Greenwich NHS Trust as a lessee

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

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

Operating lease expense	2019/20 £000	2018/19 £000
Minimum lease payments	1,826	1,414
Contingent rents	-	-
Less sublease payments received	-	-
Total	**1,826**	**1,414**

Future minimum lease payments due	31 March 2020 £000	31 March 2019 £000
- not later than one year;	1,663	2,226
- later than one year and not later than five years;	6,377	570
- later than five years.	9,893	1,280
Total	**17,933**	**4,076**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2019/20 £000	2018/19 £000
Interest on bank accounts	139	114
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total finance income	**139**	**114**

Note 12 Finance charges

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

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health and Social Care	3,610	3,072
Other loans	-	-
Overdrafts	-	-
Finance leases	50	50
Interest on late payment of commercial debt	2	-
Main finance costs on PFI and LIFT schemes obligations	9,311	9,699
Contingent finance costs on PFI and LIFT scheme obligations	9,541	8,695
Total interest expense	**22,514**	**21,516**
Unwinding of discount on provisions	251	16
Other finance costs	-	-
Total finance costs	**22,765**	**21,532**

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20 £000	2018/19 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	2	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

Operating lease expense	2019/20 £000	2018/19 £000
Gains on disposal of assets	-	-
Losses on disposal of assets	(44)	-
Total other gains / (losses)	**(44)**	**-**

Note 14 Intangible assets

Note 14.1 Intangible assets - 2019/20

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost			
Valuation / gross cost at 1 April 2019 - brought forward	**46,081**	**960**	**47,041**
Additions	4,336	60	4,396
Reclassifications	962	(962)	-
Disposals / derecognition	-	-	-
Valuation / gross cost at 31 March 2020	**51,379**	**58**	**51,437**
Amortisation			
Amortisation at 1 April 2019 - brought forward	**17,791**	**-**	**17,791**
Provided during the year	5,190	-	5,190
Reclassifications	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2020	**22,981**	**-**	**22,981**
Net book value at 31 March 2020	**28,398**	**58**	**28,456**
Net book value at 1 April 2019	**28,290**	**960**	**29,250**

Note 14.2 Intangible assets - 2018/19

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

Note 15 Property, plant and equipment

Note 15.1 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost								
Valuation/gross cost at 1 April 2019 - brought forward	**25,720**	**287,251**	**8,456**	**82,141**	**10**	**18,982**	**1,672**	**424,232**
Additions	-	12,597	5,335	6,943	-	4,067	41	28,983
Impairments	-	(644)	-	-	-	-	-	(644)
Reversals of impairments	-	-	-	-	-	-	-	-
Revaluations	-	10,989	-	-	-	-	-	10,989
Reclassifications	-	4,682	(4,692)	10	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(157)	-	(4)	(39)	(200)
Valuation/gross cost at 31 March 2020	**25,720**	**314,875**	**9,099**	**88,937**	**10**	**23,045**	**1,674**	**463,360**
Accumulated depreciation								
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**-**	**-**	**64,479**	**8**	**14,007**	**1,212**	**79,706**
Provided during the year	-	17,163	-	4,168	2	1,921	115	23,369
Impairments	-	1,970	-	-	-	-	-	1,970
Reversals of impairments	-	(3,630)	-	-	-	-	-	(3,630)
Revaluations	-	(15,503)	-	-	-	-	-	(15,503)
Reclassifications	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(106)	-	(4)	(39)	(149)
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**68,541**	**10**	**15,924**	**1,288**	**85,763**
Net book value at 31 March 2020	**25,720**	**314,875**	**9,099**	**20,396**	**-**	**7,121**	**386**	**377,597**
Net book value at 1 April 2019	**25,720**	**287,251**	**8,456**	**17,662**	**2**	**4,975**	**460**	**344,526**

Note 15.2 Property, plant and equipment - 2018/19

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

Note 15.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	25,720	130,273	9,099	19,874	-	7,121	386	192,473
Finance leased	-	-	-	510	-	-	-	510
On-SoFP PFI contracts and other service concession arrangements	-	184,066	-	-	-	-	-	184,066
Owned - donated	-	536	-	12	-	-	-	548
NBV total at 31 March 2020	**25,720**	**314,875**	**9,099**	**20,396**	**-**	**7,121**	**386**	**377,597**

Note 15.4 Property, plant and equipment financing - 2018/19

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

Note 16 Donations of property, plant and equipment

No donated assets were received during the year.

Note 17 Revaluations of property, plant and equipment

Note 17.1 Land and Buildings

Summary

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

Therefore, the Trust appointed Montagu Evans (ME), independent firm of professional valuers, to provide a report on the movement in building costs and land values during 2019/20 in order to update the fair value of land and buildings.

The valuation from ME is on an Modern Equivalent Asset (MEA) basis as at 28th February 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

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

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

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

Basis of valuations

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

- IVSC: International Valuation Standards 2017 – Market Value
- RICS: Valuation – Global Standards 2020 – Market Value (Valuation Performance Standard VPS4 – Bases of Value)
- RICS: Valuation – Global Standards 2017 – UK National Supplement (Valuation Practice Guidance – Applications – VPGA1: Valuation for Financial Reporting; VPGA6 Local Authority and Central Government Accounting: Existing Use Value (EUV) Basis of Value)
- RICS UK Guidance Note, Depreciated Replacement Cost Method of Valuation for Financial Reporting, 1st Edition.

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

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

Depreciated Replacement Cost (DRC) - Specialised Assets:

The RICS UK Guidance Note, Depreciated Replacement Cost Method of Valuation for Financial Reporting 1st Edition November 2018 sets out the definition of DRC as;

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

Valuations based on DRC are only to be used for valuing specialised property that is owner occupied for inclusion in financial statements.

ME have used DRC as the basis of valuation for the Lewisham and Queen Elizabeth Hospitals (excluding office space) and four health centres considered as specialised assets owner occupied by the Trust.

Existing Use Value (EUV) - Non Specialised Assets:

Existing Use Value is defined in the RICS Valuation – Global Standards – UK National Supplement UK VPGA 6;

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

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

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

Modern Equivalent Assets

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

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

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

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

There is also a location weighting applied to construction cost to reflect regional differences in build costs. These weightings are provided by BCIS. Weightings for the London Borough of Lewisham of 24% (2018/19: 17%) and Royal Borough of Greenwich 27% (2018/19: 20%) have been applied.

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

"Over the period since our last valuation we have seen a generally upward movement in build costs as they have continued their upward trajectory. At the present time, the BCIS is forecasting that there will be a continual, but steady, increase in build costs over the short to medium term with the falls in sterling, rising fuel and labour costs all having an adverse impact. This may increase more rapidly once the UK eventually leaves the EU."

Accounting outcomes	£000
The overall change in value from the valuation update was an increase	27,508
This gave rise to the following accounting changes:	
- Valuation increase / (decrease) charged to the revaluation reserve - Gross	10,345
- Valuation increase / (decrease) charged to the revaluation reserve - Accumulated Depn	15,503
Total charge to revaluation reserve	**25,848**
- Impairment losses	(1,970)
- Impairment reversals	3,630
Total revaluation	**27,508**

Note 18 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	1,924	1,332
Work In progress	-	-
Consumables	2,939	3,073
Energy	7	7
Other	-	-
Total inventories	**4,870**	**4,412**
Of which		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £56,492K (2018/19: £55,566K). Write-down of inventories recognised as expenses for the year were £186K (2018/19: £70K).

Note 19 Receivables

Note 19.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	44,917	44,742
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	(9,183)	(8,535)
Allowance for other impaired receivables	-	-
Prepayments (non-PFI)	29,052	6,995
PFI prepayments - capital contributions	-	-
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	162	827
VAT receivable	2,426	5,798
Other receivables	1,248	170
Total current trade and other receivables	**68,622**	**49,997**
Non-current		
Contract receivables	3,132	2,943
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	-	-
Allowance for other impaired receivables	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**3,132**	**2,943**
Of which receivables from NHS and DHSC group bodies:		
Current	30,684	35,704
Non-current	-	-

Note 19.2 Allowances for credit losses

	2019/20	
	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	**8,535**	**-**
New allowances arising	2,073	-
Changes in existing allowances	-	-
Reversals of allowances	-	-
Utilisation of allowances (write offs)	(1,425)	-
Changes arising following modification of contractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2019	**9,183**	**-**

	2018/19	
	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	**7,545**	**-**
New allowances arising	2,068	-
Changes in existing allowances	-	-
Reversals of allowances	-	-
Utilisation of allowances (write offs)	(1,078)	-
Changes arising following modification of contractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2019	**8,535**	**-**

Note 20 Cash and cash equivalents

Note 20.1 Cash and cash equivalents movements

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

	2019/20 £000	2018/19 £000
At 1 April	**2,064**	**8,532**
Net change in year	-	(6,468)
At 31 March	**2,064**	**2,064**
Broken down into:		
Cash at commercial banks and in hand	21	13
Cash with the Government Banking Service	2,043	2,051
Total cash and cash equivalents as in SoFP	**2,064**	**2,064**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**2,064**	**2,064**

Note 20.2 Third party assets held by the trust

Lewisham and Greenwich NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020 £000	31 March 2019 £000
Bank balances	23	19
Monies on deposit	-	-
Total third party assets	**23**	**19**

Note 21 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	26,174	24,289
Capital payables	7,852	3,741
Accruals	14,488	13,683
Receipts in advance and payments on account	-	-
PFI lifecycle replacement received in advance	-	-
Social security costs	-	4,456
VAT payables	-	-
Other taxes payable	-	146
PDC dividend payable	-	-
Other payables	1,028	862
Total current trade and other payables	**49,542**	**47,177**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	4,652	4,375
Non-current	-	-

Note 22 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	10,125	10,507
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Total other current liabilities	**10,125**	**10,507**
Non-current		
Deferred income: contract liabilities	507	557
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**507**	**557**

Note 23 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from DHSC	194,139	46,357
Other loans	250	-
Obligations under finance leases	182	182
Obligations under PFI, LIFT or other service concession contracts	4,596	4,596
Total current borrowings	**199,167**	**51,135**
Non-current		
Loans from DHSC	6,995	122,722
Other loans	2,250	1,000
Obligations under finance leases	278	461
Obligations under PFI, LIFT or other service concession contracts	93,534	98,130
Total non-current borrowings	**103,057**	**222,313**

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £194,139K are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

Note 23.1 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	**169,079**	**1,000**	**643**	**102,726**	**273,448**
Cash movements:					
Financing cash flows - payments and receipts of principal	31,939	1,500	(183)	(4,596)	28,660
Financing cash flows - payments of interest	(3,494)	-	(50)	(9,311)	(12,855)
Non-cash movements:					
Application of effective interest rate	3,610	-	50	9,311	12,971
Carrying value at 31 March 2020	**201,134**	**2,500**	**460**	**98,130**	**302,224**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2018/19

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

Note 24 Finance leases

Note 24.1 Lewisham and Greenwich NHS Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**460**	**835**
of which liabilities are due:		
- not later than one year;	182	233
- later than one year and not later than five years;	278	556
- later than five years.	-	46
Finance charges allocated to future periods	-	(192)
Net lease liabilities	**460**	**643**
of which payable:		
- not later than one year;	182	182
- later than one year and not later than five years;	278	461
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as expense in the period	-	-

Note 25 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Re-structuring £000	Other £000	Total £000
At 1 April 2019	**5,417**	**605**	**1,554**	**869**	**289**	**8,734**
Change in the discount rate	(27)	-	-	-	-	(27)
Arising during the year	323	-	1,327	-	1,216	2,866
Utilised during the year	(547)	(64)	(6)	(247)	(119)	(983)
Reversed unused	(52)	-	(327)	(622)	(158)	(1,159)
Unwinding of discount	252	(3)	-	-	2	251
At 31 March 2020	**5,366**	**538**	**2,548**	**-**	**1,230**	**9,682**
Expected timing of cash flows:						
- not later than one year;	540	65	2,548	-	1,149	4,302
- later than one year and not later than five years;	2,165	268	-	-	7	2,440
- later than five years.	2,661	205	-	-	74	2,940
Total	**5,366**	**538**	**2,548**	**-**	**1,230**	**9,682**

Early Departure Pensions costs of £5,366K relate to continuing contribution payments to the NHS Pensions Agency (NHSPA) for staff who retired early .
The calculation of the long-term liability in respect of future payments to the NHSPA is based on information provided by the NHS Pensions Agency and makes use of National Statistics (ONS) published life expectancy data. The provision is updated annually and changes made where notification is received of the death of a member and resulting cessation of any continuing liability or it becomes apparent that the provision is no longer sufficient to meet the liability.

NHS injury benefits relate to the cost of payments to people who sustained an injury or contracted a disease wholly or mainly due to their NHS employment .

Legal Claims of £2,548K are based on an assessment of all outstanding cases by solicitors acting on behalf of the Trust and other potential claims. The value of reported claims is based on an estimation of the probable liabilities arising from outstanding legal claims against the Trust at the year end; having taken professional legal advice and assessment by appropriate Trust directors of the likelihood of the successful defence of the relevant cases.

Restructuring costs of £869K relate to the re-organisation of management structures and processes across the Trust following the Leader Capacity Review and are specifically linked to the strategic / operational leadership and values based education programme designed to change how the Trust works. This provision has been fully utilised or reversed unused, with no balance carried forward.

Other Provisions of £1,230K include Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) claims handled by the NHS Litigation Authority totalling £74K and Clinican Pension Tax reimbursement for Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in this tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31 July 2021).

NHS provider organisations will need to create a provision broadly equal to the tax charge owed by clinicians who want to take advantage of the 2019/20 Commitment. This will be offset by the commitment from NHS England and the Government to fund the payments to clinicians as and when they arise.

Note 25.1 Clinical negligence liabilities

At 31 March 2020, £494,586K was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lewisham and Greenwich NHS Trust (31 March 2019: £481,228K).

Note 26 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(72)	(52)
Gross value of contingent liabilities	**(72)**	**(52)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(72)**	**(52)**
Net value of contingent assets	**-**	**-**

The contingent liability of £72K (£52K 2018/19) relates to employee and public liability claims handled by the NHS Litigation Authority.

Note 27 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
Property, plant and equipment	1,056	941
Intangible assets	707	218
Total	**1,763**	**1,159**

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

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**324,028**	**346,030**
Of which liabilities are due		
- not later than one year;	23,297	23,332
- later than one year and not later than five years;	100,621	98,386
- later than five years.	200,110	224,312
Finance charges allocated to future periods	(225,898)	(243,304)
Net PFI, LIFT or other service concession arrangement obligation	**98,130**	**102,726**
- not later than one year;	4,596	4,596
- later than one year and not later than five years;	24,473	22,613
- later than five years.	69,061	75,517

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

Queen Elizabeth Hospital building

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

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

In the February 2020, the Trust exercised a break in the soft FM element of the PFI contract, the soft FM services is no longer part of the PFI contract and therefore is not included in any future payments.

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

Riverside building

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

- Controls or regulates what services the operator must provide within the infrastructure, whom it must provide them to, and at what price.
- Controls (through ownership, beneficial entitlement or otherwise) any significant residual interest in the infrastructure at the end of the term of the arrangement.

Queen Elizabeth Hospital building	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**199,640**	**215,099**
Of which liabilities are due		
- not later than one year;	16,665	16,789
- later than one year and not later than five years;	73,735	71,427
- later than five years.	109,240	126,883
Finance charges allocated to future periods	(141,120)	(153,635)
Net PFI, LIFT or other service concession arrangement obligation	**58,520**	**61,464**
- not later than one year;	2,891	2,944
- later than one year and not later than five years;	17,366	15,506
- later than five years.	38,262	43,014

Riverside building	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**124,388**	**130,931**
Of which liabilities are due		
- not later than one year;	6,632	6,543
- later than one year and not later than five years;	26,886	26,959
- later than five years.	90,870	97,429
Finance charges allocated to future periods	(84,778)	(89,669)
Net PFI, LIFT or other service concession arrangement obligation	**39,610**	**41,262**
- not later than one year;	1,705	1,652
- later than one year and not later than five years;	7,107	7,107
- later than five years.	30,799	32,503

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**456,156**	**626,681**
Of which payments are due:		
- not later than one year;	31,710	41,033
- later than one year and not later than five years;	135,115	174,764
- later than five years.	289,331	410,884

Queen Elizabeth Hospital building	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**258,657**	**419,837**
Of which liabilities are due		
- not later than one year;	22,125	31,688
- later than one year and not later than five years;	94,175	134,873
- later than five years.	142,357	253,276

Riverside building	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**197,499**	**206,844**
Of which payments are due:		
- not later than one year;	9,585	9,345
- later than one year and not later than five years;	40,940	39,891
- later than five years.	146,974	157,608

Note 28.3 Analysis of amounts payable to service concession operator

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

	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**41,256**	**40,018**
Consisting of:		
- Interest charge	9,311	9,699
- Repayment of balance sheet obligation	4,596	3,974
- Service element and other charges to operating expenditure	17,808	17,650
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	9,541	8,695
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	8,182	7,412
Total amount paid to service concession operator	**49,438**	**47,430**

Queen Elizabeth Hospital building	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**31,912**	**30,915**
Consisting of:		
- Interest charge	6,927	7,219
- Repayment of balance sheet obligation	2,944	2,332
- Service element and other charges to operating expenditure	15,007	15,067
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	7,034	6,297
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	8,105	7,387
Total amount paid to service concession operator	**40,017**	**38,302**

Riverside building	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**9,344**	**9,103**
Consisting of:		
- Interest charge	2,384	2,480
- Repayment of balance sheet obligation	1,652	1,642
- Service element and other charges to operating expenditure	2,801	2,583
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	2,507	2,398
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	77	25
Total amount paid to service concession operator	**9,421**	**9,128**

Note 29 Financial instruments

Note 29.1 Financial risk management

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

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

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2020 is in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk

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

Interest rate risk

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Currency risk

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

Note 29.2 Carrying values of financial assets

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2020				
Trade and other receivables excluding non financial assets	40,114	-	-	40,114
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	2,064	-	-	2,064
Total at 31 March 2020	**42,178**	**-**	**-**	**42,178**

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

Reconciliation of Financial Instruments as in SoFP	2019/20		
	Current £000	Non Current £000	Total £000
Financial Instruments Receivables			
Contract receivables	44,917	3,132	48,049
Allowance for impaired contract receivables / assets	(9,183)	-	(9,183)
Other receivables	1,248	-	1,248
Total Receivables	**36,982**	**3,132**	**40,114**
Total cash and cash equivalents as in SoCF	2,064	-	2,064
Total Financial Instruments	**39,046**	**3,132**	**42,178**
Non-Financial Instruments Receivables			
Prepayments (non-PFI)	29,052	-	29,052
PDC dividend receivable	162	-	162
VAT receivable	2,426	-	2,426
Total Non-Financial Instruments	**31,640**	**-**	**31,640**
Total Receivables and cash and cash equivalents as in SoFP	**70,686**	**3,132**	**73,818**

Note 29.3 Carrying value of financial liabilities

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2020			
Loans from the Department of Health and Social Care	201,134	-	201,134
Obligations under finance leases	460	-	460
Obligations under PFI, LIFT and other service concession contracts	98,130	-	98,130
Other borrowings	2,500	-	2,500
Trade and other payables excluding non financial liabilities	49,542	-	49,542
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2020	**351,766**	**-**	**351,766**

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

Reconciliation of Financial Instruments as in SoFP	2019/20 Current £000	Non Current £000	Total £000
Financial Instruments Payables			
Trade payables	26,174	-	26,174
Capital payables	7,852	-	7,852
Accruals	14,488	-	14,488
Other payables	1,028	-	1,028
Total Payables	**49,542**	**-**	**49,542**
Loans from DHSC	194,139	6,995	201,134
Other loans	250	2,250	2,500
Obligations under finance leases	182	278	460
PFI lifecycle replacement received in advance	-	-	-
Obligations under PFI, LIFT or other service concession contracts	4,596	93,534	98,130
Total Borrowings	**199,167**	**103,057**	**302,224**
Total Financial Instruments	**248,709**	**103,057**	**351,766**

Note 29.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	248,709	94,210
In more than one year but not more than two years	13,863	124,704
In more than two years but not more than five years	15,616	14,979
In more than five years	73,578	82,130
Total	**351,766**	**316,023**

Note 30 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	560	1,425	394	1,078
Stores losses and damage to property	5	186	3	70
Total losses	**565**	**1,611**	**397**	**1,148**
Special payments				
Compensation under court order or legally binding arbitration award	14	6	13	5
Extra-contractual payments	-	-	-	-
Ex-gratia payments	39	9	21	11
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**53**	**15**	**34**	**16**
Total losses and special payments	**618**	**1,626**	**431**	**1,164**
Compensation payments received		-		-

Details of cases individually over £300k

There were no individual cases over £300K.

Note 31 Related parties

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

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

Details of related party transactions with individuals are as follows:

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

Entities are included based on the following criteria:

- CCG where a formal service level agreement was in place during the year
- NHS, Government Department or Local Authority where the transaction exceeds £250K

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

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

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

	2019/20 £	2018/19 £
Patient education and welfare	1,246	33,240
Staff education and welfare	37,491	20,289
New equipment	98,429	29,912
Governance	33,722	30,893
Grand Total	**170,888**	**114,334**

Note 32 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £194,139K as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 33 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 £000	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	75,988	362,332	83,147	335,151
Total non-NHS trade invoices paid within target	70,657	350,468	75,927	319,600
Percentage of non-NHS trade invoices paid within target	**93.0%**	**96.7%**	**91.3%**	**95.4%**
NHS Payables				
Total NHS trade invoices paid in the year	2,758	18,495	2,541	16,976
Total NHS trade invoices paid within target	2,170	14,317	1,846	12,147
Percentage of NHS trade invoices paid within target	**78.7%**	**77.4%**	**72.6%**	**71.6%**

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 34 External financing limit

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

SoCF	2019/20 £000	2018/19 £000
Net cash (gen from) / used in - Operations	(17,350)	(14,163)
Net cash gen from / (used in) - Investing Activities	29,122	29,956
Net cash gen from / (used in) - Financing Activities		
Less:		
Interest paid	3,496	2,954
Interest element of fin lease	50	50
Interest element of PFI	18,852	18,394
PDC dividend (paid)/refunded	1,934	2,927
Total	**36,104**	**40,118**
Cash flow financing	36,104	40,118
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**36,104**	**40,118**
External financing limit (EFL)	36,104	41,119
Under / (over) spend against EFL	**-**	**1,001**

Note 35 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	33,379	31,705
Less: Disposals	(51)	-
Charge against Capital Resource Limit	**33,328**	**31,705**
Capital Resource Limit	33,328	32,759
Under / (over) spend against CRL	**-**	**1,054**

Note 36 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(15,818)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2018/19 post-accounts PSF reallocation	807
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	8,591
Breakeven duty financial performance surplus / (deficit)	**(6,420)**

Note 37 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Breakeven duty in-year financial performance		6,753	1,058	1,427	1,750	242	(8,482)	(22,867)	(20,054)	(50,396)	(22,231)	(6,420)
Breakeven duty cumulative position	(9,337)	(2,584)	(1,526)	(99)	1,651	1,893	(6,589)	(29,456)	(49,510)	(99,906)	(122,137)	(128,557)
Operating income		188,109	222,366	229,184	241,470	382,097	517,522	518,947	539,242	543,854	574,541	626,423
Cumulative breakeven position as a percentage of operating income		**(1.4%)**	**(0.7%)**	**(0.0%)**	**0.7%**	**0.5%**	**(1.3%)**	**(5.7%)**	**(9.2%)**	**(18.4%)**	**(21.3%)**	**(20.5%)**

Glossary

Financial statements – glossary

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

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

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

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

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

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

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

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

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

Operating expenses

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

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

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

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

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

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

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

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

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

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

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

Revaluation – Depreciated Replacement Cost (DRC) is the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

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